

Brochure of Coverage  
Policy Form 9F149-CL

**Student  
Accident & Sickness Plan**  
a Non-Renewable Term Policy

Designed for

**MID-STATE  
TECHNICAL COLLEGE**

**2011 • 2012**

Administered by



[www.sas-mn.com](http://www.sas-mn.com)  
333 N. Main St. • P.O. Box 196  
Stillwater, MN 55082-0196

Underwritten by



**COLUMBIAN LIFE**  
INSURANCE COMPANY

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

**For assistance and questions about insurance benefits, ID cards, claim status, or claim processing contact the Plan Administrator:**

Student Assurance Services, Inc.  
Post Office Box 196  
Stillwater, MN 55082-0196  
[www.sas-mn.com](http://www.sas-mn.com)  
Phone: (800) 328-2739

**Servicing Agent:**

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

**Policy Number:**

48-64-0173-500-638-1

**INTRODUCTION**

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

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

- Two plan options are available to purchase.
- The maximum benefit for Plan 1 is \$15,000 for each covered injury or sickness
- The maximum benefit for Plan 2 is \$75,000 for each covered injury or sickness
- Plan 2 includes benefits for repatriation and medical evacuation.
- Students may use the hospital or physician of choice.

**STUDENT ELIGIBILITY**

All students under age 65 and attending the participating school are eligible to enroll in the insurance plan. Online and distance learning students taking home study, correspondence, or television courses are not eligible to enroll in the insurance plan.

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

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

**COVERAGE FOR DEPENDENTS**

Students who enroll in the insurance plan may also enroll their eligible dependents. Dependents must enroll when the student first enrolls in the insurance plan and must enroll for the same coverage as the student.

**PLAN 1 & 2 - PERIODS OF COVERAGE**

TERM	DATE COVERAGE BEGINS	DATE COVERAGE ENDS
ANNUAL	08-15-2011	08-14-2012
*1st INSTALLMENT	08-15-2011	12-14-2011
*2nd INSTALLMENT	12-15-2011	04-14-2012
*3rd INSTALLMENT	04-15-2012	08-14-2012

**IMPORTANT:** Coverage becomes effective on the date the coverage period begins or the date after the premium payment is received, whichever is later.

**PLAN 1 - 2011-2012 PREMIUM SCHEDULE**

	Annual	*Installment Premium		
		First	Second	Third
Student Only				
<b>Under Age 30</b>	\$ 384.00	\$ 138.00	\$ 138.00	\$ 138.00
Each Dependent	\$ 960.00	\$ 330.00	\$ 330.00	\$ 330.00
Student Only				
<b>Age 30 and Over</b>	\$ 570.00	\$ 200.00	\$ 200.00	\$ 200.00
Each Dependent	\$ 1,425.00	\$ 485.00	\$ 485.00	\$ 485.00

\*For students selecting the installment method of payment a premium due notice will be sent. The payment for the second installment is due on 12-15-2011 and payment for the third installment is due on 4-15-2012.

**IMPORTANT:** If purchasing partial year coverage, the same plan must be selected for subsequent coverage periods. For example if a student purchases Plan 1 for the first installment coverage period, the student cannot purchase Plan 2 for the second or third installment coverage periods.

**PLAN 2 - 2011-2012 PREMIUM SCHEDULE**

	Annual	*Installment Premium		
		First	Second	Third
Student Only				
<b>Under Age 30</b>	\$ 900.00	\$ 310.00	\$ 310.00	\$ 310.00
Each Dependent	\$ 2,250.00	\$ 760.00	\$ 760.00	\$ 760.00
Student Only				
<b>Age 30 and Over</b>	\$ 1,260.00	\$ 430.00	\$ 430.00	\$ 430.00
Each Dependent	\$ 3,150.00	\$ 1,060.00	\$ 1,060.00	\$ 1,060.00

\*For students selecting the installment method of payment a premium due notice will be sent. The payment for the second installment is due on 12-15-2011 and payment for the third installment is due on 4-15-2012.

**IMPORTANT:** If purchasing partial year coverage, the same plan must be selected for subsequent coverage periods. For example if a student purchases Plan 1 for the first installment coverage period, the student cannot purchase Plan 2 for the second or third installment coverage periods.

**TO ENROLL FOR COVERAGE**

Students can enroll in the plan any time prior to the coverage period effective dates or any time thereafter. **Students have two options to enroll for coverage:**

**OPTION 1 – Enroll Online – Credit Card payment only.** Students can complete an online enrollment form on the website [www.sas-mn.com](http://www.sas-mn.com). **The online form is available under “Find My School”.**

**OPTION 2 – Mail Enrollment Form and Payment**

1. Students can complete the enrollment form or download and print an enrollment form on the website [www.sas-mn.com](http://www.sas-mn.com).
2. Print all information legibly and indicate the coverage and options desired.
3. Enclose a check or money order payable to Student Assurance Services, Inc. or complete all credit card information.
4. Send the form and payment to:  
Student Assurance Services, Inc.  
P.O. Box 196 • Stillwater, MN 55082-0196

**Note:** Students who purchase partial-year coverage will have a 31-day grace period between coverage periods. To avoid a lapse in coverage, premium payment must be received within the grace period. A premium due notice will be mailed to the address on file, however it is the student’s responsibility to make timely premium payments regardless of whether or not a premium due notice is received. Contact the Plan Administrator for payment terms and information at (800) 328-2739 or send an email from website [www.sas-mn.com](http://www.sas-mn.com).

**ID CARDS**

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

**PREMIUM REFUND POLICY**

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

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

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

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

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

## **EFFECTIVE AND EXPIRATION DATES OF COVERAGE**

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

- The Master Policy effective date August 15, 2011, at 12:01 a.m.;
- The first day of the term for which the proper premium has been paid; or
- 12:01 a.m. following the date the proper premium is received by the Plan Administrator.

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

- The Master Policy expiration date August 14, 2012, at 11:59 p.m.; or
- When premium for the insurance coverage is due and unpaid.

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

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

## **CONTINUOUS COVERAGE**

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

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

## SCHEDULE OF BENEFITS

**Basic Maximum Benefit – each covered Injury or Sickness**  
**The co-insurance is 100% of the usual and customary charges incurred, unless otherwise specified below.**  
**The benefit-level maximums are for each covered Injury or Sickness, unless otherwise specified below.**

PLAN 1 BENEFIT  
\$15,000

PLAN 2 BENEFIT  
\$75,000

### **BASIC COVERED SERVICES AND BENEFITS**

<u>BASIC COVERED SERVICES AND BENEFITS</u>	<u>PLAN 1 BENEFIT</u>	<u>PLAN 2 BENEFIT</u>
<b>HOSPITAL ROOM AND BOARD AND HOSPITAL MISCELLANEOUS</b> Benefit is payable up to maximum:	\$500 per day	\$1,000 per day
<b>HOSPITAL EMERGENCY ROOM SERVICES</b> Coverage is limited to injuries; Benefit is payable up to maximum:	\$250	\$500
<b>HOSPITAL OUTPATIENT SURGICAL MISCELLANEOUS</b> Benefit is payable up to maximum:	\$750	\$1,500
<b>SURGICAL TREATMENT</b> Benefit is payable 80% of usual and customary charges, up to maximum:	\$1,500	\$3,000
<b>ANESTHESIA</b>	25% of the Surgical Treatment Benefit	25% of the Surgical Treatment Benefit
<b>ASSISTANT SURGEON</b>	Paid under Surgical Treatment	Paid under Surgical Treatment
<b>PHYSICIAN'S NON-SURGICAL VISITS</b> 1 visit per day, not paid same day as surgery; Benefit is payable up to maximum:	\$50 per visit, up to 5 visits	\$100 per visit, up to 5 visits
<b>CONSULTANT PHYSICIAN</b> When requested by attending physician; Benefit is payable up to maximum:	\$75	\$150
<b>PHYSIOTHERAPY</b> 1 visit per day	Paid under Physician Non-Surgical Visits	Paid under Physician Non-Surgical Visits
<b>OUTPATIENT DIAGNOSTIC X-RAY &amp; LAB SERVICES</b> Benefit is payable for MRI and CAT Scan up to maximum: Benefit is payable for all other x-ray & lab services up to maximum:	\$500 \$300	\$1,000 \$600
<b>MENTAL AND NERVOUS DISORDERS AND SUBSTANCE ABUSE</b> Refer to Mandated Benefits for a description of benefits payable	see page 12-13	see page 12-13
<b>MATERNITY</b> Conception must occur while coverage is in force.	Same as any Sickness	Same as any Sickness
<b>OUTPATIENT PRESCRIPTION DRUGS</b> See page 23; Benefit is payable up to maximum:	\$100	\$200
<b>SHOTS &amp; INJECTIONS</b>	Paid under Physician Non-Surgical Visits	Paid under Physician Non-Surgical Visits
<b>AMBULANCE SERVICES</b> Benefit is for ground service only; Benefit is payable up to maximum:	\$150	\$300
<b>DENTAL TREATMENT</b> Coverage is limited to injuries to sound natural teeth; Does not include biting or chewing injuries; Benefit is payable up to maximum:	\$150	\$300
<b>DENTAL EXTRACTION</b> Coverage is limited to extraction of impacted wisdom teeth; Benefit is payable up to maximum:	\$50 per Tooth	\$100 per Tooth
<b>MOTOR VEHICLE INJURY</b> Benefit is payable the same as any injury; up to a maximum:	\$1,000	\$2,000

## OTHER SCHEDULED BENEFITS

### MEDICAL EVACUATION AND REPATRIATION

**This benefit is available only for students who purchase Plan 2.** These benefits must be approved in advance by contacting the Plan Administrator. The benefit will be paid in addition to any other benefit paid under the Basic Schedule of Benefits.

**Medical Evacuation** – Benefits are payable up to maximum benefit \$10,000  
 Eligible expenses are payable to evacuate a student to their natural country, up to the policy maximum benefit. Benefits are payable when the following requirements are satisfied: 1) the student is hospital confined for at least five consecutive days; and 2) the confinement is recommended and approved by the attending physician.

**Repatriation** – Benefits are payable up to maximum benefit \$7,500  
 If a student dies while insured under the Policy, benefits will be payable for preparing and transporting the remains of the deceased body to the student's home country. Eligible expenses are payable up to the policy maximum benefit.

### BENEFITS MANDATED BY THE STATE OF WISCONSIN

The Policy pays benefits in accordance with any applicable Wisconsin law. Description of these state mandated benefits can be found on pages 12-16. Benefits may be subject to deductibles, co-insurance, limitations, or exclusions.

## EXPLANATION OF BENEFITS

### BENEFIT PAYMENTS

Benefits are payable only for expenses incurred during the policy benefit period. No benefits are payable for expenses incurred prior to or after the insured's effective or expiration dates respectively.

Medical expenses due to a covered injury or sickness are payable for the usual and customary charges as determined by the Policy; and as outlined in the Schedule of Benefits. The Policy does not provide benefits for services which are not listed in the Schedule of Benefits. Benefits will be payable up to the policy year maximum for each covered injury or sickness. In addition to the policy year maximum, the Policy may contain benefit-level maximums for a covered service, as outlined in the Schedule of Benefits.

### PRE-CERTIFICATIONS AND REFERRALS

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

### CO-INSURANCE

**Co-insurance** is the percentage of covered expenses the Policy pays. Refer to the Schedule of Benefits for the amount.

### HOSPITAL EXPENSES

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

1. **Hospital Room and Board:** Benefits are payable for the daily semi-private room rate when hospital confined. The room rate includes an allowance for general nursing care provided for and charged by the hospital.
2. **Hospital Miscellaneous (Inpatient):** Benefits are payable for services and supplies when hospital confined, including but not limited to: the cost of the operating room; laboratory tests; x-ray, examinations; anesthesia; drugs (excluding take home drugs) or medicines; therapeutic services; and supplies. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.

3. **Hospital Outpatient Surgical Miscellaneous:** Benefits are payable for facility expenses (when not hospital confined) for scheduled day surgery at an outpatient surgical care unit or licensed outpatient surgical center. Benefits for services and supplies include but not limited to: the cost of the operating room; laboratory tests; x-ray examinations; anesthesia; drugs (excluding take home drugs); or medicines; therapeutic services; and supplies.
4. **Hospital Emergency Room Services (Outpatient):** Benefits are payable for necessary emergency treatment provided in an urgent care facility or clinic, an observation room, or other room designated by the hospital.

### SURGICAL EXPENSES

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

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

### PHYSICIAN EXPENSES

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

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

### OTHER OUTPATIENT MEDICAL EXPENSES

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

1. **Outpatient Diagnostic X-ray, Radiology, and Lab Services:** Benefits are payable for diagnostic x-rays and radiology services as identified in Physicians' Current Procedural Terminology (CPT) as codes 70000 - 79999 inclusive. Laboratory procedures are those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 80000 - 89999 inclusive. Benefits include radiologist fees, charges for reading, and pathologist fees.
2. **Ambulance Services:** Benefits are payable for professional ground ambulance service, except as specifically listed in the Schedule of Benefits.
3. **Physiotherapy:** Benefits are payable for any form of therapeutic or manual treatment by an eligible provider, including but not limited to: physical or mechanical therapy, diathermy; ultrasonic treatment; EMS; whirlpool; heat treatments; or manipulation. All treatments received during one visit will be subject to the benefit limit shown on the Schedule of Benefits.
4. **Prescription Drugs:** Benefits are payable for the cost of the drug obtained from a licensed pharmacy. Does not include charges for the injection or administration of the drug. Benefits are limited to a 30-day supply for each covered prescription drug. A claim must be submitted for reimbursement, see page 23 for more information.
5. **Dental Treatment:** Benefits are payable for dentist's fees for surgery, x-rays, or dental services related to an accidental injury to sound, natural teeth, including replacement of the injured natural teeth. Benefits do not include tooth fracture due to biting or chewing. Treatment must be completed within the policy period.

### MATERNITY EXPENSES

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

Covered medical expenses include: physician visits; diagnostic services; obstetrical /surgical procedures; hospital room and board; hospital miscellaneous; and medically necessary routine screening examinations and testing as established as the standard of care by the American College of Obstetricians and Gynecologists. Routine screening and testing includes: pregnancy test; alpha-fetoprotein; antibody screening; blood group and Rh type; one pap smear; gestational diabetes screening; hemoglobin or hematocrit; hepatitis

B screening; HIV screening; one ultrasound; rubella antibody measurement; syphilis screening; urinalysis; one amniocentesis for women over age 35; and genetic testing when there is family history of genetic disorders in a parent or a sibling.

### PRE-EXISTING CONDITIONS

The Policy does not cover any condition which originates, is diagnosed, treated, or recommended for treatment within the 12 months immediately prior to insured's effective date of coverage. There are no policy provisions that reduce or eliminate the pre-existing condition waiting period. Exception to this, the Policy will provide coverage for a pre-existing condition in the case of a child who is adopted or placed for adoption.

### BENEFITS MANDATED BY STATE OF WISCONSIN

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

#### Mental or Nervous Disorders, Alcoholism, or Drug Abuse

Benefits are payable under the Policy as follows:

- A. For inpatient care - the lesser of : 100% of covered charges for the first 30 days of hospital confinement; or 90% of the first \$7,000 of covered charges.
- B. For outpatient care - a maximum of 90% of the first \$2,000 of covered charges.
- C. For transitional treatment arrangements - a maximum of 90% of the first \$3,000 of covered charges. "Transitional Treatment Arrangements" means services for the treatment of nervous or mental disorders, or alcoholism, or other drug abuse problems that are provided in a less restrictive manner than inpatient hospital services but in a more intensive manner than outpatient services. It includes the following types of certified services:
  - 1) Adult day treatment;
  - 2) Child and adolescent day treatment;
  - 3) Services for chronically mentally ill persons provided through a community support program;
  - 4) Services in residential treatment programs for alcohol and drug dependent persons;
  - 5) Services for alcoholism and other drug problems in a day treatment program ;
  - 6) Services in intensive outpatient programs provided in accordance with the patient placement criteria for the treatment of psychoactive substance use disorders published by the American Society of Addiction Medicine.

The maximum benefit provided by the Policy, in a policy period, for all inpatient, outpatient, and transitional treatment for mental or nervous disorders, alcoholism, or drug abuse combined is \$7,000.

The maximum benefit for all inpatient, outpatient, and transitional treatment for mental or nervous disorders, alcoholism, or drug abuse provided does not include costs incurred for prescription drugs and diagnostic testing. Coverage for prescription drugs and diagnostic testing are payable the same as any sickness subject to maximums, deductibles, co-insurance, and benefit limits of the Policy.

The amount applied to the maximum benefit will be the lesser of: the actual payment or reimbursement made by the Policy or the amount charged by the provider.

#### **Hospital Inpatient and Outpatient Care for the Treatment of Kidney Disease**

Benefits under the Policy may be limited to dialysis, transplantation, and donor-related services not to exceed \$30,000 annually, as defined by the Department of Health and Family Services.

#### **Home Health Care**

To the extent benefits are provided under the Policy for inpatient hospital care, benefits will be payable for home health care if visits are required at the insured's home. The visit must be provided or coordinated by a state-licensed or medicare-certified home health agency or a certified rehabilitation agency. The Policy will pay the usual and customary charges incurred for such services as limited below:

- A. Benefits will be provided for an injury or sickness if the attending physician certifies that:
  - 1) Hospitalization or confinement in a skilled nursing facility would otherwise be required if visits to insured's home are not provided;
  - 2) Necessary care and treatment are not available from a person who ordinarily resides in the insured's house or from any family member without causing undue hardship to the residing person or family member;
  - 3) A "plan of care" has been established by the attending physician, which will be reviewed every 2 months unless the physician indicates in writing that a longer review period is sufficient. If the insured is confined in a hospital immediately prior to the commencement of home care, the attending physician's "plan of care" shall also be approved by the physician who was the primary provider of services during the hospital confinement.

B. Covered services do not include any services provided by any person residing with insured or any family members, and are limited to:

- 1) Visits for part-time or intermittent home nursing care by or under the supervision of a registered nurse.
- 2) Visits for part-time or intermittent home health aide services, under the supervision of a registered nurse or medical social worker, and such visits consist solely of caring for the insured.
- 3) Visits for physical, respiratory, occupational, or speech therapy.
- 4) Visits for nutrition counseling provided by or under the supervision of a registered dietician.
- 5) Charges for the evaluation of the need for and development of a plan for visits to the insured's home: by a registered nurse; medical social worker; or physician extender.
- 6) Charges for medical supplies, drugs, and medications prescribed by a physician.
- 7) Charges for laboratory services provided by or on behalf of a hospital which were included in the attending physician's "plan of care".

Benefits payable for covered services items 1) through 5) are limited to a maximum of 40 visits during any policy period. Covered services items 6) and 7) are payable to the same extent as during a hospital confinement.

Each visit by a person providing services under a home care plan, or evaluating the need for developing a plan shall be considered as one home care visit. Up to 4 consecutive hours in a 24-hour period of home health aide services shall be considered as one home care visit.

#### **Skilled Nursing Home Confinement**

To the extent benefits are provided under the Policy for hospital care, benefits will be payable for skilled nursing home confinement up to 30 days upon transfer within 24 hours from a hospital to a licensed skilled nursing home. This skilled nursing care must be: certified as medically necessary by the attending physician; recertified as medically necessary every 7 days; must not be domiciliary or custodial; must be continued treatment for the same medical or surgical condition that the insured had been treated at the hospital; and must not be available to insured without charge or under a government health care program. The maximum payable for each day of confinement in a licensed skilled nursing home will be the daily rate established by the Department of Health and Social Services.

## MANDATED BENEFITS (cont.)

### Diabetes Treatment

Benefits are payable under the Policy for diabetes treatment for expenses incurred for the installation and use of an insulin infusion pump, or other equipment or supplies, insulin, or any other prescription medication, used in the treatment of diabetes. Coverage shall include diabetic self-management education programs. Benefits for this care shall be limited to coverage provided on the same basis as any other sickness as provided by the Policy. Coverage for insulin infusion pump is limited to the purchase of one pump per policy year.

### Mammography

Benefits are payable for 2 examinations by low dose mammography for a woman between the ages of 45 to 49. Benefits are not payable if the woman had an examination within the previous 2 years. Benefits are payable for a woman age 50 or over for an annual examination by low dose mammography.

All examinations must be performed at the direction of a licensed physician or nurse practitioner unless: the woman does not have an assigned or regular physician; the woman designates a physician to receive the results of the examination; and any examination previously obtained by the woman was at the direction of a licensed physician or nurse practitioner.

Benefits under this provision may be subject to exclusions, limitations, deductibles, co-pays, and restrictions on excessive charges that are applied to other radiological examinations covered under the Policy.

### Blood Lead Tests

Benefits are payable for blood lead tests for children under 6 years of age. Such screening tests will be conducted in accordance with the screening protocols established by the Department of Health and Social Services.

### HIV Infection

To the extent benefits are provided under the Policy for prescription drugs, benefits will be payable for drugs approved by the Federal Food and Drug Administration, and prescribed by a physician for treatment of the HIV infection or an illness or medical condition arising from or related to the HIV infection. Benefits shall include use of an investigational new drug that is prescribed and administered in accordance with treatment protocol approved by the Federal Food and Drug Administration. This Benefit is subject to all the policy limitations as applied to other prescription drugs covered by the Policy.

### Breast Reconstruction

Benefits are payable under the Policy for breast reconstruction of the affected tissue due to a mastectomy.

### Dental Care

Benefits are payable for hospital or ambulatory surgery center services and anesthetics provided for dental care treatment to an insured if any of the following apply:

- 1) The insured is a child under the age of 5 years; or
- 2) The insured has a chronic disability that meets all of the conditions under Wisconsin law; or
- 3) The insured has a medical condition that requires hospitalization or general anesthesia for dental care.

### Temporomandibular Disorders

Benefits are payable under the Policy for diagnostic procedures and medically necessary surgical or nonsurgical treatment for the correction of temporomandibular disorder if all of the following apply:

- 1) The condition is caused by congenital, developmental or acquired deformity, disease, or injury; and
- 2) Under the accepted standards of the profession of the health care provider rendering the service, the procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition; and
- 3) The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.

Benefits are payable for nonsurgical treatment that includes prescribed intraoral splint therapy devices. Diagnostic procedures and medically necessary nonsurgical treatment for correction of temporomandibular disorders will not exceed \$1,250 annually. Benefits are not payable for cosmetic, elective orthodontic care, periodontic care, or general dental care.

## EXCLUSIONS

The Policy does not provide benefits for expenses resulting from:

1. Air flight, except as a fare-paying passenger on a regularly scheduled flight of a commercial airline.
2. Dental treatment, except as specifically provided in the Schedule of Benefits.
3. Treatment where no injury or sickness is involved (physical examinations or preventive medicines); or elective surgery and elective treatment; 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.

## EXCLUSIONS (cont.)

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; orthopedic appliances; durable medical equipment; treatment for foot care including care of flat feet, corns, calluses, bunions, weak feet, chronic foot strain, and supportive foot devices.
6. Injury or sickness for which benefits are paid under Worker's Compensation or Occupational Disease Act or Law.
7. Contraceptive drugs and devices; growth hormone therapy; patient controlled analgesia; allergy treatment.
8. Injury sustained while participating in the practice or play of interscholastic sports or intercollegiate sports, including the participation in any practice or conditioning program for such sport, contest or competition.
9. Intentional self-inflicted Injuries; 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 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.
15. Pre-existing conditions.
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 programs and related nutritional supplies; treatment of obesity; surgery for the removal of excess skin or fat for weight reduction or treatment of obesity.

## MASTER POLICY DEFINITIONS

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

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

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

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

**Dependent** means:

- a) the insured student's spouse; or domestic partner;
- b) the insured student's unmarried natural child (including step-children if dependent on the insured student) under the age of twenty-six (26), who is not self-supporting; or
- c) the insured student's grandchild, if dependent on the insured student, under the age of eighteen (18); or
- d) Newborn child of the insured student or covered single dependent will be covered from birth until 60 days old. Coverage for such child will be for sickness or injury including necessary care and treatment for congenital defects and birth abnormalities. For coverage to continue after 60 days, we must be notified and receive additional premium, if any is required. If we are not notified within 60 days, you have up to one year to notify us and make payment of the premium, if any is required, plus interest at the rate of 5 1/2% per year; or
- e) Adopted child of the insured student or a child placed for adoption with the insured student will be covered until 60 days after the date the court has issued a final order granting adoption of the child by the insured or the date that the child is placed for adoption with the insured, whichever occurs first. Coverage for such child will be for sickness or injury, including necessary care and treatment for congenital defects and birth abnormalities. For coverage to continue after 60 days, we must be notified and receive additional premium, if any is required. If we are not notified within 60 days, you have up to one year to notify us and make payment of the premium, if any is required, plus interest at the rate of 5 1/2% per year. Coverage will continue until the legal obligation for the purposes of adoption ends, or the policy expiration date, whichever occurs first; or
- f) A child over the age of 23 who is incapable of self-sustaining employment because of mental retardation or physical handicap, and is chiefly dependent upon the insured student for maintenance and support.

## DEFINITIONS (cont.)

Handicapped dependents of the insured student are covered on the same basis as any other dependent.

Proof of a dependent child's incapacity or continued 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.

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

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

**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.

**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 be accredited by the Joint Commission on the Accreditation of Healthcare Organizations. This does not include a facility primarily designed for use as an extended care facility, convalescent nursing home, or skilled nursing facility. Hospital for mental and nervous disorders and substance abuse includes facilities licensed by the state to provide inpatient mental and nervous or substance abuse services or treatment in the state it is located.

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

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

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

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

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

## DEFINITIONS (cont.)

**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.

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

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

**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.

**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.

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

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

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

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

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

### COORDINATION OF BENEFIT

The coordination of benefits (COB) provision applies to the Policy when the insured has medical insurance coverage under more than one plan. The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans do not exceed 100% of the charges incurred for covered services and supplies.

### CLAIM PROCEDURE

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

### PRESCRIPTION DRUG CLAIM PROCEDURE

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

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

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

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

### COMPLAINTS AND CLAIM APPEALS

An insured has a right to file a grievance in writing for any provision of services or claim practices of Columbian Life Insurance Company which offers an insurance plan or its claim administration by Student Assurance Services, Inc. (Plan Administrator).

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

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

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

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

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

### PRIVACY NOTICE

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

### HEALTH CARE REFORM

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