Brochure of Coverage
Policy Form 9F149B-CL

Domestic Student Accident & Sickness Plan

a Non-Renewable Term Policy

Designed for

College of Saint Benedict

2011 • 2012

Administered by

www.sas-mn.com
333 N. Main St. • P.O. Box 196
Stillwater, MN 55082-0196

Underwritten by

COLUMBIAN LIFE
INSURANCE COMPANY
HOME OFFICE: CHICAGO, IL
ADMINISTRATIVE SERVICE OFFICE: VESTAL PARKWAY EAST
P.O. BOX 1381 • BINGHAMTON, NY 13902-1381

Form No. 3452-CL-11 MN

W-83MN

For assistance and questions about insurance benefits, ID cards, claim status, or claim processing contact the Plan Administrator:
Student Assurance Services, Inc.
Post Office Box 196 • Stillwater, MN 55082-0196
www.sas-mn.com
Phone: (800) 328-2739

Servicing Agent:
Candy Mears
Phone: (651) 439-7098
(800) 328-2739
FAX: (651) 439-0200
email: candym@sas-mn.com

Preferred Provider Directory or Questions
PreferredOne
Post Office Box 1527, Minneapolis, MN 55440-1527
Customer Service:
www.preferredone.com
Local (763) 847-4400
Toll-Free: (800) 451-9597
Hours: 8:00AM - 5:00PM

Policy Number:
22-64-0083-500-659-1

INTRODUCTION

The College is making available a plan of blanket accident and sickness insurance (hereinafter called "plan" or "Plan") underwritten by Columbian Life Insurance Company and administered by Student Assurance Services, Inc. This brochure provides a general summary of the insurance coverage. Keep this brochure as no individual policy will be issued. This summary is not a contract; however, the Master Policy is on file at the College or available for review by contacting Student Assurance Services, Inc. The Master Policy contains the contract provisions and shall prevail in the event of any conflict between this brochure and the Master Policy.

The insurance plan provides continuous protection, 24 hours a day, anywhere in the world during the period of coverage for which the proper premium has been paid. Coverage is not automatically renewed. Students must re-enroll when coverage terminates to maintain continuous coverage.

- The basic injury, basic sickness, and major medical maximum benefit is $75,000 for each covered injury or sickness.
- Basic benefits are subject to a $100 deductible for each covered injury or sickness.
- Major medical benefits are subject to $1,000 deductible for each covered injury or sickness.
- An option is available to purchase intercollegiate sports coverage with a maximum benefit of $90,000 for each covered sports injury.
- Repatriation and medical evacuation benefits providing 24-hour assistance services are included.
- A 24-hour nurse line program providing phone-based health information is included.
- To maximize savings and reduce out-of-pocket expenses, select a PreferredOne network provider. These providers have agreed to provide services at discounted rates.

STUDENT ELIGIBILITY

All students attending the College of Saint Benedict are eligible to enroll in the insurance plan.

Students are automatically enrolled in basic injury, basic sickness, and major medical benefits of the insurance plan at registration. The premium is added to the student's account. Optional intercollegiate sports coverage may be purchased on a voluntary basis.

Students may waive enrollment in the insurance plan if they have other comparable medical coverage. To waive coverage, the student must provide proof of coverage to the College by the waiver period deadline date of **September 18, 2011.** For new students registering for spring semester, the waiver period deadline is **January 31, 2012**. Students who initially waive coverage may not enroll in the insurance plan at a later date, unless they qualify for late enrollment.

Students age 65 or older, or online and distance learning students taking home study, correspondence, or television courses are not eligible to enroll in the insurance plan.

Students must be physically and actively attending classes on campus to enroll in the insurance plan. Except for medical withdrawal due to a covered injury or sickness, any student withdrawing from the College during the first 31 days after the effective date of coverage shall not be covered under the insurance plan. Students who graduate or withdraw from the College after 31 days, whether involuntarily or voluntarily, will remain covered under the insurance plan until coverage expires.

The Plan Administrator reserves the right to determine if the student has met the eligibility requirements. If the Plan Administrator later determines the eligibility requirements have not been met, its only obligation is to refund the premium.

PERIODS OF COVERAGE		
TERM	DATE COVERAGE BEGINS	DATE COVERAGE ENDS
ANNUAL	08-10-2011	08-09-2012
FALL	08-10-2011	12-31-2011
*SPRING	01-01-2012	08-09-2012
*SUMMER	06-01-2012	08-09-2012

*Spring or summer terms may be purchased by a new student not previously eligible to enroll for annual or fall coverage or a student who purchased fall coverage and wishes to continue coverage.

IMPORTANT: Enrollment forms and premium payments received after the enrollment period deadline date are not accepted except for new students and late enrollment.

2011-2012 PREMIUM SCHEDULE

	Annual	Fall	Spring
Student Only	$ 725.00	$ 277.00	$ 473.00
Student & 1 Dependent	$3,025.00	$ 1,105.00	$ 1,945.00
Student & 2 or more Dependents	$4,525.00	$ 1,645.00	$ 2,905.00

	Summer
Student Only	$ 179.00
Student & 1 Dependent	$ 685.00
Student & 2 or more Dependents	$1,015.00

***Optional Intercollegiate Sports Coverage**
$990.00 Per Athlete

Students must be enrolled in the basic injury and sickness benefits of the insurance plan in order to purchase optional intercollegiate sports coverage. Optional coverage will terminate when the accident and sickness insurance plan terminates.

COVERAGE FOR DEPENDENTS

Students who enroll in the insurance plan may also enroll their eligible dependents by the fall enrollment period deadline date **September 18, 2011.** Dependents of new student registering for Spring term the enrollment period deadline date is **January 31, 2012**. Enrollment forms and premium payments received after this date will only be accepted for dependents who qualify for late enrollment. Dependents must enroll when the student first enrolls in the insurance plan and must enroll for the same coverage as the student.

LATE ENROLLMENT

Students and dependents may enroll after the enrollment or waiver period deadline date only if there is a qualifying event. Qualifying events include involuntary loss of coverage under another health plan, marriage, and birth or adoption of a child. **Enrollment in the plan must be received no later than 30 days after the qualifying event.**

Students should notify the Plan Administrator immediately when eligible for late enrollment.

TO ENROLL FOR STUDENT COVERAGE

Students are automatically enrolled in basic injury, basic sickness, and major medical benefits of the insurance plan at registration. The premium is added to the student's account. Optional intercollegiate sports coverage may be purchased on a voluntary basis.

TO ENROLL FOR SPORTS AND DEPENDENT COVERAGE

Students who wish to enroll for optional intercollegiate sports coverage or dependent coverage may enroll any time prior to the coverage period through the end of the enrollment period deadline date.

1. Complete the enrollment form or download and print an enrollment form on the website **www.sas-mn.com.**
2. Print all information legibly and indicate the coverage and options desired.
3. Enclose a check or money order payable to College of Saint Benedict.
4. Send the form and payment to:

College of Saint Benedict
Student Accounts
37 College Ave. S.
St. Joseph, MN 56374

ID CARDS

An ID card will be mailed to the student's address on file approximately 2 weeks after the enrollment form and premium payment are received. Students do not need an ID card to be eligible to receive benefits under the Policy. For lost ID cards, request an ID card from the website **www.sas-mn.com.**

PREMIUM REFUND POLICY

A prorated refund will be issued only for the following situations:

- Students who withdraw from the College within the first 31 days following their effective date of coverage, unless medical benefits have been paid during the first 31 days; or
- Students who have entered into full-time active duty military service for any country; or
- Students who are non-immigrant foreign nationals who have permanently left the North American Continent.

All premium refund requests must be made in writing and include any proof and date of occurrence. Refund requests should be sent to:

Student Assurance Services, Inc.
P.O. Box 196
Stillwater, MN 55082-0196

Any refund provided is subject to a $25 administration fee.

EFFECTIVE AND EXPIRATION DATES OF COVERAGE

Student coverage becomes effective on the later of the following dates:

- The Master Policy effective date August 10, 2011, at 12:01 a.m.;
- The first day of the term for which the proper premium has been paid; or
- 12:01 a.m. following the date the proper premium is received by the College.

Student coverage will expire on the earliest of the following dates:

- The Master Policy expiration date August 09, 2012, at 11:59 p.m.; or
- When premium for the accident and sickness insurance coverage is due and unpaid.

Dependent coverage under the Policy becomes effective on the same date as the insured student for which the proper dependent premium payment is received. Coverage will not be effective prior to that of the insured student. Dependent coverage will expire on the date the student's coverage expires or the date the dependent no longer meets the definition of a dependent.

IMPORTANT: Coverage is not automatically renewed. Students are responsible for keeping the Policy in force.

CONTINUOUS COVERAGE

Coverage will be considered continuous, if the student was covered to the policy expiration date of the prior student health insurance policy of the policyholder, and the student enrolled for coverage under the Policy and paid the required premium within 31 days of the expiration date of the prior student health insurance policy.

The student will not be denied benefits under the Policy for a pre-existing condition or an injury or sickness covered under the prior student health insurance policy, unless under the Policy the injury or sickness expenses incurred are not considered a covered service, or benefits are limited by other provisions in the Policy. If the prior policy was administered by the Plan Administrator, benefits will not be paid under the Policy if any applicable lifetime maximum has been exhausted.

SCHEDULE OF BENEFITS

Basic Injury Maximum Benefit – each covered Injury .... $ 2,500
Basic Sickness Maximum Benefit – each covered Sickness .... $ 2,500
Basic Injury or Sickness Deductible – per person – each covered Injury or Sickness .... $ 100
Major Medical Maximum Benefit – each covered Injury or Sickness $75,000
Major Medical Deductible - per person – each covered Injury or Sickness $1,000
Optional Intercollegiate Sports Maximum Benefit - each covered Injury $90,000
Optional Intercollegiate Sports Deductible - each covered Injury $500

INJURY **- COVERED SERVICES AND BENEFIT LIMITS**	**Basic Injury Benefit**	**In-Network Major Medical Benefit**	**Out-of-Network Major Medical Benefit**
Outpatient Prescription Drugs 30-day supply per prescription; Refer to the Prescription Drug benefit in the Sickness schedule below for a description of benefits payable;	As Described	75%	60%
Dental Treatment Does not include biting or chewing injuries; Benefit is payable up to maximum $300	100%	No Benefit	No Benefit
Motor Vehicle Injury	Same as any Injury	No Benefit	No Benefit
Other Injury Covered Services: Hospital Inpatient Room and Board; Hospital Inpatient Miscellaneous; Hospital Outpatient Surgical Miscellaneous; Hospital Emergency Room; Surgical Treatment; Assistant Surgeon; Anesthesia; Consultant Physician; Physician Outpatient and Inpatient Non-Surgical Visits; Outpatient X-ray and Lab Services; Ambulance Services; Private Duty Nurse; Shots and Injections; Orthopedic Appliances	100%	75%	60%

SICKNESS **- COVERED SERVICES AND BENEFIT LIMITS**	**Basic Sickness Benefit**	**In-Network Major Medical Benefit**	**Out-of-Network Major Medical Benefit**
Hospital Inpatient Room & Board Benefit is payable up to maximum $300 per day	100%	75%	60%
Hospital Intensive Care Benefit is payable up maximum $300 per day	100%	75%	60%
Hospital Inpatient Miscellaneous Benefit is payable up to maximum $1,000	100%	75%	60%
Hospital Outpatient Surgical Miscellaneous Benefit is payable up to maximum $1,000	100%	75%	60%
Surgical Treatment (Inpatient or Outpatient) Benefit is payable up to maximum $1,000	100%	75%	60%
Assistant Surgeon	20% of Surgical Treatment Benefit	75%	60%
Anesthesia	20% of Surgical Treatment Benefit	75%	60%
Consultant Physician When requested by attending Physician; Benefit is payable up to a maximum $50	100%	75%	60%
Physician's Inpatient Non-Surgical Visits 1 visit per day; not paid same day as surgery; Benefit is payable $50 per visit, 30 visit maximum	100%	75%	60%
Physician's Outpatient Non-Surgical Visits 1 visit per day; Not paid same day as surgery; Benefit is payable $50 per visit, 10 visit maximum	100%	75%	60%
Physiotherapy (Outpatient) Benefit is payable under Physician Non-Surgical Visits	100%	75%	60%
Inpatient Pathology and Radiology Services Benefit is payable under Hospital Inpatient Miscellaneous	100%	75%	60%
Outpatient Diagnostic X-ray and Lab Services Benefit is payable up to maximum $500	100%	75%	60%
Outpatient Hospital Emergency Room Services Benefit is payable up to maximum $300; after $100 copay per visit; copay is waived if admitted	100%	75%	60%
Ambulance Services Benefit for ground service only; Benefit is payable up to maximum $100	100%	75%	60%
Orthopedic Appliances	No Benefit	75%	60%
Outpatient Prescription Drugs 30-day supply per prescription; When provided by CSB Healthcenter: Benefit is payable at 100% charges incurred Off-Campus Pharmacy: Benefit is payable at 80% up to maximum $500, after $10 copay per Generic Drug or $25 copay per Brand Drug; see page 26	As Described	75%	60%
Private Duty Nurse Benefit is payable under Hospital Inpatient Miscellaneous	100%	75%	60%
Shots and Injections Benefit is payable under Physician Outpatient Non-Surgical Visits	100%	75%	60%
Chemotherapy and Radiation Therapy	No Benefit	75%	60%
Maternity Benefit	Same as any Sickness	75%	60%
Mental and Nervous Disorders Inpatient - Benefits are payable the same as any Sickness Outpatient – Benefits are payable the same as any sickness, except visits are paid as follows: 80% for the first 10 hours; then 75% next 30 hours; payable up to maximum 40 hours in any 12 month benefit period.	As Described	No Benefit	No Benefit
Substance Abuse Treatment Refer to Mandated Benefits for description of benefits payable	see page 15	see page 15	see page 15
Smoking Cessation Benefit is payable up to policy year maximum $100	100%	No Benefit	No Benefit
Wellness Benefit Benefit is payable up to policy year maximum $100; One annual exam when provided by CSB Health Center	100%	No Benefit	No Benefit

MAJOR MEDICAL BENEFIT

Benefits are payable under the Basic Injury or Sickness Schedule of Benefits first, until the $2,500 basic maximum has been paid or the basic benefit-limit for the specific covered service has been paid for each covered injury or sickness. After the basic maximum has been satisfied, benefits are then payable under the Major Medical benefit. Benefits are subject to $1,000 major medical deductible for each covered injury or sickness. When services are provided by preferred provider, benefits are payable at 75% of the in-network negotiated fee. When services are provided by non-preferred provider, benefits are payable at 60% of the usual and customary charges incurred. Benefits are payable up to a $75,000 maximum benefit for each covered injury or sickness. This maximum includes the benefits payable under Basic Injury, Basic Sickness, and Major Medical. The following services are not payable under this benefit: mental and nervous disorders; substance abuse in excess of mandated benefits; motor vehicle injuries; dental treatment; intercollegiate sports injuries; smoking cessation treatment; or wellness benefit.

OTHER SCHEDULED BENEFITS

OPTIONAL INTERCOLLEGIATE SPORTS

If this coverage is purchased, benefits are payable up to maximum benefit of $90,000 for each covered intercollegiate sports injury. Benefits are subject to $500 deductible for each injury. When services are provided by a preferred provider, benefits are payable at 75% of the in-network negotiated fee. When services are provided by a non-preferred provider, benefits are payable at 60% of the usual and customary charges incurred. This maximum is separate and does not include benefits payable under Basic Injury or Basic Sickness benefit.

*STUDENT HEALTH CENTER

Covered services received at the CSB Health Center will be payable at 100% of charges incurred and the deductible will not apply. Students are strongly encouraged to use the services of CSB Health Center first. If the Student Health Center does not provide the care needed, they can provide the student with information to make informed health care decisions. The Student Health Center is located on the college campus.

BENEFITS MANDATED BY THE STATE OF MINNESOTA

The Policy pays benefits in accordance with any applicable Minnesota law. Description of these state mandated benefits can be found on pages 14-17. Benefits may be subject to deductibles, coinsurance, limitations, or exclusions.

ADDITIONAL PROGRAMS

***GLOBAL EMERGENCY SERVICES (Travel Assistance)** .... see page 20-21

****ASK MAYO CLINIC* (Nurse Line**) .... see page 21

***Note: These additional programs are not affiliated or underwritten by Columbian Life Insurance Company, but provided by independent vendors and are included if students participate in the insurance plan.**

EXPLANATION OF BENEFITS

BENEFIT PAYMENTS

Benefits are payable only for expenses incurred during the policy benefit period. No benefits are payable for expenses incurred prior to or after the insured's effective or expiration dates respectively. The Policy does not provide benefits for services that are not listed in the Schedule of Benefits.

Medical expenses under basic injury or sickness benefits are payable for the usual and customary charges as determined by the Policy, less any deductible or copay. Basic injury or sickness benefits are payable as described in the Schedule of Benefits whether a preferred provider is used or not. Benefits will be payable up to the policy year maximum for each covered injury or sickness. In addition to the policy year maximum, the Policy may contain benefit-level maximums for a covered service, as outlined in the Schedule of Benefits.

Medical expenses under Major Medical or Optional Intercollegiate benefits are payable at the in-network co-insurance for the negotiated fee or the out-of-network coinsurance for the usual and customary charges as outlined in the Schedule of Benefits.

PRE-CERTIFICATIONS AND REFERRALS

The insurance plan does not require pre-certification or referrals for any covered service prior to the date the service is performed. Covered services will be evaluated for benefits when the claim is submitted to the Plan Administrator for payment. A verbal explanation of benefits does not guarantee payment of claims.

CO-INSURANCE, COPAY, DEDUCTIBLE

Covered services are subject to co-insurance, copay, and deductible as described below.

Co-insurance is the percentage of covered expenses the Policy pays, after the deductible or copay is satisfied. Refer to the Schedule of Benefits for the amount.

Copay is the amount the insured must pay to the physician or hospital for each procedure, office visit, or confinement each time the insured receives a covered service. The prescription drug copay is not paid at the pharmacy, but rather is subtracted from benefits when a claim is submitted by the insured for payment.

Deductible is the amount subtracted from eligible expenses before benefits are considered. Each insured must satisfy the deductible.

HOSPITAL EXPENSES

The following medically necessary hospital expenses are payable, not to exceed any benefit limits listed in the Schedule of Benefit:

1. **Hospital Room and Board**: Benefits are payable for the daily semi-private room rate when hospital confined. The room rate includes an allowance for general nursing care provided for and charged by the hospital.
2. **Hospital Miscellaneous (Inpatient)**: Benefits are payable for services and supplies when hospital confined, including but not limited to: the cost of the operating room; laboratory tests; x-ray examinations; anesthesia; drugs (excluding take-home drugs) or medicines; therapeutic services; and supplies. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.
3. **Hospital Outpatient Surgical Miscellaneous**: Benefits are payable for facility expenses (when not hospital confined) for scheduled day surgery at an outpatient surgical care unit or licensed outpatient surgical center. Benefits for services and supplies include but are not limited to: the cost of the operating room; laboratory tests; x-ray examinations; anesthesia; drugs (excluding take-home drugs) or medicines; therapeutic services; and supplies.
4. **Hospital Emergency Room Services (Outpatient)**: Benefits are payable for necessary emergency treatment provided in an urgent care facility, clinic, an observation room, or other room designated by the hospital.

SURGICAL EXPENSES

The following medically necessary surgical related expenses are payable, not to exceed the benefit limits in the Schedule of Benefits:

1. **Surgical Treatment**: Eligible surgery procedures are those procedures identified in the surgery section of the Physicians' Current Procedural Terminology (CPT). Benefits are payable whether surgery is performed in or out of a hospital. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid for the subsequent procedure will not exceed 50% of the usual and customary charges for the subsequent procedure.
2. **Assistant Surgeon**: Benefits are payable when necessary and required by the attending physician.
3. **Anesthesia**: Benefits are payable for the administration of anesthesia when performed by a physician and certified registered nurse anesthetist, including drugs and supplies used in connection with the surgery or covered test or procedure.

PHYSICIAN EXPENSES

The following medically necessary physician visit related expenses are payable, not to exceed the benefit limits in the Schedule of Benefits:

1. **Physician's Non-Surgical Visits (Inpatient):** Benefits are limited to one visit per day and include physician's evaluation and management services as identified in Physicians' Current Procedural Terminology (CPT). Benefits are not paid for a visit on the same day as surgery. Covered visits will be paid under the inpatient benefit or under the outpatient benefit, but not both on the same day.
2. **Physician's Non-Surgical Visits (Outpatient):** Benefits are limited to one visit per day and include the physician's evaluation and management services as identified in Physicians' Current Procedural Terminology (CPT). Benefit includes any ancillary supplies received during the visit, except as specifically provided in the Schedule of Benefits. Benefits are not paid for a visit on the same day as surgery. Covered visits will be paid under the inpatient benefit or under the outpatient benefit, but not both on the same day.
3. **Consultant Physician:** Benefits are payable if requested and approved by the attending physician.

OTHER OUTPATIENT MEDICAL EXPENSES

The following medically necessary surgical or nonsurgical related expenses are payable, not to exceed the benefit limits in the Schedule of Benefits:

1. **Outpatient Diagnostic X-ray, Radiology, and Lab Services:** Benefits are payable for diagnostic x-rays and radiology services as identified in Physicians' Current Procedural Terminology (CPT) as codes 70000 - 79999 inclusive. Laboratory procedures are those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 80000 - 89999 inclusive. Benefits include radiologist fees, charges for reading, and pathologist fees.
2. **Ambulance Services:** Benefits are payable for professional ground ambulance service, except as specifically listed in the Schedule of Benefits
3. **Physiotherapy:** Benefits are payable for any form of therapeutic or manual treatment by an eligible provider, including but not limited to: physical or mechanical therapy; diathermy; ultrasonic treatment; EMS; whirlpool; heat treatments; or manipulation. All treatments received during one visit will be subject to the benefit limit shown on the Schedule of Benefits.
4. **Orthopedic Appliances:** Benefits are payable for any supportive appliance or device that: (i) is prescribed by a physician; (ii) is primarily and customarily used to serve a medical purpose; (iii) can withstand repeated use; (iv) generally is not useful to a person in the absence of injury or sickness; and (v) is used exclusively by the insured. Replacement braces and appliances are not covered. No benefits will be paid for rental charges in excess of purchase price. A written prescription must accompany the claim when submitted.
5. **Prescription Drugs:** Benefits are payable for the cost of the drug obtained from a licensed pharmacy. Does not include charges for the injection or administration of the drug. Benefits are limited to a 30-day supply for each covered prescription drug. A claim must be submitted for reimbursement, see page 26 for more information.
6. **Dental Treatment:** Benefits are payable for dentist's fees for surgery, x-rays, or dental services related to an accidental injury to sound, natural teeth, including replacement of the injured natural teeth. Benefits do not include tooth fracture due to biting or chewing. Treatment must be completed within the policy period.

MATERNITY EXPENSES

Benefits are payable for an insured's covered services for maternity care, including hospital, surgical, and medical expenses. Maternity expenses are paid the same as covered expenses for any other sickness. Benefits paid are shown in the Schedule of Benefits.

Covered medical expenses include: physician visits; diagnostic services; obstetrical /surgical procedures; hospital room and board; and hospital miscellaneous; and medically necessary routine screening examinations and testing as established as the standard of care by the American College of Obstetricians and Gynecologists. Routine screening and testing includes: pregnancy test; alpha-fetoprotein; antibody screening; blood group and Rh type; one pap smear; gestational diabetes screening; hemoglobin; or hematocrit; hepatitis B screening; HIV screening; one ultrasound; rubella antibody measurement; syphilis screening; urinalysis; one amniocentesis for women over age 35; and genetic testing when there is family history of genetic disorders in a parent or a sibling.

PRE-EXISTING CONDITION

The Policy does not cover any condition that is diagnosed, treated, or recommended for treatment within the 12 months immediately prior to insured's effective date of coverage.

A pre-existing condition is subject to a 12-month pre-existing condition waiting period. During this waiting period, the insured must be continuously covered under the Policy for 12 consecutive months. The pre-existing condition waiting period must expire before benefits for a pre-existing condition will be considered for payment

under the Policy. If any break in continuous coverage occurs, the pre-existing condition exclusion will apply.

Provisions that Reduce or Eliminate the Pre-existing Condition Waiting Period:

- If an insured had 12 months of continuous coverage under the prior student health plan, the injury or sickness that began during the prior year of coverage will not be considered a pre-existing condition.
- The pre-existing condition waiting period will be reduced by the period of time an insured was covered by prior creditable coverage, if such coverage was continuous (no break in coverage for 63 or more days to a date immediately prior to the effective date of coverage under the Policy). Proof of prior creditable coverage must be provided by submitting a certificate of prior coverage from the prior medical plan or other satisfactory evidence of coverage.

Prior creditable coverage means the prior student health insurance policy of the policyholder or other medical coverage provided in the United States under any of the following: a group health plan; health insurance coverage under any hospital or medical service policy or certificate; hospital or medical service plan contract; or health maintenance organization contract; Medicare; Medicaid; military health care; a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; the federal employee health benefits program; a public health plan; or a health benefit plan of the Peace Corps.

Prior creditable coverage does not include prior coverage before a break in coverage. A break in coverage occurs when an individual does not have health coverage for 63 or more continuous days.

BENEFITS MANDATED BY STATE OF MINNESOTA

The Policy shall pay benefits in accordance with the following summary of Minnesota mandated benefits. Benefits shall be subject to deductibles, copays, co-insurance, limitations, and any other provisions of the Policy, unless stated otherwise under the specific coverage provision listed below.

Reconstruction Surgery

Coverage for reconstruction surgery shall be provided if:

1) the service is incidental to or follows surgery resulting from injury, sickness, or other diseases of the involved part; or
2) the service is performed on a covered dependent child because of congenital disease or anomaly that has resulted in a functional defect as determined by the attending physician.

Coverage for reconstructive breast surgery shall be provided if the mastectomy is medically necessary as determined by the attending physician. Reconstructive surgery includes: all stages of reconstruction to the breast that the mastectomy was performed; surgery to the other breast to produce symmetrical appearance; prosthesis; and physical complications at all stages of the mastectomy, including lymphedema. Coverage will be subject to policy deductible, copay, and co-insurance provisions.

Treatment for Alcoholism, Chemical Dependency, or Drug Addiction

Treatment of alcoholism, chemical dependency, or drug addiction shall be payable on the same basis as coverage for other benefits. When treatment is rendered in a licensed hospital, or residential treatment program licensed by the state of Minnesota benefits are payable up to a maximum of 73 days in any one 12-month policy year. When treatment is rendered in a nonresidential treatment program benefits are payable up to a maximum of 130 hours of treatment in any one 12-month policy year.

Treatment for Temporomandibular Joint Disorder and Craniomandibular Disorder

Surgical and nonsurgical treatment of temporomandibular joint disorder and craniomandibular disorder shall be payable on the same basis as treatment to any other joint in the body. Benefits are payable for treatment administered or prescribed by a physician or dentist.

Treatment for Phenylketonuria

Benefits for special dietary treatment for Phenylketonuria, when recommended by a physician, shall be covered on the same basis as any other sickness.

Scalp Prosthesis

Benefits for necessary scalp prosthesis expenses shall be payable for hair loss suffered as a result of alopecia areata. Benefits are limited to a maximum of $350 in any policy benefit period. Benefits are subject to any policy copay requirement. Policy deductible is not applied to this benefit.

Child Health Supervision Services and Prenatal Care Services

Benefits are payable for the usual and customary charges incurred for child health supervision services and prenatal care services. Benefits are limited to one visit payable to one provider for all of the services covered under this provision. Benefits are not subject to policy deductible, copay, co-insurance, or dollar limitation requirements.

Child health supervision services means pediatric preventative services, developmental assessments, and laboratory services appropriate to the age of a child from birth to age six and appropriate immunizations from age six to age 18. Benefits will be limited to the following schedule: Birth to 12 months - 5 visits; 12 months to 24 months - 3 visits; 24 months to 72 months - 1 visit per year.

Prenatal care services means the comprehensive package of medical and psychosocial support provided throughout the pregnancy, including risk assessment, serial surveillance, prenatal education, and use of specialized skills and technology, when needed.

Treatment for Cleft Lip and Palate
Benefits are payable for inpatient and outpatient expenses for cleft lip and palate, including orthodontic and oral surgery treatment, up to age of 25. Benefits for dependent children age 19 up to age 25 are limited to medical and dental treatment that was scheduled or initiated prior to the dependent child turning age 19. This benefit will be coordinated with, and paid secondary to, any applicable group dental coverage that covers orthodontic services. Payment for dental or orthodontic treatment not related to the management of cleft lip and palate shall not be covered under this benefit.

Private Duty Nurse to Ventilator-Dependent Person
To the extent benefits are provided under the Policy for private duty nursing to a ventilator-dependent person in the person's home, benefits are payable for up to 120 hours of services provided by a private duty nurse to the ventilator-dependent person during the time the person is in a hospital. Benefits are limited to communicator or interpreter services for the ventilator-dependent patient during a transition period of up to 120 hours to assure adequate training of the hospital staff to communicate with the patient and to understand the unique comfort, safety, and personal care needs of the patient.

Complications Caused by Breast Implants
Benefits will be payable for necessary treatment for medical conditions and complications caused by breast implants.

Routine Screening Procedures for Cancer
Benefits are payable for routine screening procedures for cancer. This includes mammograms and pap smears ordered or provided by a physician in accordance with the standard practice of medicine.

Benefits will be payable for prostate cancer screening for men 40 years of age or over who are symptomatic or in a high-risk category and for all men 50 years of age or older. The screening must consist at a minimum of a prostate-specific antigen test (PSAT) and a digital rectal examination. Benefits are subject to any deductible, co-insurance, copay, or other limitation applicable to any other coverage under the Policy.

Prescription Drugs
Benefits are payable for prescription antipsychotic drugs prescribed to treat emotional disturbance or mental illness.

Benefits are payable for the off-label use of a drug prescribed for the treatment of a cancer, if the drug is recognized for the treatment of cancer in one of the standard reference compendia or in one article in medical literature. Benefits for the drug include coverage for medically necessary services directly related to, and required for, appropriate administration of the drug. Benefits are paid on the same basis as any other drug as listed in the policy's Schedule of Benefits.

Off-label use of drugs means when drugs are prescribed for treatments other than those stated in the labeling approved by the Federal Food and Drug Administration (FDA).

Benefits will not be paid for any experimental or non-FDA approved drug, or any drug that the FDA has determined to be contraindicated for treatment of a specific type of cancer for which the drug has been prescribed.

EXCLUSIONS

The Policy does not provide benefits for expenses resulting from:

1. Air flight, except as a fare-paying passenger on a regularly scheduled flight of a commercial airline.
2. Dental treatment, except as specifically provided in the Schedule of Benefits.
3. Treatment where no injury or sickness is involved (physical examinations or preventive medicines), except as specifically provided in the Schedule of Benefits; or elective surgery and elective treatment; or abortion. It does not include cosmetic surgery made necessary by injury. Non-medical self-care or self-help training; health or fitness club memberships; personal comfort or convenience items; treatment for hirsutism, hair growth or baldness.
4. Motor vehicle accidents, to the extent covered by another valid and collectible insurance policy, prepaid services contract, or similar plan. The motor vehicle injury benefit limit is shown on the Schedule of Benefits.
5. Eyeglasses, contact lenses, and examination for prescribing or fitting them; any other procedure for correction of refractive disorder of the eye or eyes; hearing aids and hearing examinations; durable medical equipment; treatment for foot care including care of flat feet, corns, calluses, bunions, weak feet, chronic foot strain, and supportive foot devices.

6. Injury or sickness for which benefits are paid under Worker's Compensation or Occupational Disease Act or Law.
7. Contraceptive drugs and devices; growth hormone therapy; patient controlled analgesia; allergy treatment.
8. Injury sustained while participating in the practice or play of interscholastic sports or intercollegiate sports, including the participation in any practice or conditioning program for such sport, contest or competition, except as specifically provided in the Schedule of Benefits.
9. Loss incurred while committing or attempting to commit a felony; loss incurred from violating or attempting to violate any existing city, state, or federal law; loss due to voluntary participation in a riot or civil disturbance; injuries caused by or contributed to or resulting from the use of hallucinogenics, illegal drugs, or any drugs and medicines that are not taken in the dosage or for the purpose prescribed by the insured's physician.
10. Routine newborn baby care, well baby nursery and related physician's charges.
11. Services provided normally without charge by the health service of the policyholder; or by any person employed or retained by the policyholder; or services covered or provided by the student health fee.
12. Use of any services or supplies which are experimental and/or not in accord with generally accepted standards of medical practice; organ transplants, including donor's expenses; services, supplies and/or treatment for acupuncture.
13. War or act of war, whether declared or not; and injury or sickness resulting from full-time, active-duty military service.
14. Pre-existing conditions, not subject to credit for prior coverage, until continuously covered by the policyholder's student accident and sickness Insurance plan for a period of 12 consecutive months.
15. Sleep disorders, supplies and treatment or testing related to sleep disorders.
16. Weight management services and supplies related to weight reduction programs, weight management programs and related nutritional supplies; treatment of obesity; surgery for the removal of excess skin or fat, for weight reduction or treatment of obesity.

ADDITIONAL PROGRAMS
(These programs are not underwritten by Columbian Life Insurance Company)

PREFERRED PROVIDER NETWORK

Persons insured under the plan may choose to be treated within, or out of, the PreferredOne provider network. The PreferredOne provider network consists of hospitals, doctors, and other health care providers, that are organized into a network for the purpose of delivering quality health care at a negotiated fee. If medical treatment is obtained from a PreferredOne provider, a higher reimbursement will be received toward the insured's covered medical expenses.

Under the major medical or optional intercollegiate sports benefit, when an insured uses the services of a PreferredOne provider, the covered expenses are payable at the in-network co-insurance for the negotiated fees. When treatment is received by a non-preferred provider, covered expenses are payable at the out-of-network co-insurance for the the usual and customary charges incurred. Co-insurance for in-network and out-of-network can be found on the Schedule of Benefits on page 8.

Exception: Benefits will be paid at the in-network co-insurance level for services provided by a non-preferred provider when: 1) the insured cannot reasonably obtain the services of a PreferredOne provider due to an emergency medical condition; 2) the insured is referred to a non-preferred provider by an in-network PreferredOne provider.

The insured is not responsible for the difference between the PreferredOne provider's usual billed charges and the preferred provider negotiated fees. The insured is responsible for any differences due to deductibles, co-insurance, copays, benefit limitations, and exclusions.

In order to use the services of a PreferredOne provider, the insured must present the student accident and sickness Insurance ID card.

A complete listing of PreferredOne providers is available on the website: www.preferredone.com or by calling toll free (800) 451-9597. The participation of individual providers is subject to change without notice. It is the insured's responsibility to confirm a PreferredOne provider's participation when calling for an appointment or at time of visit.

GLOBAL EMERGENCY SERVICES PROGRAM (TRAVEL ASSISTANCE)

Students who enroll and maintain medical coverage in this insurance plan are eligible for the global emergency services program administered by Scholastic Emergency Services (SES), an Assist America partner. This program provides 24-hour assistance services whenever the student is traveling more than 100 miles away from home, school, or abroad. International students studying in the United States are eligible for services both on and away from campus or while traveling in a country that is not their country of origin.

All assistance services must be arranged and provided by SES; no claims will be accepted for assistance services arranged or provided by anyone other than SES.

Note: This program does not replace medical insurance. All claims for medical expenses should be submitted to the Plan Administrator for consideration. The SES program meets or exceeds the requirements of USIA for international students and scholars. The following services are provided:

1. Medical Consultation, Evaluation & Referral - Calls to the Operations Center are evaluated by medical personnel and referred to the appropriate provider.
2. Foreign Hospital Admission Guarantee - SES will guarantee hospital admission outside the United States by validating a student's health coverage or by advancing funds to the hospital. (Any emergency hospital admittance deposit must be repaid within 45 days.)
3. Emergency Medical Evacuation - If adequate medical facilities are not available locally, SES will use whatever mode of transportation, equipment and personnel necessary to evacuate the student or family member to the nearest facility capable of providing a high standard of care.
4. Medical Monitoring - SES medical personnel will maintain regular communication with the attending physician and/or hospital and relay information to student's family.
5. Medical Repatriation - If a student still requires medical assistance upon being discharged from a hospital, SES will repatriate him/her to a rehabilitation facility or home, and if necessary will provide a medical or non-medical escort.
6. Prescription Assistance - If a member needs a replacement prescription while traveling, SES will help in filling that prescription.
7. Compassionate Visit - When traveling alone and hospitalized for more than 7 days, economy, round trip, common carrier transportation to the place of hospitalization will be provided for a designated family member or friend.
8. Care of Minor Children - SES will arrange for the care of children left unattended as the result of a medical emergency and pay for any transportation costs involved in such arrangements.

9. Return of Mortal Remains - SES will assist with the logistics of returning a member's remains home in the event of his or her death. This service includes arranging the preparation of the remains for transport, procuring required legal documentation, providing the necessary shipping container as well as paying for transport.
10. Legal Referrals - Referrals for interpreters or legal personnel are available.
11. Emergency Trauma Counseling - SES will provide initial telephone-based counseling and referrals to qualified counselors as needed or requested.
12. Lost Luggage or Document Assistance - SES will help members locate lost luggage, documents or personal belongings.
13. Pre-trip Information - SES offers members web-based country profiles that include visa requirements, vaccinations recommendations as well as security advisories for any travel destination.

For assistance call SES Operations Center toll free inside the U.S. (877) 488-9833 or outside the U.S. (609) 452-8570 or email medservices@assistamerica.com.

ASK MAYO CLINIC

Students who enroll and maintain medical coverage in the insurance plan have access to a 24-hour nurse line administered by *Ask Mayo Clinic.* This program provides:

- Phone-based, reliable health information in response to health concerns and questions; and
- Assistance in decisions on the appropriate level of care for an injury or sickness. Appropriate care may include self-care at home, a call to a physician, or a visit to the emergency room.

Calls are answered 24-hours a day, 365 days a year by experienced registered nurses who have been specifically trained to handle telephone health inquiries. This program is not a substitute for doctor visits or emergency response systems. *Ask Mayo Clinic* does not answer health plan benefit questions. Health benefit questions should be referred to the Plan Administrator. The *Ask Mayo Clinic* 24-hour nurse line toll free number will be on the ID card.

MASTER POLICY DEFINITIONS

The brochure may contain any or all of the following definitions:

Accident means an unexpected, external, and sudden event that is independent of any other cause.

Benefit (Benefits) means the amount of eligible expense payable by the Policy.

Covered Services means services and supplies which are medically necessary, prescribed or performed by a physician or hospital, not excluded, and named in the policy's Schedule of Benefits.

Dependent means the insured student's spouse; or domestic partner; or unmarried child (including step-children if dependent on the insured student); or dependent grandchildren of the insured student residing with the insured student; under the age of twenty-five (25) years who is not self-supporting, or a child over the age of 25 and who is incapable of self-sustaining employment because of mental retardation, mental illness or disorder, or physical handicap, and is chiefly dependent upon the insured student for maintenance and support. Proof of a dependent's incapacity or dependence shall be furnished to us within 31 days of a child's attainment of the limiting age. We may request subsequent proof of incapacity or dependency no more than once every year after the two-year period following the child's attainment of the limiting age. The insured student must provide proof that a child continues to be handicapped.

Newborn children of the insured student or covered single dependent will be covered from birth. Coverage shall be provided for illness, injury, congenital malformation, or premature birth. Notice of such birth is not required. However, if additional premium is required for dependent children, we are entitled to such additional premium that would have been collected had we been aware of the additional dependent. We may reduce any benefit owed to the insured student by the amount of past due premiums applicable to the additional dependent.

Children for whom the insured student has a legal obligation for the purposes of adoption will be covered effective from the date the legal obligation begins. Coverage will continue until the legal obligation for the purposes of adoption ends, or the policy expiration date, whichever occurs first.

Domestic Partner means a person who meets at least three of the following five conditions: (a) the person resides with the insured student; (b) the person and insured student hold common or joint ownership of the residence or of the lease for the residence; (c) the person and insured student have joint ownership of a motor vehicle; (d) the person and insured student have a joint checking account; and/or (e) the person must be designated as a beneficiary under the insured student's life insurance coverage, and/or identified as a primary beneficiary in the insured student's will. To obtain coverage as a domestic partner, the insured student and domestic partner must submit a written "Affidavit of Domestic Partnership" to the Plan Administrator. In the Affidavit, the insured student and domestic partner must attest that they are each other's sole domestic partner and that they have agreed to be responsible for their common welfare. They must also indicate which three of the five qualifying conditions have been met.

Elective Surgery and Elective Treatment means surgery or medical treatment which is not necessitated by a pathological change occurring after your effective date of coverage or not covered under the Policy. Elective surgery and treatment includes, but is not limited to: tubal ligation; circumcision; vasectomy; breast reduction; sexual reassignment surgery; any services or supplies rendered for the purpose or with the intent of inducing conception; cosmetic procedures; submucous resection and/or other surgical correction for deviated nasal septum; allergy testing; treatment for acne; biofeedback-type services; infertility; hypnotherapy; learning disabilities; and weight management services.

This does not include: reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection, or other diseases of the involved part; and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.

Experimental and Investigational means any treatment, procedure, drug, or device which (a) cannot be lawfully marketed without approval of the Federal Food and Drug Administration; (b) is determined to be experimental, investigational, or for research purposes based on the informed consent document or the written protocols used by the treating physician, hospital, or facility; (c) is subject to ongoing Phase 1 or Phase 2 clinical trials; (d) reliable evidence shows the prevailing opinion among experts is that further studies or clinical trials are necessary; and (e) the outcomes data published in peer-reviewed medical and scientific literature is insufficient to substantiate its safety and effectiveness as compared with the standard means of treatment for the injury or sickness. In making these determinations, the Plan Administrator will obtain an external evaluation by an appropriately licensed or qualified professional who will review the claim and any additional information provided for review.

Hospital means an institution duly licensed as a hospital in the state in which it is located and operating within the scope of such license. A hospital must have inpatient facilities, staff of physicians available at all times, 24-hour nursing services, and be accredited by the Joint Commission on the Accreditation of Healthcare Organizations. This does not include a facility primarily designed for use as an extended care facility, convalescent nursing home, or skilled nursing facility. Hospital for mental and nervous disorders and substance abuse includes facilities licensed by the state to provide inpatient mental and nervous or substance abuse services or treatment in the state it is located.

Hospital Confined/Hospital Confinement means confined in a hospital for at least 18 hours by reason of an injury or sickness for which benefits are payable.

DEFINITIONS (cont.)

Injury or Injuries means accidental bodily injury or injuries directly caused by specific accidental contact with another body or object while your coverage is in force. It is unrelated to any pathological, functional, or structural disorder or injury resulting directly and independently of all other causes in loss covered by the Policy. All related injuries and recurrent symptoms of the same or similar condition will be considered one injury.

Loss means medical expense or indemnity covered by the Policy as a result of any one injury or sickness.

Maternity means a sickness which is not a pre-existing condition. Conception must occur after your effective date of coverage. Treatment must begin prior to your expiration date of coverage.

Medical Emergency means a life-threatening medical condition resulting from an injury or sickness of the insured, which arises suddenly and requires immediate medical care to prevent permanent disability or loss of life to the insured.

Medically Necessary means those covered services provided or prescribed by a hospital or physician which are: (a) consistent with the symptoms and diagnosis or treatment of the injury or sickness and which could not have been omitted without adversely affecting the quality of care rendered; (b) in accord with standards of generally accepted medical practice; (c) not provided solely for education purposes or primarily for the convenience of you or your physician; (d) the most appropriate supply or level of service which can safely be provided to you; and (e) within the scope, duration, or intensity of the level of care needed to provide safe, adequate, and appropriate diagnosis or treatment and where ongoing treatment is not maintenance or preventive care.

Other Medical Coverage means any plan providing benefits or services for medical care or treatment, where such benefits or services are provided on a group basis by or under: group insurance; coverage provided by hospital or medical service organizations such as Blue Cross or Blue Shield or similar pre-paid medical service organizations; union welfare or trust plans; employer or employee benefit plans or arrangement whether on an insured or uninsured basis; Medicare as established by Title XVIII of the United States Social Security Act of 1965, as amended; any medical benefits coverage in group, group-type, and individual automobile “no-fault” and traditional automobile “fault” type coverage; HMO (health maintenance organization); or PPO (preferred provider organization).

Physician means a doctor of medicine or osteopathy, or any other licensed health care provider that state law requires to be recognized as a physician, other than you or your relative by blood or marriage, who is acting within the scope of such license.

Policy Benefit Period means that benefits are paid only during the period of time that you purchased coverage under the Policy. The maximum length of time of the benefit period is the policy period.

Prescription Drug means prescription legend drug or compound medication of which at least one ingredient is a prescription legend drug, or any other drug which under the applicable state or federal law may be dispensed only upon written prescription of physician.

Sickness means your bodily sickness, mental sickness, or maternity which is not a pre-existing condition and which causes loss while your coverage is in force. Sickness includes pregnancy, complications of pregnancy, and trauma-related disorders due to injuries which otherwise do not meet the definition of an injury. All related sicknesses and recurrent symptoms of the same or similar condition will be considered one sickness.

Sound, Natural Teeth means natural teeth which are not carious, abscessed, or defective. The major portion of the individual tooth is present, regardless of fillings or caps.

Usual and Customary Charges (U&C) means charges for medical services or supplies for which you are legally liable and which do not exceed the average rate charged for the same or similar services or supplies in the geographic region where the services or supplies are received. Usual and customary charges are determined by us and are described in the Schedule of Benefits.

We, Us, or Our means Columbian Life Insurance Company of Chicago, Illinois.

You, Your, Insured, Insured Person, or Student means a person who belongs to one of the classes of eligible persons insured and for whom the required premium has been paid in advance of that person’s effective date of coverage.

EXCESS COVERAGE

When there is a basis for a claim under the Policy and other medical coverage, benefits must be paid by other medical coverage first before benefits are paid under the Policy. When submitting a claim for payment, include the other medical coverage's explanation of payment with any itemized bills to the Plan Administrator.

CLAIM PROCEDURE

Usually the healthcare provider will file all necessary bills on the insured's behalf. However, some providers may require payment at the time the service is provided or may send the bill directly to the insured. In these instances, the insured should file a claim and send all itemized medical or hospital bills to the address below.

PRESCRIPTION DRUG CLAIM PROCEDURE

To obtain reimbursement for a prescription drug, the insured will need to pay for the prescription drug at the pharmacy and submit a copy of the drug label with a claim form to the address below.

Bills must be submitted within 90 days after the date of the injury or sickness, or as soon as reasonably possible. Information to identify the insured must be provided and should include: student name, patient name, address, student ID number or social security number, birthdate, and name of the school.
A company claim form is not required, unless the itemized billing statements do not provide sufficient information to process the claim. The insured can print a company claim form or complete the online claim form from the website **www.sas-mn.com**.

Send claims or inquiries to:
Student Assurance Services Inc.
P.O. Box 196
Stillwater, MN 55082-0196
(800) 328-2739
www.sas-mn.com

The claim office is available for calls between 8:00 a.m. to 4:30 p.m. Central Time, Monday – Friday.
Students may check the status of a claim already filed at **www.sas-mn.com.** The member ID number located on the ID card is needed to access the online claim status.

COMPLAINTS AND CLAIM APPEALS

An insured has a right to file a grievance in writing for any provision of services or claim practices of Columbian Life Insurance Company that offers an insurance plan or its claim administration by the Plan Administrator.

If there is a problem or concern, the insured can first call the customer service toll free number on the ID card. A customer service representative will provide assistance in resolving the problem or concern as quickly as possible. If the insured continues to disagree with the decision or explanation given, a written request may be submitted for a review through the internal grievance process.

The internal grievance process may be initiated by contacting the Plan Administrator. The insured can:

- Submit written comments, documents, records, and other material relating to the review;
- Receive, upon request, reasonable access to and copies of all documents relevant to the request for benefits relating to claim denial.

The grievance will be reviewed, and a written decision will be mailed. The grievance procedures can be obtained by contacting the Plan Administrator or from the Master Policy on file with the College.

Grievances may be sent to:
Student Assurance Services Inc.
P.O. Box 196 • Stillwater, MN 55082
(800) 328-2739

PRIVACY NOTICE

Columbian Life Insurance Company and Student Assurance Services, Inc. are committed to maintaining the privacy of the insured's personal health information and complying with all state and federal privacy laws. A copy of the privacy notice may be obtained by contacting the Plan Administrator at (800) 328-2739 or by visiting our website **www.sas-mn.com**.

HEALTH CARE REFORM

Columbian Life Insurance Company currently is evaluating this comprehensive and complex legislation and its impact on our company and student insurance plans. We will continue to monitor and identify any changes to our products and processes. We are committed to complying with all federal and state requirements within the timelines required.