

Brochure of Coverage  
Policy Form 9F138-CL

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

Designed for

**OUR LADY OF THE LAKE  
UNIVERSITY**

**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

**Servicing Agent:**

Paul Fisher  
 PINNACLE STUDENT INSURANCE  
 25 Overlook Circle  
 New Braunfels, TX 78132  
 (877) 626-0360

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

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

**Preferred Provider Directory or Questions**

Beech Street  
 Customer Service:  
 Toll-Free: (800) 937-2277  
 Website: [www.beechstreet.com](http://www.beechstreet.com)

**Policy Number:**

42-64-0021-024-615-1

**INTRODUCTION**

The University 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 University or available for review by contacting Student Assurance Services, Inc. The Master Policy contains the contract provisions and shall prevail in the event of any conflict between this brochure and the Master Policy.

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

- The basic maximum benefit is \$50,000 for each covered injury or sickness.
- An option is available to purchase the major medical benefit with a lifetime maximum of \$100,000 for each covered injury or sickness.
- An option is available to purchase the intercollegiate sports benefit with a maximum of \$500 for each covered sports injury.
- Repatriation and medical evacuation benefits providing 24-hour assistance services are included.
- 24-hour nurse line program providing phone based health information is included.
- To maximize savings and reduce out-of-pocket expenses, select a Beech Street network provider. These providers have agreed to provide services at discounted rates.

**STUDENT ELIGIBILITY**

**All registered international students taking 1 or more credit hours** are required to have health insurance coverage. Students are enrolled in the basic injury and sickness benefit of the insurance plan at registration. Premium is added to the student's account.

**Full-time student athletes** are required to have health insurance coverage either through the insurance plan or through another individual or family plan. Athletes must enroll in the insurance plan or waive coverage. Athletes may waive coverage by completing the waiver form and returning it to the University Business Office. Athletes who initially waive coverage may not enroll in the insurance plan at a later date, except for late enrollment.

Optional major medical coverage may be purchased on a voluntary basis.

**All other registered domestic students** taking 6 or more credit hours are eligible to enroll in the insurance plan on a voluntary basis. **Students must enroll no later than the enrollment period deadline dates shown on page 4.**

Students age 65 or older, or online and distance learning students taking home study, correspondence, or television courses are not eligible to enroll in the insurance plan. Students must be physically and actively attending classes to enroll in the insurance plan. Except for medical withdrawal due to a covered injury or sickness, any student withdrawing from the University during the first 31 days after the effective date of coverage shall not be covered under the insurance plan. Students who graduate or withdraw from the University 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 by the enrollment period deadline date **shown on page 4**. Enrollment forms and premium payments received after this date will only be accepted for dependents of new students and dependents who qualify for late enrollment. Dependents must enroll when the student first enrolls in the insurance plan and must enroll for the same coverage as the student.

PERIODS OF COVERAGE			
TERM	DATE COVERAGE BEGINS	DATE COVERAGE ENDS	ENROLLMENT PERIOD DEADLINE DATE
ANNUAL	08-01-2011	07-31-2012	09-01-2011
*FALL INSTALLMENT	08-01-2011	01-03-2012	09-01-2011
*SPRING/SUMMER INSTALLMENT	01-04-2012	07-31-2012	02-04-2012
FALL	08-01-2011	01-03-2012	09-01-2011
**SPRING/SUMMER	01-04-2012	07-31-2012	02-04-2012
**SUMMER	06-01-2012	07-31-2012	07-01-2012

\*The fall and spring/summer installment method of payment is only available for student athletes purchasing annual coverage.

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

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

2011-2012 PREMIUM SCHEDULE				
	Annual	Fall	Spring/Summer	Summer
Student Only	\$ 500.00	\$ 222.00	\$ 278.00	\$ 100.00
Student & Spouse	\$2,000.00	\$ 888.00	\$1,112.00	\$ 400.00
Student, Spouse & Child(ren)	\$3,000.00	\$1,332.00	\$1,668.00	\$ 600.00
Student & Child(ren)	\$1,500.00	\$ 666.00	\$ 834.00	\$ 300.00

  

	Annual	*INSTALLMENT Fall	Spring/Summer	**Spring/Summer
Student Athlete Only	\$1,200.00	\$ 600.00	\$ 600.00	\$ 689.00

Intercollegiate Sports coverage is required by the University if the student is an athlete and purchasing the accident and sickness coverage. Premium includes injury, sickness and sports coverage. \*The installment method of payment is only available to student athletes purchasing annual coverage. \*\*For new athletes not previously eligible to enroll for annual or fall coverage.

**Optional Major Medical - \$ 400.00 per person**

Students must be enrolled in the basic injury and sickness benefit of the insurance plan in order to purchase optional major medical coverage, and coverage must be purchased when first enrolled in the plan. Optional coverage will terminate when the accident and sickness plan terminates. Optional coverage can be purchased for the student only, or for the student and dependents. Optional coverage is not available for dependents only.

**LATE ENROLLMENT**

Students and dependents may enroll after the enrollment period deadline dates only if there is a qualifying event. Qualifying events include involuntary loss of coverage under another health plan, marriage, birth or adoption of a child. **Enrollment in this plan must be received no later than 30 days after the qualifying event.** Students should notify The Plan Administrator or the Servicing Agent immediately when eligible for late enrollment.

**INTERNATIONAL STUDENTS AND STUDENT ATHLETES TO ENROLL FOR COVERAGE**

International students are required to enroll in the insurance plan. Student athletes are required to enroll in the insurance plan, unless proof of other coverage is provided to the University Business Office. Students may enroll by completing the enrollment form and returning it to the University Business Office at registration.

**ALL OTHER STUDENTS AND DEPENDENTS TO ENROLL FOR COVERAGE**

All other registered domestic students (who are not athletes) or students who wish to enroll for dependent coverage may enroll any time prior to the coverage period through the end of the enrollment period deadline date. 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. 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

**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 the University 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

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

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

- The Master Policy effective date August 01, 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 or University.

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

- The Master Policy expiration date July 31, 2012, at 11:59 p.m.; or
- When premium for the accident and sickness insurance coverage is due and unpaid.

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

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

### **CONTINUOUS COVERAGE**

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

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

### **INSURANCE CONTINUATION AND EXTENSION**

A six-month continuation of insurance coverage or a 90-day extension of coverage for hospital confinement is available on the insured's expiration date of coverage. The insured must satisfy all eligibility requirements. Refer to the Master Policy or contact the Plan Administrator at [www.sas-mn.com](http://www.sas-mn.com) for details.

## SCHEDULE OF BENEFITS

Basic Maximum Benefit – each covered Injury or Sickness .....	\$ 50,000
Basic Deductible - per person - each covered Injury or Sickness (see Student Health Services page 9) .....	\$50
Optional Major Lifetime Medical Maximum Benefit - each covered Injury or Sickness .....	\$100,000
Optional Intercollegiate Sports Maximum Benefit - each covered sports Injury .....	\$500

COVERED SERVICES AND BENEFIT LIMITS	In-Network Basic Benefit	Out-of-Network Basic Benefit
<b><u>INPATIENT</u></b>		
<b>HOSPITAL ROOM AND BOARD AND HOSPITAL MISCELLANEOUS</b> Benefit is payable for semi-private room rate, up to maximum \$1,000 per day	80%	60%
<b>HOSPITAL INTENSIVE CARE</b> Includes 24-hour nursing care; Benefit is payable under Hospital Room and Board and Hospital Miscellaneous	80%	60%
<b>SURGICAL TREATMENT</b> Benefit is payable up to maximum \$2,500	80%	60%
<b>ASSISTANT SURGEON</b>	No Benefit	No Benefit
<b>ANESTHESIA</b>	25% of Surgical Treatment Benefit	25% of Surgical Treatment Benefit
<b><u>PHYSICIAN'S NON-SURGICAL VISITS</u></b>		
Benefit is payable \$50 per day; 1 visit per day; not paid same day as surgery	80%	60%
<b><u>PHYSIOTHERAPY</u></b>		
Benefit is payable under Hospital Room and Board and Hospital Miscellaneous	80%	60%
<b><u>PATHOLOGY AND RADIOLOGY</u></b>		
Benefit is payable under Hospital Room and Board and Hospital Miscellaneous	80%	60%
<b><u>MATERNITY</u></b>		
<b>PRE-ADMISSION TESTING</b> Within 3 days of admission; Benefit is payable under Hospital Room and Board and Hospital Miscellaneous	80%	60%
<b><u>OUTPATIENT</u></b>		
<b>HOSPITAL SURGICAL MISCELLANEOUS</b> Benefit is payable up to maximum \$1,000		
80%	80%	60%
<b>SURGICAL TREATMENT</b> Benefit is payable up to maximum \$2,500		
80%	80%	60%
<b>ASSISTANT SURGEON</b>		
No Benefit	No Benefit	No Benefit
<b>ANESTHESIA</b>		
25% of Surgical Treatment Benefit	25% of Surgical Treatment Benefit	25% of Surgical Treatment Benefit
<b><u>OUTPATIENT MISCELLANEOUS SERVICES</u></b>		
Benefit is payable up to aggregate maximum \$600 for following: 1. Physician Non-Surgical Visits 1 visit per day; Not paid same day as surgery; 2. Physiotherapy 1 visit per day 3. Hospital Emergency Room 4. Diagnostic X-ray and Lab Services 5. Chemotherapy and Radiation Therapy	80%	60%
<b><u>MATERNITY</u></b>		
Same as any Sickness	Same as any Sickness	Same as any Sickness
<b><u>PRESCRIPTION DRUGS</u></b>		
Benefit is payable up to policy year maximum \$300; 30-day supply per prescription drug; see page 28	50%	50%
<b><u>OTHER INPATIENT OR OUTPATIENT</u></b>		
<b>AMBULANCE SERVICES</b> Benefit for ground service only; Benefit is payable up to maximum \$300		
80%	80%	80%
<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 \$250		
80%	80%	80%
<b>CONSULTANT PHYSICIAN</b> When requested by attending physician; Benefit payable up to maximum \$100		
80%	80%	60%
<b><u>MENTAL AND NERVOUS DISORDERS</u></b>		
<b>Inpatient</b> - Benefit is payable the same as any sickness, up to policy year maximum \$3,000		
<b>Outpatient</b> - In-Network benefit is payable 80% negotiated fee, up to \$50 per day, policy year maximum \$500; or Out-of-Network no benefits available	As Described	As Described

## OTHER SCHEDULED BENEFITS

### OPTIONAL MAJOR MEDICAL BENEFIT

If this coverage is purchased, benefits are payable under the Basic Injury and Sickness Schedule of Benefits first, until the \$50,000 basic medical maximum has been paid for each covered injury or sickness. After the basic medical maximum has been satisfied, benefits are then payable under the Optional Major Medical benefit. When services are provided by preferred provider, benefits are payable at 80% of the in-network negotiated fee. When services are provided by non-preferred provider, benefits are payable at 70% of the out-of-network usual and customary charge incurred. Benefits are payable up to a \$100,000 lifetime maximum lifetime benefit for each covered injury or sickness. This maximum includes the benefits payable under Basic Injury and Sickness and Optional Major Medical. The following services are not payable under this benefit: mental and nervous disorders, substance abuse; motor vehicle injuries; dental treatment; assistant surgeon; or intercollegiate sports injuries.

### OPTIONAL INTERCOLLEGIATE SPORTS INJURY BENEFIT

If this coverage is purchased, benefits are payable up to a maximum benefit of \$500 for each covered intercollegiate sports injury. Benefits for covered services are paid the same as any injury. The intercollegiate sports maximum benefit is separate and does not include the benefits payable under the Basic Injury and Sickness benefit. No benefits are payable under the Optional Major Medical Benefit.

### \*STUDENT HEALTH SERVICE (SHS)

When non-emergency care is needed, students are strongly encouraged to use the student health service (SHS) first. If the SHS does not provide the care needed, they can provide the student with information to make informed health care decisions. When a student receives treatment at SHS, the basic Injury and Sickness deductible is waived.

### BENEFITS MANDATED BY THE STATE OF TEXAS

The Policy pays benefits in accordance with any applicable Texas law. Description of these state mandated benefits can be found on pages 14-18. Benefits may be subject to deductibles, coinsurance, limitations or exclusions.

### ADDITIONAL PROGRAMS

\*GLOBAL EMERGENCY SERVICES (Travel Assistance) ..... see details page 21-22

\*ASK MAYO CLINIC (Nurse Line) ..... see details page 22

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

## EXPLANATION OF BENEFITS

### BENEFIT PAYMENTS

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

Medical expenses under basic injury and sickness and optional major medical benefits are payable at the in-network co-insurance for the preferred provider negotiated fee or the out-of-network co-insurance for the non-preferred provider usual and customary charges. Benefits will be payable up to the policy year maximum for each covered injury or sickness. In addition to the policy maximum benefit, 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 AND DEDUCTIBLE

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

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

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

### HOSPITAL EXPENSES

The following medically necessary hospital expenses are payable, not to exceed any benefit limits listed in the Schedule of 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 (Outpatient):** Benefits are payable for necessary emergency treatment. Benefits include staff physician, use of emergency room, and supplies.

### SURGICAL EXPENSES

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

1. **Surgical Treatment:** 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. **Anesthetist (Anesthesia):** Benefits are payable for the administration of anesthesia in connection with the surgery or a covered test or procedure, when performed by a physician and certified registered nurse anesthetist.

### PHYSICIAN EXPENSES

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

1. **Physician's Non-Surgical Visits (Inpatient):** Benefits are limited to one visit per day. Benefits are not paid for a visit on the same day as surgery. Covered visits will be paid under the inpatient benefit or under the outpatient benefit, but not both on the same day.
2. **Physician's Non-Surgical Visits (Outpatient):** Benefits are limited to one visit per day and include all physician services and ancillary supplies received during the visit, except as specifically provided in the Schedule of Benefits. Benefits are not paid for a visit on the same day as surgery. Covered visits will be paid under the inpatient benefit or under the outpatient benefit, but not both on the same day.
3. **Consultant Physician:** Benefits are payable when 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, 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 pathologist fees, charges for reading x-rays, and lab services.
2. **Ambulance Services:** Benefits are payable for professional ground ambulance service, except as specifically listed in the Schedule of Benefits
3. **Physical Therapist (Physiotherapy):** Benefits are payable for the services of a physical therapist including any form of: diathermy; ultrasonic treatment; EMS; whirlpool; or heat treatments. 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. Benefit does not include charges for the administration of the drug. Benefits are limited to a 30-day supply per prescription drug. A claim must be submitted for reimbursement; see page 28 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.

### **PRE-EXISTING CONDITION**

The Policy does not cover any condition for which medical advice or treatment was received or recommended within the 12 months immediately prior to insured's effective date of coverage.

A pre-existing condition is subject to a 12-month pre-existing condition waiting period. During this waiting period, the insured must be continuously covered under the Policy for 12 consecutive months. The pre-existing condition waiting period must expire before benefits for a pre-existing condition will be considered for payment under the Policy. If any break in continuous coverage occurs, the pre-existing condition exclusion will apply.

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

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

Prior creditable coverage means the prior student health insurance policy of the policyholder or other health 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; health maintenance organization contract; Medicare; Medicaid; military health care; a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; the federal employee health benefits program; a public health plan; or a health benefit plan of the Peace Corps.

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

## BENEFITS MANDATED BY STATE OF TEXAS

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

### **Cognitive Therapy**

Benefits are payable under the Policy the same as any sickness for treatment as a result of, and related to, an acquired brain injury. Services include: cognitive rehabilitation therapy; cognitive communication therapy; neurocognitive therapy and rehabilitation; neurobehavioral, neurophysiological, neuropsychological and psychophysiological testing or treatment; neurofeedback therapy; remediation; post-acute transition services; or community reintegration services.

### **Breast Reconstruction**

Benefits are payable under the Policy the same as any sickness for breast reconstruction in connection with a mastectomy at all stages of the mastectomy, in a manner determined by the attending physician and the insured. Covered services include: reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications, including lymphedemas.

### **Prescription Contraceptive Drug or Device**

To the extent benefits are payable under the Policy for prescription drugs or devices, benefits shall include: a prescription contraceptive drug or device approved by the Food and Drug Administration, and any outpatient contraceptive services. Outpatient contraceptive services include: consultation; examination; procedure or medical service that is provided on an outpatient basis; and is related to the use of a drug or device intended to prevent pregnancy. No coverage is provided for abortifacients or any other drug or device that terminates a pregnancy.

### **Temporomandibular Joint Disorder**

Benefits are payable under the Policy the same as any sickness for the diagnostic or surgical treatment of conditions affecting the temporomandibular joint (including the jaw and the craniomandibular joint) that is medically necessary as a result of: an accident; a trauma; a congenital defect; a developmental defect; or a pathology.

### **Inpatient Care for Treatment Of Breast Cancer**

Benefits with respect to inpatient care for treatment of breast cancer covered under the Policy are payable for a minimum of: 48-hours following a mastectomy; and 24-hours following a lymph node dissection. The minimum inpatient care will not apply if the insured and the attending physician determine that a shorter period of inpatient care is appropriate.

### **Telehealth Service**

Benefits are payable under the Policy for services provided through a telemedicine medical service or a telehealth service. The treating physician or health professional who provides or facilitates the use of a telemedicine medical service or telehealth service must ensure that: the appropriate informed consent is obtained before such services are provided; and the confidentiality of the patient's medical information is maintained as required by Texas law.

Telehealth service means: a health service, other than a telemedicine medical service, delivered by a licensed or certified health professional who requires the use of advanced telecommunications technology, other than by telephone or facsimile, including:

- a. Compressed digital interactive video, audio, or data transmission;
- b. Clinical data transmission using computer imaging by way of still-image capture;
- c. Other technology that facilitates access to health care services or medical specialty expertise.

### **Well Child Care**

Benefits are payable under the Policy the same as any sickness for well child care. Benefits include childhood immunizations for a covered dependent child from birth through the date the child is 6 years of age for: diphtheria; haemophilus influenzae type b; hepatitis B; measles; mumps; pertussis; polio; rubella; tetanus; varicella; and any other immunization that is required by law for the child.

The deductible or co-insurance will not apply to immunizations, but will apply to any other service provided at the same time as the immunizations.

Well child care also includes: (a) a screening test for hearing loss from birth through the date the child is 30 days old; and (b) medically necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months old. This benefit will be paid without application of any deductible. The co-insurance will apply.

## MANDATED BENEFITS (Cont.)

### Prostate Cancer Screening

Benefits are payable under the Policy the same as any sickness for a physical examination for the detection of prostate cancer. Benefits include a prostate-specific antigen test used for the detection of prostate cancer for each male insured who is: at least 50 years of age and asymptomatic; or at least 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

### Colon Cancer Screening

Benefits are payable under the Policy the same as any sickness for screening medical procedures for the detection of colorectal cancer. Coverage is for insureds 50 years of age or older and at normal risk for developing colon cancer. Benefits include: a fecal occult blood test performed annually; a flexible sigmoidoscopy performed every 5 years; or a colonoscopy performed every 10 years.

### Craniofacial Abnormalities of a Covered Dependent

Benefits are payable under the Policy the same as any sickness for reconstructive surgery for craniofacial abnormalities of a covered dependent under 18 years of age. Reconstructive surgery for craniofacial abnormalities means surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by: congenital defects; developmental deformities; trauma; tumors; infections; or disease.

### Off-Label Prescription Drug Use

Benefits are payable under the Policy for a drug prescribed for an off-label use and the medically necessary services associated with its administration that is prescribed to an insured for a chronic, disabling, or life-threatening illness if the drug:

- a. Has been approved by the Food and Drug Administration for at least one indication; and
- b. Is recognized for treatment of the indication for which the drug is prescribed in a prescription drug reference compendium, or substantially accepted peer-reviewed medical literature. This means published scientific studies in any peer-reviewed national professional journal.

Benefits will not be provided for:

- a. Experimental drugs not otherwise approved for any indication by the Food and Drug Administration; or
- b. Any disease or condition that is excluded from coverage under the Policy; or
- c. A drug the Food and Drug Administration has determined to be contraindicated for treatment of the current indication.

### Diabetes

Benefits are payable under the Policy the same as any sickness for a qualified insured for: diabetes equipment; diabetes supplies; and diabetic self-management training programs. A "qualified insured" means an insured who has been diagnosed with: (a) insulin dependent or noninsulin dependent diabetes; (b) elevated blood glucose levels induced by pregnancy; or (c) another medical condition associated with elevated blood glucose levels.

Diabetes equipment and supplies for the treatment of diabetes for which a physician has written an order includes:

1. Blood glucose monitors, including those designed to be used by or adapted for the legally blind;
2. Test strips specified for use with a corresponding glucose monitor;
3. Lancets and lancet devices;
4. Visual reading strips and urine testing strips and tablets which test for glucose, ketones, and protein;
5. Insulin and insulin analog preparations;
6. Injection aids, including devices used to assist with insulin injection and needleless systems;
7. Insulin syringes;
8. Biohazard disposal containers;
9. Insulin pumps, both external and implantable, and associated appurtenances, that includes:
  - a. insulin infusion devices;
  - b. batteries;
  - c. skin preparation items;
  - d. adhesive supplies;
  - e. infusion sets;
  - f. insulin cartridges;
  - g. durable and disposable devices to assist in the injection of insulin; and
  - h. other required disposables;
10. Repairs and necessary maintenance of insulin pumps not otherwise provided for under a manufacturer's warranty or purchase agreement. Includes rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump;
11. Prescription medications which bear the legend "Caution: Federal Law prohibits dispensing without a prescription" and medications available without a prescription for controlling the blood sugar level;
12. Podiatric appliances, including up to two pairs of therapeutic footwear per year, for the prevention of complications associated with diabetes; and
13. Glucagon emergency kits.

As new or improved treatment, monitoring equipment, or supplies become available and are approved by the Food and Drug Administration, such equipment or supplies will be covered if determined to be medically necessary and appropriate by a treating physician through a written order.

## MANDATED BENEFITS (Cont.)

All supplies, including medications, and equipment for the control of diabetes must be dispensed as written, including brand name products; unless substitution is approved by the physician who issues the written order for the supplies or equipment.

Covered diabetes self-management training that a physician has written an order for the insured include:

1. A diabetes self-management training program recognized by the American Diabetes Association;
2. A multidisciplinary team coordinated by a Certified Diabetes Educator (CDE) who is certified by the National Certification Board for Diabetes Educators. The team shall consist of at least a dietitian and a nurse educator, other team members may include a pharmacist and a social worker. Other than a social worker, all team-members must have recent didactic and experiential preparation in diabetes clinical and educational issues;
3. A Certified Diabetes Educator (CDE); or
4. A licensed health care professional, including a physician, a physician assistant, a registered nurse, a licensed or registered dietitian, or a pharmacist, who has been determined by his licensing board to have recent didactic and experiential preparation in diabetes clinical and educational issues.

All individuals providing self-management training must be licensed, registered, or certified in Texas to provide appropriate health care services. Self-management training includes the development of an individualized management plan that this is created for and in collaboration with the insured and that meets the requirements relating to Texas minimum standards for benefits for persons with diabetes.

Medical nutritional counseling and instructions on the proper use of diabetes equipment and supplies shall be provided or covered as part of the training.

Coverage for diabetes self-management training shall be provided to an insured, upon the following occurrences relating to an insured, provided that any training involving the administration of medications must comply with the applicable delegation rules from the appropriate licensing agency:

1. The initial diagnosis of diabetes;
2. The written order of a physician indicating that a significant change in the symptoms or condition of the insured requires changes in the insured's self-management regime;
3. The written order of a physician that periodic or episodic continuing education is warranted by the development of new techniques and treatment for diabetes.

## 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 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.
4. 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, unless optional coverage for care and treatment of loss or impairment of speech or hearing is elected.
5. Injury or sickness for which benefits are paid under Worker's Compensation or Occupational Disease Act or Law.
6. 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 provided in the Schedule of Benefits.
7. Intentional self-inflicted injuries; including drug overdose; loss incurred while committing or attempting to commit a felony; or loss due to voluntary participation in a riot or civil disturbance.
8. Routine newborn baby care, well baby nursery, and related physician's charges.
9. 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.
10. Substance Abuse.
11. 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.
12. War or act of war, whether declared or not; and injury or sickness resulting from full-time, active-duty military service.
13. Pre-existing conditions, not subject to credit for prior coverage, until continuously covered by the University's student accident & sickness insurance plan for a period of 12 consecutive months.

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

**PREFERRED PROVIDER NETWORK**

Persons insured under the plan may choose to be treated within, or out of, the Beech Street preferred provider network. The Beech Street preferred provider network consists of hospitals, doctors, and other healthcare providers, which are organized into a network for the purpose of delivering quality health care at a negotiated fee. Beech Street preferred providers may be accessed throughout the United States, with the exception of Hawaii. If medical treatment is received from a Beech Street preferred provider, a higher reimbursement will be received towards the insured's covered medical expenses.

When an insured uses the services of a Beech Street preferred provider, the covered expenses are payable at the in-network co-insurance for the negotiated fee. However, when treatment is received by a non-preferred provider, covered expenses are payable at the out-of-network co-insurance for the usual and customary charges incurred. Co-insurance for in-network and out-of-network can be found on the Schedule of Benefits on page 8.

In order to use the services of a Beech Street preferred provider, you must present your student accident and sickness insurance ID card.

**Exception:** Benefits are payable at the Beech Street in-network co-insurance level even though a non-preferred provider is used under the following circumstances:

1. the Beech Street preferred provider contract is terminated and the insured has special circumstances such as: a disability; acute condition; life-threatening illness; insured is past the 24th week of pregnancy; and is receiving treatment in accordance with the dictates of medical prudence.
2. Services are not available through the Beech Street service area. However, this does not require reimbursement at the Beech Street in-network co-insurance level if the insured resides out of the service area and chooses to receive services from a non-preferred provider for the insured's convenience.
3. Care is necessary for a medical emergency and services are received outside the Beech Street service area and a non-preferred provider is used.

Insureds are not responsible for the difference between the in-network provider's usual billed charge and the in-network negotiated fee. Insureds are responsible for any differences due to deductibles, co-insurance, copays, benefit limitations, and exclusions.

A complete listing of Beech Street preferred providers is available on the website: [www.beechstreet.com](http://www.beechstreet.com) or by calling toll-free to (800) 937-2277. The participation of individual providers is subject to change without notice. It is the insured's responsibility to confirm a preferred provider's participation in the Beech Street network when calling for an appointment or at time of visit.

**GLOBAL EMERGENCY SERVICES PROGRAM**  
**(TRAVEL ASSISTANCE)**

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

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

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

1. Medical Consultation, Evaluation & Referral - Calls to the Operations Center are evaluated by medical personnel and referred to the appropriate provider.
2. Foreign Hospital Admission Guarantee - SES will guarantee hospital admission outside the United States by validating a student's health coverage or by advancing funds to the hospital. (Any emergency hospital admittance deposit must be repaid within 45 days.)
3. Emergency Medical Evacuation - If adequate medical facilities are not available locally, SES will use whatever mode of transportation, equipment and personnel necessary to evacuate the student or family member to the nearest facility capable of providing a high standard of care.
4. Medical Monitoring - SES medical personnel will maintain regular communication with the attending physician and/or hospital and relay information to student's family.
5. Medical Repatriation - If a student still requires medical assistance upon being discharged from a hospital, SES will repatriate him/her to a rehabilitation facility or home, and if necessary will provide a medical or non-medical escort.

### ADDITIONAL PROGRAMS (cont.)

6. Prescription Assistance - If a member needs a replacement prescription while traveling, SES will help in filling that prescription.
7. Compassionate Visit - When traveling alone and hospitalized for more than 7 days, economy, round trip, common carrier transportation to the place of hospitalization will be provided for a designated family member or friend.
8. Care of Minor Children - SES will arrange for the care of children left unattended as the result of a medical emergency and pay for any transportation costs involved in such arrangements.
9. Return of Mortal Remains - SES will assist with the logistics of returning a member's remains home in the event of his or her death. This service includes arranging the preparation of the remains for transport, procuring required legal documentation, providing the necessary shipping container as well as paying for transport.
10. Legal Referrals - Referrals for interpreters or legal personnel are available.
11. Emergency Trauma Counseling - SES will provide initial telephone-based counseling and referrals to qualified counselors as needed or requested.
12. Lost Luggage or Document Assistance - SES will help members locate lost luggage, documents or personal belongings.
13. Pre-trip Information - SES offers members web-based country profiles that include visa requirements, vaccinations recommendations as well as security advisories for any travel destination.

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

### ASK MAYO CLINIC

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

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

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

### MASTER POLICY DEFINITIONS

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

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

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

**Complications of Pregnancy** means: (a) conditions requiring hospital confinement (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy, but are adversely affected by pregnancy; or are caused by pregnancy such as: acute nephritis; nephrosis; cardiac decompensation; missed abortion; and similar medical and surgical conditions of comparable severity. The term does not include: false labor; occasional spotting; physician prescribed rest during a pregnancy; morning sickness; hyperemesis gravidarum; pre-eclampsia or similar conditions that are associated with a difficult pregnancy, but do not constitute a classifiably distinct complication of pregnancy; and (b) non-elective cesarean section; termination of ectopic pregnancy; and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible.

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

**Dependent** means the insured student's spouse; or domestic partner; and the following children who are under the age of twenty-five (25) years:

- a. natural born child;
- b. stepchild;
- c. adopted child from the moment the insured student is party in a suit to adopt the child;
- d. a child for whom the insured student is required by court or administrative order to provide medical support.

Dependent also includes a child who is over the age of 25, 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.

## DEFINITIONS (cont.)

Newborn children of the insured student or covered single dependent, will be covered from birth until 31 days old. For coverage to continue after 31 days, we must be notified and receive such additional premium, if any is required.

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

- a. We will permit the person to enroll without regard to any enrollment period restriction on receipt of written notice from the Texas Department of Health or its designee that states that a person who is otherwise eligible for enrollment under the Policy is: a recipient of medical assistance under the state Medicaid program; and is a participant in the health insurance premium payment reimbursement program for medical assistance recipients under Section 32.0422, Human Resources Code.
- b. We will permit the child to enroll without regard to any enrollment period restriction on receipt of written notice from the Texas Department of Health or its designee that states that a child who is otherwise eligible for enrollment under the Policy is: enrolled in the state child health plan under Chapter 62, Health and Safety Code; and is a participant in the health insurance premium payment reimbursement program under Section 62.059, Health and Safety Code.
- c. If a person in a. or b. above is not eligible to enroll unless a family member is also enrolled, we, on receipt of the written notice, will enroll both the person and the family member.

Unless enrollment occurs during an established enrollment period, enrollment takes effect on the first day of the calendar month that begins at least 30 days after the date written notice is received by us.

We will permit a person who is enrolled under a. above and any family member of the person enrolled under c. above to terminate enrollment not later than the 60<sup>th</sup> day after the date on which satisfactory proof is provided to us that the person is no longer: (a) a recipient of medical assistance under the state Medicaid program; or (b) a participant in the health insurance premium payment reimbursement program for medical assistance recipients under Section 32.0422, Human Resources Code.

We will permit a person who is enrolled under b. above and any family member of the person enrolled under c.

above to terminate enrollment not later than the 60<sup>th</sup> day after the date on which satisfactory proof is provided to us that the child is no longer a participant in the health insurance premium payment reimbursement program under Section 62.059, Health and Safety Code, provided for children eligible for the state child health plan.

**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.

**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. Elective surgery 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; and submucous resection and/or other surgical correction for deviated nasal septum, other than for treatment of covered acute purulent sinusitis. Elective treatment includes but is not limited to: allergy testing; treatment for acne; biofeedback-type services; infertility; hypnotherapy; learning disabilities; and weight reduction.

With respect to the definition of elective surgery and elective treatment, breast reduction and temporomandibular joint dysfunction (TMJ) are covered to the extent provided by any mandated benefit.

**Hospital** means a legally constituted institution duly licensed and operating within the scope of such license. This does not include a facility primarily designed for use as an extended care facility, convalescent nursing home, or skilled nursing facility.

## DEFINITIONS (cont.)

**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 this Policy as a result of any one injury or sickness.

**Maternity** means a sickness. Conception must occur after your effective date of coverage. Treatment must begin prior to your expiration date of coverage.

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

**Medically Necessary** means those covered services provided or prescribed by a hospital or physician which are: (a) consistent with the symptoms and diagnosis or treatment of sickness or injury; (b) in accord with standards of generally accepted medical practice; (c) not primarily for the convenience of you or your physician; and (d) the most appropriate supply or level of service which can safely be provided to you.

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

**Physician** means a duly licensed practitioner of the healing arts, 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.

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.

**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; 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 which do not exceed the average rate charged for the same or similar services or supplies in the geographic region where the services or supplies are received. Usual and customary charges are determined by us and are described in the Schedule of Benefits.

**We, Us, or Our** means 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 shown on the policy schedule, and for whom the required premium has been paid in advance of that person's effective date of coverage.

### COORDINATION OF BENEFITS

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 that 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. The detailed COB provisions are in the Master Policy.

### 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).

**Bills submitted later than one year after the 90 day period expires will not be considered for payment except in the case of no legal capacity.**

Send claims or inquiries to the Plan Administrator:  
**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 the Plan Administrator.

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

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

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

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

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.