



# COLUMBIAN LIFE INSURANCE COMPANY

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ADMINISTRATIVE SERVICE OFFICE: VESTAL PARKWAY EAST  
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BINGHAMTON, NY 13902-1381

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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: University of Wisconsin – Eau Claire  
105 Garfield Avenue  
Eau Claire, WI 54701

POLICY NUMBER: 48-64-0060-014-603-9

POLICY EFFECTIVE DATE: August 26, 2009 at 12:01 a.m.

POLICY EXPIRATION DATE: August 25, 2010 at 11:59 p.m.

AMENDMENTS/ENDORSEMENTS: 9E503-CL; 9E721-CL; 9E722-CL; 9E723-CL  
9E724-CL; 3860-CL (Rev 12-05)

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. Students taking 5 or more credits and who are physically and actively attending classes for at least 31 days after their Effective Date of coverage under this Policy.
2. Dependents of a Student who is an Insured Person.

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

# TABLE OF CONTENTS

	Page		Page
POLICY SCHEDULE .....	1	PART C	
TABLE OF CONTENTS.....	2	EXCLUSIONS. ....	11,12
PREMIUM SCHEDULE.....	2	PART D	
PART A		GENERAL POLICY PROVISIONS .....	12
SCHEDULE OF BENEFITS .....	3,4	PART E	
PART B		ADDITIONAL POLICY PROVISIONS .....	13,14
DEFINITIONS.....	5,6,7,8,9,10,11	AMENDMENTS, ENDORSEMENTS	

	<u>Annual</u>	<u>*Tri-Annual</u>	<u>Spring - Summer</u>	<u>Summer</u>	
	08-26-2009 to 08-25-2010	08-26-2009 to 12-25-2009 12-26-2009 to 04-25-2010 04-26-2010 to 08-25-2010	01-25-2010 to 08-25-2010	06-08-2010 to 08-25-2010	Monthly
<b>STUDENTS AGE 30 &amp; UNDER</b>					
Student Only	\$ 897	\$ 309	\$ 553	\$ 225	\$ 76
Student and Spouse	\$2,995	\$1,009	\$1,822	\$ 729	\$ 251
Student, Spouse and Child(ren)	\$5,100	\$1,710	\$3,096	\$1,234	\$ 425
Student and Child(ren)	\$2,995	\$1,009	\$1,822	\$ 729	\$ 251
<b>STUDENTS AGE 31 &amp; OVER</b>					
Student Only	\$1,168	\$ 399	\$ 717	\$ 290	\$ 99
Student and Spouse	\$3,908	\$1,313	\$2,374	\$ 948	\$ 327
Student, Spouse and Child(ren)	\$6,649	\$2,226	\$4,033	\$1,606	\$ 555
Student and Child(ren)	\$3,908	\$1,313	\$2,374	\$ 948	\$ 327

\* The Tri-Annual installment method of payment is only available to students enrolling in Annual coverage. The second installment will be billed and is due on 12-26-2009. The third installment will be billed and due on 04-26-2010. It is your responsibility to make timely premium payments regardless of whether or not you receive a premium notice.

Premiums are not prorated. The total premium must be paid for the term you enroll in even though the term may be in progress. Coverage becomes effective on the later of the Policy Effective Date (08-26-2009); the first day of the term for which the proper premium has been paid; or 12:01 A.M. following the date the proper premium is received by the Plan Administrator or Servicing Agent. All coverage expires 11:59 P.M. on 08-25-2010, or when payment is due and unpaid. No refunds, except as provided in the Master policy. Any refund will be subject to a \$25 administrative fee.

## PART A - SCHEDULE OF BENEFITS

**1. BASIC INJURY AND SICKNESS BENEFITS** - For each Insured 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.

a. Maximum Basic Benefit For Each Loss	<u>Amount</u>
b. Basic Deductible:	Benefit Limit for Each Covered Service, as noted below
c. Covered Percentage	Not Applicable
d. Health Service Benefits	100% U&C; or % noted below; up to Benefit Limits
	See Physician Non-Surgical Visit below
e. <u>Covered Services - Injury</u>	<u>Benefit Limit</u>
1. Hospital Room and Board (R&B)	Semi-Private Rate up to 30 days
2. Hospital Intensive Care Unit	Semi-Private Rate up to 30 days
3. Hospital Miscellaneous (Inpatient)	\$1,000
4. Hospital Outpatient Surgical Miscellaneous	\$1,000
5. Surgical Treatment	\$1,500
6. Assistant Surgeon	20% of Surgical Treatment Benefit
7. Anesthesia	25% of Surgical Treatment Benefit
8. Consultant Physician	\$30 (at the request of the attending physician)
9. Physician's Non-Surgical Visits (Inpatient)	\$75/1st visit, then \$25/each subsequent; up to \$250 1 visit/day; not paid day of surgery
10. Physician's Non-Surgical Visits (Outpatient)	\$50; 1 visit/day; not paid day of surgery
11. Physiotherapy	Inpatient-Paid under e.3.; Outpatient-Paid under e.10.
12. Outpatient Tests and Procedures	No Benefit
13. Inpatient Pathology and Radiology Services	Paid under e.3.
14. Outpatient Diagnostic X-ray and Lab Services	\$200
15. Hospital Emergency Room (Outpatient)	\$50 copay/visit, up to \$200
16. Ambulance Services	\$400
17. Orthopedic Appliances/Durable Medical Equipment	Orthopedic Appliances: \$100; DME: No Benefit
18. Outpatient Prescription Drugs (30 day supply/prescription)	Paid under Major Medical
19. Home Care	Paid under Endorsement 9E721-CL
20. Dental Treatment	\$500; Includes X-rays; does not include biting or chewing injuries
21. Motor Vehicle Injury	Same as any Injury, up to \$30,000
22. Private Duty Nurse	Paid under e.3.
23. Shots and Injections	Paid under e.10.
f. <u>Covered Services - Sickness</u>	<u>Benefit Limit</u>
1. Hospital Room and Board (R&B)	Semi-Private Rate up to 30 days
2. Hospital Intensive Care Unit	Semi-Private Rate up to 30 days
3. Hospital Miscellaneous (Inpatient)	\$1,000
4. Hospital Outpatient Surgical Miscellaneous	\$1,000
5. Surgical Treatment	\$1,500
6. Assistant Surgeon	20% of Surgical Treatment Benefit
7. Anesthesia	25% of Surgical Treatment Benefit
8. Consultant Physician	\$30 (at the request of the attending Physician)
9. Physician's Non-Surgical Visits (Inpatient)	\$75/1st visit, then \$25/each subsequent; up to \$250, 1 visit/day; not paid day of surgery
10. Physician's Non-Surgical Visits (Outpatient)	\$20/ visit, starts 2 <sup>nd</sup> visit, when referred by Student Health Service; up to \$200; 1 visit/day, not paid day of surgery
11. Physiotherapy	Inpatient-Paid under f.3., Outpatient-Paid under f.10.
12. Outpatient Tests and Procedures	No Benefit
13. Inpatient Pathology and Radiology Services	Paid under f.3.
14. Outpatient Diagnostic, X-ray and Lab Services	\$200
15. Hospital Emergency Room	\$50 copay/visit, up to \$200
16. Radiation/Chemotherapy Therapy	Paid under Major Medical
17. Ambulance Services	\$400
18. Maternity Benefit	Same as any Sickness (conception must occur while coverage is in force)
19. Mental and Nervous Disorders	Paid under Endorsement 9E721-CL
20. Substance Abuse Treatment	Paid under Endorsement 9E721-CL
21. Orthopedic Appliance/Durable Medical Equipment	Orthopedic Appliance: \$100; DME: No Benefit
22. Outpatient Prescription Drugs (30 day supply/prescription)	Paid under Major Medical
23. Home Care	Paid under Endorsement 9E721-CL
24. Dental Treatment	Removal of Impacted Wisdom teeth only - up to \$200 per tooth
25. Private Duty Nurse	Paid under f.3.
26. Shots and Injections	Paid under f.10.

**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.

	<u>Amount</u>
a. Maximum Major Medical Benefit For Each Loss:	\$500,000 Lifetime Maximum
b. Deductible Type: Each Loss	
Threshold Deductible	Covered Service Basic Benefit Limit
Corridor Deductible	\$500 (Paid under Major Medical)
c. Covered Percentage:	80% PPO Allowable or 60% U&C for non-PPO to \$50,000; then 100% of PPO Allowable or 80% U&C for non-PPO in excess of \$50,000
d. Out-Of-Pocket Maximum Per Loss:	Not Applicable

Major Medical Covered Services include the Covered Services-Injury and the Covered Services-Sickness for which Benefits are payable, as shown in the SCHEDULE OF BENEFITS.

Benefits will not be paid under Major Medical Benefits for: Mental and Nervous Disorders and Substance Abuse in excess of Mandated Benefit limits (see Endorsement 9E721-CL); Dental Treatment; or Motor Vehicle Injuries in excess of \$30,000; or Wisdom Teeth Removal.

The Covered Percentage will be applied to all Eligible Expenses incurred after the Threshold and/or Corridor Deductible has been met, until the Maximum Major Medical Benefit For Each Loss has been paid. This maximum includes both benefits paid under the Basic Benefits and Major Medical Benefits.

**3. OTHER BENEFITS** - for each Insured Person We will pay Other Benefits as set forth in Part A.3. for Eligible Expenses incurred during the Benefit Period, limited by all maximums set forth in Part A.3.

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

**4. VARIABLE PROVISIONS -**

- a. Benefits Determination: Coordination of Benefits
- b. Benefit Period: Policy Benefit Period
- c. Enrollment Period:

Dependents must enroll in the plan when the Student first enrolls in the plan, and must enroll for the same coverage as the Student.

- d. Pre-Existing Conditions Waiting Period: Yes - Number of Months 12
- 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.

## PART B - DEFINITIONS CONTINUED

- 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.

## PART B - DEFINITIONS CONTINUED

- 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. **Prescription 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.

## PART B - DEFINITIONS CONTINUED

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.

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.

## PART B - DEFINITIONS CONTINUED

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.

## PART B - DEFINITIONS CONTINUED

- 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).
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 12 months immediately prior to Your Effective Date of coverage.
31. **Pre-Existing Conditions Waiting Period** means the time period You must have continuous coverage in force 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.

## PART B - DEFINITIONS CONTINUED

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. 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, in excess of \$30,000.
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; Durable medical equipment;. Treatment for foot care including care of flat feet, corns, calluses, bunions, weak feet, chronic foot strain, and supportive foot devices.
6. Injury or Sickness for which benefits are paid under Worker's Compensation or Occupational Disease Act or Law.
7. Prescription Drugs (except as specifically provided in the SCHEDULE OF BENEFITS); Contraceptive drugs and devices; Growth Hormone therapy; Patient Controlled Analgesia; Allergy Treatment.
8. Injury sustained while participating in the practice or play of interscholastic sports or Intercollegiate Sports, including the participation in any practice or conditioning program for such sport, contest or competition.
9. Intentional self-inflicted Injuries; Loss incurred while committing or attempting to commit a felony; Loss incurred from violating or attempting to violate any existing city, state, or federal law; Loss due to voluntary participation in a riot or civil disturbance; Injuries caused by or contributed to or resulting from the use of hallucinogenics, illegal drugs, or any drugs and medicines that are not taken in the dosage or for the purpose prescribed by the Insured's Physician.
10. Routine newborn baby care, well baby nursery and related Physician's charges.
11. Services provided normally without charge by the Health Service of the Policyholder; or by any person employed or retained by the Policyholder; or services covered or provided by the student health fee.
12. Treatment of Mental and Nervous Disorders and Substance Abuse, except as specifically provided in the SCHEDULE OF BENEFITS; 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. Services, supplies and/or treatment for acupuncture.
14. War or act of war, whether declared or not; and Injury or Sickness resulting from full-time, active-duty military service.
15. Pre-existing Conditions, until continuously covered by the Policyholder's Student Accident and Sickness Insurance plan for a period of 12 consecutive months.

## PART C - EXCLUSIONS CONTINUED

16. Sleep disorders, supplies and treatment or testing related to sleep disorders.
17. Weight management services and supplies related to weight reduction programs, weight management 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. 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
  - (ii) 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
- 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.

## PART E - ADDITIONAL POLICY PROVISIONS CONTINUED

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.

Countersigned by:

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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 12 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

# BENEFITS ENDORSEMENT FOR WISCONSIN RESIDENTS

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

Benefits are payable as described below on the same basis as any Injury or on the same basis as any Sickness, and unless otherwise noted, subject to the maximums, deductibles, coinsurance percentages, and benefit limits of the Policy.

The Policy shall include Benefits for the following:

**1. Mental or Nervous Disorders, Alcoholism or Drug Abuse**, benefits will be paid as follows:

- A. For Inpatient Care - the lesser of : 100% of covered charges for the first thirty (30) days of hospital confinement; or 90% of the first \$7,000.00 of covered charges.
- B. For Outpatient Care - a maximum of 90% of the first \$2,000.00 of covered charges.
- C. For transitional treatment arrangements - a maximum of 90% of the first \$3,000.00 of covered charges. "Transitional Treatment Arrangements" means services for the treatment of nervous or mental disorders or alcoholism or other drug abuse problems that are provided in a less restrictive manner than inpatient hospital services but in a more intensive manner than outpatient services. It includes the following types of services:
  - 1) Adult day treatment certified under s. HSS 61.75.
  - 2) Child and adolescent day treatment certified under s. HSS 61.81.
  - 3) Services for chronically mentally ill persons provided through a community support program certified under s. HSS 63.03.
  - 4) Services in residential treatment programs for alcohol and drug dependent persons certified under s. HSS 61.60.
  - 5) Services for alcoholism and other drug problems in a day treatment program certified under s. HSS 61.61.
  - 6) Services in intensive outpatient programs provided in accordance with the Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders of the American Society of Addiction Medicine (ASAM).

The maximum Benefits provided by this Policy for You in a Policy Period for all inpatient, outpatient and transitional treatment for mental and nervous disorders, alcoholism or drug abuse combined is \$7,000.00.

The maximum Benefits for all inpatient, outpatient and transitional treatment for mental and nervous disorders, alcoholism or drug abuse provided under this benefit does not include costs incurred for prescription drugs and diagnostic testing. Coverage for prescription drugs and diagnostic testing are payable the same as any other Sickness subject to maximums, deductibles, coinsurance percentages, and benefit limits of the Policy.

The amount applied to the maximum Benefit will be the lesser of: the actual payments or reimbursements made by Us or the amount charged by the provider.

- 2. Hospital inpatient and outpatient care for the treatment of kidney disease**, which may be limited to dialysis, transplantation and donor-related services not to exceed \$30,000.00 annually, as defined by the department of health and family services.
- 3.** To the extent benefits are provided under the policy for inpatient hospital care, benefits will be payable for **Home Health Care** if visits are required at Your home and such visits are provided or coordinated by a state-licensed or Medicare-certified home health agency or a certified rehabilitation agency. We will pay the Usual and Customary charges incurred for such services as limited below:

- A. Benefits will be provided for an Injury or Sickness if the attending Physician certifies that:
- 1) Hospitalization or confinement in a skilled nursing facility would otherwise be required if visits to Your home are not provided, and
  - 2) Necessary care and treatment are not available from a person who ordinarily resides in Your house or from any family member without causing undue hardship to the residing person or family member, and
  - 3) A "plan of care" has been established by of the attending Physician, which will be reviewed every 2 months unless the Physician indicates in writing that a longer review period is sufficient. If You were confined in a Hospital immediately prior to the commencement of home care, the attending Physician's "plan of care" shall also be approved by the Physician who was the primary provider of services during the Hospital Confinement.
- B. Covered Services do not include any services provided by any person residing with You, or any of Your family members, and are limited to:
- 1) Visits for part-time or intermittent home nursing care by or under the supervision of a registered nurse.
  - 2) Visits for part-time or intermittent home health aide services, under the supervision of a registered nurse or medical social worker, and such visits consist solely of caring for You.
  - 3) Visits for physical, respiratory, occupational or speech therapy.
  - 4) Visits for nutrition counseling provided by or under the supervision of a registered dietician.
  - 5) Charges for the evaluation of the need for and development of a plan, by a registered nurse, medical social worker or physician extender, for visits to Your home.
  - 6) Charges for medical supplies, drugs and medications prescribed by a Physician.
  - 7) Charges for laboratory services provided by or on behalf of a hospital which were included in the attending Physician's "plan of care".

Benefits Payable for Covered Services items (1) through (5) are limited to a maximum of 40 visits during any Policy Period. Covered Services item's (6) and (7) are payable to the same extent they would be payable during a Hospital Confinement.

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

4. To the extent benefits are provided under the policy for hospital care, benefits will be payable for **Skilled Nursing Home Confinement** for up to 30 days upon transfer within 24 hours from a hospital to a licensed skilled nursing home. This skilled nursing care must be certified as medically necessary by the attending physician and recertified as medically necessary every 7 days, must not be domiciliary or custodial, must be continued treatment for the same medical or surgical condition for which You had been treated at the hospital, and must not be available to You without charge or under a government health care program. The maximum payable for each day of confinement in a licensed skilled nursing home will be the daily rate established for such home by the Department of Health and Social Services.
5. Benefits for **diabetes treatment** for expenses incurred by the installation and use of an insulin infusion pump or other equipment or supplies, including insulin or any other prescription medication used in the treatment of diabetes, and shall provide coverage of diabetic self-management education programs. Benefits for this care shall be limited to coverage provided on the same basis as any other Sickness as provided by the Policy. Coverage for insulin infusion pump is limited to the purchase of one pump per policy year.
6. If the insured student purchases coverage for dependent children, the Policy will provide the same **Maternity** Benefits for the dependent child that it provides to the insured student.
7. Benefits for 2 examinations by low dose **mammography** will be payable for a woman between the ages of 45 to 49, if the woman has not had an examination by low dose mammography within 2 years before each examination has been performed. A woman age 50 or over will receive benefits for an annual examination by low dose mammography.

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

Benefits under this provision may only be subject to exclusions and limitations, including deductibles, copayments and restrictions on excessive charges that are applied to other radiological examinations covered under this Policy.

8. Benefits will be paid for **blood lead tests** for children under 6 years of age. Such screening tests will be conducted in accordance with any recommended lead screening methods and intervals contained in any rules promulgated by the department of health and social services under s.254.158.
9. To the extent benefits are provided under the policy for Prescription Drugs, benefits will be payable for drugs prescribed by the Your Physician for treatment of the **HIV infection** or an illness or medical condition arising from or related to HIV infection. Such drugs must be approved by the federal food and drug administration for treatment of HIV infection or an illness or medical condition arising from or related to HIV infection. This shall include use of an investigational new drug that is prescribed and administered in accordance with treatment protocol approved by the federal food and drug administration. This Benefit is subject to all Policy limitations as they apply to prescription drugs.
10. Benefits are payable for **breast reconstruction** of the affected tissue incident to a mastectomy.
11. Benefits are payable for hospital or ambulatory surgery center services and anesthetics provided for **dental care treatment** to an insured person if any of the following apply:
  - 1) The person is a child under the age of 5 years; or
  - 2) The person has a chronic disability that meets all of the conditions under s.230.04(9r) (a)2.a., b., and c.; or
  - 3) The person has a medical condition that requires hospitalization or general anesthesia for dental care.
12. Benefits are payable for diagnostic procedures and medically necessary surgical or nonsurgical treatment for the correction of **temporomandibular disorders** if all of the following apply:
  1. The condition is caused by congenital, developmental or acquired deformity, disease or injury; and
  2. Under the accepted standards of the profession of the health care provider rendering the service, the procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition; and
  3. The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.

Benefits are payable for nonsurgical treatment that includes prescribed intraoral splint therapy devices. Diagnostic procedures and medically necessary non-surgical treatment for correction of temporomandibular disorders will not exceed \$1,250 annually.

Benefits are not payable for cosmetic or elective orthodontic care, periodontic care or general dental care.

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 WISCONSIN RESIDENTS

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

### **PART B - DEFINITIONS is revised as follows:**

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

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

Proof of a dependent child's incapacity or continued dependence shall be furnished to Us within 31 days of a child's attainment of the limiting age. We may request subsequent proof of incapacity or dependency no more than once every year. The insured student must provide proof that a child continues to be handicapped.

10. **Elective Surgery and Elective Treatment** is revised by removing the words "temporomandibular joint dysfunction (TMJ)."
13. **Excess Coverage** is deleted entirely from this Policy.
26. **Other Medical Coverage** is deleted entirely from this Policy.
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. A Pre-Existing Conditions Waiting Period shall not exclude coverage in the case of a child who is adopted or placed for adoption.
34. **Primary Coverage** is deleted entirely from this Policy.

### **PART C - EXCLUSIONS is revised as follows:**

9. Exclusion is revised by removing the words "including drug overdose."
13. Use of any services or supplies which are not in accord with generally accepted standards of medical practice; organ transplants, including donor's expenses; except as required by state law.

**PART D - GENERAL POLICY PROVISION is revised as follows:**

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 payment by or for the liable party has not been made by the time We receive acceptable Proof of Loss. Our Subrogation rights will only be valid if You are made whole for the Loss for which Benefits are provided under this Policy, and then only to the extent of the excess funds. 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.
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.
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

## **COORDINATION OF BENEFITS ENDORSEMENT**

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

This COORDINATION of BENEFITS (COB) provision applies to this Policy when You have health coverage under more than one Plan.

If this COB provision applies, the order of benefit determination rules should be reviewed. Those rules determine whether the benefits of this Policy are determined before or after those of another Plan. The benefits of this Policy:

1. Will not be reduced when, under the order of benefit determination rules, this Policy determines its benefits before those of another Plan; but
2. May be reduced when, under the order of benefit determination rules, another Plan determines its benefits first.

### **DEFINITIONS**

"Plan" means any of the following other medical coverage that provides benefits or services for, or because of, medical or dental care or treatment.

1. "Plan" includes: group insurance and group subscriber contracts or other group or group-type coverage, whether insured or uninsured; group or group-type coverage through HMOs and other prepayment group practice and individual practice plans, hospital indemnity benefits in excess of \$100 per day; medical care components of group long-term care contracts, such as skilled nursing care; medical benefits under group and individual automobile contracts; and Medicare or other governmental benefits as permitted by law.
2. "Plan" does not include: individual or family insurance or subscriber contracts, individual coverage (except group-type coverage); amounts of hospital indemnity insurance of \$100 or less per day; school accident type coverage, benefits for non-medical components of group long-term care policies; Medicare supplement policies; state Medicaid and coverage under other governmental plans, unless permitted by law.

Each contract or other arrangement for coverage under 1. or 2. is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

"Primary Plan/Secondary Plan" The order of benefit determination rules state whether this Plan is a Primary Plan or Secondary Plan as to another plan covering the person. When this Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits. When this Plan is a Secondary Plan its benefits are determined after those of the other Plan and may be reduce because of the other Plan's benefits. When there are more than two Plans covering the person, this Plan may be a Primary Plan as to one or more other Plans and may be a Secondary Plan as to a different Plan(s).

"Allowable Expense" means the necessary, reasonable and customary item of expense for a health care when the item of expense is covered at least in part by one or more Plans covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered an Allowable Expense and a benefit paid.

"Claim Period" means any 12 month period. However, it does not include any part of a year during which a person has no coverage under this Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

### **ORDER OF BENEFIT DETERMINATION**

When there is a basis for claim under this Plan and another Plan, this Plan is a Secondary Plan, which has its benefits determined after those of the other plan, unless:

1. The other Plan has rules coordinating its benefits with those of this Plan; and
2. Both those rules and this Plan's rules, require that this Plan's benefits be determined before those of the other Plan.

**Rules - This Plan determines its order of benefits using the first of the following rules which applies:**

1. Non-Dependent/Dependent: The benefits of the Plan covering a person as an employee, member or subscriber (other than as a dependent) are determined before those of the Plan which covers a person as a dependent, except that, if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
  - a. secondary to the Plan covering the person as a dependent; and
  - b. primary to the Plan covering the person as other than a dependent, then the benefits of the Plan covering the person as a dependent are determined before those of the Plan covering the person as other than a dependent.
2. Dependent Child/Parents Not Separated or Divorced: Except as stated in paragraph 3), if two or more Plans cover the same child as a dependent of different parents:
  - a. the benefits of the Plan of the parent with a birthday earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but
  - b. if both parents have the same birthday, the benefits of the Plan covering the parent longer are determined before those of the other parent's Plan.

However, if the other Plan does not have this rule and as a result the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

3. Dependent Child/Parents Separated or Divorced: If two or more Plans cover a dependent child of divorced or separated parents, benefits for the child are determined in this order:
  - a. first, the Plan of the parent with custody of the child.
  - b. then, the Plan of the spouse of the parent with custody of the child.
  - c. finally, the plan of the parent not having custody of the child.

However, if the terms of a court decree state that one of the parents is responsible for health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The Plan of the other parent will be Secondary. This paragraph will not apply with respect to any Claim Period during which any benefits are actually paid or provided before the entity has that actual knowledge.

4. Joint Custody: If the specific terms of a court decree state that the parents will share joint custody, without stating which one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in paragraph 2. above.
5. Active/Inactive Employee: The benefits of a Plan covering a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other Plan does not have this rule and the Plans do not agree on the order of benefits, this rule is ignored.
- 6.. Continuation Coverage: If a person whose coverage is provided under a right of continuation Plan pursuant to federal or state law and also under this Plan, the following order of benefits applies:
  - a. first, the Plan covering the person as an employee, or as the employee's dependent;
  - b. second, the benefits of the continuation coverage.

If the other Plan does not have this rule and the Plans do not agree on the order of benefits, this rule is ignored.

7. Longer/Shorter Length of Coverage: If none of the above rules determine the order of benefits, the benefits of the Plan which covered an employee, member or subscriber longer are determined before those of the plan which covered that person for the shorter time.

## **EFFECT ON THE BENEFITS OF THIS PLAN**

This section applies when this Plan is a Secondary Plan as to one or more other Plans. In that event, the benefits of this Plan may be reduced. Such other Plans are referred to as "the other Plans" .

Reduction in This Plan's Benefits: The benefits of this Plan will be reduced when the sum of:

1. the benefits that would be payable for the Allowable Expenses under this Plan in the absence of the COB provision; and
2. the benefits that would be payable for Allowable Expenses under the other Plans in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those Allowable Expenses in a Claim Period. In that case, the benefits of this Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

**RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION:** Certain facts are needed to apply these COB rules. We have the right to decide which facts We need. We may get needed facts from or give them to any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give Us any facts We need to pay the claim.

**FACILITY OF PAYMENT:** A payment made under another Plan may include an amount which should have been paid under this Plan. If it does, We may pay that amount to the organization making the payment. That amount will then be treated as though it were a benefit paid under this Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

**RIGHT OF RECOVERY:** If the amount of the payments made by Us is more than We should have paid under this COB provision, We may recover the excess from one or more of the following: a) the person We paid or for whom We paid benefits; b) insurance companies; and c) other organizations.

The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

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

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

Please read this notice carefully. This notice contains important information about how to appeal decisions made by your health benefit plan. Any reference to "you" or "your" automatically extends to any authorized representative acting on your behalf.

#### DEFINITIONS.

**"Adverse Determination"** means a determination that a) an admission, availability of care, continued stay, or other covered service has been reviewed and denied, reduced or terminated on the basis that the treatment is not medically necessary, consistent with generally accepted medical standards, provided in a setting appropriate for the condition, or does not meet the health benefit plan's requirement for level of care and effectiveness; or b) the proposed treatment has been reviewed and denied on the basis the treatment was experimental or investigational.

**"Compelling Reason"**. A Covered Person or the Covered Person's authorized representative may file a request for Independent Review without first exhausting our internal grievance process if the request for Independent Review demonstrates to the satisfaction of the Commissioner of Insurance a) the potential delay in receipt of a health care service until after the Covered Person or the Covered Person's authorized representative exhausts the internal grievance process and obtains a Grievance Decision under the grievance process could result in loss of life, serious impairment to a bodily function, serious dysfunction of a bodily organ, or b) the Covered Person remaining seriously mentally ill with symptoms that cause the Covered Person to be in danger to self or others, or c) you and your health benefit plan agree to proceed directly to Independent Review.

**"Grievance"** means any dissatisfaction with the provision of services or claims practices of Columbian Life Insurance Company which offers a health benefit plan or its administration by Student Assurance Services, Inc., Our Administrator, that is expressed in writing to us by a Covered Person or on behalf of a Covered Person. Such term also includes any dissatisfaction relating to covered services provided by preferred network providers or dissatisfaction relating to an Adverse Determination.

**"Grievance Decision"** means a final determination by us that arises from an appeal of an Adverse Determination or any Grievance filed with us under our internal grievance process.

**"Request for Independent Review"**. A Covered Person or the Covered Person's authorized representative may file a request for Independent review in accordance with Wisconsin law if such Covered Person or Covered Person's authorized representative has received an Adverse Determination and has exhausted our internal grievance process.

#### GRIEVANCE 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 through our internal grievance process. You should also review the informational packet that was sent to you as it describes in detail each level of grievance review. The informational packet is also available upon request.

We do not certify or verify benefits or make decisions for treatment or a service not yet provided.

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 have the right to:

- Submit written comments, documents, records, and other material relating to the review;
- Receive upon request, free of charge, reasonable access to and copies of all documents relevant to your request for benefits relating to the determination that resulted in the claim denial or disenrollment.
- Request an Independent review without first exhausting the grievance process if the request for Independent review demonstrates a Compelling Reason to do so.

You may appear in person to present written or oral information. If you choose to meet with and question the decision makers in person, we will notify you in writing on the time and place of the grievance meeting at least 7 days before the meeting.

Within 5 working days after we have received your written Grievance, we will mail an acknowledgement to you, confirming receipt of your Grievance. If we do not have sufficient information or written authorization to complete the grievance process, you will be notified that we cannot proceed with our review unless additional information is provided. We will assist you in gathering the necessary information without further delay. The review and response to your Grievance will be completed within 30 days following the receipt of the Grievance. The time period for completing the Grievance review may be extended an additional 30 days if agreed to in writing. Such extension will include the reason your Grievance is not resolved, the date resolution may be expected, and the reason additional time is needed.

Our Grievance Decision will be provided to you in writing. Said notice shall:

- The titles and credentials of the person or persons participating in the 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 if we relied upon an internal rule, guideline, protocol, or other similar criterion to make the adverse determination;
  - If appropriate, an explanation of the scientific or clinical judgment for making the determination; and
  - Your right to request an Independent Review and information on the Independent Review process.
- A statement of your right to contact the Commissioner of Insurance at any time for assistance.

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

**Grievances can be sent to the following parties:**

Columbian Life Insurance Company  
PO Box 1381  
Vestal Parkway East  
Binghamton, NY 13902  
Attn: Grievance Coordinator  
(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/Grievance Coordinator  
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 Wisconsin  
Office of the Commissioner of Insurance  
125 South Webster Street  
P O Box 7873  
Madison, Wisconsin 53707-7873  
(608) 266-3585 or (800) 236-8517  
[www.oci.state.wi.gov](http://www.oci.state.wi.gov)

# PREFERRED PROVIDER ENDORSEMENT

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

DEFINITIONS are revised to include the following:

**Allowable Charge(s)** 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 Wisconsin 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 Allowable Charges 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:	HealthEOS Plus by Multi Plan www.healtheos.com
PPO Provider Coinsurance Percentage	Major Medical: 80% or 100% of PPO Allowable
Non-PPO Provider Coinsurance Percentage	Major Medical: 60% or 80% of U&C

**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:

- up to 90 days from the date the PPO Provider contract terminated; or
- until the completion of postpartum care if the insured is in the 2<sup>nd</sup> or 3<sup>rd</sup> 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.

**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.

**Referrals:**

A referral is not required to obtain treatment from a non-PPO Provider. We will provide reimbursement for Covered Services as described above for treatment by a non-PPO provider.

**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.

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