

Brochure of Coverage  
Policy Form 9F149-CL

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

Designed for

**GRAND VALLEY  
STATE  
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

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

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

**Servicing Agent:**

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

**Policy Number:**

21-64-0088-500-650-1

**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.

This 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 major medical benefits with a lifetime maximum of \$100,000 for each covered injury or sickness.
- Injury benefits are subject to a \$50 deductible for each covered injury. No deductible for sickness benefits.
- Repatriation and medical evacuation benefits providing 24-hour assistance services are included.
- 24-hour nurse line program providing phone based health information is included.
- Students may use the hospital or physician of choice.

**STUDENT ELIGIBILITY**

All students under age 65 and attending Grand Valley State University are eligible to enroll in the insurance plan. 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.

**Students who wish to enroll in the insurance plan must enroll by the enrollment deadline dates shown on page 4.**

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 deadline dates 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.

**LATE ENROLLMENT**

Students and dependents may enroll after the enrollment period deadline date 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.

**PERIODS OF COVERAGE AND ENROLLMENT PERIOD DEADLINE DATES**

TERM	DATE COVERAGE BEGINS	DATE COVERAGE ENDS	*ENROLLMENT PERIOD DEADLINE DATE
ANNUAL	08-15-2011	08-14-2012	10-03-2011
FIRST TERM	08-15-2011	12-31-2011	10-03-2011
SECOND TERM	01-01-2012	08-14-2012	01-30-2012
SUMMER	05-01-2012	08-14-2012	06-01-2012

**\*IMPORTANT: Enrollment forms and premium payments received after the enrollment period deadline date are not accepted, unless a qualifying event for late enrollment occurs.**

**2011-2012 PREMIUM SCHEDULE**

	Annual	First Term	Second Term	Summer
Student Only				
<b>Under Age 30</b>	\$ 680.00	\$ 268.00	\$ 432.00	\$ 207.00
Each Dependent	\$ 1,360.00	\$ 527.00	\$ 853.00	\$ 404.00
Student Only				
<b>Age 30 or Over</b>	\$ 1,035.00	\$ 403.00	\$ 652.00	\$ 310.00
Each Dependent	\$ 2,585.00	\$ 992.00	\$ 1,613.00	\$ 760.00

**Optional Major Medical \$ 250.00 per person**

Students must be enrolled in the basic injury and sickness benefit of the insurance plan in order to purchase optional major medical, and coverage must be purchased when first enrolled in the plan. Optional coverage will terminate when the accident and sickness insurance 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.

**TO ENROLL FOR COVERAGE**

Students and dependents can enroll in the plan any time prior to the coverage period effective date through the end of the enrollment period deadline date. **There are two options to enroll for coverage:**

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

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

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

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

**ID CARDS**

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

**PREMIUM REFUND POLICY**

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

- Students who withdraw from 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. Any refund provided is subject to a \$25 administration fee.

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

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

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

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

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

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

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

## **CONTINUOUS COVERAGE**

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

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

## SCHEDULE OF BENEFITS

Basic Injury Maximum Benefit - each covered Injury .....	\$ 50,000
Basic Sickness Maximum Benefit - each covered Sickness .....	\$ 50,000
Optional Major Medical Maximum Lifetime Benefit - each covered Injury or Sickness (requires additional premium) .....	\$100,000
Basic Injury Deductible – per person – each covered Injury .....	\$50

<b>BASIC INJURY - COVERED SERVICES AND BENEFIT LIMITS</b>	<b>INJURY BENEFIT</b>	<b>MAJOR MEDICAL BENEFIT</b>
<b>Prescription Drugs (Outpatient)</b> <i>Benefit is payable up to maximum \$500; after \$15 copay per drug; 30-day supply per prescription; see page 24</i>	100%	100%
<b>Dental Treatment</b> <i>Does not include biting or chewing injuries; Benefit is payable up to maximum \$500</i>	100%	No Benefit
<b>Physiotherapy (Outpatient)</b> <i>Benefit is payable \$25 per visit; 1 visit per day</i>	100%	100%
<b>Motor Vehicle Injury</b> <i>Benefit is payable up to maximum \$1,000</i>	Same as any Injury	No Benefit
<b>Other Injury Covered Services:</b> <b>Hospital Inpatient Room and Board; Hospital Inpatient Miscellaneous; Hospital Outpatient Surgical Miscellaneous; Hospital Emergency Room; Surgical Treatment; Assistant Surgeon; Anesthesia; Consultant Physician; Physician Outpatient and Inpatient Non-Surgical Visits; Outpatient X-ray and Lab Services; Ambulance Services; Private Duty Nurse; Shots and Injections; Orthopedic Appliances</b>	100%	100%
<b>BASIC SICKNESS - COVERED SERVICES AND BENEFIT LIMITS</b>	<b>SICKNESS BENEFIT</b>	<b>MAJOR MEDICAL BENEFIT</b>
<b>Hospital Inpatient Room and Board</b> <i>Includes hospital intensive care; Benefit is payable up to maximum \$1,000 per day</i>	100%	100%
<b>Hospital Inpatient Miscellaneous</b> <i>Benefit is payable up to maximum \$4,000</i>	100%	100%
<b>Hospital Outpatient Surgical Miscellaneous</b> <i>Benefit is payable up to maximum \$4,000</i>	100%	100%
<b>Surgical Treatment (inpatient or outpatient)</b> <i>Benefit is payable up to maximum \$4,000</i>	80%	100%
<b>Assistant Surgeon</b>	25% of Surgical Treatment Benefit	100%
<b>Anesthesia</b>	25% of Surgical Treatment Benefit	100%
<b>Consultant Physician</b> <i>Benefit is payable under Physician Non-Surgical Visits</i>	100%	100%
<b>Physician's Inpatient Non-Surgical Visits</b> <i>1 visit per day; Not paid same day as surgery; Benefit is payable \$100 per visit</i>	100%	100%
<b>Physician's Outpatient Non-Surgical Visits</b> <i>1 visit per day; Not paid same day as surgery; Benefit is payable \$100 per visit</i>	100%	100%
<b>Physiotherapy (Outpatient)</b> <i>Benefit is payable under Physician Non-Surgical Visits</i>	100%	100%
<b>Inpatient Pathology and Radiology Services</b> <i>Benefit is payable under Hospital Inpatient Miscellaneous</i>	100%	100%
<b>Outpatient Diagnostic X-ray and Lab Services</b> <i>Benefit is payable up to maximum \$700</i>	80%	100%
<b>Hospital Emergency Room Services (Outpatient)</b> <i>Benefit is payable up to maximum \$500; after \$50 copay per visit; Copay is waived if admitted into hospital</i>	80%	100%
<b>Ambulance Services</b> <i>Benefit for ground service only; Benefit is payable up to maximum \$400</i>	100%	100%
<b>Orthopedic Appliances</b> <i>Does not include benefits for durable medical equipment</i>	No Benefit	100%
<b>Prescription Drugs (Outpatient)</b> <i>Benefit is payable up to maximum \$500; after \$15 copay per drug; 30-day supply per prescription; see page 24</i>	100%	100%
<b>Private Duty Nurse</b> <i>Benefit is payable under Hospital Inpatient Miscellaneous</i>	100%	100%
<b>Shots and Injections</b> <i>Benefit is payable under Physician Non-Surgical Visits - Outpatient</i>	100%	100%
<b>Chemotherapy and Radiation Therapy</b>	No Benefit	100%
<b>Maternity Benefit</b>	Same as any Sickness	100%
<b>Mental and Nervous Disorders</b> <i>Benefit is payable the same as any Sickness; Except outpatient physician non-surgical visits payable up to \$100 per visit, 1 visit per day, maximum 10 visits</i>	Same as any Sickness	No Benefit
<b>Substance Abuse Treatment</b> <i>Refer to Mandated Benefits for a description of benefits payable</i>	see page 16	No Benefit

## OTHER SCHEDULED BENEFITS

### OPTIONAL MAJOR MEDICAL BENEFIT

If this coverage is purchased, 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 Optional Major Medical benefit. Benefits are payable at 100% of the usual and customary charges incurred up to lifetime maximum benefit of \$100,000 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; or dental treatment.

### ACCIDENTAL DEATH AND DISMEMBERMENT

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

Accidental Death .....	\$ 1,000
Single Dismemberment or Loss of One Eye .....	\$ 1,000
Double Dismemberment or Loss of Both Eyes .....	\$ 2,000

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 MICHIGAN

The Policy pays benefits in accordance with any applicable Michigan law. Description of these state mandated benefits can be found on pages 14-16. Benefits may be subject to deductibles, co-insurance, 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 Life Insurance Company, but provided by independent vendors and are included if students participate in the insurance plan.

## EXPLANATION OF BENEFITS

### BENEFIT PAYMENTS

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

Medical expenses under basic injury and sickness and optional major medical benefits are payable for the usual and customary charges incurred as determined by the Policy, 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

This 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 Plan Administrator for payment. A verbal explanation of benefits does not guarantee payment of claims.

### CO-INSURANCE, COPAY, AND DEDUCTIBLE

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

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

**Copay** is the amount the insured must pay to the physician, pharmacy, or hospital for each procedure, office visit, prescription drug, or confinement, each time the insured receives a covered service.

**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 Services (Outpatient):** Benefits are payable for necessary emergency treatment provided in an urgent care facility or clinic, an observation room, or other room designated by the hospital.

### SURGICAL EXPENSES

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

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

### PHYSICIAN EXPENSES

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

1. **Physician's Non-Surgical Visits (Inpatient):** Benefits are limited to one visit per day and include physician's evaluation and management services as identified in Physicians' Current Procedural Terminology (CPT). Benefits are not paid for a visit on the same day as surgery. Covered visits will be paid under the inpatient benefit or under the outpatient benefit, but not both on the same day.
2. **Physician's Non-Surgical Visits (Outpatient):** Benefits are limited to one visit per day and include the physician's evaluation and management services as identified in Physicians' Current Procedural Terminology (CPT). Benefit includes any ancillary supplies received during the visit, except as specifically provided in the Schedule of Benefits. Benefits are not paid for a visit on the same day as surgery. Covered visits will be paid under the 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, Radiology, and Lab Services:** Benefits are payable for diagnostic x-rays and radiology services as identified in Physicians' Current Procedural Terminology (CPT) as codes 70000 - 79999 inclusive. Laboratory procedures are those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 80000 - 89999 inclusive. Benefits include radiologist fees, charges for reading, and pathologist fees.
2. **Ambulance Services:** Benefits are payable for professional ground ambulance service, except as specifically listed in the Schedule of Benefits.
3. **Physiotherapy:** Benefits are payable for any form of therapeutic or manual treatment by an eligible provider, including but not limited to: physical or mechanical therapy; diathermy; ultrasonic treatment; EMS; whirlpool; heat treatments; or manipulation. All treatments received during one visit will be subject to the benefit limit shown on the Schedule of Benefits.
4. **Orthopedic Appliances:** Benefits are payable for any supportive appliance or device that (i) is prescribed by a physician; (ii) is primarily and customarily used to serve a medical purpose; (iii) can withstand repeated use; (iv) generally is not useful to a person in the absence of injury or sickness; and (v) is used exclusively by the Insured. Replacement braces and appliances are not covered. No benefits will be paid for rental charges in excess of purchase price. A written prescription must accompany the claim when submitted.
5. **Prescription Drugs:** Benefits are payable for the cost of the drug obtained from a licensed pharmacy. Does not include charges for the injection or administration of the drug. Benefits are limited to a 30-day supply for each covered prescription drug. A claim must be submitted for reimbursement, see page 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.

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

## PRE-EXISTING CONDITION

The Policy does not cover any condition that is diagnosed, treated, or recommended for treatment within the 6 months immediately prior to the 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 medical coverage provided in the United States under any of the following: a group health plan; health insurance coverage under any hospital or medical service policy or certificate; hospital or medical service plan contract; or health maintenance organization contract; Medicare; Medicaid; military health care; a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; the Federal Employee Health Benefits Program; a public health plan; or a health benefit plan of the Peace Corps.

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

## BENEFITS MANDATED BY STATE OF MICHIGAN

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

### Diabetes Treatment

Benefits are payable for the following equipment, supplies, and educational training for the treatment of diabetes as determined to be medically necessary and prescribed by a physician. The term "diabetes" includes an insured with gestational diabetes; insulin-dependent diabetes; or non-insulin-dependent diabetes.

- (1) Blood glucose monitors and blood glucose monitors for the legally blind;
- (2) Test strips for glucose monitors, visual reading and urine testing strips, lancets and spring-powered lancet devices;
- (3) Syringes;
- (4) Insulin pumps and medical supplies required for the use of an insulin pump;
- (5) Diabetes self-management training to ensure that insureds with diabetes are trained as to the proper self-management and treatment of their diabetic condition, subject to the following:
  - (a) is limited to completion of a certified diabetes education program upon occurrence of either of the following:
    - (i) if considered medically necessary upon the diagnosis of diabetes by a physician who is managing the insured's diabetic condition and if the services are needed under a comprehensive plan of care to ensure therapy compliance or to provide necessary skills and knowledge;

- (ii) if a physician diagnoses a significant change with long-term implications in the insured's symptoms or conditions that necessitates changes in the insured's self-management or a significant change in medical protocol or treatment modalities.
  - (b) must be provided by a diabetes outpatient training program certified to receive Medicaid or Medicare reimbursement or certified by the Department of Community Health. Training shall be conducted in group settings whenever practicable.

Prescription drugs, if covered, include the following if determined to be medically necessary and prescribed by a physician for diabetes:

- (1) Insulin;
- (2) Non-experimental medication for controlling blood sugar;
- (3) Medications used in the treatment of foot ailments, infections and other medical conditions of the foot, ankle or nails associated with diabetes.

### Prescription Drug used in Antineoplastic Therapy

Benefits are payable for Federal Food & Drug Administration (FDA) approved drugs used in antineoplastic therapy and the reasonable cost of its administration. Benefits shall be payable regardless of whether the specific neoplasm for which the drug is being used as treatment is the specific neoplasm for which the drug received approval by the FDA. All of the following conditions must be met:

- (1) The drug is ordered by a physician for treatment of a specific type of neoplasm;
- (2) The drug is approved by the FDA for use in antineoplastic therapy;
- (3) The drug is used as part of an antineoplastic drug regimen;
- (4) Current medical literature substantiates its efficacy and recognized oncology organizations generally accept the treatment; and
- (5) The physician has obtained informed consent from the insured for the treatment regimen which includes FDA approved drugs for off-label indications.

### Prescription Drug for Off-Label Uses

Benefits are payable for an off-label use of a Federal Food & Drug Administration (FDA) approved drug and the reasonable cost of supplies medically necessary to administer the drug when all of the following conditions are met:

- (1) The drug is approved by the FDA;
- (2) The drug is prescribed by a physician for the treatment of a life-threatening or a chronic and seriously debilitating condition. The drug must be medically necessary to treat the condition and the drug is on the health plan formulary or accessible through the plan formulary procedures;

- (3) The drug has been recognized for the treatment of the condition by one of the following:
  - (a) The American Medical Association drug evaluations
  - (b) The American Hospital Formulary service drug information
  - (c) The United States Pharmacopoeia dispensing information, Volume 1, "drug information for the health care professional"
  - (d) Two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal

Coverage for off-label FDA approved drugs is subject to the same benefits and policy provisions as any other prescription drug.

### Substance Abuse Treatment

Benefits are payable for intermediate and outpatient care for substance abuse. Such benefits are: (a) payable without any reduction in the terms or conditions applied to other policy benefits; and (b) limited to \$3,969.00 for each policy year and for each insured.

"Intermediate Care" means the use, in a full 24-hour residential therapy setting or in a partial less than 24 hours residential therapy setting, any or all of the following therapeutic techniques as identified in a treatment plan for persons physiologically or psychologically dependent upon or abusing alcohol or drugs:

- (a) Chemotherapy;
- (b) Counseling;
- (c) Detoxification services;
- (d) Other ancillary service such as medical testing, diagnostic evaluation, and referral to other services identified in a treatment plan.

### EXCLUSIONS

The Policy does not provide benefits for expenses resulting from:

1. Air flight, except as a fare-paying passenger on a regularly scheduled flight of a commercial airline.
2. Dental treatment, except as specifically provided in the Schedule of Benefits.
3. Treatment where no injury or sickness is involved (physical examinations or preventive medicines); or elective surgery and elective treatment; or abortion. It does not include cosmetic surgery made necessary by injury. Non-medical self-care or self-help training; health or fitness club memberships; personal comfort or convenience items; treatment for Hirsutism, hair growth, or baldness.

4. Eyeglasses, contact lenses, and examination for prescribing or fitting them; any other procedure for correction of refractive disorder of the eye or eyes; hearing aids and hearing examinations; durable medical equipment; treatment for foot care including care of flat feet, corns, calluses, bunions, weak feet, chronic foot strain, and supportive foot devices.
5. Injury or sickness for which benefits are paid under Worker's Compensation or Occupational Disease Act or Law.
6. Contraceptive drugs and devices; growth hormone therapy; patient controlled analgesia; allergy treatment.
7. 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.
8. Intentional self-inflicted injuries; including drug overdose; loss incurred while committing or attempting to commit a felony; loss incurred from violating or attempting to violate any existing city, state, or federal law; loss due to voluntary participation in a riot or civil disturbance; injuries caused by or contributed to or resulting from the use of hallucinogenics, illegal drugs, or any drugs and medicines that are not taken in the dosage or for the purpose prescribed by the insured's physician.
9. Routine newborn baby care, well baby nursery, and related physician's charges.
10. 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.
11. Treatment related to nicotine addiction or smoking cessation.
12. Use of any services or supplies which are experimental and/or not in accord with generally accepted standards of medical practice; Organ transplants, including donor's expenses; services, supplies, and/or treatment for acupuncture.
13. War or act of war, whether declared or not; and injury or sickness resulting from full-time, active-duty military service.
14. Pre-existing conditions, not subject to credit for prior coverage, until continuously covered by the policyholder's student accident and sickness insurance plan for a period of 12 consecutive months.
15. Sleep disorders, supplies and treatment, or testing related to sleep disorders.
16. Weight management services and supplies related to weight reduction programs, weight management programs and related nutritional supplies; treatment of obesity; surgery for the removal of excess skin or fat for weight reduction or treatment of obesity.

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

**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](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.

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

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

A newborn child of the insured student will be covered from birth until 31 days old. Coverage for such child will be for a sickness and injury including necessary care and treatment for medically diagnosed congenital defects and birth abnormalities. Coverage will expire at the end of the 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 the 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" to the Plan Administrator. In the Affidavit, the insured student and domestic partner must attest that they are each other's sole domestic partner, that they have agreed to be responsible for their common welfare. They must also indicate which three of the five qualifying conditions have been met.

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

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

## DEFINITIONS (cont.)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## DEFINITIONS (cont.)

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

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

### EXCESS COVERAGE

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

### CLAIM PROCEDURE

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

### PRESCRIPTION DRUG CLAIM PROCEDURE

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

**Bills must be submitted within 90 days after the date of the injury or sickness, or as soon as reasonably possible.** Information to identify the insured must be provided and should include: student name, patient name, address, student ID number or social security number, birthdate, and name of the school. A company claim form is not required, unless the itemized billing statements do not provide sufficient information to process the claim. The insured can print a company claim form or complete the online claim form from the website [www.sas-mn.com](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. and 4:30 p.m. Central Time, Monday – Friday. Students may check the status of a claim already filed at [www.sas-mn.com](http://www.sas-mn.com). The member ID number located on the ID card is needed to access the online claim status.

### COMPLAINTS AND CLAIM APPEALS

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

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

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

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

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

Grievance may be sent to the Plan Administrator:  
**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.