

Brochure of Coverage
Policy Form 9F138

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

Designed for

**NORTH DAKOTA
UNIVERSITY SYSTEM**

2011 • 2012

Administered by



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

Underwritten by



COLUMBIAN MUTUAL
LIFE INSURANCE COMPANY
HOME 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
Phone: (800) 328-2739

Servicing Agent:

Chad Lindgren
VAALER INSURANCE, INC.
2701 South Columbia Road
P.O. Box 12848
Grand Forks, ND 58208-2848
www.vaaler.com
(701) 775-3131
(800) 553-4291

Preferred Provider Directory or Questions

PreferredOne
Toll-Free: (800) 451-9597
www.preferredone.com

Policy Number:

33-67-0199-030-613-1

INTRODUCTION

The University is making available a plan of blanket accident and sickness insurance (hereinafter called "plan" or "Plan") underwritten by Columbian Mutual 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.
- Basic benefits are subject to a \$50 deductible for each injury or sickness. The deductible is waived when student is first seen by or treatment received at the student health service, campus nurse, or health office.

- Major medical lifetime maximum benefit provides coverage for students only up to \$100,000 for each injury or sickness. This coverage is not available to dependents
- 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 PreferredOne provider. These providers have agreed to provide services at discounted rates.

STUDENT ELIGIBILITY

All international students taking credit hours, visiting scholars, and pre-doctoral interns are eligible to enroll in the insurance plan. Students age 65 or over, online or distance learning students taking home study, correspondence, or television courses are not eligible to enroll in the insurance plan.

Students must be physically and actively attending classes on campus to enroll in the insurance plan. Except for medical withdrawal due to a covered injury or sickness, any student withdrawing from the 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. Eligible dependents must enroll when the student first enrolls in the insurance plan and must enroll for the same coverage as the student. Dependent enrollment received after the student first enrolls will not be accepted, unless the dependent qualifies for late enrollment.

LATE ENROLLMENT

Students may enroll dependents after the student first enrolls only if there is a qualifying event. Qualifying events includes: arriving in the United States after the student arrives, involuntary loss of coverage under another health plan, marriage, birth or adoption of a child. **Enrollment in the plan must be received no later than 30 days after the qualifying event.** Student should notify the Servicing Agent or the Plan Administrator immediately when eligible for late enrollment.

PERIODS OF COVERAGE

TERM	DATE COVERAGE BEGINS	DATE COVERAGE ENDS
ANNUAL	08-15-2011	08-14-2012
FALL	08-15-2011	01-04-2012
SPRING	01-05-2012	05-09-2012
SPRING/SUMMER	01-05-2012	08-14-2012
SUMMER	05-10-2012	08-14-2012

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

2011-2012 PREMIUM SCHEDULE FOR INTERNATIONAL STUDENTS

	Annual	Fall	Spring
Student Only	\$ 894	NA	NA
Spouse	\$2,682	\$1,051	\$ 925
Children	\$1,922	\$ 753	\$ 663

	Spring/Summer	Summer
Student Only	NA	NA
Spouse	\$ 1,631	\$ 706
Children	\$ 1,169	\$ 506

2011-2012 MONTHLY PREMIUM SCHEDULE FOR VISITING SCHOLARS ONLY

	Monthly
Scholars Only	\$ 74.50
Spouse	\$ 223.50
Children	\$ 160.50

Monthly means each 30 day period (15th of current month to 14th of succeeding month), or portion of a 30 day period for the coverage period selected.

INTERNATIONAL STUDENTS TO ENROLL FOR COVERAGE

International students are automatically enrolled in the insurance plan at registration and the premium added to the student's account. Students arriving after fall term must contact the University International Business Office for applicable premium rates.

VISITING SCHOLARS TO ENROLL FOR COVERAGE

Visiting scholars must contact the University International Business Office for an enrollment form and applicable premium rates.

DEPENDENTS TO ENROLL FOR COVERAGE

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

ID CARDS

ID cards will be mailed to the University International Business Office to distribute to the student. An ID card is not necessary to be eligible to receive benefits under the Policy. For lost ID cards, request an ID card from the website www.sas-mn.com.

PREMIUM REFUND POLICY

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

- Students who withdraw from the University within the first 31-days following their effective date of coverage, unless medical benefits have been paid during the first 31 days;
- 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 must be recommended for refund by the University international Business Office.

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 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 University or 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 \$ 50,000
 Basic Deductible - per person, each Injury or Sickness \$50
 Major Medical Lifetime Maximum Benefit – Student Only - each covered Injury or Sickness \$100,000
 Student Health Services Benefits See page 9

COVERED SERVICES AND BENEFIT LIMITS	In-Network Basic Benefit	Out-of-Network Basic Benefit	In-Network Major Medical Benefit	Out-of-Network Major Medical Benefit
<u>INPATIENT</u>				
HOSPITAL ROOM AND BOARD				
Out-of-Network benefit is payable for semi-private room rate, up to \$750 per day	100%	90%	100%	90%
HOSPITAL INTENSIVE CARE				
Out-of-Network benefit is payable for 2 times semi-private room rate	100%	90%	100%	90%
HOSPITAL MISCELLANEOUS				
	100%	90%	100%	90%
SURGICAL TREATMENT				
	100%	90%	100%	90%
ASSISTANT SURGEON				
	No Benefit	No Benefit	No Benefit	No Benefit
ANESTHESIA				
	100%	90%	100%	90%
PHYSICIAN'S NON-SURGICAL VISITS				
1 visit per day; not paid same day as surgery	100%	90%	100%	90%
PHYSIOTHERAPY Includes chiropractic treatment; Benefit is payable up to maximum \$2,500				
	100%	90%	100%	90%
PATHOLOGY AND RADIOLOGY				
Benefit is payable under Hospital Miscellaneous	100%	90%	100%	90%
PRIVATE DUTY NURSE When medically necessary; Benefit is payable under Hospital Room and Board				
	100%	90%	100%	90%
MATERNITY				
	Same as any Sickness	Same as any Sickness	100%	90%
<u>OUTPATIENT</u>				
HOSPITAL EMERGENCY ROOM				
	100%	90%	100%	90%
HOSPITAL OUTPATIENT SURGICAL MISCELLANEOUS				
	100%	90%	100%	90%
SURGICAL TREATMENT				
	100%	90%	100%	90%
ASSISTANT SURGEON				
	No Benefit	No Benefit	No Benefit	No Benefit
ANESTHESIA				
	100%	90%	100%	90%
PHYSICIAN'S NON-SURGICAL VISITS				
1 visit per day; not paid same day as surgery	100%	90%	100%	90%
PHYSIOTHERAPY Includes chiropractic treatment; Benefit is payable up to maximum \$2,500				
	100%	90%	100%	90%
DIAGNOSTIC, XRAY & LAB SERVICES				
	100%	90%	100%	90%
MATERNITY				
	Same as any Sickness	Same as any Sickness	100%	90%
PRESCRIPTION DRUGS				
30-day supply per prescription drug; See page 24	100%	100%	100%	100%
CHEMOTHERAPY AND RADIATION THERAPY				
	100%	90%	100%	90%
<u>OTHER INPATIENT OR OUTPATIENT</u>				
AMBULANCE SERVICES				
Benefit is payable for ground service only	100%	90%	100%	90%
DENTAL TREATMENT Coverage is limited to injuries to sound natural teeth; does not include biting or chewing injuries; Benefit is payable up to maximum \$250 per tooth				
	100%	90%	No Benefit	No Benefit
ORTHOPEDIC APPLIANCES AND BRACES				
When prescribed by a physician; replacements are not covered	100%	90%	100%	90%
MOTOR VEHICLE INJURY				
	Same as any Injury	Same as any Injury	No Benefit	No Benefit
CHEST XRAY REQUIRED FOR TB SCREENING				
	100%	100%	100%	90%
INTERCOLLEGIATE SPORTS INJURY				
	Same as any Injury	Same as any Injury	100%	90%
MENTAL AND NERVOUS DISORDERS AND SUBSTANCE ABUSE				
Refer to Mandated Benefit for description of benefits payable	Refer to pages 14-15	Refer to pages 14-15	No Benefit	No Benefit
PREVENTIVE CARE Benefit is payable up to policy year maximum \$500 for the following immunizations/vaccines: TB testing including QFT; Influenza, Hepatitis A or B, Human Papillomas virus (HPV), Meningococcal, Measles/mumps/ruebella (MMR), and Varicella per physician recommendation.				
	100%	100%	No Benefit	No Benefit

MAJOR MEDICAL BENEFIT - STUDENTS ONLY

This additional coverage is applicable to students only. Benefits are payable under the Basic Injury or Sickness Schedule of Benefits first, until the \$50,000 basic maximum has been paid for each covered injury or sickness. After the basic maximum has been satisfied, benefits are then payable under the Major Medical benefit. When services are provided by preferred provider, benefits are payable at 100% of the in-network negotiated fee. When services are provided by non-preferred provider, benefits are payable at 90% of the out-of-network usual and customary charges incurred. Benefits are payable up to a \$100,000 lifetime maximum benefit for each covered injury or sickness. This maximum includes the benefits payable under Basic Injury or Sickness and Major Medical. The following services are not payable under this benefit: mental and nervous disorders and substance abuse in excess of mandated benefits; motor vehicle injuries; dental treatment; or preventive care.

OTHER SCHEDULED BENEFITS

***STUDENT HEALTH SERVICE (SHS)**

When non-emergency care is needed, students are strongly encouraged to use the Student Health Service first. If the Student Health Service does not provide the care needed, they can provide the student with information to make informed health care decisions. The following benefits are available when a student first receives covered services (as listed in the Schedule of Benefits and not excluded in the Policy) at the Student Health Service:

- **Basic Injury or Sickness deductible is waived**
- **The co-insurance for payment of covered services is 100% of the usual & customary charges**

Note: For schools without a Student Health Service, the deductible will be waived if first seen by a campus nurse or health office.

ACCIDENTAL DEATH AND DISMEMBERMENT

If the specific loss occurs within 180 days from date of injury, the Policy shall pay one of the following (the largest applicable amount):

Accidental Death	\$ 2,000
Single Dismemberment or Loss of One Eye	\$ 1,000
Double Dismemberment or Loss of Both Eyes	\$ 7,500
Thumb and Index Finger on Either Hand	\$ 500

The benefit paid will be in addition to any other benefits paid for the injury. Dismemberment means, at a minimum, the severance of a hand or foot above the wrist or ankle joint. Loss of eye means entire and irrecoverable loss of vision in the eye.

BENEFITS MANDATED BY THE STATE OF NORTH DAKOTA

The Policy pays benefits in accordance with any applicable North Dakota law. Description of these state mandated benefits can be found on pages 13-16. Benefits may be subject to deductibles, coinsurance, limitations, or exclusions.

ADDITIONAL PROGRAMS

***GLOBAL EMERGENCY SERVICES (Travel Assistance)** see details page 18-19

***ASK MAYO CLINIC (Nurse Line)** see details page 19

***Note:** These additional programs are not underwritten by Columbian Mutual 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 coverage 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 major medical benefits are payable at the in-network co-insurance for the negotiated fee or the out-of-network co-insurance for the usual and customary charges, less any deductible or copay if applicable. 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. A verbal explanation of benefits does not guarantee payment of claims.

CO-INSURANCE AND DEDUCTIBLE

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

Co-insurance is the percentage of covered expenses the Policy pays, after the deductible 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 outpatient benefit or under the inpatient benefit, but not both on the same day.
3. **Consultant Physician:** Benefits are payable if requested and approved by the attending Physician.

OTHER OUTPATIENT MEDICAL EXPENSES

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

- 1. Outpatient Diagnostic, X-ray 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 and 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. Orthopedic Appliances:** Benefits are payable when: a) prescribed by a physician; and b) a written prescription accompanies the claim when submitted. Replacement braces and appliances are not covered. Braces and appliances include durable medical equipment which is equipment that: a) is primarily and customarily used to serve a medical purpose; b) can withstand repeated use; and c) generally is not useful to a person in the absence of injury or sickness. No benefits will be paid for rental charges in excess of purchase price
- 5. 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 each covered prescription drug. A claim must be submitted for reimbursement, see page 24 for more information.
- 6. Dental Treatment:** Benefits are payable for dentist's fees for surgery, x-rays, or dental services related to an accidental injury to sound, natural teeth, including replacement of the injured natural teeth. Benefits do not include tooth fracture due to biting or chewing. Treatment must be completed within the policy period.

MATERNITY EXPENSES

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

PRE-EXISTING CONDITION

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. A pre-existing condition is subject to a 6-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.

BENEFITS MANDATED BY STATE OF NORTH DAKOTA

The Policy pays benefits in accordance with the following summary of North Dakota 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.

DENTAL ANESTHESIA AND HOSPITALIZATION

Benefits are payable the same as any injury or sickness for anesthesia and hospitalization for dental care when provided to an insured person who:

- is a child under age nine (9);
- is severely disabled; or
- has a medical condition that requires hospitalization or general anesthesia for dental care treatment.

Benefits are payable when services are provided in a hospital or ambulatory surgery center.

MAMMOGRAPHY

Benefits are payable the same as any sickness for mammography examinations as scheduled below:

- One baseline mammogram for any woman who is thirty-five through thirty-nine years of age;
- One mammogram every twelve months for any woman who is forty years of age or older or more frequently if recommended by her physician.

INHERITED METABOLIC DISEASE

Benefits are payable on the same basis as any prescription drug benefit under the Policy for medical foods and low protein modified food products; determined to be medically necessary by a physician for the therapeutic treatment of an inherited metabolic disease. Benefits for low protein modified food products or medical food are limited to a maximum benefit of \$3,000. Benefits are not payable to the extent that benefits are available under a Department of Health program.

"Inherited metabolic disease" means maple syrup urine disease or phenylketonuria.

"Low protein modified food product" means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease. The term does not include a natural food that is naturally low in protein.

"Medical food" means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and is formulated to be consumed or administered under the direction of a physician.

MENTAL DISORDERS AND SUBSTANCE ABUSE TREATMENT

Benefits are payable for inpatient treatment, partial hospitalization treatment, residential treatment, and outpatient treatment for Mental Disorders, Substance Abuse, and other related illness as limited below:

Mental Disorder or Other Related Mental Illness:

- Inpatient Calendar Year Maximum Benefit - 45 Days*
- Partial Hospitalization Calendar Year Maximum Benefit - 120 Days
- Residential Treatment Program Calendar Year Maximum Benefit - 120 Days*
- Outpatient Calendar Year Maximum Benefit - 30 Hours

*Each day of inpatient treatment is equivalent to two days of treatment by a residential treatment program. An insured who requires residential treatment services beyond 120 days may trade any unused inpatient treatment days to extend his or her residential treatment calendar year maximum. No more than 23 days of inpatient treatment may be traded for residential treatment services.

For inpatient treatment the Plan Administrator may require an individualized treatment plan from the inpatient treatment service provider which indicates that the course of treatment is the most appropriate and least restrictive form of treatment available in the community.

Residential treatment applies only to individuals under 21 years of age and must be provided by: a hospital; a regional human services center licensed under North Dakota law offering treatment for the prevention or cure of mental disorders or other mental illness; or residential treatment program as defined by North Dakota law.

Substance Abuse or Other Related Illness:

- Inpatient Calendar Year Maximum Benefit - 60 Days (any of the 45 days used under Mental Disorders above count toward this maximum)**
- Partial Hospitalization Calendar Year Maximum Benefit - 120 Days (any of the 120 days used under Mental Disorders above count toward this maximum)**
- Outpatient Calendar Year Maximum Benefit - 20 Visits

**Benefits are also provided for a combination of inpatient and partial hospitalization treatment. Each day of inpatient treatment is equivalent to two days of treatment by partial hospitalization. No more than 46 days of inpatient treatment may be traded for treatment by partial hospitalization.

Outpatient treatment is not subject to a deductible, copayment, or co-insurance for the first 5 hours of treatment for mental disorders or the first 5 visits for substance abuse in a policy year. A covered percentage of 80% or more, as shown on the Schedule of Benefits will be applied to remaining hours or visits.

Services received for the remaining hours or visits from an out-of-network provider without a referral from within the in-network provider network may be subject to a covered percentage less than 80%, if applicable and as shown on the Schedule of Benefits.

Outpatient treatment services may be provided by a nurse who holds advanced licensure with a scope of practice within mental health, a licensed physician, a licensed psychologist who is eligible for listing on the national register of health service providers in psychology, or a licensed independent clinical social worker.

Partial hospitalization means continuous treatment for at least 3 hours but not more than 12 hours in any 24-hour period and includes the medically necessary treatment services provided by licensed professionals under the supervision of a physician. Partial hospitalization must be provided by:

1. a hospital, or
2. a regional human services center licensed under North Dakota law offering treatment for the prevention or cure of mental disorders or other mental illness, or substance abuse or other related illness.

For services provided in a regional human services center, charges must be reasonably similar to the charges for care provided by a hospital.

PROSTATE-SPECIFIC ANTIGEN

Benefits are payable for an annual digital rectal examination and an annual prostate-specific antigen test for:

- an asymptomatic male age fifty (50) and over;
- a black male age forty (40) and over; and
- a male age forty (40) and over with a family history of prostate cancer.

TEMPOROMANDIBULAR JOINT DISORDER TREATMENT

Benefits are payable for the surgical and non-surgical treatment of temporomandibular joint disorders and craniomandibular disorders. Benefits will be payable on the same basis as treatment to any other joint of the body, and whether treatment is provided by a physician or dentist. Benefits are limited to a lifetime maximum of \$10,000 for surgical treatment and \$2,500 for non-surgical treatment.

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. This exclusion does not apply to an aviation class which is part of the University's Curriculum.
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); except as specifically provided in the Schedule of Benefits; or elective surgery and elective treatment; or abortion. It does not include cosmetic surgery made necessary by injury.
4. Motor vehicle accidents, to the extent covered by another valid and collectible insurance policy, prepaid services contract, or similar plan. The motor vehicle injury benefit limit is shown on the Schedule of Benefits.
5. Eyeglasses, contact lenses, and examination for prescribing or fitting them; any other procedure for correction of refractive disorder of the eye or eyes; hearing aids and hearing examinations.
6. Injury or sickness for which benefits are paid under Worker's Compensation or Occupational Disease Act or Law.
7. Loss incurred while committing or attempting to commit a felony; or loss due to voluntary participation in a riot or civil disturbance.
8. Routine new-born 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. 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.
11. War or act of war, whether declared or not; and injury or sickness resulting from full-time, active-duty military service.
12. Pre-existing conditions, until continuously covered by the University's student accident and sickness insurance plan for a period of 6 consecutive months.

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

PREFERRED PROVIDER NETWORK

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

When an insured uses the services of a PreferredOne provider, the covered expenses are payable at the in-network co-insurance for the negotiated fee. 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.

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

The insured is not responsible for the difference between the PreferredOne provider's usual billed charges and the preferred provider negotiated fees. The insured is responsible for any differences due to deductibles, co-insurance, copays, benefit limitations, and exclusions. In order to use the services of a PreferredOne provider, the insured must present the student accident and sickness insurance ID card.

A complete listing of PreferredOne providers is available on the web at: www.preferredone.com. The participation of individual providers is subject to change without notice. It is the insured's responsibility to confirm a PreferredOne provider's participation when calling for an appointment or at time of visit.

GLOBAL EMERGENCY SERVICES PROGRAM (TRAVEL ASSISTANCE)

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

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

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

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

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

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

ASK MAYO CLINIC

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

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

Calls are answered 24 hours a day, 365 days a year by experienced registered nurses who have been specifically trained to handle telephone health inquiries. This program is not a substitute for doctor visits or emergency response systems. *Ask Mayo Clinic* does not answer health plan benefit questions. Health benefit questions should be referred to 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 this Policy.

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

Dependent means the insured student's spouse; or domestic partner; or student's unmarried natural child (including step-children if dependent on the insured student) under the age of twenty-three (23) years, who is not self-supporting or a child over the age of 23 who is incapable of self-sustaining employment because of mental or physical handicap, and is chiefly dependent upon the insured student for maintenance and support. Proof of a dependent's incapacity or dependence shall be furnished to us within 31 days of a child's attainment of the limiting age. We may request subsequent proof of incapacity or dependency no more than once every year. The insured student must provide proof that a child continues to be handicapped.

A newborn child of the insured student will be covered from birth until 31 days old. Coverage for such child will be for sickness and injury including necessary care and treatment for medically diagnosed congenital defects and birth abnormalities. Coverage will expire at the end of 31 days. To continue coverage past the 31 days, the insured must enroll the newborn child within 31 days of birth and pay the required additional premium starting from the date of birth.

A child for whom the insured student has a legal obligation for the purposes of adoption will be covered from the date the legal obligation begins until 31 days after the date the legal obligation began. Coverage for such child will be for sickness and injury including necessary care and treatment for medically diagnosed congenital defects and birth abnormalities. Coverage will expire at the end of 31 days. To continue coverage past the 31 days, the Insured must enroll the adopted child within 31 days from the date legal obligation began, and pay the required additional premium starting from the date the legal obligation began.

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" 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; 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.

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.

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. 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.

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; 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 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 Mutual Life Insurance Company of Binghamton, New York.

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.

EXCESS COVERAGE

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

CLAIM PROCEDURE

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

PRESCRIPTION DRUG CLAIM PROCEDURE

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

Bills must be submitted within 90 days after the date of the injury or sickness, or as soon as reasonably possible. Information to identify the insured must be provided and should include: student name, patient name, address, student ID number or social security number, birthdate, and name of the school.

A company claim form is not required, unless the itemized billing statements do not provide sufficient information to process the claim. The insured can print a company claim form or complete the online claim form from the website www.sas-mn.com.

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

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

COMPLAINTS AND CLAIM APPEALS

An insured has a right to file a grievance in writing for any provision of services or claim practices of Columbian Mutual 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 Mutual Life Insurance Company and Student Assurance Services, Inc. are committed to maintaining the privacy of the insured's personal health information and complying with all state and federal privacy laws. A copy of the privacy notice may be obtained by contacting the Plan Administrator at (800) 328-2739 or by visiting our website www.sas-mn.com.

HEALTH CARE REFORM

Columbian Mutual 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.