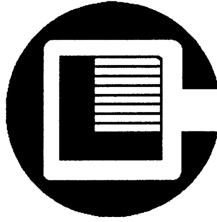
GROUP STUDENT BLANKET INSURANCE - NON-RENEWABLE



COLUMBIAN LIFE INSURANCE COMPANY

HOME OFFICE: CHICAGO, IL
ADMINISTRATIVE SERVICE OFFICE: VESTAL PARKWAY EAST
PO BOX 1381
BINGHAMTON, NY 13902-1381

Customer Service (800) 328-2739

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

POLICY SCHEDULE

POLICYHOLDER:	Saint Xavier University 3700 West 103rd Street Chicago, IL 60655
POLICY NUMBER:	12-64-0040-016-608-0
POLICY EFFECTIVE DATE:	08-11-2010 at 12:01 a.m.
POLICY EXPIRATION DATE:	08-10-2011 at 11:59 p.m.
AMENDMENTS/ENDORSEMENTS:	9E503-CL; 9E609-CL; 9E729-CL; 9E804-CL; 3960-CL

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

CLASSES OF ELIGIBLE PERSONS INSURED:

1. Undergraduate Students and Scholars under the age of 70; and
2. Graduate Students

Student must be enrolled in the plan and physically and actively attending classes for at least 31 days after their Effective Date of coverage under this Policy. Eligible persons do NOT include online students or distance learning students taking home study, correspondence, or television courses.

3. Dependents of a Student who is an Insured Person and enrolled in the plan.

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

Signed for Columbian Life Insurance Company:

DANIEL J. FISCHER Secretary	THOMAS E. RATTMANN Chairman, President and Chief Executive Officer

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PREMIUM SCHEDULE

Premiums do NOT include Administrative Fees

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PERIOD OF COVERAGE AND WAIVER DEADLINE DATES FOR UNDERGRADUATES/SCHOLARS

Term	Date Coverage Begins	Date Coverage Ends	Waiver/Enrollment Deadline Date
Fall 1	**08-11-2010**	**12-31-2010**	**09-13-2010**
Fall 2	**10-03-2010**	**12-31-2010**	**10-23-2010**
Spring/Summer 1	**01-01-2011**	**08-10-2011**	**01-26-2011**
Spring/Summer 2	**03-01-2011**	**08-10-2011**	**03-11-2011**
Summer	**05-19-2011**	**08-10-2011**	**06-13-2011**

PERIOD OF COVERAGE AND ENROLLMENT DATES FOR GRADUATE STUDENTS AND DEPENDENTS OF ALL STUDENTS

Term	Date Coverage Begins	Date Coverage Ends	Enrollment Deadline Date
Annual	**08-11-2010**	**08-10-2011**	**09-30-2010**
Fall	**08-11-2010**	**12-31-2010**	**09-30-2010**
Spring/Summer	**01-01-2011**	**08-10-2011**	**02-15-2011**
Summer	**05-19-2011**	**08-10-2011**	**06-15-2011**

IMPORTANT: We do not accept enrollment forms and premium payments received after the Enrollment Period Deadline Date, unless you qualify for late enrollment.

	Annual	*Fall Installment	*Spring&Summer Installment
Student Only	$ 1,355	$ 678	$ 678
Additional for Spouse	$ 2,710	$ 1,355	$ 1,355
Additional for Each Child	$ 2,033	$ 1,017	$ 1,017

	** New Students Spring/Summer	Summer	Monthly
Student Only	$ 825	$ 310	$ 113
Additional for Spouse	$ 1,650	$ 620	$ 226
Additional for Each Child	$ 1,238	$ 465	$ 170

* The Fall and Spring/Summer Installment method of payment is only available for students purchasing Annual Coverage.

**For new students not previously eligible to enroll for Annual or Fall insurance coverage.

Student and dependent coverage under the Policy becomes effective on the later of the following dates: the Policy Effective Date August 11, 2010 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 Servicing Agent. Student and dependent coverage under the Policy will expire on the earliest of the following dates: The Policy Expiration date August 10, 2011 at 11:59 p.m.; or when payment for your Accident or Sickness coverage is due and unpaid. It is your responsibility to make timely premium payments regardless of whether or not you receive a premium notice. No refunds, except as provided in the Master policy.

PART A - SCHEDULE OF BENEFITS

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

		Amount
a.	Maximum Basic Benefit For Each Loss:	$250,000 Lifetime Maximum
b.	Basic Deductible - Policy Year – per person:	$300 (Refer to 1.d.)
c.	Covered Percentage:	80% PPO Negotiated Fee or 60% U&C non-PPO; or % listed below; up to the Benefit Limits
d.	Health Service Benefits:	The Deductible is waived when covered services are received at the Student Health Center. Covered services are payable at 100% U&C.

COVERED SERVICES	INJURY or SICKNESS BENEFIT LIMITS
e. INPATIENT	
1. HOSPITAL ROOM AND BOARD (semi-private room and general nursing care)	$100 copay per confinement; PPO 80%; non-PPO 60%
2. HOSPITAL INTENSIVE CARE (includes 24 hour nursing care)	Paid under e.1.
3. HOSPITAL MISCELLANEOUS INPATIENT (services and supplies including but not limited to: the cost of the operating room; laboratory tests; x-ray examinations, anesthesia; drugs - excluding take home drugs or medications; therapeutic services; supplies; Private Duty Nurse)	Paid under e.1.
4. SURGICAL TREATMENT	PPO 80%; non-PPO 60%
5. ASSISTANT SURGEON	30% of Surgical Treatment Benefit
6. ANESTHESIA	30% of Surgical Treatment Benefit
7. CHEMOTHERAPY AND RADIATION THERAPY	No Benefit
8. PHYSICIAN'S NON-SURGICAL VISITS (paid day of surgery)	PPO 80%; non-PPO 60%
9. PHYSIOTHERAPY (1 visit/day)	Paid under e.1.
10. MATERNITY BENEFITS	Same as any Sickness
11. MENTAL AND NERVOUS DISORDERS (Paid same as any Sickness)	$50 copay/confinement; up to $10,000/Policy year; PPO 80%; non-PPO 60%
12. SUBSTANCE ABUSE (Paid the same as any Sickness)	PPO 80%; non-PPO 60%; up to $10,000/Policy year
l3. MOTOR VEHICLE INJURY	Same as any Injury
f. OUTPATIENT	
1. HOSPITAL OUTPATIENT SURGICAL MISCELLANEOUS	PPO 80%; non-PPO 60%
2. SURGICAL TREATMENT	PPO 80%; non-PPO 60%
3. ASSISTANT SURGEON	30% Surgery Treatment Benefit
4. ANESTHESIA	30% Surgery Treatment Benefit
5. PHYSICIAN'S NON-SURGICAL VISITS (paid day of surgery)	$20 copay per visit; PPO 80%; non-PPO 60%
6. PHYSIOTHERAPY (includes occupational therapy; 1 visit per day)	20% copay/visit, up to 10 visits; PPO 80%; non-PPO 60%
7. OUTPATIENT TESTS AND PROCECURES (in lieu of all other Policy benefits)	Paid under f.8.
8. DIAGNOSTIC XRAY, RADIOLOGY & LAB SERVICES (includes ultrasound, nuclear medicine, ECG, EEG, other Diagnostic procedures)	$25 copay per visit; PPO 80%; non-PPO 60%
9. HOSPITAL EMERGENCY ROOM SERVICES (copay waived if admitted)	$100 copay per visit; PPO 80%; non-PPO 60%
10. CHEMOTHERAPY AND RADIATION THERAPY	No Benefit
11. MATERNITY BENEFITS (includes abortion if life threatening to mother)	Same as any Sickness
12. MENTAL AND NERVOUS DISORDERS (in lieu of other Policy Benefits)	$20 copay per visit, up to 20 visits per Policy year; PPO 80%; non-PPO 60%
13. SUBSTANCE ABUSE (in lieu of other Policy benefits)	$20 copay per visit, up to 20 visits per Policy year; PPO 80%; non-PPO 60%
14. PRESCRIPTION DRUGS (Refer to the Prescription Drug Program; 30 day supply per Prescription)	$15 copay/Generic Drug; $25 copay/Brand Drug up to $1,500 per Policy year
15. MOTOR VEHICLE INJURY	Same as any Injury
16. SHOTS AND INJECTIONS	Paid under f.5.
g. OTHER COVERED SERVICES	
1. AMBULANCE SERVICES	U&C, up to $300
2. DENTAL TREATMENT (Injury Only, Includes X-rays)	80% U&C
3. ORTHOPEDIC APPLIANCE/DURABLE MEDICAL EQUIPMENT	PPO 80%; non-PPO 60%; up to $200 per Policy year
4. HOME HEALTH CARE	$50 deductible/Policy year; 40 visits/Policy year; Up to $300 per Policy year; PPO 80%; non-PPO 60%

g. OTHER COVERED SERVICES CONTINUED	INJURY or SICKNESS BENEFIT LIMITS
5. CONSULTANT PHYSICIAN (when requested by attending Physician)	PPO 80%; non-PPO 60%
6. WELL CHILD CARE (includes immunizations and age appropriate tests)	PPO 80%; non-PPO 60%
7. IMMUNIZATIONS (when received at the SHS only)	$10 copay/immunization; 100% U&C; up to $200 per Policy Year
8. WELLNESS BENEFIT	PPO 80%; non-PPO 60%; Up to $300 Policy year
9. INPATIENT NEWBORN CARE (hospital nursery and related physician services)	Same as any Sickness, up to 48 hours following Vaginal delivery or 96 hours following Cesarean delivery
10. PRE ADMISSION TESTING (INPATIENT)	PPO 80%; non-PPO 60%
11. ACNE TREATMENT	Same as any Sickness

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

	Amount
a. Maximum Major Medical Benefit For Each Loss:	No Benefit
b. Deductible Type: Each Loss	
Threshold Deductible	No Benefit
Corridor Deductible	No Benefit
c. Covered Percentage	No Benefit
d. Out-Of-Pocket Maximum Per Loss:	No Benefit

Major Medical Benefits are not covered under this Policy.
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3. OTHER BENEFITS - for each Insured Person We will pay Other Benefits as set forth in Part A3. for Eligible Expenses incurred during the Benefit Period, limited by all maximums set forth in Part A3.

	Amount
a. Accidental Death and Dismemberment	No Benefit
(i) Death Benefit	
(ii) Single Dismemberment/Loss of Eye	
(iii) Double Dismemberment/Loss of Both Eyes	
b. Medical Evacuation/Repatriation	See Separate Brochure
c. Intercollegiate Sports Injuries	No Benefit

4. VARIABLE PROVISIONS -

a. Benefits Determination: Excess Coverage

b. Benefit Period: Policy Benefit Period

c. Enrollment Period: Undergraduate students and scholars are automatically enrolled unless coverage is waived. Students and dependents must enroll by the Enrollment Deadline dates shown on page 2. Dependents must enroll when the student first enrolls in the plan and must enroll for the same coverage as the student.
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 or dependent arriving from a foreign homeland. **You must enroll in this plan within 31 days of the qualifying event.**

d. Pre-Existing Conditions Waiting Period: Yes - Number of Months – 12. The pre-existing waiting period does not apply to pregnancy, newborn or adopted children.

e. Usual and Customary Charges: Determined by referencing the 80th percentile of the most current survey published by Ingenix.

PART B - DEFINITIONS

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

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

2. **Amendments/Endorsements** means any lawful change which the Policyholder and We agree to make to the original terms of this Policy. If a change is made, We will include an Amendment or provide an Endorsement in this Policy. We will specify any form number in the Policy Schedule.

3. **Benefit (Benefits)** means the amount of Eligible Expense payable by this Policy.

4. **Complications of Pregnancy** means any disease, disorder or condition that has a diagnosis nosologically distinct from the pregnancy but that is adversely affected by the pregnancy.

5. **Covered Percentage** means the portion of Eligible Expenses that are payable as Benefits by Us.

6. **Covered Services** means any of the following services and supplies which are Medically Necessary, prescribed or performed by a Physician or Hospital, not excluded by this Policy, and named in this Policy's SCHEDULE OF BENEFITS.

   a. **Hospital Room and Board (R&B):** Benefits are paid for the daily semi-private room rate when Hospital Confined, except as specifically provided in the SCHEDULE OF BENEFITS. The semi-private room rate includes an allowance for general nursing care provided and charged for by the Hospital.

   b. **Hospital Intensive Care Unit:** Benefits are paid as shown on the SCHEDULE OF BENEFITS.

   c. **Hospital Miscellaneous (Inpatient):** When You are Hospital Confined. Benefits will be paid for services and supplies including but not limited to: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs (excluding take home drugs) or medicines; therapeutic services; and supplies. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.

   d. **Hospital Outpatient Surgical Miscellaneous:** When You are not Hospital Confined and are undergoing major scheduled day surgery at an outpatient surgical care unit or licensed outpatient surgical center. Benefits will be paid for services and supplies including but not limited to: the cost of the operating room, laboratory tests, X-ray examinations, anesthesia, drugs (excluding take home drugs) or medicines, therapeutic services, and supplies.

   e. **Outpatient Tests and Procedures**: When You are not Hospital confined and are undergoing necessary, scheduled diagnostic or therapeutic tests and procedures, benefits are payable when no other policy benefit is provided in the SCHEDULE OF BENEFITS, or not excluded by this Policy. Diagnostic or therapeutic tests and procedures are identified in the Medicine section of the Physicians' Current Procedural Terminology (CPT). These tests and procedures include, but are not limited to: therapeutic or diagnostic infusions or injections, dialysis, gastroenterology procedures, Ophthalmology procedures, Otorhinolaryngologic procedures, Cardiovascular procedures, non-invasive Vascular studies, Pulmonary procedures, Neurology and Neuromuscular procedures. We reserve the right to determine whether a diagnostic test and procedure is eligible as a Covered Service.

   f. **Surgical Treatment:** Benefits are payable for surgical procedures based on the Usual and Customary Charges. 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.

g. **Assistant Surgeon:** When necessary and required by the attending Physician.

h. **Anesthesia:** Benefits are payable for the administration of anesthesia when performed by a Physician and Certified Registered Nurse Anesthetist, including drugs and supplies used in connection with the surgery or covered test or procedure.

i. **Consultant Physician:** When requested and approved by the attending Physician.

j. **Physician's Non-Surgical Visits (Inpatient):** Benefits are limited to one visit per day and includes Physician's evaluation and management services as identified in Physicians' Current Procedural Terminology (CPT). Benefits are not paid on the day of surgery. Covered Services will be paid under the inpatient benefit or under the outpatient benefit for Physician's Visits, but not both on the same day.

k. **Physician's Non-Surgical Visits (Outpatient):** Benefits are limited to one visit per day and includes the Physician's evaluation and management services as identified in Physicians' Current Procedural Terminology (CPT). Includes any ancillary supplies received during the visit, except as specifically provided in the SCHEDULE OF BENEFITS. Benefits are not paid on the day of surgery. Covered Services will be paid under the outpatient benefit or under the inpatient benefit for Physician's Visits, but not both on the same day.

l. **Physiotherapy:** Any form of therapeutic or manual treatment provided by a Physician, including but not limited to: physical or mechanical therapy, diathermy, ultrasonic treatment, EMS, whirlpool, heat treatments or manipulation. All treatments received during one visit will be subject to the Benefit Limit shown on the SCHEDULE OF BENEFITS.

m. **Inpatient Pathology and Radiology Services:** Pathologist's fees and/or Radiologist fees, including charges for reading of X-rays.

n. **Outpatient Diagnostic X-ray, Radiology and Lab Services:** Includes Radiologist fees, charges for reading of X-rays, and Pathologist's fees. Diagnostic X-rays and Radiology services are those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 70000 - 79999 inclusive. Laboratory Procedures are those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 80000 - 89999 inclusive.

o. **Chemotherapy:** Benefits are limited to one treatment per day.

p. **Radiation Therapy:** Benefits are limited to one treatment per day.

q. **Hospital Emergency Room Services (Outpatient):** Includes staff Physician, use of emergency room, and supplies. Hospital Emergency Room includes necessary emergency treatment provided in an urgent care facility or clinic, or an observation room or other room designated by the hospital.

r. **Ambulance Services:** Professional ground ambulance service, except as specifically listed in the SCHEDULE OF BENEFITS.

s. **Maternity Benefit:** Benefits for normal pregnancy and childbirth are payable on the same basis as a Sickness, except as specifically listed in the SCHEDULE OF BENEFITS. Covered Medical expenses include: Physician visits, Diagnostic services, Obstetrical /surgical procedures, Hospital room and board, and Hospital miscellaneous. Includes medically necessary routine screening examinations and testing as established as the standard of care by the American College of Obstetricians and Gynecologists. Routine screening and testing includes, pregnancy test, alpha-fetoprotein, antibody screening, blood group and Rh type, one pap smear, gestational diabetes screening, hemoglobin or hematocrit, hepatitis B screening, HIV screening, one ultrasound, rubella antibody measurement, syphilis screening, urinalysis,

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

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

t. **Mental and Nervous Disorders:** Benefits are payable for Inpatient and Outpatient treatment as shown on the SCHEDULE OF BENEFITS for a Sickness that is a mental emotional or behavioral disorder. All diagnoses classified as a "Mental Disorder" according to the ICD-9 (International Classification of Diseases, 9th Revision, codes 290 through 319 inclusive) are considered one Sickness. Mental and Nervous Disorders do not include diagnoses and treatment for Substance Abuse Treatment.

u. **Substance Abuse Treatment:** means a Sickness of psychological or physical dependence or addiction to alcohol or drugs and medication, does not include treatment for nicotine addiction or smoking cessation. Inpatient and Outpatient treatment as shown on the SCHEDULE OF BENEFITS and/or any Amendment.

v. **Orthopedic Appliances or Durable Medical Equipment:** Any supportive appliance or device which (i) is prescribed by a Physician; (ii) is primarily and customarily used to serve a medical purpose; (iii) can withstand repeated use; (iv) generally is not useful to a person in the absence of Injury or Sickness; and (v) is used exclusively by the Covered Person. Replacement braces and appliances are not covered. No benefits will be paid for rental charges in excess of purchase price. Durable Medical Equipment does not include for example: non-prescription therapy devices or medical supplies; comfort and convenience items; modifications of the Covered Person's residence, property or automobiles; corrective shoes; exercise and sports equipment. A written prescription must accompany the claim when submitted. We reserve the right to determine whether an Orthopedic Appliance or Durable Medical Equipment is eligible as a Covered Service.

w. P**rescription Drugs:** Includes only the cost of the drug obtained from a licensed Pharmacy. Does not include charges for the injection or administration of the drug. Benefits are limited to a 30-day supply per Prescription Drug.

x. **Home Care:** Health services provided in the Covered person's home under an established plan of care approved in writing by the attending Physician, and certified by the Physician as an alternative to hospital confinement. Home Care services include, but are not limited to: part-time or intermittent nursing services; physical, occupational, respiratory and speech therapy; durable medical equipment; drugs and medicines; and lab services. Home Care Does not include health aide services or twenty-four hour Private Duty Nursing. Benefits are provided as shown on the SCHEDULE OF BENEFITS.

y. **Dental Treatment:** Dentist's fees for surgery, x-rays or dental services related to an accidental Injury to Sound, Natural Teeth, including replacement of the injured Natural Teeth. Benefits do not include tooth fracture due to biting or chewing. You must have the treatment performed within the Policy Period.

z. **Private Duty Nurse:** Inpatient hospital services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.), other than a member of Your family or other person employed or retained by the Policyholder. Does not include Home Care nursing services.

z1. **Shots and Injections**: Diagnostic or therapeutic injections when administered in the Physician's office and charged as a separate item on the Physician's statement. Includes the cost of the drug. Benefits are payable when no other policy benefit is provided in the SCHEDULE OF BENEFITS or as required state mandate. Does not include shots and injections excluded by this Policy.

z2. **Other Covered Services:** includes miscellaneous Covered Services designated on the SCHEDULE OF BENEFITS, and not provided elsewhere under this Definition.

7. **Deductible** means an amount or amounts of Eligible Expenses that You must pay. This Policy's SCHEDULE OF BENEFITS page identifies the Deductible(s). It also specifies whether the Deductible applies per Loss or per policy year.
   a. Basic Deductible is the amount either applied to Benefits or applied to Eligible Expenses under Part A, 1. Basic Injury and Sickness Benefit.
   b. Threshold Deductible is the Amount shown as the Maximum Basic Benefit For Each Loss on the SCHEDULE OF BENEFITS that must be paid before Major Medical Benefits will be payable under this Policy.
   c. Corridor Deductible is the amount of Eligible Expenses in excess of the Threshold Deductible, or the Covered Services Benefit Limits under the Basic Injury and Sickness Benefits that are accumulated before Benefits are payable under the Major Medical Benefits.

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

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

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

   Benefits for routine well newborn or adoption child care expenses are covered, if the insured Student enrolls the child and pays the additional premium within 31 days from the date of birth or the date the legal obligation began.

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

10. **Elective Surgery and Elective Treatment** means surgery or medical treatment which is not necessitated by a pathological change occurring after Your Effective Date of coverage or not covered under the policy. Elective Surgery and treatment includes but is not limited to: tubal ligation; circumcision; vasectomy; breast reduction;

sexual reassignment surgery; any services or supplies rendered for the purpose or with the intent of inducing conception; temporomandibular joint dysfunction (TMJ); cosmetic procedures; submucous resection and/or other surgical correction for deviated nasal septum; allergy testing; treatment for acne; biofeedback-type services; infertility; hypnotherapy; learning disabilities; and weight management services.

11. **Eligible Expense** means the Usual and Customary (U&C) Charges You incur for Covered Services as a result of Injury or Sickness.

12. **Eligible Person(s)** means those persons eligible to be insured under this Policy, and who are shown in the CLASSES OF ELIGIBLE PERSONS INSURED of the POLICY SCHEDULE.

13. **Excess Coverage** means this Policy will pay the dollar amount shown on the SCHEDULE OF BENEFITS regardless of Other Medical Coverage. All Eligible Expenses in excess of that amount must be paid by Other Medical Coverage before Benefits are paid by this Policy.

14. **Experimental and Investigational** means any treatment, procedure, drug or device which (a) cannot be lawfully marketed without approval of the federal food and drug administration, (b) is determined to be experimental, investigational or for research purposes based on the informed consent document or the written protocols used by the treating Physician, Hospital or facility, (c) is subject to ongoing Phase 1 or Phase 2 clinical trials, (d) reliable evidence show the prevailing opinion among experts is that further studies or clinical trials are necessary, and (e) the outcomes data published in peer-reviewed medical and scientific literature is insufficient to substantiate its safety and effectiveness as compared with the standard means of treatment for the Injury or Sickness.

    In making these determinations, the Plan Administrator will obtain an external evaluation by an appropriately licensed or qualified professional who will review the claim and any additional information provided for review.

15. **Fifty-Two (52) Week Benefit Period** means that Benefits are paid for up to 52 weeks from the date of Injury or first treatment for a Sickness, occurring during the Policy Period.

16. **Health Service Benefits** means those benefits paid for expenses incurred as a result of services provided at the Policyholder's Health Center.

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

18. **Hospital Confined/Hospital Confinement** means confined in a Hospital for at least 18 hours by reason of an Injury or Sickness for which Benefits are payable.

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

20. **Loss** means medical expense or indemnity covered by this Policy as a result of any one Injury or Sickness.

21. **Maternity** means a Sickness, which is not a Pre-existing Condition. Conception must occur after Your Effective Date of coverage. Treatment must begin prior to Your Expiration Date of coverage.

22. **Medical Emergency** means a life threatening medical condition resulting from an Injury or Sickness of the Insured, which arises suddenly and required immediate medical care to prevent permanent disability or loss of life to the Insured.

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

24. **Nurse or Private Duty Nurse** is a registered nurse (R.N.) or licensed practical nurse (L.P.N.) other than a member of Your family or other person employed or retained by the Policyholder.

25. **Other Benefits** means the Benefits described below:

    a. **Accidental Death, Single Dismemberment/Loss of Eye, Double Dismemberment/Loss of both Eyes:** When an Injury covered by this Policy results in a loss within 180 days from the date of the Accident causing the Injury, the Benefit Limit for the loss shown on the SCHEDULE OF BENEFITS under Other Benefits will be paid. The Benefit paid under this provision will be in addition to any other Benefits paid for the Injury. Dismemberment means, at a minimum, the severance of a hand or foot above the wrist or ankle joint. Loss of Eye means entire and irrecoverable loss of vision in the eye.

    b. **Medical Evacuation:** When Hospital confined for at least five consecutive days; and when recommended and approved by the attending Physician, Benefits will be paid for evacuation to Your natural country. This Benefit is limited to the Benefit Limit specified in the SCHEDULE OF BENEFITS. No additional benefits will be paid under Basic or Major Medical coverage.

    c. **Repatriation:** If You die while insured under this Policy; Benefits will be paid for: preparing and transporting Your remains to Your home country. This benefit is limited to the Benefit Limit specified in the SCHEDULE OF BENEFITS. No additional Benefits will be paid under Basic or Major Medical coverage.

    d. **Intercollegiate Sports/Club Sports: Intercollegiate Sports** means any athletic contest or competition, regulated by a national association, between accredited colleges or universities. The participants are sponsored by the Policyholder, and are under the direct and immediate supervision of an employee of the Policyholder. It includes the practice or training for the competition and the travel to or from such practice or competition in a vehicle designated by the Policyholder, both while under the direct and immediate supervision of an employee of the Policyholder. **Club Sports** means any athletic contest or competition by clubs or organizations that is not an Intercollegiate Sport and that may or may not be sponsored by the Policyholder. Club sports may or may not be under the direct and immediate supervision of an employee of the Policyholder.

26. **Other Medical Coverage** means any plan providing benefits or services for medical care or treatment, where such benefits or services are provided on a group basis by or under: group insurance; coverage provided by hospital or medical service organizations such as Blue Cross or Blue Shield or similar pre-paid medical service organizations; union welfare or trust plans; employer or employee benefit plans or arrangement whether on an insured or uninsured basis; Medicare as established by Title XVIII of the United States Social Security Act of 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).

PART B - DEFINITIONS CONTINUED

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

28. **Policy Benefit Period** means that Benefits are paid only during the period of time that You purchased coverage under this Policy. The maximum length of time of the Benefit Period is the Policy Period.

29. **Policy Period** means the period of time beginning at 12:01 a.m. on the Policy Effective Date, and ending at 11:59 p.m. on the Policy Expiration Date, as shown on the POLICY SCHEDULE.

30. **Pre-Existing Condition** means any condition which originates, is diagnosed, treated, or recommended for treatment within the 6 months immediately prior to Your Effective Date of coverage.

31. **Pre-Existing Conditions Waiting Period** means the time period You must have continuous coverage inforce under this Policy before a Pre-Existing Condition is considered a Loss.

32. **Prescription Drugs** means prescription legend drugs; or compound medications of which at least one ingredient is a prescription legend drug; or any other drug which under the applicable state or federal law may be dispensed only upon the written prescription of a Physician.

33. **Premium** means the Premiums shown on the PREMIUM SCHEDULE of this Policy.

34. **Primary Coverage** means that the Benefits of this Policy are paid regardless of Other Medical Coverage which pays Benefits for the same Loss.

35. **Sickness** means Your bodily sickness, mental sickness, or Maternity which is not a Pre-existing Condition and which causes Loss while Your coverage is in force. Sickness includes pregnancy, Complications of Pregnancy and trauma related disorders due to injuries which otherwise do not meet the definition of an Injury. All related sicknesses and recurrent symptoms of the same or similar condition will be considered one Sickness.

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

37. **Student** means a person described in the CLASSES OF ELIGIBLE PERSONS INSURED on the POLICY SCHEDULE.

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

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

40. **You or Your, or Insured or Insured Person** means a Person who belongs to one of the CLASSES OF ELIGIBLE PERSONS INSURED shown on the POLICY SCHEDULE, and for whom the required Premium has been paid in advance of that person's Effective Date of coverage.

PART C - EXCLUSIONS

This Policy does not provide Benefits for expense resulting from:

1. Air flight, except as a fare-paying passenger on a regularly scheduled flight of a commercial airline.

2. Dental treatment, except as specifically provided in the SCHEDULE OF BENEFITS.

3. Treatment where no Injury or Sickness is involved (physical examinations or preventive medicines); or Elective Surgery and Elective Treatment; or abortion; except as specifically provided in the Schedule of Benefits or by state law; It does not include cosmetic surgery made necessary by Injury. Non-medical self-care or self-help training; health or fitness club memberships; personal comfort or convenience items; treatment for Hirsutism, hair growth or baldness.

4. Motor vehicle Accidents, to the extent covered by another valid and collectible insurance policy, prepaid services contract, or similar plan. The Motor Vehicle Injury Benefit Limit is shown on the SCHEDULE OF BENEFITS.

5. Eyeglasses, contact lenses, and examination for prescribing or fitting them; any other procedure for correction of refractive disorder of the eye or eyes; hearing aids and hearing examinations; Treatment for foot care including care of flat feet, corns, calluses, bunions, weak feet, chronic foot strain, and supportive foot devices

6. Injury or Sickness for which benefits are paid under Worker's Compensation or Occupational Disease Act or Law.

7. Growth Hormone therapy; Patient Controlled Analgesia; Allergy Treatment.

8. Injury sustained while participating in the practice or play of interscholastic sports or Intercollegiate Sports, including the participation in any practice or conditioning program for such sport, contest or competition.

9. Intentional self-inflicted Injuries; including drug overdose; Loss incurred while committing or attempting to commit a felony; Loss due to voluntary participation in a riot or civil disturbance.

10. Routine newborn baby care, well baby nursery and related Physician's charges, except as specifically provided in the SCHEDULE OF BENEFITS.

11. Services provided normally without charge by the Health Service of the Policyholder; or by any person employed or retained by the Policyholder; or services covered or provided by the student health fee.

12. Treatment related to nicotine addiction or smoking cessation.

13. Use of any services or supplies which are experimental and/or not in accord with generally accepted standards of medical practice; organ transplants, including donor’s expenses.

14. War or act of war, whether declared or not; and Injury or Sickness resulting from full-time, active-duty military service.

15. Pre-existing Conditions, 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.

16. Weight management services and supplies related to weight reduction programs, weight management program, and related nutritional supplies; treatment of obesity; surgery for the removal of excess skin or fat, and for weight reduction or treatment of obesity.

PART D - GENERAL POLICY PROVISIONS

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

PART E - ADDITIONAL POLICY PROVISIONS

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

   Eligible Persons may be insured under this Policy when: the person enrolls for the coverage provided by this Policy; and pays the required premium as shown in the PREMIUM SCHEDULE. Each person must meet the Eligibility requirements as shown on the POLICY SCHEDULE each time premium is paid to continue coverage. Any student withdrawing from school within the first 31 days of the period for which coverage is purchased shall not be covered under the Policy.

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

   Eligibility will be maintained for a Student who must involuntarily withdraw from school within thirty-one (31) days from the period for which coverage is purchased, due to a medical condition that would be covered by this Policy, and which has been documented by the attending Physician. Coverage will terminate on the earliest of the dates as stated in Part E.3.

   Dependent's eligibility is determined as follows:

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

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

2. **Effective Date**:

   a. Your coverage under this Policy will become effective on the later of the following dates;

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

3. **Expiration Date**:

   a. Your coverage under this Policy will terminate on the earliest of the following dates;

      (i) The last day of the coverage period for which the Premium is paid, or as provided in Additional Policy Provisions, Grace Period, or
      (ii) The Policy Expiration Date shown on the POLICY SCHEDULE, or
      (iii) The end of the month following the date of graduation; or the date the student voluntarily stops attending school after satisfying the Eligibility requirements or the date your have entered into full-time active duty military service of any country.

   b. Coverage for each Dependent will terminate on the earliest of the following dates;

      (i) The last day of the period through which the Premium for the Dependent is paid,
      (ii) The Policy Expiration Date as shown on the POLICY SCHEDULE, or
      (iii) The date the Student's coverage terminates.

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.

4. **Grace Period**: Insured Persons that purchase partial year coverage will have a 31 day grace period between coverage periods. If the Premium is not paid within the 31 day period, coverage will end on the last day of the coverage period for which Premium was paid. If the student is eligible for coverage, a new Effective Date will be in effect, as stated in PART E.2. above, upon receipt of the Premium.

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

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

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

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

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

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

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

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

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

Prior Creditable Coverage means Your prior Student health insurance policy of the Policyholder or other coverage provided in the United States under any of the following: a group health plan; health insurance coverage under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract; Medicare; Medicaid; military health care; a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; the Federal Employee Health Benefits Program; a public health plan; or a health benefit plan of the Peace Corps.

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

9. PREFERRED PROVIDER PROGRAM

DEFINITIONS are revised to include the following:

Allowable Charge(s) (Negotiated Fee) means a charge for services or supplies received from a Preferred Provider. Such charge will be paid according to the agreement between the Preferred Provider Organization and the Company, and, according to the Policy's maximum benefits, limitations, and exclusions.

Coinsurance Percentage means the percentage of covered expenses paid by the Company and by the Insured Person. It is a method of cost sharing by which the Insured Person and the Company each pay a specified percentage of the hospital or medical expenses resulting from an Injury or Sickness that are in excess of any Co-Payments or Deductibles.

Co-Payment means the amount of covered expenses the Insured Person must pay a PPO Provider or Non-PPO Provider for each visit, service, supply, or prescription.

Emergency Medical Condition means a medical condition that manifests itself by acute symptoms of sufficient severity including severe pain, or by acute symptoms developing from a chronic medical condition that would cause a prudent lay person, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:

1. placing the health of an Insured, unborn child, or Insured dependent in serious jeopardy;
2. serious impairment to a bodily function;
3. serious dysfunction of any bodily organ or part.

Non-Preferred Provider or Non-PPO Provider means a Physician, Hospital, or other health care provider or health care facility that has no contractual agreement with a Preferred Provider Organization. Covered Services rendered by a Non-Preferred Provider are payable as shown in the Schedule of Benefits.

Preferred Provider or PPO Provider means a Physician, Hospital, or other health care provider or health care facility that has a contractual agreement with a Preferred Provider Organization. Covered Services rendered by a Preferred Provider are payable as shown in the Schedule of Benefits.

Preferred Provider Organization (PPO) means a health care delivery system through which providers contract to offer medical services on a discounted fee basis within a defined service area.

Service Area means the geographic area in the state of Illinois as defined in the agreement signed between the Preferred Provider Organization and the Company.

Utilization Review means a program the Insured uses to obtain prior authorization for an admission, surgery or medical procedure. Prior authorization is not a guarantee that benefits will be paid.

BENEFITS

When Your covered Injury or Sickness results in treatment by a Physician, the Company will pay the PPO Provider Coinsurance Percentage of Negotiated Fee shown below for services received from a PPO Provider, and the Non-PPO Provider Coinsurance Percentage of the Usual and Customary (U&C) Charges shown below for services received from a Non-PPO Provider, for the Covered Services and Benefit Limits described in the Schedule of Benefits.

If services are received from a Non-PPO Provider, benefits will be paid at the PPO Provider Coinsurance Percentage for U&C Charges when care is necessary for: a.) a Medical Emergency and services are received outside the Service Area; or b.) a Medical Emergency inside the Service Area and a PPO Provider could not be available to provide services.

Benefits will be paid at the Non-PPO Provider Coinsurance Percentage for U&C Charges when the Insured Person: a.) receives services from a non-PPO Provider inside or outside of the Service Area; or b.) receives services from a provider who is no longer a member of the Network, except as specified under Continuity of Care below.

The availability of PPO Providers is subject to change. You should always verify that the physician is participating when the appointment is made or prior to the time services are required.
Regardless of the provider, the Insured Person is responsible for all Coinsurance Percentage payments, Co-payments and Deductibles shown in the Policy and Endorsement. Coverage under this Policy is not a guarantee of benefits. The Company does not pre-certify or verify benefits.

Preferred Provider Organization:	Beech Street www.beechstreet.com or 800-432-1776
PPO Provider Coinsurance Percentage:	80% of PPO Negotiated Fee
Non-PPO Provider Coinsurance Percentage:	60% of Usual and Customary Charge

Continuity of Care
If the Insured is actively undergoing medical treatment for a disability or acute condition from a provider whose contract with the PPO has been terminated during a necessary course of treatment, We will continue to pay PPO benefits under the terms of the Policy until the later of:

1. the 90th day after the date the Insured is notified of the PPO contract termination, or
2. the date of delivery, including post-partum care directly related to the delivery if the Insured is in the third trimester of pregnancy.

During this period, the physician must agree to continue to provide services in accordance with the terms of the PPO Provider contract existing before the termination. We will not pay PPO benefits for such physician if the contract was terminated for cause.

If a new Insured enrolls in this Policy and is actively undergoing medical treatment from a provider who is not a member of the PPO but is within the service area, benefits will be paid at the PPO Provider Coinsurance Percentage for U&C charges incurred for a necessary ongoing course of treatment until the later of:

1. the 90th day after the enrollment date, or
2. The date of delivery, including post-partum care directly related to the delivery, if the insured is in the third trimester of pregnancy at the effective date of enrollment.

We must authorize the ongoing care during the transition period and the Non-PPO Provider agrees to accept reimbursement at the negotiated rates established by Us as payment in full (which rates shall be no more than the level of reimbursement applicable to similar PPO Providers), adhere to PPO quality assurance requirements, agrees to provide Us with necessary medical information related to such care, and to adhere to the Our policy and procedures.

We will not pay the PPO benefit level for such provider if the provider does not agree to provide treatment according to the terms above. In no event shall this provision be construed to require Us to provide coverage for benefits not otherwise covered under this Policy or to diminish or impair the Pre-existing condition limitation. Benefits for the treatment performed by the Non-PPO Provider will be subject to the same benefit limits, exclusions, and plan provisions for covered services received by PPO Provider.

Access to Specialty Care:
A referral is not required to obtain services or treatment from an obstetrician or gynecologist or other specialist provider. We will provide reimbursement for Covered Services as described above for treatment by a non-PPO provider. Benefits will be paid at the PPO Provider Coinsurance Percentage for U&C charges incurred for necessary treatment, If:

1. We determine that the Service Area does not have a PPO Provider with the appropriate training and experience to meet the particular health care needs of an Insured.

Benefits for the treatment performed by the Non-PPO specialty provider is subject to the same benefit limits, exclusions, and plan provisions as specified in this Policy's Benefits Schedule for covered services received by PPO Provider.

Emergency Care:
If the Insured cannot reasonably obtain the services of a PPO Provider, due to an Emergency Medical Condition, We will provide reimbursement for the following Non-PPO Provider emergency care services for the Usual and Customary charges incurred at the PPO Provider Coinsurance Percentage until the Insured can reasonably obtain the care or services of a PPO Provider:

1. any medical screening examination or other evaluation required by state or federal law to be provided in the emergency facility of a hospital which is necessary to determine whether an Emergency Medical Condition exists;
2. necessary emergency care services including the treatment and stabilization of an Emergency Medical Condition; and
3. services originating in a hospital emergency facility following treatment or stabilization of an Emergency Medical Condition.

Utilization Review
Prior authorization is not required, We will provide reimbursement for Covered Services as described above for treatment by a PPO Provider or a non-PPO Provider.

10. PRESCRIPTION DRUG PROGRAM

PROGRAM OVERVIEW
The Plan Administrator has contracted with a Prescription Benefit Manager (PBM) for access to a network of Participating Pharmacies.

When Your physician prescribes a drug for a covered Injury and Sickness, You can purchase the Prescription Drug at a Participating Pharmacy by showing Your ID card to the pharmacy as proof of coverage. You pay a Copay based on the type of Prescription Drug purchased, Copay amounts are listed below. You can also choose to use a pharmacy of your choice and pay non-Participating Pharmacy prices.

You can obtain information about specific Pharmacies or drugs by calling the PBM or visiting their website. Addresses are listed below and on Your ID card.

Regardless of the Pharmacy used, benefits for Prescription Drugs are subject to any Maximums and Benefit Limits described in the Schedule of Benefits.

DEFINITIONS is revised to include the following:

Allowable Charge(s) means a charge for Prescription Drugs received from a Participating Pharmacy. Such charge will be paid according to the agreement between the PBM and the Company, and, according to the Policy's maximum benefits, limitations, and exclusions.

Brand-Name or Preferred Brand-Name means the name of the Prescription Drug that appears in advertising. A Brand-Name drug is protected by a patent; this means that only one company can produce it until the patent expires. A Preferred Brand-Name is a drug on the Formulary list.

Coinsurance Percentage means the percentage of covered expenses paid by the Company and by the Insured Person. It is a method of cost sharing by which the Insured Person and the Company each pay a specified percentage of the Prescription Drug expenses resulting from a covered Injury or Sickness that are in excess of any Copays or Deductibles.

Copay means Your cost for purchasing each Prescription Drug at a Participating Pharmacy.

Formulary means a list of Covered Generic and Brand-Name Prescription Drugs that can be purchased at a reduced cost and Copay at a Participating Pharmacy. The list is created, maintained and approved by the PBM.

Generic or Preferred Generic means a Prescription Drug whose patent has expired. Other drug companies can produce and distribute the Prescription Drug under a different name than the original Brand-Name. The Generic drug's chemical composition is the same as the Brand-Name drug. A Preferred Generic is a drug on the Formulary list.

Non-Participating Pharmacy means a Pharmacy that has no contractual agreement with a PBM. Covered Prescription Drugs purchased at a non-Participating Pharmacy are payable at the Coinsurance Percentage as shown in the Schedule of Benefits.

Non-Preferred Drug means a Prescription Drug not on the Formulary list.

Participating Pharmacy means a Pharmacy that has a contractual agreement with a PBM. Covered Prescription Drug purchased at a Participating Pharmacy are payable as shown in the Schedule of Benefits.

Prescription Drug means a drug approved by the Federal Food and Drug Administration and can only be obtained with a Physician's prescription for the treatment of a Covered Injury or Sickness.

Prescription Benefit Manager (PBM) means a company that has contracted with pharmacies to offer prescription drugs on a discounted fee basis within a defined Service Area.

Service Area means the geographic area within the United States, as defined in the agreement signed between the PBM and the Company.

BENEFITS

The Prescription Drug Program pays benefits when You choose to fill Your Covered Prescription Drug at a Participating Pharmacy. The Company will pay the Participating Co-Insurance Percentage of Allowable Charges after the Insured pays the Copay amount (shown below).

The Company will pay the Usual and Customary (U&C) Charges at the Co-Insurance Percentage (shown below) if you choose to fill your Covered Prescription Drug at a non-Participating Pharmacy.

Prescription Drug Card Vendor	Express Scripts www.express-scripts.com or 800-332-5455
Participating Pharmacy Coinsurance	100%
Participating Pharmacy Copay	$15 per Generic Drug Copay $25 per Brand-Name Drug Copay
Non-Participating Pharmacy Coinsurance:	No Benefit
Prescription Drug Maximum:	$1,500 per Policy year

Generic Drug Benefit
When a Generic drug is available and You choose to purchase a Brand-Name drug, We will pay the Allowable Charge for the Generic drug. You will pay the Brand-Name Copay plus any price difference between the Generic and Brand-Name drug.

30-Day Supply Limit
Benefits payable are limited to a 30 day supply per covered Prescription Drug.

Submitting Claims to the Prescription Drug Card Vendor
If a Prescription Drug is purchased from a non-Participating Pharmacy or a Participating Pharmacy when Your ID card is not used, You must pay the entire cost of the Prescription Drug. You must then submit the claim to the PBM for reimbursement.

Refill Limit
Benefits for a covered Prescription Drug is limited to the number of refills specified by the Physician and up to one year from the date of the order by the Physician.

Excluded Prescription Drugs
If You have a question on a specific drug, please contact the PBM or visit their website. Examples of excluded drugs and medicines include, but are not limited to:

- Over the counter drugs and medicines
- Drugs purchased outside the US which are not legal inside the US
- Drugs not approved by the FDA for any use/indication in the US
- Medical Supplies or devices, including Insulin prescribed needles, syringes, test scripts
- Charges for the administration or injection of any drug or medicine
- Injectible medication not designed for patient administration
- Serums, toxoids, and vaccines
- A drug or medicine dispensed or administered while hospital confined, including any confinement any facility or institution that dispenses drugs
- Vitamins and minerals
- Growth hormones
- Drugs for weight loss
- Drugs for smoking cessation purposes
- Drugs solely for cosmetic purposes

Drug Formulary
You will pay the Preferred Drug Copay amount when You purchase a non-Formulary Prescription Drug when the following circumstances occur. Your physician will need to contact the PBM.

1. The Preferred Drug on the Formulary List has been ineffective in the treatment of Your condition; or
2. The Preferred Drug causes or is reasonably expected to cause adverse or harmful reactions.

Countersigned by:

____

Licensed Resident Agent

INSURANCE CONTINUATION ENDORSEMENT

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

Insured Persons under this Policy may continue their coverage for a period of 6 months after they no longer meet the eligibility requirements of the policy succeeding this Policy if:

a.) a policy that provides benefits similar to or like this Policy is issued to the Policyholder by the Company for the Policy Period following the Policy Expiration Date of this Policy; and

b.) the Insured Person maintained continuous coverage under this Policy for twelve (12) months and was covered by this Policy on the Policy Expiration Date; and

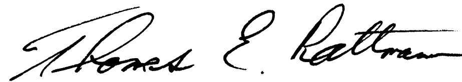
c.) the Insured Person has not exhausted this Policy's maximum benefit for any one Loss; and

d.) the Insured Person is not eligible for other insurance that covers a condition for which a claim has been made.

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

Signed for Columbian Life Insurance Company:

DANIEL J. FISCHER
Secretary



THOMAS E. RATTMANN
Chairman, President
and Chief Executive Officer

OPTIONAL BENEFITS ENDORSEMENT FOR ILLINOIS RESIDENTS

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

Cervical and Prostate Cancer Test Benefits
Benefits are payable under this Policy on the same basis as any Sickness for all of the following:

1. An annual cervical smear or Pap smear test for female Insureds.
2. An annual digital rectal examination and prostate-specific antigen test, for male Insureds upon the recommendation of a Physician licensed to practice medicine in all its branches for:
   a. asymptomatic men age 50 or older;
   b. African-American men age 40 or older; and
   c. men age 40 or older with a family history of prostate cancer.
3. Annual surveillance tests (CA-125 serum tumor marker testing, transvaginal ultrasound, or pelvic examination) for ovarian cancer for female Insureds who are at risk for ovarian cancer. At risk for ovarian cancer means (1) having a family history with one or more first degree relatives or cluster of women relatives with breast cancer, or nonpolyposis colorectal cancer; or (2) testing positive for BRCA1 or BRCA2 mutations.

Colorectal Cancer Examination and Screening Benefits
Benefits are payable on the same basis as any Sickness for colorectal cancer examinations and laboratory tests for colorectal cancer as prescribed by a Physician, in accordance with the published american cancer society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the national cancer institute, the centers for disease control and prevention, and the american college of gastroenterology.

Diabetes Self-Management Training and Education Benefits
Benefits are payable under this Policy on the same basis as any Sickness for Physician's services provided for outpatient self-management training and education of Insureds with Type 1 or Type 2 diabetes, or gestational diabetes mellitus. Services may include:

1. up to 3 Medically Necessary visits to a provider upon initial diagnosis of diabetes by the Insured's Physician.
2. up to 2 Medically Necessary visits to a provider when the Insured's Physician determines that a significant change in the Insured's symptoms or medical condition has occurred.

"Significant Change" means symptomatic hyperglycemia (greater than 250 mg/dl on repeated occasions), severe hypoglycemia (requiring the assistance of another person), onset or progression of diabetes, or a significant change in medical condition that would require a significantly different treatment regimen.

"Diabetes Self-Management Training" means instruction in an outpatient setting which enables a diabetic patient to understand the diabetic management process and daily management of diabetic therapy as a means to avoid hospitalization and complications.

Diabetes Pharmaceuticals and Supplies
Benefits are payable on the same basis as any drug benefit under this Policy for the following prescribed, pharmaceuticals and supplies for Insureds with Type 1 or Type 2 diabetes, or gestational diabetes mellitus: insulin; syringes and needles; test strips for glucose monitors; FDA approved oral agents used to control blood sugar; and glucagon emergency kits.

Diabetes Durable Medical Equipment
Benefits are payable on the same basis as any durable medical equipment benefit under this Policy for the following prescribed equipment for Insureds with Type 1 or Type 2 diabetes, or gestational diabetes mellitus: blood glucose monitors, blood glucose monitors for the legally blind, cartridges for the legally blind, and lancets and lancing devices.

Diabetes Foot Care
Benefits are payable under this Policy on the same basis as any Sickness for regular foot care exams by physician.

Mammography Benefits
Benefits are payable under this Policy on the same basis as any Sickness for screening by low-dose mammography for the presence of occult breast cancer according to the following schedule:
1. A baseline mammogram for women 35 to 39 years of age; or
2. An annual mammogram for women 40 years of age or older; or
3. A mammogram a the age and intervals considered medically necessary by the women's health care provider for women 40 years of age and having a family history of breast cancer or other risks.

"Low dose mammography" means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube filter, compression device, and image receptor, with radiation exposure delivery of less than one (1) rad per breast for 2 views of an average size breast.

Breast Reconstruction After Mastectomy
If an Insured who is receiving benefits under the Policy in connection with a mastectomy elects breast reconstruction in connection with such mastectomy, Covered Services include those incurred for:
1. reconstruction of the breast on which the mastectomy was performed;
2. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. prostheses and treatment for physical complications from all stages of the mastectomy, including lymphedemas,

Care will be determined in consultation with the attending Physician and the Insured patient.

Post-Mastectomy Treatment
Benefits are payable under this Policy on the same basis as any Sickness for hospital inpatient care following a mastectomy for a length of time determined by the attending physician to be medically necessary and in accordance with protocols and guidelines based on sound scientific evidence and upon evaluation of the patient. Benefits are also payable for a post-discharge physician's office visit or in-home nurse visit to verify the condition of the patient in the first 48 hours after discharge.

Prenatal HIV Testing
Maternity benefits include prenatal testing for HIV order by a Physician, Physician's assistant or advanced practice registered nurse who has a written collaborative agreement with a collaborating Physician that authorizes such services. This includes, but is not limited to, orders consistent with the recommendations of the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics.

Maternity and Postpartum Care
With respect to Covered Services for pregnancy, benefits will be provided for an Insured who is the mother and her newborn for:
1. a minimum of 48 hours of inpatient care following a vaginal delivery; and
2. a minimum of 96 hours of inpatient care following a caesarean section.

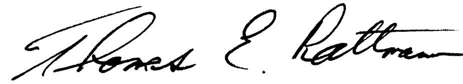
Benefits may be provided for a shorter length of inpatient stay for services related to maternity and newborn care if the attending Physician determines in accordance with the protocols and guidelines developed by the American Academy of Pediatrics or the American College of Obstetricians and Gynecologists that the mother and her newborn meet the appropriate guidelines for length of stay based upon evaluation of the mother and the newborn. In this instance Covered Services will include one post-discharge physician office visit or one in-home nurse visit, to verify the condition of the newborn in the first 48 hour after hospital discharge.
This provision does not require an Insured to give birth in a Hospital or to stay in the Hospital for a fixed period of time.

Coverage for Contraceptives
To the extent benefits are payable under this Policy for outpatient services and outpatient Prescription Drugs or durable medical equipment, coverage will be provided for all outpatient contraceptive services and all outpatient contraceptive drugs or devices approved by the federal food and drug administration.
As used in this provision, outpatient contraceptive service means consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy.
Nothing in this provision shall be construed to require coverage for services related to an abortion or services related to permanent sterilization that requires a surgical procedure.

Prescription Inhalants
To the extent benefits are payable under this Policy for outpatient Prescription Drugs, coverage will be provided for prescription inhalants to enable persons to breathe when suffering from asthma or other life-threatening bronchial ailments. Coverage will not be restricted on the number of days before an inhaler refill may be obtained, if contrary to those restrictions, the inhalants have been ordered or prescribed by the treating physician and are medically appropriate.

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

Signed for Columbian Life Insurance Company.



DANIEL J. FISCHER
Secretary

THOMAS E. RATTMANN
Chairman, President
and Chief Executive Officer

GENERAL ENDORSEMENT FOR ILLINOIS RESIDENTS

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

PART B - DEFINITIONS is revised as follows:

1. **Accident** means accidental bodily injuries which are the direct cause of loss, independent of disease or bodily infirmity and occurring while the insurance is in force.

8. In the definition of **Dependent** "mental or physical handicap" is changed to "a handicapped condition". Further it is Our responsibility to inquire 2 months prior to attainment of the limiting age or at any reasonable time thereafter, whether a Dependent is in fact disabled and dependent on You. If You do not provide the requested proof within 31 days of Our inquiry coverage may terminate when the Dependent reaches the limiting age. In the absence of any such inquiry by Us, the Dependent's coverage will continue until otherwise terminated as provided in this Policy.

   This provision applies whether the Dependent is dependent on his parents or Other Care Provider for lifetime care and supervision. Other Care Provider includes Community Integrated Living Arrangement, group home, supervised apartment and other residential services licensed or certified by Illinois.

   This provision also includes a child for whom the insured Student is a legal guardian, if the child is dependent on the insured student.

19. **Injury or Injuries** means accidental bodily Injury or Injuries which are the direct cause of loss, independent of disease or bodily infirmity and occurring while the insurance is in force. All related Injuries and recurrent symptoms of the same or similar condition will be considered one Injury.

30. **Pre-Existing Condition** means any condition which for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months immediately prior to Your Effective Date of Coverage.

PART D - GENERAL POLICY PROVISIONS is revised as follows:

5. **Time Of Payment Of Claims**: Benefits will be paid immediately upon receipt of written proof of Loss. All claims and indemnities payable under the terms of this Policy will be paid within 30 days following receipt by Us of due proof of Loss. Failure to pay benefits within such period will entitle the Insured to interest at the rate of 9% per annum from the 30th day after receipt of such information to the date of late payment. Interest amounting to less than $1.00 will not be paid. We will notify you or your assignee of any known failure to provide sufficient documentation for a due proof of loss within 30 days after receipt of the claim. Any required interest payment will be made within 30 days after the claim payment.

6. The following is added to the **Physical Examination and Autopsy** provision:

   Any such examination or autopsy will be at Our expense.

12. The **Subrogation** provision is replaced with the following:

Right of Reimbursement: If an Insured incurs expenses for Sickness or Injury that occurred due to the negligence of a third party: (a) We have the right to reimbursement for all benefits We paid from any and all damages collected from the third party for those same expenses whether by action at law, settlement or compromise, by the Insured, the Insured's parents, if the Insured is a minor or the Insured's legal representative as a result of that Sickness or Injury; and (b) We are assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits We paid for that Sickness or Injury.

We shall have the right to first reimbursement out of all funds the Insured, the Insured's parents, if the Insured is a minor, or the Insured's legal representative, is or was able to obtain for the same expenses We paid as a result of that Sickness or Injury.

You are required to furnish any information or assistance or provide any documents that We may reasonably require in order to obtain Our rights under this provision. This provision applies whether or not the third party admits liability.

14. **Time Limit on Certain Defenses:** (a) After 2 years from the Policy Effective Date no misstatements, except false misstatements made by the applicant in the application, can be used to void the policy or to deny a claim for Loss incurred or disability (as defined in the Policy) commencing after the expiration of such two-year period.

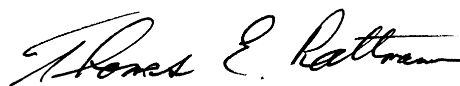
(b) No claim for Loss incurred or disability (as defined in the Policy) commencing after 2 years from the Policy Effective Date will be reduced or denied on the grounds that a disease or physical condition not excluded from coverage by name or description effective on the date of loss had existed prior to the Policy Effective Date.

15. **Change of Beneficiary:** The right to change of beneficiary is reserved to You and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this Policy or to any change of beneficiary or beneficiaries, or to any other changes in this Policy.

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

Signed for Columbian Life Insurance Company:

DANIEL J. FISCHER
Secretary



THOMAS E. RATTMANN
Chairman, President
and Chief Executive Officer

COLUMBIAN LIFE INSURANCE COMPANY

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

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

GRIEVANCE NOTICE

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

DEFINITIONS.

"Adverse Determination" means any of the following: (a) A determination that, based upon the information provided, your request for a benefit under the health benefit plan upon the application of any Utilization Review technique does not meet the requirements for medical necessity, or appropriateness, and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit.

"Grievance" means a written complaint, or oral complaint if the complaint involves an urgent care request or a request for expedited review, submitted by you regarding: (a) Availability, delivery, or quality of health care services; (b) Claims payment, handling, or reimbursement for health care services, including a complaint regarding an Adverse Determination made pursuant to Utilization Review; (c) Any other matter to the contractual relationship between you and the health carrier.

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

"Utilization Review" means a set of formal techniques used by a managed care plan or utilization review organization to monitor and evaluate the medical necessity, appropriateness, and efficiency of health care services and procedures.

GRIEVANCE PROCESS SUMMARY

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

If you have a problem or concern, you should first call the customer service toll free number on your ID Card. A customer service representative will work with you to help you understand your coverage or resolve your problem or concern as quickly as possible. If you disagree with the decision or explanation given, you may submit a written request for a review though our internal grievance process.

You may initiate the internal grievance process by contacting our Plan Administrator, Student Assurance Services, Inc., at the address shown below. You may also contact our Grievance Coordinator at the address or phone number for Columbian Life Insurance Company shown below. You do not have the right to attend the first level review, but you do have the right to:

1. Submit written comments, documents, records, and other material relating to the review;
2. Receive upon request, free of charge, reasonable access to and copies of all documents relevant to your request for benefits relating to an Adverse Determination.

For a retrospective claim denial involving an Adverse Determination, you have the right of one level of appeal by making a written request within sixty (60) calendar days from the receipt of a notice of an adverse determination. We shall notify within 3 business days of all information we require to evaluate the appeal. We will issue a decision within a reasonable time, but no later than fifteen (15) business days after the date the required information is received.

For a standard grievance not involving an Adverse Determination, you have the right of one level of appeal by making a written request within sixty days from the date of the treatment, event or circumstances, such as the date of the claim denial. We shall notify and issue a decision within thirty (30) calendar days after the receipt of the grievance. The time for making a decision may be extended if we do not have sufficient information to complete the grievance process and we notify you of the reasons for the delay.

The grievance review process does not include the review of a claim denial that is limited to veracity of documentation, or accuracy of coding, or adjudication for payment. We do not certify or verify benefits or make decisions for treatment or a service not yet provided.

If we uphold the adverse determination or denial, we shall provide you with a notice of the following:

- The titles and credentials of the person or persons participating in the first level review process and responsible for the decision;
- A statement of the reviewer's understanding of your grievance;
- The reviewer's decision in clear terms and the contract basis or medical rationale in sufficient detail;
- A reference to the evidence or documentation used as the basis for the decision;
- For a decision involving an adverse determination:
  - The specific reason or reasons for the adverse determination;
  - A reference to the specific plan provisions on which the determination was based;
  - A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other relevant information.
  - A statement if we relied upon an internal rule, guideline, protocol, or other similar criterion to make the adverse determination and that a copy of the criterion used will be provided free of charge to you upon request.
  - If appropriate, an explanation of the scientific or clinical judgment for making the determination, or a statement that an explanation will be provided to you free of charge upon request.
- A statement of your right to contact the Division of Insurance at any time for assistance, or upon completion of our grievance procedure process to file a civil suit in a court of competent jurisdiction.

EXTERNAL APPEAL

You have the right to request an external independent review. You must send us a written request for external independent review within 30 days after receipt of the adverse determination. We will forward your request and all medical records and supporting documentation to the external independent reviewer within 30 days after receipt of your request. The external independent reviewer must make a decision within 5 days after receipt of all necessary information . The decision by the independent reviewer is final.

Grievances can be sent to the following parties:

Columbian Life Insurance Company
Home Office: Chicago IL
Administrative Service Office: Vestal Parkway East, P.O. Box 1381
Binghamton, NY 13902-1381
Attn: Grievance Coordinator
Phone: (607) 724-2472 or (800) 452-0555 (toll free in New York State) or
(800) 423-9765 (toll free outside New York State)
Fax: (607) 723-7701

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

You can also contact the Office of the Commissioner of Insurance and file a complaint:

State of Illinois
Department of Insurance
320 West Washington Street
Springfield, Illinois 62767-0001
Phone: 877-527-9431

TEMPOROMANDIBULAR JOINT DISORDER AND CRANIOMANDIBULAR DISORDER ENDORSEMENT FOR ILLINOIS RESIDENTS

This Endorsement is made a part of the policy to which it is attached. All Policy provisions apply, except as stated below.

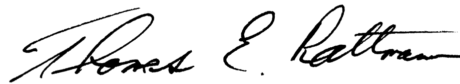
Benefits will be provided under the Policy for Covered Services for the necessary treatment of temporomandibular joint disorder and craniomandibular disorder to the same extent as services for other Sickness.

Benefits payable are subject to the same provisions, conditions and limitations of the Policy, except each Insured's lifetime maximum benefit for treatment of temporomandibular joint disorder and craniomandibular disorder is limited to $2,500 .

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

Signed for Columbian Life Insurance Company:

DANIEL J. FISCHER
Secretary



THOMAS E. RATTMANN
Chairman, President
and Chief Executive Officer