

COLUMBIAN LIFE INSURANCE COMPANY

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COLUMBIAN LIFE INSURANCE COMPANY, hereinafter referred to as "the Company" or "Our", or "Us", or "We", agrees subject to all provisions, conditions, exclusions and limitations of this Policy to pay the benefits provided by this Policy for Loss resulting from a cause covered by this Policy.

POLICY SCHEDULE

POLICYHOLDER: Providence Christian College
1056 East Philadelphia Street
Ontario, CA 91761

POLICY NUMBER: 21-64-0031-016-677-1

POLICY EFFECTIVE DATE: August 15, 2011 at 12:01 a.m.

POLICY EXPIRATION DATE: August 14, 2012 at 11:59 p.m.

AMENDMENTS/ENDORSEMENTS: 9E825-CL; 9E826-CL; 6011-CL

ELIGIBILITY DEFINITION: Each person who belongs to one of the "Classes of Eligible Persons Insured", and as described in PART E.1. is eligible to be insured under this Policy.

CLASSES OF ELIGIBLE PERSONS INSURED:

1. All students who are enrolled in the plan. Students must be physically and actively attending classes for at least 31 days after their Effective Date of coverage under this Policy. Eligible persons do NOT include students age 65 or over, online or distance learning students taking home study, correspondence, or television courses.
2. Dependents of a Student who is an Insured Person and enrolled in the plan.

This Policy is issued in consideration of the application and payment of the premiums. Premiums as specified in the Premium Schedule are payable for each Insured Person.

Signed for Columbian Life Insurance Company:

DANIEL J. FISCHER
Secretary

THOMAS E. RATTMANN
Chairman, President
and Chief Executive Officer

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PREMIUM SCHEDULE

	Annual	*Semi-Annual Installment
	<u>08-15-2011 to 08-14-2012</u>	<u>08-15-2011 to 02-14-2012</u> <u>02-15-2012 to 08/14/2012</u>
Student (Basic Injury)	\$ 53	N/A
Student (Basic Sickness & Major Medical)	\$ 300	N/A
Each Dependent (Basic Injury Sickness, & Major Medical)	\$1,765	\$ 883.00

*Semi-annual installment method of payment is only available for students purchasing annual coverage.

Dependents must enroll in the plan when the student first enrolls in the plan and enroll for the same coverage as the student. Your basic injury benefits become effective on the later of: the Master Policy effective date 08-15-2011; or the first day of the term for which the premium has been paid. Your basic sickness and major medical benefits become effective on the later of: the Master Policy effective date 08-15-2011; 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 Servicing Agent. All coverage expires on the earlier of: the Master Policy expiration date 08-14-2012, or when premium for the accident and sickness insurance coverage is due and unpaid. No refunds, except as provided in the Master Policy. Any refund provided is subject to a \$25 administration fee.

PART A - SCHEDULE OF BENEFITS

1. BASIC INJURY AND SICKNESS BENEFITS - For each Insured Person We will pay Basic Injury and Sickness Benefits as set forth in Part A.1. for Eligible Expenses incurred during the Benefit Period, limited by all maximums, deductibles, coinsurance percentages and benefit limits set forth in Part A.1.

a. Maximum Basic Benefit For Each Loss:	<u>Amount</u> Injury: \$50,000-Students; \$5,000-Dependents
b. Basic Deductible: Each Loss – Per Person	Sickness: \$5,000-Students and Dependents Injury: \$1,000-Students; None-Dependents
c. Covered Percentage:	Sickness: None
d. Health Service Benefits:	100% U&C; or % listed below; up to Benefit Limit No benefit
e. Covered Services - Injury	<u>Benefit Limit</u>
1. Hospital Room and Board (R&B)	U&C
2. Hospital Intensive Care Unit (In lieu of R&B)	U&C
3. Hospital Miscellaneous (Inpatient)	U&C
4. Hospital Outpatient Surgical Miscellaneous	U&C
5. Surgical Treatment	U&C
6. Assistant Surgeon	U&C
7. Anesthesia	U&C
8. Consultant Physician	No benefit
9. Physician's Non-Surgical Visits (Inpatient)	U&C; 1 visit per day; not paid same day as surgery
10. Physician's Non-Surgical Visits (Outpatient)	U&C; 1 visit per day; not paid same day as surgery
11. Physiotherapy	U&C
12. Outpatient Tests and Procedures (in lieu of all other services)	No benefit
13. Inpatient Pathology and Radiology Services	Paid under e.3.
14. Outpatient Diagnostic X-ray and Lab Services	U&C
15. Hospital Emergency Room Services(Outpatient)	U&C
16. Ambulance Services	U&C
17. Orthopedic Appliances/Durable Medical Equipment	Orthopedic appliances: U&C; DME: no benefit
18. Prescription Drugs	U&C
19. Home Care	No benefit
20. Dental Treatment (repair and/or replacement sound natural teeth, includes x-rays)	\$200 per tooth; does not include biting or chewing injuries
21. Motor Vehicle Injury	Same as any Injury
22. Private Duty Nurse	No benefit
23. Shots and Injections	No benefit
f. Covered Services - Sickness	<u>Benefit Limit</u>
1. Hospital Room and Board (R&B)	Semi-private room rate
2. Hospital Intensive Care Unit (In lieu of R&B)	Paid under f.1.
3. Hospital Miscellaneous (Inpatient)	\$2,500
4. Hospital Outpatient Surgical Miscellaneous	\$2,500
5. Surgical Treatment	80% U&C; up to \$2,500
6. Assistant Surgeon	25% Surgical Treatment benefit
7. Anesthesia	25% Surgical Treatment benefit
8. Consultant Physician	No benefit
9. Physician's Non-Surgical Visits (Inpatient)	\$50 per visit; 1 visit per day; not paid same day as surgery
10. Physician's Non-Surgical Visits (Outpatient)	\$50 per visit; 1 visit per day; not paid same day as surgery
11. Physiotherapy	Inpatient: paid under f.3.; Outpatient: paid under f.10.
12. Outpatient Tests and Procedures (in lieu of all other Policy Benefits)	No benefit
13. Inpatient Pathology and Radiology Services	Paid under f.3.
14. Outpatient Diagnostic X-ray and Lab Services	80% U&C; up to \$700
15. Hospital Emergency Room Services (Outpatient)	80% U&C; up to \$500; after \$100 copay per visit (copay waived if admitted)
16. Chemotherapy and Radiation Therapy	Paid under Major Medical
17. Ambulance Services	\$400
18. Maternity Benefit	Same as any Sickness
19. Mental and Nervous Disorders	Inpatient: same as any Sickness; Outpatient: \$50 per visit; up to 10 visits
20. Substance Abuse Treatment	Paid under f.19.
21. Orthopedic Appliances/Durable Medical Equipment	Orthopedic appliances: paid under Major Medical; DME: No benefit
22. Prescription Drugs	\$250
23. Home Care	No benefit
24. Dental Treatment	No benefit
25. Private Duty Nurse	No benefit
26. Shots and Injections	No benefit

2. MAJOR MEDICAL BENEFITS - for each Insured Person We will pay Major Medical Benefits as set forth in Part A.2. for Eligible Expenses incurred during the Benefit Period, limited by all maximums, deductibles, coinsurance percentages and benefit limits set forth in Part A.1. and Part A.2.

	<u>Amount</u>
a. Maximum Major Medical Benefit For Each Loss:	\$100,000 Lifetime Maximum
b. Deductible Type: Each Loss	
Threshold Deductible	Basic Benefit Limit for each Covered Service
Corridor Deductible	Not Applicable
c. Covered Percentage:	80% U&C
d. Out-Of-Pocket Maximum Per Loss:	Not Applicable

Major Medical Covered Services include the Covered Services-Injury and the Covered Services-Sickness for which Benefits are payable, as shown in the SCHEDULE OF BENEFITS.

Benefits will not be paid under Major Medical Benefits for: Mental and Nervous Disorders; Substance Abuse; Dental Treatment; Motor Vehicle Injuries; or Intercollegiate Sports Injuries.

The Covered Percentage will be applied to all Eligible Expenses incurred after the Threshold and/or Corridor Deductible have been met, until the maximum lifetime Major Medical benefit for each Loss has been paid. This maximum includes benefits paid under the Basic Injury and Sickness and Major Medical Benefits.

3. OTHER BENEFITS - for each Insured Person We will pay Other Benefits as set forth in Part A.3. for Eligible Expenses incurred during the Benefit Period, limited by all maximums set forth in Part A.3.

	<u>Amount</u>
a. Accidental Death and Dismemberment	
(i) Death Benefit	\$1,000
(ii) Single Dismemberment/Loss of Eye	\$1,000
(iii) Double Dismemberment/Loss of Both Eyes	\$2,000
b. Medical Evacuation/ Repatriation	Program available to enrolled students; see separate brochure
c. Intercollegiate Sports Injuries (Cross Country sports coverage only)	Same as any Injury; Benefits paid under Part A.1.e.

4. VARIABLE PROVISIONS -

- a. Benefits Determination: Excess Coverage-over \$ 100 each Loss
- b. Benefit Period: Policy Benefit Period
- c. Enrollment Period:

Eligible students may enroll dependents in the plan by the annual or fall enrollment period deadline date of **08-25-2011**. We do not accept enrollment forms and premium payments postmarked by the US Postal Service after **08-25-2011**, unless you qualify for late enrollment. To qualify for late enrollment, you must submit an enrollment form and premium payment no later than 30 days after the qualifying event of involuntary loss of coverage under another health plan, marriage, or birth/adoption of child
Dependents must enroll in the plan when the Student first enrolls in the plan, and must enroll for the same coverage as the Student.

- d. Pre-Existing Conditions Waiting Period: Yes – 6 months
- e. Usual and Customary Charges: Determined by referencing the 80th percentile of the most current survey published by FAIR Health, Inc.

PART B - DEFINITIONS

This policy may contain any or all of the following terms:

1. **Accident** means an unexpected, external and sudden event that is independent of any other cause.
2. **Amendments/Endorsements** means any lawful change which the Policyholder and We agree to make to the original terms of this Policy. If a change is made, We will include an Amendment or provide an Endorsement in this Policy. We will specify any form number in the Policy Schedule.
3. **Benefit (Benefits)** means the amount of Eligible Expense payable by this Policy.
4. **Complications of Pregnancy** means any disease, disorder or condition that has a diagnosis nosologically distinct from the pregnancy but that is adversely affected by the pregnancy.
5. **Covered Percentage** means the portion of Eligible Expenses that are payable as Benefits by Us.
6. **Covered Services** means any of the following services and supplies which are Medically Necessary, prescribed or performed by a Physician or Hospital, not excluded by this Policy, and named in this Policy's SCHEDULE OF BENEFITS.
 - a. **Hospital Room and Board (R&B):** Daily room and board when Hospital Confined. Benefits are paid for the daily semi-private room rate, except as specifically provided in the SCHEDULE OF BENEFITS. The room rate includes an allowance for general nursing care provided and charged for by the Hospital.
 - b. **Hospital Intensive Care Unit:** Benefits are paid as shown on the SCHEDULE OF BENEFITS.
 - c. **Hospital Miscellaneous (Inpatient):** When You are Hospital Confined. Benefits will be paid for services and supplies 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.
 - d. **Hospital Outpatient Surgical Miscellaneous:** When You are not Hospital Confined and are undergoing major scheduled day surgery at an outpatient surgical care unit or licensed outpatient surgical center. Benefits will be paid for services and supplies 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.
 - e. **Outpatient Tests and Procedures:** When You are not Hospital confined and are undergoing necessary, scheduled diagnostic or therapeutic tests and procedures, benefits are payable when no other policy benefit is provided in the SCHEDULE OF BENEFITS, or not excluded by this Policy. Diagnostic or therapeutic tests and procedures are identified in the Medicine section of the Physicians' Current Procedural Terminology (CPT). These tests and procedures include, but are not limited to: therapeutic or diagnostic infusions or injections, dialysis, gastroenterology procedures, Ophthalmology procedures, Otorhinolaryngologic procedures, Cardiovascular procedures, non-invasive Vascular studies, Pulmonary procedures, Neurology and Neuromuscular procedures. We reserve the right to determine whether a diagnostic test and procedure is eligible as a Covered Service.
 - f. **Surgical Treatment:** 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.

PART B - DEFINITIONS CONTINUED

- g. **Assistant Surgeon:** When necessary and required by the attending Physician.
- h. **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.
- i. **Consultant Physician:** When requested and approved by the attending Physician.
- j. **Physician's Non-Surgical Visits (Inpatient):** Benefits are limited to one visit per day and includes Physician's evaluation and management services as identified in Physicians' Current Procedural Terminology (CPT). Benefits are not paid on the day of surgery. Covered Services will be paid under the inpatient benefit or under the outpatient benefit for Physician's Visits, but not both on the same day.
- k. **Physician's Non-Surgical Visits (Outpatient):** Benefits are limited to one visit per day and includes the Physician's evaluation and management services as identified in Physicians' Current Procedural Terminology (CPT). Includes any ancillary supplies received during the visit, except as specifically provided in the SCHEDULE OF BENEFITS. Benefits are not paid on the day of surgery. Covered Services will be paid under the outpatient benefit or under the inpatient benefit for Physician's Visits, but not both on the same day.
- l. **Physiotherapy:** Any form of therapeutic or manual treatment provided by a Physician, 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.
- m. **Inpatient Pathology and Radiology Services:** Pathologist's fees and/or Radiologist fees, including charges for reading of X-rays.
- n. **Outpatient Diagnostic X-ray, Radiology and Lab Services:** Includes Radiologist fees, charges for reading of X-rays, and Pathologist's fees. Diagnostic X-rays and Radiology services are those procedures 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.
- o. **Chemotherapy:** Benefits are limited to one treatment per day.
- p. **Radiation Therapy:** Benefits are limited to one treatment per day.
- q. **Hospital Emergency Room Services (Outpatient):** Includes staff Physician, use of emergency room, and supplies. Hospital Emergency Room includes necessary emergency treatment provided in an urgent care facility or clinic, or an observation room or other room designated by the hospital.
- r. **Ambulance Services:** Professional ground ambulance service, except as specifically listed in the SCHEDULE OF BENEFITS.
- s. **Maternity Benefit:** Benefits for normal pregnancy and childbirth are payable on the same basis as a Sickness, except as specifically listed in the SCHEDULE OF BENEFITS. Covered Medical expenses include: Physician visits, Diagnostic services, Obstetrical /surgical procedures, Hospital room and board, and Hospital miscellaneous. Includes 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,

PART B - DEFINITIONS CONTINUED

one amniocentesis for women over age 35, and genetic testing when there is family history of genetic disorders in a parent or a sibling.

Covered nursery room and board, miscellaneous hospital and all related outpatient expenses for the newborn or adopted child will be considered for benefits under the mother's Maternity Benefit, unless the student enrolls the newborn or adopted child and pays the additional premium, if any, within 31 days from the birth date or the date the legal obligation began for the adopted child.

- t. **Mental and Nervous Disorders:** Benefits are payable for Inpatient and Outpatient treatment as shown on the SCHEDULE OF BENEFITS for a Sickness that is a mental emotional or behavioral disorder. All diagnoses classified as a "Mental Disorder" according to the ICD-9 (International Classification of Diseases, 9th Revision, codes 290 through 319 inclusive) are considered one Sickness. Mental and Nervous Disorders do not include diagnoses and treatment for Substance Abuse Treatment.
- u. **Substance Abuse Treatment:** means a Sickness of psychological or physical dependence or addiction to alcohol or drugs and medication, does not include treatment for nicotine addiction or smoking cessation. Inpatient and Outpatient treatment as shown on the SCHEDULE OF BENEFITS and/or any Amendment.
- v. **Orthopedic Appliances or Durable Medical Equipment:** Any supportive appliance or device which (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 Covered Person. Replacement braces and appliances are not covered. No benefits will be paid for rental charges in excess of purchase price. Durable Medical Equipment does not include for example: non-prescription therapy devices or medical supplies; comfort and convenience items; modifications of the Covered Person's residence, property or automobiles; corrective shoes; exercise and sports equipment. A written prescription must accompany the claim when submitted. We reserve the right to determine whether an Orthopedic Appliance or Durable Medical Equipment is eligible as a Covered Service.
- w. **Prescription Drugs:** Includes only 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 per Prescription Drug.
- x. **Home Care:** Health services provided in the Covered person's home under an established plan of care approved in writing by the attending Physician, and certified by the Physician as an alternative to hospital confinement. Home Care services include, but are not limited to: part-time or intermittent nursing services; physical, occupational, respiratory and speech therapy; durable medical equipment; drugs and medicines; and lab services. Home Care Does not include health aide services or twenty-four hour Private Duty Nursing. Benefits are provided as shown on the SCHEDULE OF BENEFITS.
- y. **Dental Treatment:** 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. You must have the treatment performed within the Policy Period.
- z. **Private Duty Nurse:** Inpatient hospital services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.), other than a member of Your family or other person employed or retained by the Policyholder. Does not include Home Care nursing services.
- z1. **Shots and Injections:** Diagnostic or therapeutic injections when administered in the Physician's office and charged as a separate item on the Physician's statement. Includes the cost of the drug. Benefits are payable when no other policy benefit is provided in the SCHEDULE OF BENEFITS or as required state mandate. Does not include shots and injections excluded by this Policy.

PART B - DEFINITIONS CONTINUED

- z2. **Other Covered Services:** includes miscellaneous Covered Services designated on the SCHEDULE OF BENEFITS, and not provided elsewhere under this Definition.
7. **Deductible** means an amount or amounts of Eligible Expenses that You must pay. This Policy's SCHEDULE OF BENEFITS page identifies the Deductible(s). It also specifies whether the Deductible applies per Loss or per policy year.
- Basic Deductible is the amount either applied to Benefits or applied to Eligible Expenses under Part A, 1. Basic Injury and Sickness Benefit.
 - Threshold Deductible is the Amount shown as the Maximum Basic Benefit For Each Loss on the SCHEDULE OF BENEFITS that must be paid before Major Medical Benefits will be payable under this Policy.
 - Corridor Deductible is the amount of Eligible Expenses in excess of the Threshold Deductible, or the Covered Services Benefit Limits under the Basic Injury and Sickness Benefits that are accumulated before Benefits are payable under the Major Medical Benefits.
8. **Dependent** means the insured Student's spouse; or Domestic Partner; or Student's unmarried natural child (including step children if dependent on the insured Student) under the age of twenty-three (23) years, who is not self supporting or a child over the age of 23 who is incapable of self sustaining employment because of mental 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. The insured Student must provide proof that a child continues to be handicapped.
- A newborn child of the insured Student will be covered from birth until 31 days old. Coverage for such child will be for a Sickness and Injury including necessary care and treatment for medically diagnosed congenital defects and birth abnormalities. Coverage at the end of the 31 days will expire. To continue coverage past the 31 days, the Insured must enroll the newborn child within 31 days of birth and pay the required additional premium starting from the date of birth.
- A child for whom the insured Student has a legal obligation for the purposes of adoption, will be covered from the date the legal obligation begins until 31 days after the date the legal obligation began. Coverage for such child will be for Sickness and Injury including necessary care and treatment for medically diagnosed congenital defects and birth abnormalities. Coverage at the end of the 31 days will expire. To continue coverage past the 31 days, the Insured must enroll the adopted child within 31 days from the date legal obligation began, and pay the required additional premium starting from the date the legal obligation began.
9. **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 Policyholder's Student Health Center and to the Plan Administrator. In the Affidavit, the insured Student and domestic partner must attest that they are each other's sole domestic partner, 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.
10. **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; temporomandibular joint dysfunction (TMJ); 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.

PART B - DEFINITIONS CONTINUED

11. **Eligible Expense** means the Usual and Customary Charges, or PPO Allowable fee (if applicable) You incur for Covered Services as a result of Injury or Sickness. Eligible expenses are limited by all maximums, deductibles, coinsurance percentages, and benefit limits as set forth in the SCHEDULE OF BENEFITS. Eligible Expenses may include other benefit payment methods as set forth in the SCHEDULE OF BENEFITS
12. **Eligible Person(s)** means those persons eligible to be insured under this Policy, and who are shown in the CLASSES OF ELIGIBLE PERSONS INSURED of the POLICY SCHEDULE.
13. **Excess Coverage** means this Policy will pay the dollar amount shown on the SCHEDULE OF BENEFITS regardless of Other Medical Coverage. All Eligible Expenses in excess of that amount must be paid by Other Medical Coverage before Benefits are paid by this Policy.
14. **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 show 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.
15. **Fifty-Two (52) Week Benefit Period** means that Benefits are paid for up to 52 weeks from the date of Injury or first treatment for a Sickness, occurring during the Policy Period.
16. **Health Service Benefits** means those benefits paid for expenses incurred as a result of services provided at the Policyholder's Health Center.
17. **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 a day nursing services, and 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 Nervous or Substance Abuse services or treatment in the state it is located.
18. **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.
19. **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 this Policy. All related injuries and recurrent symptoms of the same or similar condition will be considered one Injury.
20. **Loss** means medical expense or indemnity covered by this Policy as a result of any one Injury or Sickness.

PART B - DEFINITIONS CONTINUED

21. **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.
22. **Medical Emergency** means a life threatening medical condition resulting from an Injury or Sickness of the Insured, which arises suddenly and required immediate medical care to prevent permanent disability or loss of life to the Insured.
23. **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 Sickness or Injury 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.
24. **Nurse or Private Duty Nurse** is a registered nurse (R.N.) or licensed practical nurse (L.P.N.) other than a member of Your family or other person employed or retained by the Policyholder.
25. **Other Benefits** means the Benefits described below:
 - a. **Accidental Death, Single Dismemberment/Loss of Eye, Double Dismemberment/Loss of both Eyes:** When an Injury covered by this Policy results in a loss within 180 days from the date of the Accident causing the Injury, the Benefit Limit for the loss shown on the SCHEDULE OF BENEFITS under Other Benefits will be paid. The Benefit paid under this provision will be in addition to any other Benefits paid for the Injury. Dismemberment means, at a minimum, the severance of a hand or foot above the wrist or ankle joint. Loss of Eye means entire and irrecoverable loss of vision in the eye.
 - b. **Medical Evacuation:** When Hospital confined for at least five consecutive days; and when recommended and approved by the attending Physician, Benefits will be paid for evacuation to Your natural country. This Benefit is limited to the Benefit Limit specified in the SCHEDULE OF BENEFITS. No additional benefits will be paid under Basic or Major Medical coverage.
 - c. **Repatriation:** If You die while insured under this Policy; Benefits will be paid for: preparing and transporting Your remains to Your home country. This benefit is limited to the Benefit Limit specified in the SCHEDULE OF BENEFITS. No additional Benefits will be paid under Basic or Major Medical coverage.
 - d. **Intercollegiate Sports/Club Sports:** **Intercollegiate Sports** means any athletic contest or competition, regulated by a national association, between accredited colleges or universities. The participants are sponsored by the Policyholder, and are under the direct and immediate supervision of an employee of the Policyholder. It includes the practice or training for the competition and the travel to or from such practice or competition in a vehicle designated by the Policyholder, both while under the direct and immediate supervision of an employee of the Policyholder. **Club Sports** means any athletic contest or competition by clubs or organizations that is not an Intercollegiate Sport and that may or may not be sponsored by the Policyholder. Club sports may or may not be under the direct and immediate supervision of an employee of the Policyholder.
26. **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

PART B - DEFINITIONS CONTINUED

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).

27. **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.
28. **Policy Benefit Period** means that Benefits are paid only during the period of time that You purchased coverage under this Policy. The maximum length of time of the Benefit Period is the Policy Period.
29. **Policy Period** means the period of time beginning at 12:01 a.m. on the Policy Effective Date, and ending at 11:59 p.m. on the Policy Expiration Date, as shown on the POLICY SCHEDULE.
30. **Pre-Existing Condition** means any condition which originates, is diagnosed, treated, or recommended for treatment within the 6 months immediately prior to Your Effective Date of coverage.
31. **Pre-Existing Conditions Waiting Period** means the time period You must have continuous coverage in force under this Policy before a Pre-Existing Condition is considered a Loss.
32. **Prescription Drugs** means prescription legend drugs; or compound medications 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 the written prescription of a Physician.
33. **Premium** means the Premiums shown on the PREMIUM SCHEDULE of this Policy.
34. **Primary Coverage** means that the Benefits of this Policy are paid regardless of Other Medical Coverage which pays Benefits for the same Loss.
35. **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.
36. **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.
37. **Student** means a person described in the CLASSES OF ELIGIBLE PERSONS INSURED on the POLICY SCHEDULE.
38. **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.
39. **We, Us, or Our** means the Columbian Life Insurance Company of Chicago, Illinois.
40. **You or Your, or Insured or Insured Person** means a Person who belongs to one of the CLASSES OF ELIGIBLE PERSONS INSURED shown on the POLICY SCHEDULE, and for whom the required Premium has been paid in advance of that person's Effective Date of coverage.

PART C - EXCLUSIONS

This Policy does not provide Benefits for expense 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); 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. 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. Intentional self-inflicted Injuries; including drug overdose; 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. Treatment related to nicotine addiction or smoking cessation.
13. 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.
14. War or act of war, whether declared or not; and Injury or Sickness resulting from full-time, active-duty military service.

PART C - EXCLUSIONS CONTINUED

15. 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 6 consecutive months.
16. Sleep disorders, supplies and treatment or testing related to sleep disorders.
17. Weight management services and supplies related to weight reduction programs, weight management program, and related nutritional supplies; treatment of obesity; surgery for the removal of excess skin or fat, and for weight reduction or treatment of obesity.

PART D - GENERAL POLICY PROVISIONS

1. **Entire Contract; Changes:** This Policy with the application, and any endorsements attached to it, is the entire contract between the Policyholder and Us. Any statement made by the Policyholder or You is considered a representation instead of a warranty, unless it is made with the intent to commit fraud against Us. No such statements can be used to deny a claim under this Policy unless they have been included in the written application. You, Your beneficiary, or assignee can request a copy of the application by requesting one in writing. We will furnish a copy of the application within fifteen (15) days of the day We receive the request. No change in this Policy will be effective until approved by one of Our executive officers. The approval must be noted on or attached to this Policy. No agent or broker may change this Policy or waive any of its provisions.
2. **Notice Of Claim:** We must receive written notice of the Injury or Sickness on which your claim will be based within thirty (30) days of the date the loss occurred or as soon as reasonably possible. In no event will a notice of claim be accepted after one year from the date the Loss occurred. Notice must be given to Our Administrator's Office. The notice must include information that enables Us to identify You.
3. **Claim Forms:** We will provide claim forms after We receive notice of claim. If We do not provide Our usual claim forms within fifteen (15) days after We receive notice of claim, a claim may be filed without using a claim form. The claim filing must still provide written proof of Loss describing the occurrence, type, and extent of Loss. It must be provided within the time allowed in the Proof of Loss provision.
4. **Proofs Of Loss:** You must provide Us with written proof of Loss on the form(s) We provide. It must be provided to Our Administrator's Office, 333 North Main Street, Stillwater, MN 55082-0196 within ninety (90) days of the Loss or as soon as reasonably possible. Proof of Loss provided later than one year after the ninety (90) day period expires will not be accepted, unless You had no legal capacity in that year.
5. **Time Of Payment Of Claims:** Benefits will be paid promptly upon receipt of written proof of Loss.
6. **Physical Examination And Autopsy:** We may have You examined by a Physician We choose, as often as is reasonable while a claim is pending. If You die, We may order an autopsy to be performed, where it is not prohibited by law.
7. **Payment Of Claims:** Benefits will be paid to You, Your estate, or beneficiary. Unless We have your written instructions to the contrary, We may pay all or part of a benefit for health care or services to its provider, regardless of the provider. Once You have given assignment to a provider, We are obligated to honor that assignment unless We have written proof from the provider that Your obligations have been satisfied. Claims paid in good faith will fulfill Our responsibility to the extent of the payment.
8. **Other Insurance With Us:** If You have insurance in effect under a similar policy or policies with Us, coverage will be effective for one policy only, as chosen by You, Your beneficiary, or Your estate.
9. **Legal Actions:** No legal action may be taken on a claim prior to sixty (60) days after the date written proof of Loss was provided. No such action must be taken more than three (3) years after the date proof of Loss is required by this Policy.
10. **Right Of Recovery:** Payments made by Us which exceed the Benefits payable under this Policy may be recovered by Us from or among any persons, firms, or corporations to or for whom such payments were made or from any insurance organizations who are obligated to pay benefits for any covered Injury or Sickness.
11. **Conformity With State Laws:** The laws of the state where this Policy is issued will apply to this Policy. Any part of this Policy in conflict with the laws of that state is changed to conform to the minimum requirements of that state's laws.

PART D – GENERAL POLICY PROVISIONS CONTINUED

12. **Subrogation:** This Policy will not cover an expense to the extent that it is paid as part of a settlement or judgment by any party who may be liable for Your Injury or Sickness. We will provide payment when a third party is liable if: (a) payment by or for the liable party has not been made by the time We receive acceptable Proof of Loss; and (b) You (or Your guardian) agrees in writing to pay back to Us the Benefits paid, if a settlement or judgment is collected. This provision applies whether or not any party who may be liable admits liability and whether or not the payments are itemized. We may reduce other Benefits under this Policy by the amounts You have agreed to repay Us.
13. **Non-Participating:** This Policy and Certificates issued under it are non-participating. No dividends will be paid.

PART E - ADDITIONAL POLICY PROVISIONS

1. **Eligibility:** Each person who belongs to one of the “CLASSES OF ELIGIBLE PERSONS INSURED” shown on the POLICY SCHEDULE is eligible to be insured under this Policy.

Eligible Persons may be insured under this Policy when: the person enrolls for the coverage provided by this Policy; and pays the required premium as shown in the PREMIUM SCHEDULE. Except for medical withdrawal due to Injury or Sickness, any student withdrawing from school within the first 31 days of the period for which coverage is purchased does not satisfy the Policy eligibility requirements and a full refund of Premium will be made.

We maintain Our right to investigate Student status and attendance records to verify that this Policy’s eligibility requirements have been met. If We discover that this Policy’s eligibility requirements have not been met, Our only obligation is a refund of Premium.

Dependent’s eligibility is determined as follows:

- a. Dependents of a Student are eligible on the date the Student is eligible for coverage;
- b. Dependents acquired by a Student after his or her Effective Date will be eligible on the date the Student marries the Dependent, or on the date the Student acquires a dependent child who meets the definition of Dependent found in the Definitions section of this Policy.

Dependent coverage will not be effective prior to that of the Insured Student. Dependent eligibility expires concurrently with that of the Student.

2. **Effective Date:**

- a. Your coverage under this Policy will become effective on the later of the following dates;
 - (i) The Policy Effective Date shown on the POLICY SCHEDULE, or
 - (ii) The first day of the period for which proper Premium is paid as shown in PREMIUM SCHEDULE, or
 - (iii) 12:01 a.m. following the date the proper Premium is received by the Policyholder, Servicing Agent, or Administrator of this Policy.

3. **Expiration Date:**

- a. Your coverage under this Policy will terminate on the earliest of the following dates;
 - (i) The last day of the coverage period for which the Premium is paid, or as provided in Additional Policy Provisions, Grace Period, or
 - (ii) The Policy Expiration Date shown on the POLICY SCHEDULE.
- b. Coverage for each Dependent will terminate on the earliest of the following dates;
 - (i) The last day of the period through which the Premium for the Dependent is paid,
 - (ii) The Policy Expiration Date as shown on the POLICY SCHEDULE, or
 - (iii) The date the Student’s coverage terminates.

PART E - ADDITIONAL POLICY PROVISIONS CONTINUED

4. **Grace Period:** Insured Persons that purchase partial year coverage will have a 31 day grace period between coverage periods. If the Premium is not paid within the 31 day period, coverage will end on the last day of the coverage period for which Premium was paid. If the student is eligible for coverage, a new Effective Date will be in effect, as stated in PART E.2. above, upon receipt of the Premium.
5. **Extension of Benefits:** If you must involuntarily withdraw from school within thirty-one (31) days from the period for which coverage is purchased, due to a medical condition that would be covered by this Policy, Your eligibility under the Policy will be maintained. We will require documentation of Your medical condition by Your attending Physician. Benefits for the treatment of the condition causing the involuntary withdraw from school will be payable until the earlier of the dates stated in PART E.3. above or ninety (90) days from the date of Your involuntary Expiration Date of coverage.

If You are Hospital Confined on Your involuntary Expiration Date of coverage, Benefits for treatment of the condition causing the Confinement will be payable until the earlier of; the date You are discharged from the Hospital, the date the Maximum Benefits shown on the SCHEDULE OF BENEFITS have been paid for the confinement, or ninety (90) days from the date of Your involuntary Expiration Date of coverage.

6. **Continuous Coverage:** Coverage will be considered continuous, if You were covered to the policy expiration date of Your prior Student Health insurance policy of the Policyholder, and You enroll for coverage under this Policy and pay the required Premium within 31 days of the expiration date of the prior student health insurance policy.

You will not be denied benefits under this Policy for a Pre-existing Condition or an Injury or Sickness covered under your prior Student Health insurance policy, unless under this Policy the Injury or Sickness expenses incurred are not considered a Covered Service, or benefits are limited by other provisions in this Policy, including Credit for Prior Coverage. If the prior Policy was with Us, benefits will not be paid under this Policy if any applicable Lifetime Maximum has been exhausted.

7. **Refunds:** Upon written notice, a refund will be issued to a student withdrawing from school within the first thirty-one (31) days of the beginning of the period of coverage purchased, unless you or your covered dependent files a medical claim. No refunds will be allowed for Students withdrawing from school after this 31 day period.

Upon written notice to Us, including proof (such as a copy of an airline ticket) and the date of occurrence, a refund will be issued to a student who has entered into full-time active-duty military service of any country; or who is a non-immigrant Foreign National who has left the North American continent. We will make a prorata Premium refund, less an administrative fee. No refund will be issued when the coverage period remaining is less than six (6) weeks from the expiration date.

8. **Portability:** If You are covered by this Policy and transfer to a new school that maintains a Student Health insurance policy with Us, You may a) continue to pay the premium for the remainder of the Policy year under this Policy, or b) enroll in the new school's Policy with Us and pay the premium for the remainder of the Policy year within 31 days after you become eligible for coverage. If you choose to enroll in the new school's Policy with Us, Your Premium may be adjusted. Contact the Plan Administrator for further information.

PART E - ADDITIONAL POLICY PROVISIONS CONTINUED

9. **Credit for Prior Coverage:** The Pre-existing Conditions Waiting Period will be reduced by the period of time You were covered by Prior Creditable Coverage, if such coverage was continuous (no break in coverage 63 or more days) to a date immediately prior to Your Effective Date of coverage under this Policy. The Pre-existing Conditions Waiting Period must expire before benefits for a Pre-existing Condition will be considered for payment under this Policy. Periods of coverage under several prior plans may be added together, provided there is no break in coverage. If You were covered by more than one health plan, only one day of creditable coverage is credited for each day your dual coverage existed.

If You enroll in the coverage provided by this Policy, and You experienced a period of 63 or more continuous days before your Effective Date of coverage under this Policy during which You had no Prior Creditable Coverage in force, this Policy will require a Pre-Existing Conditions Waiting Period.

You must show proof of Prior Creditable Coverage by submitting a Certificate of Prior Coverage from the prior health plan or other satisfactory evidence of coverage.

Certificate of Prior Coverage means a document showing prior health coverage issued upon written request to You, when Your coverage ends under this Policy or under Your prior health plan.

Prior Creditable Coverage means Your prior Student health insurance policy of the Policyholder or other 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 more than 63 or more continuous days.

Countersigned by:

Licensed Resident Agent

BENEFITS ENDORSEMENT FOR CALIFORNIA RESIDENTS

This Endorsement is made part of the policy to which it is attached.

This Policy includes Benefits for the Usual and Customary (U&C) charges incurred, on the same basis as any other Sickness for:

1. Low-dose mammography for breast cancer screening or diagnostic purposes for a female insured on the referral of her physician, a nurse practitioner or a certified nurse midwife, who is providing care and operating within the scope of practice permitted under existing law according to the following guidelines:
 - a. a baseline mammogram for age 35 to 39, inclusive;
 - b. a mammogram age 40 to 49, inclusive every two years or more frequently if recommended by the woman's physician; and
 - c. a mammogram every year for women 50 years and older.
2. An annual cervical cancer screening test on referral of physician, nurse practitioner or certified nurse midwife. This includes a conventional Pap test and the option of any cervical cancer screening test approved by the federal Food and Drug Administration upon referral of the Insured's Physician.
3. Preventive child care for dependent children covered under this Policy who are age 16 and younger consistent with Guidelines for Health Supervision of Children, as adopted by the American Academy of Pediatrics in September 1987 for the following:
 - a. periodic physical exams; and
 - b. immunizations; and
 - c. lab services in connection with periodic physical exams.
4. Surgical procedure known as a laryngectomy to include a prosthetic device to restore a method of speaking for the Insured incident to the laryngectomy.
5. Breast cancer screening, diagnosis and treatment, including prosthetic devices and reconstructive surgery. If an Insured who is receiving benefits under the Policy in connection with a mastectomy elects breast reconstruction in connection with such mastectomy, benefits for the mastectomy will include:
 - a. reconstruction of the breast on which the mastectomy was performed;
 - b. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
 - c. prostheses and physical complications from all stages of the mastectomy, including lymphedemas.
6. Screening and diagnosis of prostate cancer, including, but not limited to, prostate-specific antigen testing and digital rectal examination, when Medically Necessary and consistent with good professional practice.
7. Testing and treatment, including formulas and special food products, of phenylketonuria (PKU). This includes those formulas and special food products that are part of a diet prescribed by a Physician that is deemed to be Medically Necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU. Benefits are payable only to the extent that the cost of necessary formulas and special food products exceed the cost of a normal diet.

“Formula” means an enteral product(s) for use at home that are prescribed by a Physician or nurse practitioner or order by a registered dietician upon referral by a health care provider authorized to prescribe dietary treatments as Medically Necessary for the treatment of PKU.

“Special food product” means a food product that is both of the following: (a) prescribed by a Physician or nurse practitioner for the treatment of PKU and is consistent with expertise germane to and experience in the treatment and care of PKU. It does not include food that is naturally low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving; (b) used in place of normal food products, such as grocery store food, used by the general population.

8. When maternity benefits are provided, participation in the Expanded Alpha Feto Protein (AFP) prenatal testing program, which is a statewide prenatal testing program administered by the State Department of Health Services.
9. To the extent benefits are provided under the Policy for prescription drugs, a drug will not be limited or excluded on the basis that it is prescribed for a use that is different from the use for which it has been approved by the federal Food and Drug Administration (FDA), provided that all of the following conditions are met:
 - a. the drug is approved by the FDA.
 - b. (1) the drug is prescribed by a contracting licensed health care professional for the treatment of a life-threatening condition; or
(2) the drug is prescribed by a contracting licensed health care professional for the treatment of a chronic and seriously debilitating condition and the drug is medically Necessary to treat that condition.
 - c. the drug has been recognized for treatment of that condition by one of the following:
 - (1) the American Medical Association Drug Evaluations;
 - (2) the American Hospital Formulary Service Drug Information;
 - (3) the United States Pharmacopoeia Dispensing Information, Volume 1, "Drug Information for the Health Care Professional".
 - (4) two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

It is the contracting prescriber's responsibility to provide Us with documentation of compliance with the above requirements.

Prescription drug benefits provided under this provision include Medically Necessary administration of the off-label drug, subject to the terms of the Policy.

"Life-threatening" means either or both of the following:

- a. diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.
- b. diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

"Chronic and seriously debilitating" means diseases or condition that requires ongoing treatment to maintain remission or prevent deterioration and cause significant long-term morbidity.

10. To the extent benefits are provided under the Policy for outpatient prescription drugs, FDA approved prescription contraceptive methods as designated by Us. If the Insured's Physician determines that none of the methods designated by Us is medically appropriate for the Insured's medical or personal history, We shall, in the alternative, provide coverage for some other FDA approved prescription contraceptive method prescribed by the Insured's Physician. Experimental or investigational contraceptive methods are not covered.
11. Diagnosis/treatment of Severe Mental Illnesses for Insured adults and children and Serious Emotional Disturbances of Children. Benefits will be paid as for any Sickness for:
 - a. Outpatient services;
 - b. Inpatient hospital services;
 - c. Partial hospital services;
 - d. Prescription drugs to the extent they are covered under the policy

Severe Mental Illness includes: (1) schizophrenia; (2) schizoaffective disorder; (3) bipolar disorder (manic-depressive illness); (4) major depressive disorders; (5) panic disorder; (6) obsessive-compulsive disorders; (7) pervasive developmental disorder or autism; (8) anorexia nervosa; and (9) bulimia nervosa.

Serious Emotional Disturbances of Children is defined as a child who: (1) has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms; and (2) who meets the criteria in paragraph (2) subdivision (a) of Section 5600.3 of the Welfare and Institutions Code.

We may provide coverage for all or part of the mental health services required by California law through a separate specialized health care service plan or mental health plan.

Mental health coverage will be provided in our PPO service area and in emergency situations as may be required by applicable laws and regulations. We may require Insureds who reside or work in geographic areas served by specialized health care service plans or mental health plans to secure all or part of their mental health services within those geographic areas served by specialized health care service plans or mental health plans.

We may use case management, managed care or utilization review when administering this benefit.

12. Routine Patient Care Costs related to a phase I, Phase II, Phase III or Phase IV clinical trial for cancer for an Insured who is diagnosed with cancer and accepted into such trial. The Insured's treating physician must recommend participation in the clinical trial after deterring that participation in the clinical trial has a meaningful potential to benefit the Insured. The clinical trial's endpoints shall not be defined exclusively to test toxicity, but shall have a therapeutic intent.

Routine Patient Care Costs means the costs associated with the provision of health care services, including drugs, items, devices, and services that would otherwise be covered under the Policy if those drugs, items, devices and services were not provided in connection with an approved clinical trial program. This includes health care services:

- a. typically provided absent a clinical trial;
- b. required for the provision of the investigational drug, item, device or service;
- c. required for clinically appropriate monitoring of the investigational item or service;
- d. provided for the prevention of complications arising from the provision of the investigational drug, item, device or service;
- e. needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device or service, including the diagnosis and treatment of the complications.

Routine Patient Care Costs do not include:

- a. drugs or devices that have not been approved by the federal Food and Drug Administration and that are associated the clinical trial;
- b. services other than health care services, such as travel, housing, companion expenses and other nonclinical expenses that a Covered Person may require as a result of the treatment being provided for the purpose of the clinical trial;
- c. any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient;
- d. health care services which, except for the fact that they are not being provided in a clinical trial, are otherwise specifically excluded from coverage under the policy;
- e. health care services customarily provided by the research sponsors free of charge for any Covered Person in the trial.

Treatment must be provided in the clinical trial that either: (a) involves a drug that is exempt under federal regulations from a new drug application; or (b) that is approved by one of the following:

- a. one of the National Institutes of Health;
- b. the federal Food and Drug Administration, in the form of an investigational new drug application;
- c. the United States Department of Defense;
- d. the United States Veterans Administration.

Health care services by a PPO plan will be paid at the agreed-upon rate. In the case of a non-PPO, payment will be at the negotiated PPO rate less any applicable copayment and deductible. Clinical trials may be restricted to Hospitals and Physicians in California unless the protocol for the clinical trial is not provided for at a California Hospital or California Physician.

13. The following equipment, supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes and gestational diabetes as Medically Necessary, even if the items are available without a prescription:
- a. blood glucose monitors and blood glucose testing strips;
 - b. blood glucose monitors designed to assist the visually impaired;
 - c. insulin pumps and all related necessary supplies;
 - d. ketone urine testing strips;
 - e. lancets and lancet puncture devices;
 - f. pan delivery systems to prevent or treat diabetes-related complications;
 - g. podiatric devices to prevent or treat diabetes-related complications;
 - h. insulin syringes;
 - i. visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.

If prescription drugs are covered benefits must include the following prescription items that are determined to be Medically Necessary:

- a. insulin;
- b. prescriptive medications for the treatment of diabetes;
- c. glucagons.

Benefits also include diabetes outpatient self-management training, educations and medical nutrition therapy necessary to enable an Insured to properly use the equipment, supplies and medications and additional diabetes outpatient self-management training, education and medical nutrition therapy upon the direction or prescription of those services by the Insured's participating Physician.

14. General anesthesia and associated facility charges for dental procedures rendered in a hospital or surgery center setting when the clinical status or underlying medical condition of the Insured requires dental procedures that ordinarily would not require general anesthesia to be rendered in a hospital or surgery center.

Benefits shall apply only to general anesthesia and associated facility charges for the following Insureds, and only if the Insured meets the criteria in the first paragraph above:

- a. Insured is under seven years of age,
- b. Insured is developmentally disabled, regardless of age,
- c. Insured whose health is compromised and for whom general anesthesia is medically necessary, regardless of age.

Nothing in this section shall require coverage for the dental procedure itself, including the professional fee of the dentist.

15. Necessary surgical procedures for covered conditions directly affecting the upper and lower jawbone, or associated bone joints. Nothing in this section shall require coverage for dental services, unless dental services are specifically covered under this Policy.

16. Conditions attributable to or exposure to diethylstilbestrol.

17. Reconstructive surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infections, tumors, or disease and do either of the following:

- a. To improve function
- b. To create a normal appearance, to the extent possible

Nothing in this section requires coverage for cosmetic surgery performed to alter or reshape normal structures of the body in order to improve the Insured's appearance.

Reconstructive surgery may not be covered under this Policy:

- a. If We determine there is another more appropriate surgical procedure
- b. If We determine the procedure or procedures, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery, offer only a minimal improvement in the appearance of the Insured.
- c. The surgery or procedure was performed without prior authorization.

18. Progressive, degenerative, and dementing illnesses, including but not limited to Alzheimer's disease, except for a preexisting condition. Nothing in this section requires coverage, unless the Policy provides coverage for long-term care facility services or home-based care.
19. Medically accepted cancer screening tests, subject to all other terms and conditions in the Policy.
20. Diagnosis, treatment, and appropriate management of osteoporosis. Services include, but are not limited to, all Food and Drug Administration approved technologies including medically appropriate bone mass measurement technologies.
21. Coverage will be provided the same as any Sickness for human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to the primary diagnosis.

Nothing contained in this endorsement shall be held to alter, extend, vary or waive any other terms of the Policy, except as stated above. All such other terms of the Policy apply.

Signed for Columbian Life Insurance Company.



DANIEL J. FISCHER
Secretary



THOMAS E. RATTMANN
Chairman, President
and Chief Executive Officer

GENERAL ENDORSEMENT FOR CALIFORNIA RESIDENTS

This Endorsement is made a part of the policy to which it is attached.

PART B - DEFINITIONS is revised as follows:

Domestic Partner means two adults of the same sex who have chosen to share one another's lives in an intimate and committed relationship of mutual caring; have satisfied all the requirements under section 297 of the Family Code; and who have filed a valid Declaration of Domestic Partnership with the Secretary of State pursuant to section 298 of the Family Code or an equivalent document issued by a state agency, or a local agency of another state under which the domestic partnership was created. To obtain coverage as a domestic partner, the insured Student must provide a copy of the valid Declaration of Domestic Partnership to the Policyholder's Student Health Center and to the Plan Administrator. If the domestic partnership terminates, the insured Student must provide written notification to the Plan Administrator within 60 days of the termination. The Plan Administrator shall be entitled to seek recovery for any actual loss resulting from the failure to provide notice of termination.

"Maternity" means a Sickness. Treatment must begin prior to Your Expiration Date of coverage.

"Pre-Existing Condition" means any condition for which medical advice, diagnosis, care or treatment, including use of Prescription Drugs, was recommended or received during the 6 months immediately prior to Your Effective Date of coverage.

Pre-existing conditions are covered after You have been insured under the policy for 6 consecutive months following Your Effective Date of coverage.

"Pre-existing Conditions Waiting Period" means the time period You must have continuous coverage in force under this Policy before a Pre-existing Condition is considered a loss. A Pre-existing Condition Waiting Period does not apply to newborn, a child who is adopted or placed for adoption, or to a condition related to Pregnancy or Maternity.

"Sickness" means Your bodily sickness, mental sickness, or Maternity which causes Loss while Your coverage is in force. Sickness includes pregnancy, Complications of Pregnancy and trauma related disorders due to injury 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.

The following Definition is added to **PART B - DEFINITIONS**:

Prior Creditable Coverage means Your prior Student health insurance policy of the Policyholder or coverage provided in the United States to an individual under any of the following:

1. A group health plan.
2. Health insurance coverage.
3. Part A or Part B Medicare pursuant to Title XVIII of the federal Social Security Act.
4. Medicaid pursuant to Title SIX of the federal Social Security Act.
5. 10 U.S.C. CH. 55.
6. A health or medical care program provided through the Indian Health Services or tribal organization.
7. A state health benefits risk pool.
8. A health plan offered under 5 U.S.C. ch. 89.
9. A public health plan as defined under federal regulations.
10. A health benefit plan under Section 5 (e) of the Peace Corps Act, 22 U.S.C. 2504(e).
11. Any other creditable coverage as defined by subsection c of Section 2701 of Title XXVII of federal Public Health Services Act.

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

PART C - EXCLUSIONS is revised as follows:

9. Intentional self-inflicted Injuries; Loss sustained or contracted in consequence of being intoxicated or under the influence of any controlled substance unless administered on the advice of a Physician; Loss incurred while committing or attempting to commit a felony; or Loss due to voluntary participation in a riot or civil disturbance.
15. Pre-existing Conditions, not subject to Prior Creditable Coverage, until insured by this Policy for six (6) consecutive months following the Effective Date of coverage.

PART D - GENERAL POLICY PROVISIONS is revised by adding the following:

TIME LIMIT ON CERTAIN DEFENSES:

- (a) After two years from the date of issue of this Policy, no misstatement of the Policyholder, except a fraudulent misstatement, made in his application shall be used to void this Policy; and after two years from the effective date of the coverage with respect to which any claim is made no misstatement of any person eligible for coverage under this Policy, except a fraudulent misstatement, made in an application under this Policy shall be used to deny a claim for loss incurred or disability (as defined in this Policy) commencing after expiration of such two years.
- (b) No claims for loss incurred or disability (as defined in this Policy) commencing after six months from the effective date of the insurance coverage with respect to which the claim is made shall be reduced or denied on the ground that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of loss, had existed during the six months immediately prior to the effective date of the coverage with respect to which the claim is made.

CHANGE OF BENEFICIARY: The right to change of beneficiary is reserved to You, and the consent of the beneficiary or beneficiaries shall not be requisite to any change in beneficiary.


SUBROGATION, and any other reference to subrogation is deleted in its entirety.

Nothing contained in this endorsement shall be held to alter, extend, vary or waive any other terms of the Policy, except as stated above. All such other terms of the Policy apply.

Signed for Columbian Life Insurance Company:



DANIEL J. FISCHER
Secretary



THOMAS E. RATTMANN
Chairman, President
and Chief Executive Officer

COLUMBIAN LIFE INSURANCE COMPANY

Home Office: Chicago IL
Administrative Service Office: Vestal Parkway East, P.O. Box 1381
Binghamton, NY 13902-1381

(Herein called We, Our, Us, and Company)

GRIEVANCE NOTICE FOR CALIFORNIA RESIDENTS

This Grievance Notice is issued as part of and ends with the Policy and any Certificate to which it is attached. It is subject to all the terms and provisions of the Policy, except as stated below. Any reference to “you” or “your” automatically extends to any authorized representative acting on your behalf.

DEFINITIONS.

"Complaint" means an expression of dissatisfaction, either oral or written.

"Coverage Decision" means the denial of benefits based on a finding that the health care service is excluded from coverage under the terms and conditions of this Policy.

"Disputed Health Care Service" means any health care service eligible for coverage and benefits have been denied, modified or delayed (in whole or in part) due to a finding that the service is not medically necessary or experimental or investigational.

"Grievance" means a written complaint or appeal submitted by You regarding Our decision, policy, or action related to:
(a) Availability, delivery, or quality of health care services; (b) Claims payment, handling, or reimbursement for health care services, including a complaint or appeal regarding a Medical Necessity or experimental or investigational decision; (c) Any other matter to the contractual relationship between You and Us.

"Grievance Decision" means a final determination by Us that arises from a Grievance filed under Our internal grievance process.

"Independent Medical Review" means the process where expert independent medical professionals review Disputed Health Care Services made by Us.

"Prospective Review" Grievance review of medical necessity, experimental or investigational conducted before any required pre-authorization or pre-certification.

"Retrospective Review" Grievance review of medical necessity, experimental or investigational services and supplies conducted after the services have been provided.

GRIEVANCE SUMMARY

You have the right to file a Grievance in writing for any provision of services or claim practices of Columbian Life Insurance Company which offers a health benefit plan or its administration by Student Assurance Services Inc, our Plan Administrator.

If You have a problem or concern, You should first call the customer service toll free number on your ID Card. A customer service representative will work with You to help You understand your coverage or resolve your problem or concern as quickly as possible. If You disagree with the decision or explanation given, You may submit a written request for a review through Our internal grievance process. Each type of review is discussed in more detail under the section titled “Levels of Review” below.

COLUMBIAN LIFE INSURANCE COMPANY

Home Office: Chicago IL

Administrative Service Office: Vestal Parkway East, P.O. Box 1381 Binghamton, NY 13902-1381

WE DO NOT CERTIFY OR VERIFY BENEFITS OR MAKE DECISIONS FOR TREATMENT OR A SERVICE NOT YET PROVIDED.

You may initiate the internal grievance process by contacting our Plan Administrator, Student Assurance Services, Inc. at the address shown below. You may also contact our Grievance Coordinator at the address or phone number for Columbian Life Insurance Company shown below. You do have the right to:

- 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 your request for benefits relating to the determination that resulted in the claim denial or disenrollment.

You have the right to a first-level Grievance review by submitting a written request within sixty (60) calendar days after you receive notice of the claim denial, or the date of the treatment, event or circumstance. We shall send You a written acknowledgement within fifteen (15) calendar days after we received the Grievance. If We do not have sufficient information or require written authorization to complete the grievance process, You will be notified that We cannot proceed with Our review unless additional information is provided. We will assist You in gathering the necessary information without further delay. The review and response to your Grievance will be completed within thirty (30) calendar days after the receipt of the Grievance or the signed authorization for release of medical records.

If We uphold the first-level Grievance decision, You have the right to a second-level grievance review. A second-level review is initiated by submitting a written request to Us within sixty (60) calendar days after You receive notice of the first-level Grievance Decision. We shall send You a written acknowledgement within fifteen (15) calendar days after We receive the Grievance. The review and response to your Grievance will be completed within thirty (30) calendar days after the receipt of the Grievance.

Our Grievance Decision will be provided to You in writing. Said notice shall:

- The titles and credentials of the person or persons participating in the review process and responsible for the decision;
- A statement of the reviewer's understanding of your grievance;
- The reviewer's decision in clear terms and the contract basis or medical rationale in sufficient detail;
- A reference to the evidence or documentation used as the basis for the decision;
- For a decision involving a Medical Necessity, Experimental or Investigational Determination:
 - The specific reason or reasons for the determination;
 - A reference to the specific plan provisions on which the determination was based;
 - A statement if we relied upon an internal rule, guideline, protocol, or other similar criterion to make the determination; and
 - If appropriate, an explanation of the scientific or clinical judgment for making the determination.
- Your right to request an Independent Medical Review, including the application form.
- A statement of your right to contact the Commissioner of Insurance at any time for assistance.

INDEPENDENT MEDICAL REVIEW

You have the right to apply for an Independent Medical Review for the following Disputed Health Care Services:

- Your claim has been denied, modified or delayed (in whole or in part) because a covered service or treatment was not considered medically necessary; or
- Your claim has been denied for investigational or experimental; or
- Your claim has been denied for urgent or emergency medical services.

The application is sent to the California Insurance Department. We will pay for any application or processing fees. Your decision not to participate in the independent review process may cause You to forfeit any statutory right to pursue legal action against Us for a Disputed Health Care Service. Refer to the section below for more detailed information on the Independent Medical Review process.

COLUMBIAN LIFE INSURANCE COMPANY

Home Office: Chicago IL

Administrative Service Office: Vestal Parkway East, P.O. Box 1381 Binghamton, NY 13902-1381

Grievances can be sent to the following parties:

Columbian Life Insurance Company

Home Office: Chicago IL

Administrative Service Office: Vestal Parkway East, P.O. Box 1381

Binghamton, NY 13902-1381

Attn: Grievance Coordinator

Phone: (607) 724-2472 or (800) 452-0555 (toll free in New York State) or

(800) 423-9765 (toll free outside New York State)

Fax (607) 723-7701

Student Assurance Services, Inc.

P.O. Box 196

Stillwater, MN 55082

Phone: (651) 439-7098 or (800) 328-2739

Fax: (651) 439-0200

You can also contact the Commissioner of Insurance to file a complaint or request assistance:

California Department of Insurance

Consumer Communications Bureau

300 S. Spring Street, South Tower

Los Angeles CA 90013

800-927-HELP (in CA)

213-897-8921 (outside CA)

I. Levels of Review

There are 3 levels of grievance reviews that You may request from Us to review our decisions involving your request for services or your request to have your claims paid. The types of Grievance reviews are:

A. First-Level Grievance Review

B. Second-Level Grievance Review

C. Independent Medical Review

A. First-Level Grievance Review

1. Eligibility

a. Claim for a covered service already provided:

If We deny your claim for a service or treatment that has already been provided or You are dissatisfied with Our decision, You have the right to a Grievance review. You may provide a written request for a Grievance Review within 60 calendar days after receipt of our claim denial to:

Student Assurance Services, Inc.

P.O. Box 196

Stillwater, MN 55082

Attn: Claim Supervisor/Grievance Coordinator

Phone: (651) 439-7098 or (800) 328-2739 Fax: (651) 439-0200

Within 15 calendar days after receiving your Grievance request, We shall send You written acknowledgement showing your request was received.

2. Decision

We will review your request and make a Grievance Decision within 30 calendar days after the date your Grievance was received.

If We do not have sufficient information to complete the Grievance review or require the review of medical records, a written notice will be provided to You. We will make a Grievance Decision within 30 calendar days after receipt of the signed authorization for release of medical records. In the event a signed authorization is not provided, a Grievance decision will be made based on the information provided within 30 calendar days after the date your Grievance was received.

The Grievance will not be reviewed by the same person(s) who was involved in the initial claim denial or handled the matter that is subject of the Grievance. For medical necessity, experimental or investigational reviews, a medical physician or a health care provider who has appropriate training and experience in the field of medicine involved in the medical judgment will evaluate the your grievance. In conducting the review, We shall take into consideration all comments, documents, records, and other information regarding the request for services submitted by You, without regard to whether the information was submitted or considered in making the initial determination.

a. Denial upheld

If denial is upheld, We shall send You a written notice of Our Grievance decision. If You are not satisfied with Our decision, You have the right to request a Second-Level Grievance review. Failure to provide additional information necessary to conduct the Grievance review will result in the claim denial being upheld.

b. Denial reversed

If We reverse the denial, We shall authorize the services or pay the claim.

B. Second-Level Grievance Review

1. Eligibility

a. Claim for a covered service already provided:

If You are dissatisfied with the First-Level Grievance decision, You may make an written request for a Second-Level Grievance review within 30 calendar days after receipt of our first-level claim denial. The Second-Level Grievance review requests can be submitted to:

Student Assurance Services, Inc.
P.O. Box 196
Stillwater, MN 55082
Attn: Claim Supervisor/Grievance Coordinator
Phone: (651) 439-7098 or (800) 328-2739
Fax: (651) 439-0200

Within 15 calendar days after receiving your Grievance request, We shall send You written acknowledgement showing your request was received.

2. Decision

We will review your request and make a Grievance Decision within 30 calendar days after the date your Grievance was received.

The Grievance will not be reviewed by the same person(s) who was involved in the first-level Grievance. For medical necessity, experimental or investigational reviews, a medical physician or a health care provider who has appropriate training and experience in the field of medicine involved in the medical judgment will evaluate the your grievance. In conducting the review, We shall take into consideration all comments, documents, records, and other information regarding the request for services submitted by You, without regard to whether the information was submitted or considered in making the initial determination.

a. Denial upheld

If denial is upheld, We shall send You a written notice of our Grievance decision. For Disputed Health Care Decisions, We will provide you with an application and information concerning your right for an Independent Medical Review.

b. Denial reversed

If We determine that the covered service should have been provided, or that your claim should have been paid, We will authorize the service or pay the claim.

C. Independent Medical Review

1. Eligibility

After exhausting all internal Grievance procedures available, You may complete an application for Independent Medical Review (IMR) only if Our decision involves:

- The medical necessity of a treatment
- An experimental or investigational therapy for a serious medical condition; or
- Emergency or urgent medical services that you have already received.

An IMR cannot be used for a Coverage Decision made by Us, legal interpretations of Policy language, or bad faith allegations or other demands for extra payments under this Policy.

You must apply for IMR within 6 months after receiving Our final Grievance Decision or if We have not made a decision within 30 calendar days after receiving your Grievance. If special circumstances are present, the Insurance Commissioner may consider extending the filing deadline beyond the 6 months.

2. Application and Fees

If You are eligible to obtain an IMR, You may apply by completing the application form. If You do not have any application form, You can request one from the California Department of Insurance website. We are responsible for any application or review fees.

COLUMBIAN LIFE INSURANCE COMPANY

Home Office: Chicago IL

Administrative Service Office: Vestal Parkway East, P.O. Box 1381 Binghamton, NY 13902-1381

You can either mail the application directly to:

California Department of Insurance
Consumer Communications Bureau
300 S. Spring Street, South Tower
Los Angeles CA 90013
800-927-HELP (in CA)
213-897-8921 (outside CA)

or

You can mail the application to the health carrier at the following address (and upon receipt, We will forward Your request to the California Department of Insurance):

Student Assurance Services, Inc.
P.O. Box 196
Stillwater, MN 55082
Phone: (651) 439-7098 or (800) 328-2739
Fax: (651) 439-0200

3. Review Procedures

The California Department of Insurance will, at the time of the receipt of the request for an IMR, assign an Independent Medical Review Organization (IMRO) from the list of certified IMROs and will so inform Us.

If the request for an IMR is not based on a Disputed Health Care Service, but on a Coverage Decision, the California Department of Insurance will instead conduct the review. If there is ambiguity as to what entity should conduct the review, the review will be conducted by an IMRO.

Within 3 business days after the date on which We receive notice of the IMRO from the California Department of Insurance, We will provide to the assigned IMRO all documents and information utilized in making the Disputed Health Care Service, as well as Our final written decision, including:

- A copy of all of your medical records in Our possession relevant to your medical condition, the health care services being provided for that condition, and the Disputed Health Care Services.
- Any newly developed or discovered relevant medical records in Our possession after the initial documents are provided to the IMRO shall be forwarded immediately to the IMRO independent medical review, with copies forwarded to You (or your provider, if authorized by you), unless declined or otherwise prohibited by law.
- A copy of all information provided to You by Us concerning Our and provider decisions regarding your condition and care, and a copy of any materials You or your provider submitted to Us in support of your request for the Disputed Health Care Services. This documentation shall include the Grievance Review determination.
- A copy of any other relevant documents or information used by Us in determining whether the Disputed Health Care Services should have been provided, and any statements by Us explaining the reasons for the decision to deny benefits for the Disputed Health Care Services on the basis of Medical Necessity, with copies forwarded to you (or your provider, if authorized by you), unless declined, prohibited by law, or the Commissioner of the California Department of Insurance determines it to be legally privileged information.

We may at any time determine to provide the requested medical services by so notifying the IMRO or the California Department of Insurance, and you. Such notification will terminate the Independent Medical Review process.

4. Decision

The IMRO shall complete its review and make written a decision within 30 days after receipt of the application for review and supporting documentation. The decision of the IMRO is binding on Us.

II. Obtaining Medical Records

A. Requesting Medical Records

California law permits You to ask for a copy of your medical records. Your request must be in writing. Your request must specify who you want to receive the records. The health care provider who has your records will provide you or the person you specified with a copy of your records.

B. Designated Decision Maker

If You have a designated health care provider, that person must send a written request for access to or copies of your medical records. The medical records must be provided to your health care provider or a person designated in writing by your health care decision maker unless You limit access to your medical records only to yourself or your health care decision maker.

C. Confidentiality

Medical records disclosed will remain confidential.

III. Contact Person at Each Level of Review

Student Assurance Services, Inc.
P.O. Box 196
Stillwater, MN 55082
Attn: Claim Supervisor/Grievance Coordinator
Phone: (651) 439-7098 or (800) 328-2739
Fax: (651) 439-0200

IV. Name and Title of Person Responsible for Processing the Review

Student Assurance Services, Inc.
P.O. Box 196
Stillwater, MN 55082
Attn: Claim Supervisor/Grievance Coordinator
Phone: (651) 439-7098 or (800) 328-2739
Fax: (651) 439-0200

V. Documentation for a Grievance

If You decide to file a grievance, You must give the person who will be responsible for processing the grievance any material justification or documentation at the time the grievance is filed. You must also give that person the address and phone number where you can be contacted.

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VI. Confidentiality

If You participate in the review process, the relevant portions of your medical records may be disclosed only to people authorized to participate in the review process for the medical condition under review. These people may not disclose your medical information to any other people.

The California Department of Insurance and the IMRO shall maintain the confidentiality of any information found by the Commissioner to be proprietary information of Ours and the confidentiality of all your medical record information shall be maintained pursuant to applicable state and federal laws.

Your medical records provided to Us and the IMRO and the findings and recommendations of the IMRO are confidential and will be used only by the California Department of Insurance, the IMRO, and Us. The medical records and findings and determinations will not otherwise be divulged or made public so as to disclose the identity of any person to whom they relate and will not be included under any materials available to public inspection.

VII. Receipt of Documents

Any written notice, acknowledgment, request, decision or other written document required to be mailed is deemed received by the person to whom the document is properly addressed on the fifth business day after being mailed. As discussed above in Section V, "properly addressed means your last known address.

VIII. Maintenance of Records

Records for each grievance received and reviewed, as well as documentation sufficient to demonstrate compliance with state law, will be maintained for three years or until the Commissioner has adopted a final report of the general examination that contains review of these records for that calendar year, whichever is later.

IX. Complaints to the California Department of Insurance

After exhausting Our internal Grievance Process, the Covered Person or the Covered Person's authorized representative on behalf of a Covered Person may file a complaint with the California Department of Insurance relating to a Grievance.