



COLUMBIAN LIFE INSURANCE COMPANY

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

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: Martin Methodist College
433 West Madison St.
Pulaski, TN 38478

POLICY NUMBER: 41-64-0089-016-603-2

POLICY EFFECTIVE DATE: August 19, 2012 at 12:01 a.m.

POLICY EXPIRATION DATE: August 18, 2013 at 11:59 p.m.

AMENDMENTS/ENDORSEMENTS: 9E502-CL; 9E537-CL; 9E829-CL

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

CLASSES OF ELIGIBLE PERSONS INSURED:

1. International students and scholars, under age 70, who are enrolled in the plan. Students must be 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 and enrolled in the plan.

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

Signed for Columbian Life Insurance Company:

DANIEL J. FISCHER
Secretary

THOMAS E. RATTMANN
Chairman, President
and Chief Executive Officer

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PREMIUM SCHEDULE

The total insurance cost to the student includes accident and sickness premium, other non-insurance service fees and an agent service fee.

	Fall Semester <u>08-19-2012 to 12-31-2012</u>	Spring Semester <u>01-01-2013 to 05-05-2013</u>	Summer <u>05-06-2013 to 08-18-2013</u>
Student Only	\$ 331	\$ 331	\$ 331
Spouse	\$1,411	\$1,411	\$1,411
Each Child	\$ 871	\$ 871	\$ 871

Spring and summer may only be purchased by a new student not eligible to enroll for fall coverage or a student who purchased fall coverage and wishes to continue coverage.

Coverage becomes effective on the later of the following dates: The Master Policy effective date August 19, 2012 at 12:01 a.m.; or 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 College or Servicing Agent. Coverage will expire on the earliest of the following dates: the Master Policy expiration date August 18, 2013 at 11:59 p.m.; or when premium for your accident and sickness insurance coverage is due and unpaid.

It is your responsibility to make timely premium payments regardless of whether or not you receive a premium notice. No refunds, except as provided in the Master Policy.

PART A - SCHEDULE OF BENEFITS

1. **BASIC INJURY AND SICKNESS BENEFITS** - for Eligible Persons We will pay Basic Injury and Sickness Benefits as set forth in Part A.1. for Eligible Expenses incurred during the Benefit Period, limited by all maximums, deductibles, coinsurance percentages and benefit limits set forth in Part A.1.
 - a. **Maximum Basic Benefit - policy year:** **\$100,000**
 - b. **Deductible - each Loss – per person:** **\$100**
 - c. **Covered Percentage** (Policy pays): Benefit are payable at the following covered percentage of the Usual and customary Charge – each covered injury or sickness:
 - **For the first \$3,000 in paid benefits:** **90%**
 - **For the next \$72,000 in paid benefits:** **80%**
 - **For the next \$25,000 in paid benefits:** **100%**
 - d. **Health Service Benefits:** **Not Applicable**

COVERED SERVICES

BENEFIT LIMITS

e. INPATIENT

1. **HOSPITAL ROOM AND BOARD** (semi-private room rate) covered percentage 1.c. above
2. **HOSPITAL INTENSIVE CARE** (24-hour nursing care; semi-private room rate) covered percentage 1.c. above
3. **HOSPITAL MISCELLANEOUS INPATIENT** (services and supplies including but..... covered percentage 1.c. above
not limited to: the cost of the operating room; laboratory tests; x-ray examinations;
anesthesia; drugs - excluding take home drugs or medications; therapeutic services;
supplies)
4. **SURGICAL TREATMENT** covered percentage 1.c. above
5. **ASSISTANT SURGEON** covered percentage 1.c. above
6. **ANESTHESIA** covered percentage 1.c. above
7. **PRIVATE DUTY NURSE** (when medically necessary) covered percentage 1.c. above
8. **PHYSICIAN'S NON-SURGICAL VISITS** (1 visit per day, not paid same day covered percentage 1.c. above
as surgery; includes benefits for consultant physician)
9. **MATERNITY BENEFITS** Same as any Sickness
10. **MENTAL AND NERVOUS DISORDERS** Same as any Sickness; up to
policy year maximum 10 days
11. **SUBSTANCE ABUSE** Same as any Sickness; up to
policy year maximum 7 days
12. **MOTOR VEHICLE INJURY**(inpatient and outpatient aggregate limit) Same as any Injury; up to
maximum \$5,000

f. OUTPATIENT

1. **HOSPITAL OUTPATIENT SURGICAL MISCELLANEOUS** covered percentage 1.c. above
2. **SURGICAL TREATMENT** covered percentage 1.c. above
3. **ASSISTANT SURGEON** covered percentage 1.c. above
4. **ANESTHESIA** covered percentage 1.c. above
5. **PHYSICIAN'S NON-SURGICAL VISITS** (1 visit per day, not paid same day..... covered percentage 1.c. above;
as surgery; includes benefits for consultant physician) up to maximum 30 visits
6. **PHYSIOTHERAPY** (1 visit per day) covered percentage 1.c. above;
up to maximum 30 visits
7. **OUTPATIENT HOSPITAL SERVICES** Paid under f.1.
8. **OUTPATIENT DIAGNOSTIC, XRAY & LAB SERVICES** covered percentage 1.c. above
(does not include MRI and CT Scan)
9. **HOSPITAL EMERGENCY ROOM SERVICES** (copay is waived if admitted) covered percentage 1.c. above;
after \$100 copay per visit
10. **MATERNITY BENEFITS** Same as any Sickness
11. **MENTAL AND NERVOUS DISORDERS** Same as any Sickness; up to
policy year maximum 10 visits
12. **SUBSTANCE ABUSE** Same as any Sickness; up to
policy year maximum 10 visits
13. **PRESCRIPTION DRUGS** (30-day supply per prescription)..... covered percentage 1.c. above;
\$25 copay per generic drug;
\$50 copay per brand drug
14. **MOTOR VEHICLE INJURY** (inpatient and outpatient aggregate limit) Same as any Injury; up to
maximum \$5,000

g. OTHER COVERED SERVICES

1. **AMBULANCE SERVICES** (ground service only) covered percentage 1.c. above
2. **DENTAL TREATMENT** (Injury Only; does not include biting or chewing injuries)..... covered percentage 1.c. above;
up to maximum \$250
3. **INPATIENT PHYSIOTHERAPY** (1 visit per day) covered percentage 1.c. above;
up to maximum 30 visits

PART A - SCHEDULE OF BENEFITS - CONTINUED

g. OTHER COVERED SERVICES CONTINUED

BENEFIT LIMITS

- 4. **DURABLE MEDICAL EQUIPMENT AND ORTHOPEDIC APPLIANCE** covered percentage 1.c. above;
(when prescribed by a physician) after \$50 copay per prescription
- 5. **ROUTINE INPATIENT NEWBORN CARE** Same as any Sickness; up to 48
hours following vaginal delivery or
96 hours following cesarean
delivery
- 6. **PREVENTATIVE CARE** (as required under the Patient Protection and Affordable 100% U&C
Care Act; deductible and copay does not apply)
- 7. **CHEMOTHERAPY AND RADIATION THERAPY** covered percentage 1.c. above
- 8. **INPATIENT PRE-ADMISSION TESTING** (within 3 working day of admission) covered percentage 1.c. above
- 9. **INPATIENT PATHOLOGY AND RADIOLOGY** covered percentage 1.c. above
- 10. **OUTPATIENT SHOTS AND INJECTIONS** (when administered in a physician’s covered percentage 1.c. above
office)
- 11. **MRI AND CT SCAN** covered percentage 1.c. above;
after \$100 copay per procedure

2. MAJOR MEDICAL BENEFITS - for Eligible Persons We will pay Major Medical Benefits as set forth in Part A2 for Eligible Expenses incurred during the Benefit Period, limited by all maximums, deductible, coinsurance percentages and benefit limits set forth in Part A.1. and Part A2.

AMOUNT

- a. **Maximum Major Medical Benefit – policy year:** Not Applicable
- b. **Deductible Type – per person:**
 - Threshold Deductible: Not Applicable
 - Corridor Deductible: Not Applicable
- c. **Covered Percentage (Policy pays):** Not Applicable
- d. **Out-Of-Pocket Maximum - per Loss:** Not Applicable

Major Medical Benefits are not payable under the Policy.

3. OTHER BENEFITS

AMOUNT

- a. **Accidental Death and Dismemberment**
 - (i) Death Benefit \$5,000
 - (ii) Single Dismemberment/Loss of Eye \$2,500
 - (iii) Double Dismemberment/Loss of Both Eyes \$5,000
 - (iv) Thumb and Index Finger of One Hand \$1,250
- b. **Medical Evacuation** (non-insurance coverage) See Separate Brochure
- Repatriation** (non-insurance coverage) See Separate Brochure
- c. **Intercollegiate Sports Injuries** No Benefit

4. VARIABLE PROVISIONS

- a. **Benefits Determination:** Coordination of Benefits
- b. **Benefit Period:** Policy Benefit Period
- c. **Enrollment Period:** Enrollment forms and premium payments received after the following waiver/enrollment period deadline dates are not accepted except for new students or when a qualifying event for late enrollment occurs:
Fall: 09-19-2012; spring: 02-01-2013; Summer: 06-03-2013
Qualifying events for late enrollment include involuntary loss of coverage under another health plan, marriage and birth or adoption of a child. Enrollment in the plan must be received no later than 30 days after the qualifying event.
- d. **Pre-Existing Conditions Waiting Period:** 12 Months, subject to credit for
prior coverage; does not apply
to insureds under age 19
- e. **Usual and Customary Charges:** 80th percentile
determined by referencing the most current survey published by FAIR Health, Inc.

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):** (i) daily semi-private room rate when Hospital Confined; and (ii) 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 such as; the cost of the operating room, laboratory tests, X-ray examinations, anesthesia, drugs (excluding take home drugs) or medicines, therapeutic services, and supplies.
 - e. **Surgical Treatment:** Benefits are payable for surgical procedures based on the Usual and Customary Charges determined by reference to the most current survey published by FAIR Health, Inc. 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.
 - f. **Assistant Surgeon:** When required by the attending Physician.
 - g. **Anesthetist:** In connection with surgery.
 - h. **Consultant Physician:** When requested and approved by the attending Physician.
 - i. **Physician's Non-Surgical Visits(Inpatient):** Benefits are limited to one visit per day. 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.

PART B - DEFINITIONS CONTINUED

- j. **Physician's Non-Surgical Visits(Outpatient):** Benefits are limited to one visit per day and include all Physician's services and ancillary supplies received during the visit. 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.
- k. **Physical Therapist:** For the services of a Physical Therapist including any form of diathermy, ultrasonic treatment, EMS, whirlpool or heat treatments. All treatments received during one visit will be subject to the Benefit Limit shown on the SCHEDULE OF BENEFITS.
- l. **Inpatient Pathology and Radiology Services:** Pathologist's fees and/or charges for reading of X-rays.
- m. **Outpatient Diagnostic, X-ray and Lab Services:** Includes charges for reading of X-rays and Pathologist's fees. Diagnostic X-rays 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.
- n. **Chemotherapy:** Benefits are limited to one treatment per day.
- o. **Radiation Therapy:** Benefits are limited to one treatment per day.
- p. **Hospital Emergency Room(Outpatient):** Includes staff Physician, use of emergency room, and supplies.
- q. **Ambulance Services:** Professional ground ambulance service.
- r. **Maternity Benefit:** Benefits for maternity are payable on the same basis as a Sickness.
- s. **Mental and Nervous Disorders:** Inpatient and Outpatient treatment as shown on the SCHEDULE OF BENEFITS and/or any Amendment.
- t. **Substance Abuse Treatment:** Inpatient and Outpatient treatment as shown on the SCHEDULE OF BENEFITS and/or any Amendment.
- u. **Orthopedic Appliances:** (i) when prescribed by a Physician; and (ii) a written prescription accompanies the claim when submitted. Replacement braces and appliances are not covered. Braces and appliances include durable, medical equipment which is equipment that: (iii) is primarily and customarily used to serve a medical purpose; (iv) can withstand repeated use; and (v) generally is not useful to a person in the absence of Injury or Sickness. No benefits will be paid for rental charges in excess of purchase price.
- v. **Prescription Drugs:** includes only the cost of the drug. Does not include charges for the administration of the drug.
- w. **Home Care:** Benefits are provided as shown on the SCHEDULE OF BENEFITS.
- x. **Dental Treatment:** Includes injury to Sound, Natural Teeth, and dental x-rays.
- y. **Private Duty Nurse:** includes Registered Nurse (RN) or other provider designated on the SCHEDULE OF BENEFITS.
- z. **Other Covered Services:** includes miscellaneous Covered Services designated on the SCHEDULE OF BENEFITS, and not provided elsewhere under this Definition.

PART B - DEFINITIONS CONTINUED

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.
- Basic Deductible is the amount either applied to Benefits or applied to Eligible Expenses under Part A, 1. Basic Injury and Sickness Benefit.
 - 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.
 - 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 unmarried 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.
- Newborn children of the insured Student or covered single dependent, will be covered from birth until 31 days old. For coverage to continue after 31 days, We must be notified and receive such additional premium, if any is required.
- Children for whom the insured Student has a legal obligation for the purposes of adoption, will be covered effective from the date the legal obligation begins. Coverage will continue until the legal obligation for the purposes of adoption ends, or the Policy Expiration Date, whichever occurs first.
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. Elective Surgery includes but is not limited to: tubal ligation; circumcision; vasectomy; breast reduction; sexual reassignment surgery; any services or supplies rendered for the purpose or with the intent of inducing conception; temporomandibular joint dysfunction (TMJ); cosmetic procedures; and submucous resection and/or other surgical correction for deviated nasal septum, other than for treatment of covered acute purulent sinusitis. Elective Treatment includes but is not limited to: allergy testing; treatment for acne; biofeedback-type services; infertility; hypnotherapy; learning disabilities; and weight reduction.

PART B - DEFINITIONS CONTINUED

11. **Eligible Expense** means the Usual and Customary 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. **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.
15. **Health Service Benefits** means those benefits paid for expenses incurred as a result of services provided at the Policyholder's Health Center.
16. **Hospital** means a legally constituted institution duly licensed and operating within the scope of such license. This does not include a facility primarily designed for use as an extended care facility, convalescent nursing home or skilled nursing facility.
17. **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.
18. **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.
19. **Loss** means medical expense or indemnity covered by this Policy as a result of any one Injury or Sickness.
20. **Maternity** means a Sickness. Conception must occur after Your Effective Date of coverage. Treatment must begin prior to Your Expiration Date of coverage.
21. **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.
22. **Medically Necessary** means those Covered Services provided or prescribed by a Hospital or Physician which are: (a) consistent with the symptoms and diagnosis or treatment of Sickness or Injury, (b) in accord with standards of generally accepted medical practice, (c) not primarily for the convenience of You or Your Physician, and (d) the most appropriate supply or level of service which can safely be provided to You.
23. **Mental and Nervous Disorder** means 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.
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.

PART B - DEFINITIONS CONTINUED

25. **Other Benefits** means the Benefits described below:
- a. **Accidental Death, Single Dismemberment/Loss of Eye, Double Dismemberment/Loss of both Eyes:** When an Injury covered by this Policy results in a loss within 180 days from the date of the Accident causing the Injury, the Benefit Limit for the loss shown on the SCHEDULE OF BENEFITS under Other Benefits will be paid. The Benefit paid under this provision will be in addition to any other Benefits paid for the Injury. Dismemberment means, at a minimum, the severance of a hand or foot above the wrist or ankle joint. Loss of Eye means entire and irrecoverable loss of vision in the eye.
 - b. **Medical Evacuation:** When Hospital confined for at least five consecutive days; and when recommended and approved by the attending Physician, Benefits will be paid for evacuation to Your natural country. This Benefit is limited to the Benefit Limit specified in the SCHEDULE OF BENEFITS. No additional benefits will be paid under Basic or Major Medical coverage.
 - c. **Repatriation:** If You die while insured under this Policy; Benefits will be paid for: preparing and transporting Your remains to Your home country. This benefit is limited to the Benefit Limit specified in the SCHEDULE OF BENEFITS. No additional Benefits will be paid under Basic or Major Medical coverage.
 - d. **Intercollegiate Sports/Club Sports:** means any athletic contest or competition 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 is 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 duly licensed practitioner of the healing arts, other than You or Your relative by blood or marriage, who is acting within the scope of such license.
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.

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.

PART B - DEFINITIONS CONTINUED

29. **Policy Period** means the period of time beginning at 12:01 a.m. on the Policy Effective Date, and ending at 11:59 a.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.
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 provided in the Schedule of Benefits.
3. Treatment where no Injury or Sickness is involved (physical examinations or preventive medicines, except as provided in the Schedule of Benefits); or elective surgery and elective treatment; or abortion. It does not include cosmetic surgery made necessary by Injury.
4. Motor vehicle accidents, to the extent covered by another valid and collectible insurance policy, prepaid services contract, or similar plan. The motor vehicle injury benefit limit is shown on the Schedule of Benefits.
5. Eyeglasses, contact lenses, and examination for prescribing or fitting them; any other procedure for correction of refractive disorder of the eye or eyes; hearing aids and hearing examinations.
6. Injury or Sickness for which benefits are paid under Worker's Compensation or Occupational Disease Act or Law.
7. Injury sustained while participating in the practice or play of interscholastic sports, intercollegiate sports, or club sports, including the participation in any practice or conditioning program for such sport, contest or competition.
8. Intentional self-inflicted Injuries; including drug overdose; loss incurred while committing or attempting to commit a felony; or loss due to voluntary participation in a riot or civil disturbance.
9. Routine new-born baby care, well baby nursery and related physician's charges, except as provided in the Schedule of Benefits.
10. Services provided normally without charge by the health service of the policyholder; or by any person employed or retained by the policyholder; or services covered or provided by the student health fee.
11. Use of any services or supplies which are experimental and/or not in accord with generally accepted standards of medical practice; organ transplants, including donor's expenses.
12. War or act of war, whether declared or not; and Injury or Sickness resulting from full-time, active-duty military service.
13. Pre-existing conditions, not subject to credit for prior coverage, until continuously covered by the policyholder's student accident and sickness insurance plan for a period of 12 consecutive months.

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 a claim 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, Suite 300, 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. 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 withdraw from school within thirty-one (31) days of the date the Student purchased coverage, due to a medical condition that would be covered by this Policy, and which has been documented by the attending Physician.

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 eligibility expires concurrently with that of the Student.

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.

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) 12:01 a.m. following the date the proper Premium is received by the Policyholder, Servicing Agent, or Administrator of this Policy.
- b. Coverage for new Students begins five (5) days prior to the first day of classes for the session, provided that the Student has enrolled for coverage and paid the Premium before that time.

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.

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, and 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:** If You were covered to the Policy Expiration Date of the prior Student health insurance policy of the Policyholder, You will not be denied benefits under this Policy for an Injury or Sickness which was the basis of a covered claim under the prior policy. Benefits must not be available from the prior policy and You must be enrolled in this Policy and pay the Premium within 31 days of the expiration date of the prior Student health insurance policy. For purposes of this provision, Benefits for the aggravation of an old injury will be paid on the same basis as a Sickness.
6. **Refunds:** If We receive a written notice, including the date of occurrence that: You have entered into full-time active-duty military service of any country; or You are a non-immigrant Foreign National and have left the North American continent, We will make a prorata Premium refund, less an administrative fee.
7. **Portability:** If You are covered by this Policy until: (a) You are enrolled in another institution; or (b) the Policy Expiration Date, You will not experience a break in coverage if the other institution maintains a master policy with Us. Enrollment in the other institution's policy and initial premium payment must occur: (c) within thirty-one (31) days after You become eligible for coverage; and (d) no more than forty-five (45) days after the Policy Expiration Date.

Countersigned by:

Licensed Resident Agent

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 Other Medical Coverage.

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 OTHER MEDICAL COVERAGE. The benefits of this Policy:

- (1) Will not be reduced when, under the order of benefit determination rules, this Policy determines its benefits before Other Medical Coverage; but
- (2) May be reduced when, under the order of benefit determination rules, "Other Medical Coverage" determines its benefits first.

"Other Medical Coverage" is any of these which provides benefits or services for, or because of, medical or dental care or treatment:

- (1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school Accident-type coverage.
- (2) Coverage under a governmental plan or required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan when, by law, its benefits are excess to those of any private insurance program or other nongovernmental program. 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 to only one of the two, each of the parts is a separate plan.

ORDER OF BENEFIT DETERMINATION RULES

When there is a basis for a claim under this Policy and Other Medical Coverage, this Policy is secondary and has its benefits determined after those of Other Medical Coverage, unless:

- (1) Other Medical Coverage has rules COORDINATING its BENEFITS with those of this Policy; and
- (2) Both those rules and this Policy's rules, as shown below, require that this Policy's benefits be determined before those of the other plan.

This Policy determines its order of benefits using the first of the following rules which applies:

- (1) Nondependent/Dependent. The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a Dependent) are determined before those of the plan which covers the person as a Dependent.

- (2) Dependent child/parents not separated or divorced. Except as stated in subparagraph (3) below, when this Policy and another plan cover the same child as a Dependent of different persons, called 'parents':
 - (a) The benefits of the plan of the parent whose birthday falls 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 which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.
 - (c) If the other plan does not have the rule described in (a) immediately above, but instead has a rule based upon the gender of the parent, and if, 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/separated or divorced parents. If two or more plans cover a person as 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 the custody of the child; and
 - (c) Finally, the plan of the parent not having custody of the child.
- (4) If the specific terms of a court decree state that one of the parents is responsible for the 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. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.
- (5) Active/inactive employee. The benefits of a plan which covers 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 if, as a result, the plans do not agree on the order of benefits, this rule (5) is ignored.
- (6) 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 POLICY

This section applies when, in accordance with the order of benefit determination rules, this Policy is secondary to Other Medical Coverage. In that event, the benefits of this Policy may be reduced under this section. The benefits of this Policy will be reduced when the sum of:

- (1) the benefits that would be payable for the allowable expenses under this Policy in the absence of this COB provision; and
- (2) the benefits that would be payable for the allowable expenses under Other Medical Coverage, in the absence of a COB provision exceed the allowable expenses in a claim determination period. In that case, the benefits of this Policy will be reduced so that they and the benefits payable under Other Medical Coverage do not total more than those allowable expenses.

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

FACILITY OF PAYMENT

If Other Medical Coverage makes benefit payments that should have been made by Us pursuant to the Policy, We may make payment to the Other Medical Coverage to satisfy Our obligation under the 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.

Signed for Columbian Life Insurance Company:



DANIEL J. FISCHER
Secretary



THOMAS E. RATTMANN
Chairman, President
and Chief Executive Officer

GENERAL ENDORSEMENT FOR TENNESSEE RESIDENTS

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

PART B - DEFINITIONS is revised as follows:

Definition 1. Accident, is revised in part;

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

Definition 8. Dependent, is revised in part;

8. **Dependent** means the insured student's spouse; or Domestic Partner; or unmarried child (including step children if dependent on the insured Student) under the age of twenty-four (24) years, who is not self supporting or a child over the age of 24 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.

Definition 10. Elective Surgery and Elective Treatment, is revised as follows;

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. Elective Surgery includes but is not limited to: tubal ligation; circumcision; vasectomy; breast reduction; sexual reassignment surgery; any services or supplies rendered for the purpose or with the intent of inducing conception; cosmetic procedures; and submucous resection and/or other surgical correction for deviated nasal septum, other than for treatment of covered acute purulent sinusitis. Elective Treatment includes but is not limited to: allergy testing; treatment for acne; biofeedback-type services; infertility; hypnotherapy; learning disabilities; and weight reduction.

Definition 13., Excess Coverage, and Definition 26., Other Medical Coverage are deleted from this Policy.

PART C - EXCLUSIONS is revised as follows:

Exclusion 9., which reads as follows;

9. "Routine new-born baby care, well baby nursery and related Physician's charges" is deleted from this Policy.

PART D – GENERAL POLICY PROVISIONS

Subrogation: If We provide payment for benefits to an Insured We will be subrogated to the Insured's rights of recovery from any third party. We may require an assignment from the Insured of the Insured's right to recover to the extent of payments by Us, or for the reasonable value of benefits and services provided by Us. Our subrogation rights will be valid only if an Insured is fully compensated for the loss for which benefits are provided under this Policy. Any payment of benefits made by Us will not constitute a satisfaction of the liability of the party or parties responsible for the bodily injury or property damage incurred by the Insured.

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

Credit for Prior Coverage

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

PART B - DEFINITIONS is revised as follows:

Pre-existing Conditions Waiting Period means the **12** month time period You must have continuous coverage in force under this Policy before a Pre-Existing Condition is considered a Loss.

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

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

PART E - ADDITIONAL POLICY PROVISIONS is revised as follows:

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

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

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

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

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