2003–2004

STUDENT INJURY AND SICKNESS INSURANCE PLAN

Designed Especially for the Students of

CARLETON COLLEGE

One North College St.
Northfield, MN 55057

Effective Date:
September 1, 2003 to
September 1, 2004

Policy # CUH200464
TO ALL STUDENTS OF CARLETON COLLEGE

Carleton College strongly recommends that all students enrolled at the College have health insurance coverage. An unexpected or expected illness or injury can result in heavy financial burdens for a student and his/her family. This burden added to the high cost of education may force a student to withdraw from school. Knowing this, Carleton College offers a Student Accident and Sickness Insurance Plan designed to meet student’s needs and to enhance retention of students following an illness or injury.

This brochure is a brief description of the Plan. The exact provisions governing the insurance are contained in the Master Policy issued to Carleton College and may be viewed at the school during regular business hours. This Plan is underwritten by Combined Insurance Company of America, and serviced by Specialty Risk Group International, Inc. Claims are processed by Administrative Concepts, Inc.

STUDENT ELIGIBILITY AND ENROLLMENT

All full-time and part-time students attending Carleton College must participate in this Student Accident and Sickness Insurance Plan unless proof of comparable coverage is furnished. Students who do not have proof of comparable coverage must return the Enrollment Card along with a check payable to Carleton College to the Wellness Center.

Previously Insured Students and their Dependents must be re-enrolled within 15 days from the start of the period of coverage in order to avoid a break in coverage. An Insured Person who has a break in continuous coverage will not be covered for any Pre-existing Conditions that originated before or during such break.

Students must actively attend classes for 31 consecutive class days following the date of enrollment in this insurance program. Home study and auditing scholars do not qualify as a student for the purposes of purchasing insurance coverage.
Dependent Eligibility

Insured Students may also purchase Dependent coverage. Dependent means: (a) the Insured Student’s spouse residing with the Insured Student; or (b) the Insured Student’s unmarried Children or Grandchildren who reside with the Insured Student and are under the age of nineteen years; and (c) a child born to or adopted by an Insured Person while this Plan is in force. Newborns will be covered by this Plan from the moment of birth, adopted children will be covered from the date of placement for adoption. Coverage for such newborn children will consist of coverage for Sickness or Injury, including benefits for inpatient or outpatient charges arising from medical and dental treatment up to age 18, including orthodontic and oral surgery treatment, for the necessary care or treatment of congenital defects, birth abnormalities including orthodontic and oral surgery treatment involved in the management of a cleft lip and cleft palate, or premature birth. Such coverage will start from the moment of birth, if the Insured Student is already insured for dependent coverage when the child is born. If the Insured Student does not have dependent coverage when the child is born, We cover the newborn child for dependent benefits from and after the moment of birth, or any minor child placed with an Insured Student for adoption for dependent benefits from and after the moment the child is placed in the physical custody of the Insured Student for adoption. Proper notice will be furnished to the Insured Student by the Company as to the amount of any additional premium for such newborn child’s coverage. In addition, We are entitled to all premiums that would have been collected had We been made aware of the additional Dependent.

Policy Term

The insurance under Carleton College’s Student Accident and Sickness Insurance Plan for the Annual Policy is effective 12:01 a.m. on September 1, 2003. An eligible student’s coverage becomes effective on that date or the date the application and full premium are received by the Company or Plan Administrator, whichever is later. The Annual Policy terminates at 12:01 a.m. on September 1, 2004 or at the end of the period through which the premiums are paid.
PREMIUM RATES

Student Accident and Sickness Insurance Plan
(Basic and Supplemental Plans)
September 1, 2003 to September 1, 2004

Student Only $ 519.00
Spouse Only $1,297.00
Each Child $ 649.00

Optional Catastrophic Accident and Sickness Insurance Plan

Student Only $ 275.00
Spouse Only $ 275.00
Each Child $ 275.00

PREMIUM REFUND POLICY

Insured Students entering the Armed Forces of any country will not be covered under this Plan as of the date of such entry. Those students withdrawing from the school to enter military service will be entitled to a pro-rata refund of premium upon written request. Requests should be made to Specialty Risk Group at the address on the back of the brochure. Premium received by the Company is fully earned upon receipt. No other requests for a refund of premium will be considered.

DEFINITIONS

Covered Charge or Expense as used herein means those charges for any treatment, services or supplies that are: (a) for Network Providers, not in excess of the Preferred Allowance; (b) for Non-Network Providers, not in excess of the Reasonable and Customary Expenses; (c) not in excess of the charges that would have been made in the absence of this insurance; and (d) incurred while this Plan is in force as to the Insured Person except with respect to any expense payable under the Extension of Benefits Provision.

Doctor as used herein means: (a) a legally qualified physician licensed by the state in which he or she practices; or (b) a practitioner of the healing arts performing services within the scope of his or her license as specified by the laws of the state of residence of such practitioner; or (c) a certified nurse midwife while acting within the scope of that certification.

Injury means bodily injury caused by an Accident, which is the sole cause of the Loss. All injuries due to
the same or a related cause are considered one Injury. **Insured Person** means an Insured Student and his or her covered Dependent(s) while insured under this Plan.

**Loss** means medical expense covered by this Plan as a result of Injury or Sickness as defined in this Plan.

**Medical Emergency** means the unexpected onset of an Injury or Sickness which requires immediate or urgent medical attention which, if not provided, could result in a Loss of life or serious permanent damage to a limb or organ or pain sufficient to warrant immediate care. A Medical Emergency does not include elective or routine care.

**Medically Necessary** means that a service, drug or supply is needed for the diagnosis or treatment of an Injury or Sickness in accordance with generally accepted standards of medical practice in the United States at the time the service, drug or supply is provided. A service, drug or supply shall be considered “needed” if it:

(a) is ordered by a licensed Doctor; and

(b) is commonly and customarily recognized through the medical profession as appropriate for the particular Injury

(c) or Sickness for which it was ordered.

A service, drug or supply shall not be considered as Medically Necessary if it is investigational, experimental, or educational.

**Per Condition Aggregate Maximum** means the total amount of benefits payable for each Injury or Sickness under the Student Health Insurance Policy or Policies issued to the Policyholder immediately before this Policy.

**Reasonable and Customary Expenses** means fees and prices generally charged within the locality where performed for Medically Necessary services and supplies required for treatment of cases of comparable severity and nature.

**Sickness** means sickness or disease, which is the sole cause of the Loss. Sickness includes both normal pregnancy and Complications of Pregnancy. All sicknesses due to the same or a related cause are considered one Sickness.

**We, Us, and Our** means Combined Insurance Company of America.
PRE-EXISTING CONDITIONS LIMITATION
A Pre-existing Condition is a Sickness, Injury, or related condition for which medical advice, diagnosis, care or treatment was recommended or received by a Doctor during the twelve (12) consecutive months prior to the Effective Date of the Insured Person’s coverage under this Plan.

The Pre-existing Condition Waiting Period is twelve (12) months. Coverage will not be provided for a Pre-existing Condition until the waiting period has elapsed. The Preexisting Condition Waiting Period applies to all persons covered under this Plan and begins on the Insured Person’s Effective Date.

If an Insured Person receives treatment or service for a Pre-existing Condition: (a) We will not pay benefits for such condition until the day after a twelve (12) consecutive month period has passed from the Insured Student’s effective date; and (b) We will pay only for Loss or Expense incurred after such twelve (12) consecutive month period.

CONTINUOUS INSURANCE
Injury or Sickness shall include an Injury sustained, or a Sickness first manifesting itself, while the Insured Person is continuously insured under the Prior Plan and became insured under this Plan without a break in coverage. But no benefits shall be payable for such Injury or Sickness to the extent that such benefits are payable under the Prior Plan for the same expenses. This will apply even though the Prior Plan provided that it will not duplicate the benefits under another Policy. This Plan may be replacing a Prior Plan with another insurer. Prior Plan means the Student Health Insurance policy or policies issued to the Policyholder immediately before the current Policy.

DESCRIPTION OF BENEFITS
The insured is responsible for a $50.00 deductible per policy.

BASIC ACCIDENT MEDICAL EXPENSE BENEFIT
If as a result of an Injury, an Insured Person incurs covered medical Expenses, We will pay 100% of the Preferred Allowance for Network Providers and 60% of the Reasonable and Customary Expense for NonNetwork Providers incurred up to a maximum of $5,000 per Injury. The following Expenses will be paid: (a) hospital room and board; (b) miscellaneous hospital; (c) inpatient and outpatient surgery; (d) inpatient and outpatient anesthetist; (e) inpatient and
outpatient Doctor visits; (f) consultant; (g) licensed nurse; (h) hospital outpatient department; (i) emergency room; (j) diagnostic x-ray and laboratory tests; (k) outpatient prescription drug; (l) ambulance; (m) accidental dental injury; (n) durable medical equipment, and (o) other expenses incurred for the treatment of an Injury.

Injuries resulting from participation in an intercollegiate, club or intramural sport will be paid as any other Injury up to a maximum of $500.00 per Injury. Carleton College has purchased an additional athletic policy that will cover claims in excess of $500.00 per Injury. Please contact the Carleton College Athletic Director for additional information.

**BASIC SICKNESS MEDICAL EXPENSE BENEFIT**

If as the result of Injury or Sickness, an Insured Person incurs covered medical expenses, We will pay the Covered Percentage of the Covered Charges incurred, as allocated below for a Sickness.

**Hospital Room and Board Expense Benefit:** If an Insured Person requires confinement in a hospital, We will pay 100% of the Preferred Allowance for Network Providers or 60% of the Reasonable and Customary Expense for Non-Network Providers incurred up to the semi-private room rate up to a maximum of 60 days per Sickness. Coverage includes a bed in special care or intensive care unit.

**Miscellaneous Hospital Expense Benefit:** If an Insured Person incurs Expenses during a hospital confinement or day surgery on an outpatient basis (will also include surgery performed in a Doctor’s office, trauma unit, surgical center or clinic), We will pay 100% of the Preferred Allowance for Network Providers or 60% of the Reasonable and Customary Expense for Non-Network Providers incurred up to a maximum of $500.00 per Sickness. Such Expenses included: (a) anesthesia, anesthesia supplies and services; (b) operating, delivery and treatment rooms and equipment; (c) diagnostic x-ray and laboratory tests; (d) lab studies; (e) oxygen tent; (f) blood and blood services; (g) prescribed drugs and medicines; (h) medical and surgical dressings, supplies, casts and splints; (i) radiation therapy, intravenous chemotherapy, kidney dialysis, and inhalation therapy; (j) chemotherapy treatment with radioactive substances; (k) intravenous injections and solutions, and their administration; (l) physical and occupational therapy; and (m) other necessary and prescribed hospital expenses. Pre-Admission Test Expense Benefits will be
Surgical Expense Benefit (inpatient or Outpatient): We will pay 100% of the Preferred Allowance for Network Providers or 60% of the Reasonable and Customary Expense for Non-Network Providers incurred up to a maximum of $500.00 per Sickness for surgery performed by a licensed Doctor (in or Out of the Hospital). Benefits will be paid in accordance with the MDR Schedule for Reasonable and Customary Expense.

In-Hospital Doctor’s Fees and Medical Expense Benefit: If an Insured Person, who is confined as a resident bed-patient in a hospital, requires the services of a Doctor, who may or may not have performed the surgery on the Insured Person, We will pay 100% of the Preferred Allowance for Network Providers or 60% of the Reasonable and Customary Expense incurred up to $10.00 per visit, limited to one visit per day, up to maximum 60 days per Sickness.

Mammographic Examination Expense Benefit: We cover charges for mammographic exams. The charges must be incurred while the Insured Person is insured for these benefits. Benefits will be paid for mammographic exam charges incurred for the following: (a) one baseline mammogram for a woman thirty-five through thirty-nine years of age; (b) one mammogram every twenty-four months for a woman forty through forty-nine years of age, inclusive, or more frequently upon recommendation of a Doctor; (c) one mammogram every twelve months for a woman fifty years of age or older. We cover such charges the same way We treat Covered Charges for any other Sickness.

Outpatient Miscellaneous Expense Benefit: If an Insured Person requires the use of: (1) diagnostic x-ray and laboratory tests when prescribed by an attending Doctor; or (2) radiation therapy or chemotherapy treatment when prescribed by an attending Doctor, We will pay 100% of the Preferred Allowance for Network Providers and 60% of the Reasonable and Customary Expense incurred up to a maximum of $100 per Sickness.

Outpatient Prescription Drug Expense Benefit: If an Insured Person requires a prescription drug prescribed by a Doctor, We will pay, after an $8.00 copayment per prescription, 100% of the Reasonable and Customary Expenses for Non-Network Providers incurred up to a maximum of $200.00 per Sickness.
Ambulance Expense Benefit: If an Insured Person requires the use of a community or hospital ambulance for a Medical Emergency, We will pay 100% of the Reasonable and Customary Expenses for Non-Network Providers incurred up to a maximum of $150.00 per Sickness.

Licensed Nurse Expense Benefit: If an Insured Person requires the services of a licensed nurse or practical nurse during a hospital confinement, We will pay 100% of the Preferred Allowance for Network Providers or 60% of the Reasonable and Customary Expense incurred up to $25.00 per day, up to a maximum of 60 days per Sickness.

**Supplemental Accident and Sickness Medical Expense Benefit**

If as a result of an Injury, an Insured Person incurs covered Expenses in excess of the Basic Accident Medical Expense Benefit of $5,000 per Injury, We will pay 80% of the Preferred Allowance for Network Providers or 60% of the Reasonable and Customary Expense for Non-Network Providers incurred up to a Per Condition Aggregate Maximum of $50,000 per Injury.

If as a result of a Sickness, an Insured Person incurs covered Expenses in excess of the allocated benefits under the Basic Sickness Medical Expense Benefit, We will pay 80% of the Preferred Allowance for Network Providers or 60% of the Reasonable and Customary Expense for Non-Network Providers up to the Per Condition Aggregate Maximum of $50,000 per Sickness.

The following Expenses will be paid under the Supplemental Accident and Sickness Expense Benefit: (a) hospital room and board (semi-private room rate in excess of the first 60 days); (b) miscellaneous hospital; (c) inpatient and outpatient surgery; (d) inpatient and outpatient anesthetist; (e) inpatient and outpatient Doctor visits; (f) consultant; (g) licensed nurse; (h) hospital outpatient department; (i) emergency room; (j) diagnostic x-ray and laboratory tests; (k) outpatient prescription drug; (l) ambulance; and (m) other expenses incurred for the treatment of an Injury or Sickness.

Injury due to a motor vehicle accident is limited to $10,000 per Injury under this portion of the Plan.
Students enrolled in the Student Accident and Sickness Insurance Plan are eligible to purchase the Optional Catastrophic Accident and Sickness Insurance Plan that provides coverage over and above the Student Accident and Sickness Insurance Plan. This Plan does not start providing coverage until the $50,000 Per Condition Aggregate Maximum has been met under the Student Accident and Sickness Insurance Plan. We will pay 100% of the Covered Charges incurred up to a new Per Condition Aggregate Maximum of $250,000 per Insured Person.

Benefit limitations and exclusions are the same as defined under the Student Accident and Sickness Insurance Plan.

The following Expenses will be paid under the Optional Catastrophic Accident and Sickness Expense Benefit: (a) hospital room and board (semi-private room rate); (b) miscellaneous hospital; (c) inpatient and outpatient surgery; (d) inpatient and outpatient anesthetist; (e) inpatient and outpatient Doctor visits; (f) consultant; (g) licensed nurse; (h) hospital outpatient department; (i) emergency room; (j) diagnostic x-ray and laboratory tests; (k) outpatient prescription drug; (l) ambulance; and (m) other expenses incurred for the treatment of an Injury or Sickness.

The insurance under the Optional Catastrophic Accident and Sickness Insurance Plan for the Annual Policy is effective at 12:01 a.m. on September 1, 2003 An Insured Person's coverage becomes effective on that date or the date the application and full premium are received by the Plan Administrator, whichever is later. Purchase must be made at the same time as enrollment under the Student Accident and Sickness Insurance Plan, subject to the same enrollment deadlines. Dependents may not be enrolled for this option without the student being enrolled, or without being insured under the Student Accident and Sickness Insurance Plan.

To purchase these benefits, complete the separate Enrollment Form and return it with payment to the Plan Administrator.

Note: The premium charged for this Optional Catastrophic Benefit cannot be prorated so the cost remains the same when purchased for the Spring/
Summer Semester enrollment period.

**STATE MANDATED BENEFITS**

**Outpatient Mental and Nervous Conditions Expense Benefit:** We will pay the Covered Charges for covered outpatient services for the treatment of Mental or Nervous Conditions as follows:

The policy year maximum benefit will be limited to: (a) 80% of the Reasonable and Customary Expense not to exceed ten (10) Hours of Treatment in any policy year; and (b) 75% of the Reasonable and Customary Expense in excess of ten (10) Hours of Treatment in any policy year. Prior authorization from Us will be required for any and all outpatient services in excess of ten (10) hours. Such authorization will be based upon the severity of the disorder, the Insured Person’s risk of deterioration without ongoing treatment, the degree of functional impairment, and the receipt of a Doctor’s concise treatment plan. No authorization for extended treatment will exceed a maximum of thirty (30) treatment hours in any one policy year. For outpatient services for the treatment of Mental or Nervous Conditions, includes treatment or outpatient services rendered either on an individual or a single-family basis. If outpatient services or treatment is rendered on a group basis, each two-group session will equal one hour of treatment. The Mental and Nervous services must be: (a) in a licensed Hospital, a community mental health center, or a mental health clinic approved or licensed by the state of Minnesota; and/or (b) by any licensed mental health professional; and/or (c) for the family, if family therapy is advised by the approved provider of service of a Dependent child.

**Inpatient Alcohol and Drug Abuse Expense Benefit:** When the Insured Person is confined as an inpatient in: (a) a hospital; or (b) a residential treatment program licensed by the state of Minnesota for diagnosis or recommendation by a Doctor of medicine, We will pay the Covered Charges incurred for such hospital confinement for the treatment of alcoholism, chemical dependency or drug addiction on the same basis as any other Sickness. Payment will be made for at least twenty-eight (28) days in a policy year.

**Outpatient Alcohol and Drug Abuse Expense Benefit:** When the Insured Person is not so Hospital Confined as an inpatient, We will pay the Covered Charges incurred for up to 130 hours of treatment during any one-policy year, for outpatient treatment services on the same basis as any other Sickness.
Payment will be made only for charges made by a nonresidential treatment program approved or licensed by the state of Minnesota.

**Cancer Screening and Cytologic Screening (Pap Smear) Expense Benefit:** We cover charges for Expenses incurred for routine Cancer Screening procedures including Cytologic Screenings (Pap Smear) when recommended by a Doctor in accordance with the standard practice of medicine. We cover such charges the same way We treat Cover Charges for any other Sickness.

**Maternity Expense Benefit:** We cover charges as a result of normal pregnancy or as a result of non-elective termination of pregnancy, or as a result of elective termination of pregnancy as shown in the following schedule. Coverage will be provided for at least four days of confinement in a Hospital or Birthing Center. We will pay the Covered Percentage of the Covered Charges incurred for any Postdelivery Care to an Insured Person and the newborn for a minimum of four days of confinement in a Hospital or Birthing Center and for Perinatal Care. For a mother and newborn child who remain in the Hospital for the minimum length of time stated above, We will pay for one home health care visit if prescribed by the attending Doctor. For a mother and newborn child who have a shorter Hospital stay, We will pay for one home visit scheduled within 24 hours after Hospital discharge; and an additional home visit if prescribed by an attending Doctor. Newborn infant care is covered when the infant is confined in the Hospital and has received continuous Hospital care from the moment of birth. This includes: (a) nursery charges; (b) charges for routine Doctor’s examinations and tests; and (c) charges for routine procedures, except circumcision. This benefit also includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of newborn children covered from birth. Covered services may be provided by a certified nurse-midwife under qualified medical direction if he or she is affiliated with or practicing in conjunction with a licensed facility. We cover such charges the same way We treat Covered Charges for any other Sickness.

**Reconstructive Breast Surgery Expense Benefit:** We cover charges following a covered mastectomy for the following services: (a) reconstruction of the breast on which the mastectomy has been performed; (b) surgery and reconstruction of the nondiseased breast to restore and achieve symmetry; (c) prosthetic
devices and treatment of physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes); and (d) hospitalization, for a length of stay as determined by the attending Doctor and surgeon in consultation with the Insured Person, and consistent with sound clinical principles and processes. We cover such charges the same way We treat Covered Charges for any other Sickness.

Reconstructive Surgery Expense Benefit: We will pay the Covered Percentage of the Covered Charges incurred for reconstructive surgery when such service is incidental to or follows surgery resulting from Injury or Sickness or other diseases of the involved part. We will also pay benefits for the Covered Percentage of the Covered Charges incurred for service performed on an insured Dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending Doctor. Cosmetic Surgery is performed to alter or reshape normal structures of the body in order to improve the patient's appearance and is therefore not a Covered Charge. We cover such charges the same way We treat Covered Charges for any other Sickness.

Laryngectomy Expense Benefit: We cover benefits for charges for Prosthetic Devices to restore a method of speaking for the Insured Person incident to a Laryngectomy. We cover such charges the same way We treat Covered Charges for any other Sickness.

Osteoporosis Expense Benefit: We cover charges for services related to diagnosis, treatment, and appropriate management of Osteoporosis. Such services may include, but need not be limited to all Food and Drug Administration approved technologies, including bone mass measurement technologies as deemed medically appropriate. We cover such charges the same way We treat Covered Charges for any other Sickness.

Children’s Health Supervision Services And Prenatal Care Services Expense Benefit: We cover charges for Child Health Supervision Services and Prenatal Care Services. Charges include coverage for at least one visit payable to one provider at each visit. We cover such charges the same way We treat Covered Charges for any other Sickness. Child Health Supervision Services means pediatric preventive services, appropriate immunizations, developmental assessments, and laboratory services appropriate to the age of a child from birth to age six
(6), and appropriate immunizations from ages six (6) to eighteen (18), as defined by Standards of Child Health are issued by the American Academy of Pediatrics. Reimbursement must be made for at least five child health supervision visits from birth to twelve (12) months, three child health supervision visits from twelve (12) months to twenty-four (24) months, once a year from twenty-four (24) months to seventy-two (72) months. Prenatal Care Services means the comprehensive package of medical and psychosocial support provided throughout the pregnancy, including risk assessment, serial surveillance, prenatal education, and use of specialized skills and technology, when needed, as defined by Standards for Obstetric-Gynecologic Services issued by the American College of Obstetricians and Gynecologists.

**Phenylketonuria Treatment Expense Benefit:** We cover charges for special dietary treatment for Phenylketonuria when recommended by a Doctor. We cover such charges the same way we treat Covered Charges for any other Sickness.

**Scalp Hair Prostheses Expense Benefit:** We cover charges for expenses incurred for scalp hair prostheses worn for scalp hair loss as a result of alopecia. We will not pay more than a maximum of $350.00 in any one policy year.

**Ventilator-Dependent Expense Benefit:** We cover charges for services provided by a private duty nurse or personal care assistant to a ventilator-dependent Insured Person for up to 120 hours during the time the ventilator-dependent Insured Person is in a Hospital. The personal care assistant or private duty nurse shall perform only the services of communicator or interpreter for the ventilator-dependent Insured Person during a transition period to assure adequate training of the Hospital staff to communicate with the Insured Person and to understand the unique comfort, safety and personal care needs of the Insured Person. We cover such charges the same way we treat Covered Charges for any other Sickness.

**Temporomandibular Joint/Craniomandibular Disorder Expense Benefit:** We cover charges for surgical and non-surgical treatment of a temporomandibular joint disorder and/or craniomandibular disorder. We cover such charges the same way we treat Covered Charges for any other Sickness.
Prostate Cancer Screening Expense Benefit: We will pay the Covered Percentage of the Covered Charges incurred for Prostate Cancer Screening for:
(a) men age 40 and over who are symptomatic or in a high-risk category; or
(b) all men age 50 and over.
As used herein, the Prostate Cancer Screening must consist at a minimum of a Prostate Specific Antigen blood test and a digital rectal examination. We cover such charges the same way We treat Covered Charges for any other Sickness.

Off-Label Drug Use Expense Benefit: We will pay the Covered Percentage of the Covered Charges incurred for a cancer drug even if that drug has not been approved by the Federal Food and Drug Administration for a particular indication provided such drug is recognized in one of the Standard Reference Compendia or in one article in the Medical Literature.

Medical Literature means articles from major peer reviewed medical journals that have recognized the drug or combination of drugs safety and effectiveness for treatment of the indication for which it has been prescribed. Each article shall meet the uniform requirements for manuscripts submitted to biomedical journals established by the international committee of medical journal editors or be published in a journal specified by the United States Secretary of Health and Human Services, as amended, as acceptable peer review Medical Literature. Each article must use generally acceptable scientific standards and must not use case reports to satisfy this criterion.

Standard Reference Compendia means:
(a) the United Stated Pharmacopeia Drug Information; or
(b) the American Hospital Formulary Service Drug Information.

Pre-Admission Tests Expense Benefit: Notwithstanding any provision in the Policy to the contrary, We will pay benefits for Covered Charges made by a Hospital for use of its outpatient facilities for tests ordered by a Doctor. The tests must be performed as a planned preliminary to the Insured Person’s admission as an inpatient for surgery in that same Hospital. However: (a) the test must be necessary for, and consistent with, the diagnosis and treatment of the condition for which surgery is to be performed; (b) reservations for a Hospital bed and for an operating room must be made prior to the date the
tests are done; (c) the surgery actually takes place within seven days of pre-surgical tests; and (d) the Insured Person is physically present at the Hospital for the tests.

No benefit shall be payable under this provision in excess of either: (1) the benefits that would have been provided under this Policy had the Insured Person received those tests while confined in the Hospital as a resident bed-patient; or (2) the Miscellaneous Hospital Expense Maximum shown in the Plan of Insurance for the Miscellaneous Hospital Expense Benefit. If, by reason of similar benefit provisions elsewhere contained, the Policy provides for reimbursement for the same charges, no benefits shall be payable under these provisions, except to the extent by which the amount of benefit produced under those provisions for a given charge exceeds the amount of benefits produced for that same charge under this provision.

**EMERGENCY MEDICAL EVACUATION AND REPATRIATION OF REMAINS EXPENSE BENEFIT**

**Emergency Medical Evacuation Expense Benefit:** In the event of a serious Injury or Sickness, the Plan will pay benefits up to $10,000 to evacuate an Insured Person if: (a) the Insured Person’s medical condition warrants immediate transportation from the place where the Insured Person is injured or sick to the nearest hospital where appropriate medical treatment can be obtained; or b) after being treated at a local hospital, the Insured Person’s medical condition warrants transportation to the Insured Person’s home country to obtain further medical treatment to recover. An Emergency Medical Evacuation must be approved in advance by the Company. This benefit is only available for Insured Persons outside their home country.

**Repatriation of Remains Expense Benefit:** The Company will pay the reasonable covered expenses to return the Insured Person’s body to his or her home country if he or she dies; not to exceed a maximum of $7,500. Covered expenses include expenses for embalming, cremation, coffins, and transportation. Repatriation of Remains must be approved in advance by the Company. This benefit is only available for Insured Persons outside their home country.
ACCIDENTAL DEATH AND DISMEMBERMENT EXPENSE BENEFIT

When, because of an Injury, the Insured Person suffers any of the following Losses within 365 days from the date of the Accident, We will pay as follows:

**Table For Loss Of:**

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<th>Loss of</th>
<th>Amount</th>
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<tr>
<td>Life</td>
<td>$1,000</td>
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<tr>
<td>Two hands</td>
<td>$1,000</td>
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<td>Two feet</td>
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<td>Sight of two eyes</td>
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<td>One hand and one foot</td>
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<td>One hand and sight of one eye</td>
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<td>One foot and sight of one eye</td>
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<td>One hand or one foot or one eye</td>
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Loss of hands and feet means the loss at or above the wrist or ankle joints. Loss of eyes means total irrecoverable loss of the entire sight. Only one of the amounts named above will be paid for Injuries resulting from any one Accident. The amount so paid shall be the largest amount that applies.

This provision does not cover the Loss if it in any way results from or is caused or contributed: (1) by physical or mental illness; medical or surgical treatment except treatment that results directly from a surgical operation made necessary solely by an Injury covered by the Plan; (2) by an infection, unless it is caused solely and independently by a covered Accident; (3) for Expenses for which a contributing cause was the Insured Person's commission of, or attempt to commit a felony, or for which an Insured Person's engagement in an illegal occupation was the contributing cause; or (4) Bodily injuries received while the Insured Person was operating a motor vehicle under the influence of alcohol as evidenced by a blood level in excess of the state legal intoxication limit.

**EXCLUSIONS**

The Plan does not cover nor provide benefits for:

1. Services provided without charge by the Policyholder’s student health service center, infirmary, or Hospital, or by Health Care Providers employed by the Policyholder;
2. Preventative medicines, serums, immunizations, or vaccines, except as specifically provided;
3. Private duty nursing or skilled nursing services,
except as specifically provided;
4. Home health care services, except as specifically provided;
5. Care and/or treatment in skilled nursing facility, except as specifically provided;
6. Pre-existing Conditions as defined in this Plan;
7. Injury sustained or Sickness contracted while in service of the Armed Forces of any country, except as specifically provided. Upon the Insured Person entering the Armed Forces of any country, We will refund the unearned pro-rata premium to such Insured Person;
8. Illness, Accident, treatment or medical condition arising out of the play or practice of or traveling in conjunction with intercollegiate sports, intercollegiate club sports, and professional sports;
9. Injury resulting from motor vehicle accident to the extent that benefits are payable under any automobile medical expense insurance or automobile no-fault plans;
10. Cosmetic surgery, except as the result of covered Injury occurring while this Plan is in force as to the Insured Person. This exclusion shall also not apply to cosmetic surgery which is reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other disease of the involved body part, and reconstructive surgery because of congenital disease or anomaly of a covered Dependent child which has resulted in a functional defect;
11. Illness, Accident, treatment or medical condition arising out of hang-gliding, skydiving, glider flying, parasailing, sail planing, bungee jumping, racing or speed contests, skin diving, parachuting or bungi-cord jumping;
12. Correction of congenital defects except as specifically provided;
13. Injury or Sickness for which benefits are paid under any Workers’ Compensation or Occupational Disease Law;
14. Expense incurred as the result of dental treatment. This exclusion does not apply to treatment resulting from Injury to natural teeth;
15. Expense incurred after the date insurance terminates for an Insured Person except as may be specifically provided in the Extension of Benefits Provision, when applicable;
16. Medical services that are not Medically Necessary or that do not conform with medical standards of practice within the community. Also services and supplies in connection with experimental or investigational treatment;
17. Injury or Sickness resulting from war; or any act thereof;
18. Charges for treatment of any Injury or Sickness due to an Insured Person’s commission of, or attempt to commit a felony, or a crime which would be considered a felony if prosecuted;
19. Injury due to participation in a riot;
20. For services or supplies rendered by a close relative of the Insured Person. By close relative We mean an Insured Person’s spouse, children, parents, brothers and sisters;
21. For services, supplies or treatment, including any period of Hospital Confinement, which were not recommended, approved and certified as necessary and reasonable by a Doctor; or expenses non-medical in nature;
22. Expenses incurred in connection with foot care only to improve comfort or appearance such as care for weak, strained or flat feet; subluxation; corns; callouses; bunions; routine care of toenails, except for the removal of the nail root and necessary services in treatment of metabolic or peripheral-vascular disease; treatment of the instability and imbalance of the feet; and any tarsalgia, metatarsalgia. Expenses incurred for the care and treatment of Injury, infection, or disease are not excluded;
23. Expenses incurred in connection with family planning, the enhancement of fertility, fertility tests, correction of infertility, in-vitro fertilization, artificial insemination, and services or supplies for inducing conception;
24. Expenses incurred in connection with a voluntary sterilization procedure or any sterilization reversal process;
25. Treatment of obesity, including any care which is primarily dieting or exercise for weight loss;
26. Expenses incurred for transsexual surgery or any treatment leading to or in connection with transsexual surgery;
27. Expense incurred for eye examinations or prescriptions, eyeglasses, and contact lenses (except for sclera shells which are intended for use of corneal bandages), eye refractions, vision therapy, multiphasic testing, or lasix or other vision procedures except as required for repair caused by a covered Injury;
28. Routine periodical physical examinations and routine chest x-rays, except as specifically provided;
29. Expenses incurred for allergy testing and allergy treatment;
30. Treatment provided in a governmental Hospital unless there is a legal obligation to pay such
charges in the absence of insurance;
31. An amount of a charge in excess of the Reasonable and Customary Expense;
32. Elective I treatment or elective surgery, except as specifically provided;
33. Oral contraceptives and other forms of contraception used for contraceptive purposes only;
34. Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route;
35. Treatment of mental or nervous disorders except as specifically provided;
36. Treatment of alcohol and substance abuse except as specifically provided;
37. For International Students, expenses incurred within the Insured Person’s Home Country or Country of regular domicile;
38. Suicide, attempted suicide, or intentionally self-inflicted injury;
39. Injuries incurred by the Insured Person while intoxicated or under the influence of any drug unless taken as prescribed by a Doctor;
40. Expense incurred for: tubal ligation; vasectomy; breast implants; breast reduction; sexual reassignment surgery; impotence (organic or otherwise); acne; birth control; submucus resection and/or other surgical correction for deviated nasal septum, other than for required treatment of acute purulent sinusitis; circumcision; gynecomastia; hirsutism; and learning disabilities or disorders or Attention Deficit Disorder;
41. Voluntary or elective abortion; except as specifically provided;
42. Expense incurred for: topical acne treatments, moles, non-malignant warts or lesions, fertility medication; legend vitamins or food supplements; smoking deterrents; immunization agents; biological sera; drugs to promote or stimulate hair growth; experimental drugs; drugs dispensed in a rest home or hospital, except as provided under the Hospital Expense Benefit;
43. Expenses incurred for replacement braces and appliances, except for repair or replacement that is required by a changed condition due to Sickness or Injury;
44. Expenses incurred for services or supplies for the diagnosis and treatment of sleep disorders, including but not limited to apnea monitoring and sleep studies;
45. Hearing aids, including exams for fitting, except as required to correct damage caused by an Injury which occurs while the patient is covered by this Plan, provided they are obtained within four months of the date of the Injury;
46. Services, supplies and facility that are provided mainly for a rest cure, maintenance or custodial care;
47. Hospital inpatient admissions primarily for diagnostic studies when bed care is not Medically Necessary;

PREFERRED PROVIDER NETWORK
The Carleton College Student Accident and Sickness Insurance Plan provides access to hospitals and health care providers locally through the Preferred Provider Organization of Preferred One. The advantage to using a Network Provider is that these providers have agreed to accept a predetermined fee or Preferred Allowance as payment for their services. Consequently, when Insured Persons use Network Providers. Out-of-Pocket expenses will be less because any applicable copayment will be based on a Preferred Allowance. The Insured Person should be aware that Network Provider Hospitals may be staffed with Non-Network Providers. Receiving services or care from a Non-Network Providers does not guarantee that all charges will be paid at the Network Provider level of benefits. It is important that the Insured Person verify that his or her Doctors are Network Providers each time he or she calls for an appointment or at the time of service. The most efficient and accurate way to identify Preferred One Network Providers is by visiting their web site at www.preferredone.com.

COORDINATION OF BENEFITS PROVISION
Minnesota Law permits Coordination of Benefits when an Insured Person is covered under more than one valid and collectible health insurance plan. A complete description of the Coordination of Benefits provision is included in the Master Policy on file with Carleton College.

SUBROGATION AND RECOVERY OF RIGHTS PROVISION
This Plan has a Subrogation and Recovery Rights Provision outlined in the Master Policy. A complete description of the Subrogation and Recovery Rights provision is included in the Master Policy on file with Carleton College.

APPEALS PROCEDURE
If a claim is wholly or partially denied, a written notice
or a message on the Explanation of Benefits (EOB) will be sent to the Insured Person containing the reason for the denial. The notice or message will include a reference to the provision in the Plan and a description of any additional information, which might be necessary for reconsideration of the claim.

CLAIM PROCEDURES

In the event of an Injury or Sickness the Insured Person should:

1. If at Carleton College, report immediately to the Wellness Center so that proper treatment can be prescribed or referred, and obtain a Claim Form; or

2. If away from Carleton College, or if the Wellness Center is closed, consult a Doctor and follow his/her advice.

3. Notify Administrative Concepts Inc. (ACI) within 30 days after the date of the Injury or commencement of the Sickness or as soon thereafter as is reasonably possible.

4. Complete the claim form in full and sign it.

5. The completed and signed claim form should be mailed within 90 days from the date of Injury or from the date of the first medical treatment for a Sickness, or as soon as reasonably possible. Retain a copy for your records and mail a copy to ACI at the address below.

6. Itemized medical bills must be attached to the claim form at the time of submission. Subsequent medical bills should be mailed promptly to ACI at the address below. No additional claim forms are needed as long as the Insured Person’s/Student’s name and identification number are included on the bill.

7. Direct all questions regarding benefits available under this Plan, claim procedures, status of a submitted claim or payment of a claim to ACI at the address below. Office hours are 9:00 a.m. to 4:00 p.m. (EST) Monday through Friday.

REMEMBER THAT EACH INJURY OR SICKNESS IS A SEPARATE CONDITION AND A SEPARATE CLAIM FORM IS REQUIRED FOR EACH
Any provisions of this Plan which, on its effective date, is in conflict with the statutes of the state in which the Insured Person resides on such date, is hereby amended to conform to the minimum requirements of such statutes.

Under HIPAA's Privacy Rule we are required to provide you with notice of our legal duties and privacy practices with respect to personal health information. You should receive a copy of this notice with your enrollment materials. If, at anytime, you wish to request a copy of Combined Insurance Company of America's Privacy Notice, write to 5050 Broadway, Chicago, IL 60640  Attn: HIPAA Privacy Office or call 1-800-225-4500, select HIPAA.
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Wayne, PA 19087-1706
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The Plan is Underwritten by:
Combined Insurance Company of America
Policy No. CUH 200464