Your student health insurance coverage, offered by Companion Life Insurance Company, may not meet the minimum standards required by the health care reform law for the restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are $1.25 million for policy years before September 23, 2012; and $2 million for policy years beginning on or after September 21, 2012 but before January 1, 2014. Restrictions for annual dollar limits for student health insurance coverage are $100,000 for policy years before September 23, 2012, $500,000 for policy years beginning on or after September 23, 2012, but before January 1, 2014. Your student health insurance coverage put an annual limit of $500,000 that applies to the essential benefits provided in the Schedule of Benefits unless otherwise specified. If you have any questions or concerns about this notice, contact Customer Service at 1-800-322-9901. Be advised that you may be eligible for coverage under a group health plan of a parent’s employer or under a parent’s individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent’s employer plan or the parent’s individual health insurance issuer for more information.
2013–2014
STUDENT
INJURY AND
SICKNESS
INSURANCE
PLAN

Designed Especially
for the Students of

CARLETON
COLLEGE

One North College St.
Northfield, MN 55057

Effective Date:
August 15, 2013
to
August 15, 2014

Policy Number: CLSP0047-13

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TO ALL STUDENTS OF
CARLETON COLLEGE

Carleton College requires 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 students insurance 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 Companion Life Insurance Company, and serviced by Collegiate Insurance Resources. Claims are processed by Administrative Concepts, Inc.

We suggest that you retain this brochure so you will have a ready reference to the benefits of the Plan. Any provisions of this Plan which, on its effective date, is in conflict with the statutes of the state in which the Covered Person resides on such date, is to conform to the minimum requirements of such statutes.

STUDENT ELIGIBILITY
AND ENROLLMENT

All full-time students attending Carleton College must participate in this Student Accident and Sickness Insurance Plan unless proof of alternate coverage is furnished. Students who have not provided proof of alternate coverage through the waiver process will be automatically enrolled in the Student Health Insurance Plan. Waiver and enrollment must be submitted online by August 15, 2013 at www.cirstudenthealth.com/carleton.

Previously Covered Students and their Dependents must re-enroll within 30 days from the start of the period of coverage in order to avoid a break in coverage.

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

Covered Students may also purchase Dependent coverage. Dependent means: (a) the Covered Student’s spouse residing with the Covered Student; or (b) the Covered Student’s unmarried Children or Grandchildren who are financially dependent and have resided with the insured student from birth; and (c) a child born to or adopted by a Covered 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 Covered Student is already insured for dependent coverage when the child is born. If the Covered 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 a Covered Student for adoption for dependent benefits from and after the moment the child is placed in the physical custody of the Covered Student for adoption. Proper notice will be furnished to the Covered 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 is effective 12:01 a.m. on August 15, 2013. 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. Coverage under the Policy terminates at 12:01 a.m. on August 15, 2014 or at the end of the period through which the premiums are paid.

PREMIUM RATES

Student Accident and Sickness Insurance Plan

August 15, 2013 to August 15, 2014

Student Only $ 940.00
Spouse Only $ 2,073.00
Child (ren) $ 1,180.00

Administrative fee included.

PREMIUM REFUND POLICY

Covered 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 the Plan Manager, Collegiate Insurance Resources at 1-800-322-9901. Premium received by the Company is fully earned upon receipt. No other requests for a refund of premium will be considered.

DEFINITIONS

Covered Expenses are the Usual, Customary and Reasonable Charges incurred by the Covered Person for Medically Necessary care and Treatment.

Covered Person means any Eligible Person and, where applicable, Eligible Dependents who makes application for, or for whom application is made and who is approved to participate in the benefit plans issued under this Policy, provided the required premium for such Person’s and Dependents’ insurance is paid when due.

Injury means accidental bodily harm sustained by the Covered Person that resulted directly and independently of all other causes from an Accident and occurs while coverage under this Policy is in effect.

Medically Necessary or Medical Necessity means the services or supplies provided by a Hospital, Physician, or other provider that are required to identify or treat an Injury or Sickness and which, as determined by the Company, are: (1) consistent with the symptom or diagnosis and Treatment of the Injury or Sickness; (2) appropriate with regard to standards of good medical practice; (3) not solely for the convenience of the Covered Person; (4) the most appropriate supply or level of service which can be safely provided. When applied to the care of an Inpatient, it further means that the Covered Person’s medical symptoms or condition requires that the services cannot be safely provided as an Outpatient.

Physician means a practitioner of the healing arts who is duly licensed in the state where he is practicing and who is treating within the scope and limitation of that license. The term Physician will not include the Covered Person or his spouse, children, brothers, sisters, or parents, or any person residing in his household.

Sickness means illness or disease contracted and causing loss as to the Covered Person whose Sickness is the basis of claim. Any complications or any condition arising out of a Sickness for which the Covered Person is being treated or has received Treatment will be considered as part of the original Sickness.

Usual, Customary, and Reasonable Charges

"Usual" means those charges made by a provider for services and supplies rendered to all patients for the same or similar Injury or Sickness. "Customary" means those charges made by the majority of providers in the area for the same or similar services or supplies. "Reasonable" means those charges that do not exceed the majority of prevailing fees in the area for the same or similar services or supplies. Area means a county or larger geographically significant area as determined by the Company.
PRE-EXISTING CONDITION LIMITATION
A Pre-existing Condition is a Sickness, Injury, or related condition for which medical advice, diagnosis, care or treatment was recommended by or received from a Physician during the six (6) consecutive months prior to the Effective Date of the Insured Person’s coverage under this Plan. A pre-existing condition is any condition, which was treated or diagnosed six (6) months prior to the Covered Person’s effective date of coverage under this policy. The pre-existing condition exclusion will be waived once the Covered Person has maintained continuous and uninterrupted coverage for a period of twelve (12) consecutive months. Pre-existing conditions are covered for insureds 19 years or younger.

CONTINUOUS INSURANCE
Injury or Sickness shall include an Injury sustained, or a Sickness first manifesting itself, while the Covered 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 Covered Person is responsible for a $100 deductible per policy year. The deductible is waived if a student first uses the Student Health and Counseling (SHAC).

ENROLLMENT PERIOD
Late enrollment, after an open enrollment period has ended, is only considered if a change has occurred in your insurance status regarding coverage that was in-force during the open enrollment period. Late enrollment must be completed within 30 days of the termination of other coverage. Contact Collegiate Insurance Resources for the cost and forms.

SPORTS INJURY EXPENSE BENEFIT
Injuries resulting from participating in an intercollegiate and club sport will be paid as any other injury up to a maximum of $500 per injury on the Student Health Plan. Students enrolled for the Accident and Sickness plan are also eligible to enroll for Intercollegiate and Club Sports coverage. By enrolling for and paying the additional cost toward the Intercollegiate and Club Sports coverage, each injury occurring while participating in Intercollegiate and Club Sports will be covered for a maximum of $90,000 and payable at 100%. Students who purchase the Carleton College student health plan are eligible to purchase the voluntary sports accident plan for an additional premium.

To enroll in the sports plan, go to: www.cirstudenthealth.com/carleton

ACCIDENT AND SICKNESS MEDICAL EXPENSE BENEFIT
If as the result of Injury or Sickness, a Covered Person incurs covered medical expenses, We will pay 80% of the negotiated charges for Network Providers and 50% of the Usual, Customary and Reasonable Expense for Non-Network Providers up to $500,000 per policy year.

Hospital Room and Board Expenses: a) daily semi-private room rate when confined in a Hospital as an Inpatient; and b) general nursing care provided and charged for by the Hospital. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.

Hospital Miscellaneous Expenses: a) while confined in a Hospital as an Inpatient; or b) as a precondition for being confined in a Hospital as an Inpatient. Benefits will be paid for services and supplies such as: the cost of an operating room; laboratory tests; x-ray examinations (not treatment); anesthesia; drugs
(excluding take home drugs) or medicines; therapeutic services; and supplies.

**Inpatient Surgery:** Physician's fees for Inpatient surgery. Payment for surgery will be made based upon the surgical schedule as specified in the Schedule of Benefits. For an additional procedure through the same incision We will pay 50% of benefits for the less expensive procedure. Covered Expenses for surgery will be paid under this Inpatient surgery benefit or under the outpatient surgery benefit, but not both.

**Outpatient Medical Emergency Expenses:** Benefits will be paid at 80% after a copay of $150. Copay is waived if insured is admitted.

**Outpatient Surgery:** Physician's fees for Outpatient surgery. Payment for surgery will be made based upon the surgical schedule as specified in the Schedule of Benefits. For an additional procedure through the same incision We will pay 50% of benefits for the less expensive procedure. Covered Expenses for surgery will be paid under this Inpatient surgery benefit or under the outpatient surgery benefit, but not both.

**Inpatient Physicians Visits:** When confined in a Hospital as an Inpatient, benefits are limited to one visit per day. Benefits do not apply when related to surgery. Covered Expenses for Physicians visits will be paid under this Inpatient Physicians visits benefit or under the outpatient Physicians visits benefit, but not both on the same day.

**Outpatient Physicians Visits:** Benefits are limited to one visit per day. Benefits do not apply when related to surgery or physiotherapy.

**Outpatient Diagnostic X-ray Services:** If so noted in the Schedule of Benefits, separate maximums apply to positive and negative x-rays. Diagnostic x-rays are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 70000 - 79999 inclusive.

**Outpatient Laboratory Procedures:** Laboratory procedures are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 80000 - 89999 inclusive. Outpatient Radiation Therapy.

**Outpatient Chemotherapy.**

**Prescription Drug Expense Benefit:** Following a $15 copay for each generic prescription drug a $30 copay for each brand name prescription drug and $45 for single source, eligible expenses are payable up to the plan maximum. This Pharmacy benefit is provided to cover prescriptions associated with a covered Sickness or Covered accident occurring during the plan year.

**Ambulance Expense Benefit:** If a Covered Person requires the use of a community or hospital ambulance, We will pay the Covered Charges incurred.

**Inpatient Registered Nurse's Services:**a) private duty nursing care only;  b) while confined in a Hospital as an Inpatient; c) ordered by a licensed Physician; and d) a Medical Necessity. General nursing care provided by the Hospital is not covered under this benefit.

**Motor Vehicle Injury Expense Benefit:** Expenses for treatment of Injuries sustained by reason of a Covered motor vehicle accident are covered up to a maximum of $10,000.

**Wellness Benefit:** Includes preventive services such as screenings, exams and immunizations as specified by the Patient Protection and Affordable Care Act (PPACA). For more information visit http://www.healthcare.gov/prevention/index.html. Paid at 100% of Preferred Allowance for services rendered In-Network, not subject to deductible, copays or coinsurance. Services received Out-of-Network are paid at 50% of U&C, but the Deductible is waived. Deductible does not apply when covered wellness services are received at the Student Health and Counseling (SHAC).

**STATE MANDATED BENEFITS**

**Inpatient and Outpatient Mental and Nervous Conditions Expense Benefit:** We will pay the Covered Charges for covered services for the treatment of Mental or Nervous Conditions as any other Illness.

**Inpatient and Outpatient Alcohol and Drug Abuse Expense Benefit:** We will pay the Covered Charges for covered inpatient and outpatient services for the treatment of Alcohol and Drug Abuse as any other Illness.
Cancer Screening Expense Benefit: We cover charges for Expenses incurred for routine Cancer Screening procedures when recommended by a Physician in accordance with the standard practice of medicine. We cover such charges the same way We treat Covered Charges for any other Sickness. Such charges and procedures include: Routine screening procedures for cancer and the office or facility visit, including mammograms, surveillance tests for ovarian cancer for women who are at risk for ovarian cancer, pap smears, and colorectal screening tests for men and women, when ordered or provided by a Physician in accordance with the standard practice of medicine.

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 the same as any other sickness under the policy. 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.

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 Physician’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.

Reconstructive Surgery Expense Benefit: Expenses incurred by a Covered Person for Reconstructive Surgery as described below are considered Covered Expenses and will be payable under this Policy to the same extent as any other Covered Expense. Payment of this benefit is subject to all other terms and conditions of this Policy.

To be considered a Covered Expense, the reconstructive surgery must be incidental to or follow surgery resulting from injury, sickness or other disease of the involved part or the surgery must be performed on a covered dependent child due to a congenital disease or anomaly which has resulted in a functional defect, as determined by the attending Physician.

Expenses incurred for reconstructive breast surgery will be considered Covered Expenses if the reconstructive breast surgery is needed following a mastectomy, provided if the mastectomy is medically necessary as determined by the attending Physician.

Reconstructive surgery benefits include all stages of reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prosthesis and physical complications at all stages of a mastectomy, including lymphedemas, as determined in consultation with the attending Physician.

Home Health Care Benefits: Expenses incurred by a Covered Person for Home Health Care as described below are considered Covered Expenses and will be payable under this Policy to the same extent as any other Covered Expenses incurred for the Treatment of a covered Injury or Sickness. "Home Health Care" means those nursing and other home health care services rendered to a Covered Person who is the patient in his place of residence, under the following conditions:

1. on a part-time and intermittent basis, except when full-time or 24-hour services are needed on a short-term (no more than 3 days) basis; and
2. if continuing hospitalization would have been otherwise required if home health care were not provided; and
3. pursuant to a Physician’s written order and under a plan of care established by the responsible Physician working with a Home Health Care Provider. The Physician must review the plan monthly and certify monthly that continued confinement in a Hospital would otherwise be required. That Physician may not be related to the Home Health care provider by ownership or contract. All care plans must be established within 14 days following commencement of home health care.

"Home Health Care Provider" means an agency that is licensed as a home health agency.
Preventive and Primary Care Benefit: Expenses incurred by Covered Dependent Children up to 18 years of age for preventive and primary care services as described below are considered Covered Expenses and will be payable under this Policy to the same extent as any other Covered Expenses incurred for the Treatment of a covered Injury or sickness.

"Preventive and Primary" care services include physical examinations, measurements, sensory screening, neuropsychiatric evaluation, and development screening. Services also include, as recommended by the Physician, heredity and metabolic screening at birth, immunizations, urinalysis, tuberculin tests, and hematocrit, hemoglobin, and other appropriate blood tests, including tests to screen for sickle hemoglobinopathy. Coverage shall include unlimited visits for children up to the age of 12 years, and 3 visits per year for minor children ages 12 years up to 18 years of age.

Temporomandibular Joint / Craniomandibular Disorder Expense Benefit: Expenses incurred by a Covered Person for the treatment of TMJ and CMB, as described below, will be considered a Covered Expense and will be payable under the Policy the same as any other Covered Expense.

The surgical and non-surgical treatment and diagnosis of Temporomandibular and Craniomandibular disorder will be considered a Covered Expense. Coverage for orthodontic appliances and treatment for crowns, bridges and dentures is not covered, unless the disorder is trauma related.

Payment of this benefit is subject to all other terms and conditions of the Policy.

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.
**Diabetes Treatment Benefit:** Expenses incurred by a Covered Person for the treatment of diabetes, as described below, will be considered a Covered Expense under the policy and will be payable to the same extent as any other Covered Expense.

Covered Expenses are limited to the following:

1. All physician prescribed medically appropriate and necessary equipment used in the management and treatment of diabetes;
2. Diabetes outpatient self-management training education, including medical nutrition therapy, provided by a certified, registered, or licensed health care professional working in a program consistent with the standards of diabetes self-management education as established by the American Diabetes Association.

Coverage under this section includes Covered Persons with gestational, Type I or Type II diabetes. Payment of this benefit is subject to all other terms and conditions of the Policy.

**Non-Formulary Drugs for Mental Illness and Emotional Disturbance Benefit:** In the event the company uses a formulary for prescription drugs, benefits will be provided by the Policy to the same extent as other prescription drugs for Anti-Psychotic drugs for the treatment of mental illness or emotional disturbance subject to the following:

1. the Physician indicates to the dispensing pharmacist, orally or in writing that the prescription must be dispensed as communicated; and
2. the Physician prescribing the medication certifies in writing to the Company that the Physician has considered all equivalent drugs in the formulary and has determined that the drug prescribed will best treat the patient’s condition.

This benefit does not extend coverage to include drugs that have been removed from the Company’s formulary for safety reasons.

Payment of this benefit is subject to all other terms and conditions of the Policy.

**Off-Label Drug Benefit:** Benefits provided by the Policy for prescription drugs include coverage for an Off-Label Use of a drug if the drug is recognized for such treatment in the Standard Reference Compendia literature.

As used in this subsection, Off-Label Use means the prescription of a drug for a treatment other than those treatments stated in the labeling approved by the federal Food and Drug Administration.

Standard Reference Compendia means the United States Pharmacopeia Drug Information, or the American Hospital Formulary Service Drug information.

Payment of this benefit is subject to all other terms and conditions of the Policy.

**Emotionally Handicapped Children Treatment Benefit:** Expenses incurred for treatment in a residential treatment center for the mental health treatment of a covered dependent child who is emotionally handicapped will be considered a Covered Expense under the Policy and will be payable the same as any other Covered Expense.

Payment of this benefit is subject to all other terms and conditions of the Policy.

**Port Wine Stain Benefit:** Expenses incurred by a Covered Person for the treatment of port-wine stains will be considered a Covered Expense under the policy and will be payable to the same extent as any other Covered Expense.

Payment of this benefit is subject to all other terms and conditions of the Policy.

**Lyme Disease Treatment Benefit:** Expenses incurred by a Covered Person for the treatment of Lyme disease, that has been diagnosed by a Physician, will be considered a Covered Expense under the policy and will be payable to the same extent as any other Covered Expense.

Payment of this benefit is subject to all other terms and conditions of the Policy.
Phenylketonuria Treatment Expense Benefit: Expense incurred by a Covered Person for dietary treatment of phenylketonuria will be considered a Covered Expense and will be payable the same as any other Covered Expense. Payment of this benefit is subject to all other terms and conditions of the Policy.

Scalp Hair Prostheses Expense Benefit: Expense incurred for a scalp hair prosthesis worn for hair loss due to alopecia areata will be considered a Covered Expense under the Policy. This benefit is subject to any deductible or copayment required under the Policy and is limited to a maximum benefit.

PREFERRED PROVIDER NETWORK

PreferredOne

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 Covered Persons use Network Providers Out-of-Pocket expenses will be less because any applicable copayment will be based on a preferred allowance. The Covered Person should be aware that Network Provider Hospitals may be staffed with Non-Network Providers. Receiving services or care from a Network Provider 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 Physicians 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.

PRESCRIPTION DRUG EXPENSE BENEFIT

After a copayment of $15 for generic or $30 for a brand name drug and $45 for single source per prescription, the cost of prescription drugs is payable in full, up to the plan maximum. Prescriptions must be filled at a Express Scripts Participating Pharmacy. Covered Persons will be given an insurance ID card to show to the Pharmacy as proof of coverage. Before you receive your insurance ID card, and if you need to have a prescription filled, go to any pharmacy, pay for the medication in full and save the receipt. Your insurance ID card will include instructions on how to file for reimbursement for prescriptions filled before you received your card. Reimbursement will be at the Express Scripts contracted discount rate and will be less than the rate charged by the pharmacy. Not all medications are covered.

After you receive your insurance ID card, no claim forms need to be completed. After you receive the card you may call the toll-free customer service number listed on your card for assistance with pharmacy locations (800-400-0136). The number is effective for enrolled members only. You will need the Group Number and Member Number printed on your insurance ID card.

Home Delivery Pharmacy Service is available for medication taken to treat on going health conditions. Instructions on how to order will be included with your insurance ID card.
Emergency Medical Evacuation

In the event of a serious Injury or Sickness, We will pay the Usual and Customary Expenses incurred up to a maximum of $100,000 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. Emergency medical evacuation must be approved in advance by the Company.

ON CALL INTERNATIONAL ASSISTANCE PROGRAM

The International Assistance Program (IAP) is included in the Student Insurance Plan that provides access to a 24-hour worldwide assistance network, On Call International, for emergency assistance anywhere in the world. Simply call the assistance center at 800-407-7307 or collect at 603-898-9159. The multilingual staff will answer your call and immediately provide reliable, professional and thorough assistance. The following services are included in this Plan:

1. Referral to the nearest, most appropriate medical facility, and/or Provider.
2. Medical monitoring by board certified emergency physicians in the United States.
3. Urgent message relay between family, friends, personal physician, school, and Insured.
4. Guarantee of payment to Provider and assistance in coordinating insurance benefits.
5. Arranging and coordinating emergency medical evacuations and repatriation of remains.
6. Emergency travel arrangements for disrupted travel as the consequence of a medical emergency.
7. Referral to legal assistance.
8. Assistance in locating lost or stolen items including lost ticket application processing.

Contact On Call International for any of these services:
Toll Free from U.S. and Canada: 1-800-407-7307
Dial Direct/Call Collect Worldwide: 1-603-898-9159
Website: www.oncallinternational.com

Repatriation of Remains

In the event of the death of an Insured Person, We will pay the actual charges up to a maximum of $100,000 for preparing and transporting the Insured Person's remains to his or her home country. Covered expenses include expenses for embalming, cremation, coffins, and transportation. Repatriation of remains must be approved in advance by the Company.

24-HOUR NURSE ADVICE LINE

Wouldn’t you feel better knowing you could get health care answers from a Registered Nurse 24 hours a day? Students may utilize the Nurse Advice Line when the school health clinic is closed or anytime they need confidential medical advice. ON CALL provides Members with clinical assessment, education and general health information. This service shall be performed by a registered Nurse Counselor to assist in identifying the appropriate level and source(s) of care for Members (based on symptoms reported and/or health care questions asked by or on behalf of Members). Nurses shall not diagnose Member's ailments. Students must be enrolled in the Student Health Insurance Plan in order to be eligible to utilize the Nurse Advice program, which is sponsored by the school. This program gives students access to a toll-free nurse information line 24-hours a day, 7 days a week. One phone call is all it takes to access a wealth of useful health care information at 1-866-525-1955.
ACCIDENTAL DEATH AND DISMEMBERMENT EXPENSE BENEFIT

If, within 365 days of an Accident covered under this Policy, bodily Injury results in any of the following losses, the Company will pay the benefit amount shown opposite such loss in the Table of Benefits. If theCovered Person sustains more than one such loss as the result of any one Accident, the Company will pay only the one largest amount to which the Covered Person is entitled.

Table of Benefits:

<table>
<thead>
<tr>
<th>Loss</th>
<th>Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>$1,000</td>
</tr>
<tr>
<td>Two hands</td>
<td>$1,000</td>
</tr>
<tr>
<td>Two feet</td>
<td>$1,000</td>
</tr>
<tr>
<td>Sight of two eyes</td>
<td>$1,000</td>
</tr>
<tr>
<td>One hand and one foot</td>
<td>$1,000</td>
</tr>
<tr>
<td>One hand and sight of one eye</td>
<td>$1,000</td>
</tr>
<tr>
<td>One foot and sight of one eye</td>
<td>$1,000</td>
</tr>
<tr>
<td>One hand or one foot or one eye</td>
<td>$500</td>
</tr>
</tbody>
</table>

Loss of hand or foot means complete Severance through or above the wrist or ankle joint.

Loss of Entire Sight means the total, permanent loss of sight of the eye. The loss of sight must be unrecoverable by natural, surgical or artificial means.

"Severance" means the complete separation and dismemberment of the part from the body.

This benefit will be payable in addition to any other benefit payable under this Policy, subject to all the terms and conditions of this Policy.

EXCLUSIONS

No benefits will be paid for: a) loss or expense caused by, contributed to, or resulting from; or b) treatment, services or supplies for, at, or related to:

1. Treatment, services or supplies provided by the Policyholder’s infirmary, or its employees, or physicians employed by the Policyholder;

2. Preventative medicines, serums, immunizations, or vaccines, except as specifically provided;

3. Pre-existing Conditions as defined in this Policy. A condition is no longer considered a Pre-existing Condition per the provision entitled Limitation for Pre-Existing Conditions below;

4. 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;

5. Injury resulting from motor vehicle accident to the extent that benefits are payable under other valid and collectible insurance whether or not a claim is made for such benefits;

6. Cosmetic surgery, except as the result of covered Injury occurring while this Policy 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 newborn child which has resulted in a functional defect or to the extent specifically covered under this Policy;

7. 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, bungee jumping, or flight in any type of aircraft, except while riding as a fare paying passenger on a regularly scheduled airline;

8. Treatment of congenital anomalies and conditions arising or resulting directly therefrom, except as provided by the Policy for newborn children and children to age 18 for the medical and dental treatment, including orthodontic and oral surgery treatment, involved in the management of cleft lip and cleft palate;

9. Injury or Sickness for which benefits are paid under any Workers’ Compensation, Employer’s Liability or Occupational Disease Laws, or by any coverage provided or required by law including, but not limited to group, group type, and individual automobile “No-Fault” coverage;

10. Injury or Sickness resulting from declared or undeclared war; or any act thereof;
11. Participation in a riot or civil disorder; commission of or attempt to commit a felony; or fighting or brawling, except in self defense;

12. 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;

13. Expenses incurred in connection with foot care only to improve comfort or appearance such as care for weak, strained or flat feet; subluxation; corns; calluses; bunions, except open cutting operations; 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;

14. 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;

15. 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;

16. Routine periodical physical examinations and routine chest x-rays, except as specifically provided;

17. Expenses incurred for allergy testing and allergy treatment;

18. Treatment provided in a governmental Hospital unless there is a legal obligation to pay such charges in the absence of insurance;

19. Charges used to meet any deductible, or in excess of the coinsurance level, or in excess of those considered Usual, Customary and Reasonable Charges;

20. Elective Treatment or elective surgery, except as specifically provided;

21. Suicide, attempted suicide, or intentionally self-inflicted injury while sane, or insane;

22. Expense incurred for: tubal ligation; vasectomy; breast implants; breast reduction; sexual reassignment surgery; impotence (organic or otherwise); non-cystic acne; non-prescription birth control; submucus resection and/or other surgical correction for deviated nasal septum, unless required due to an injury resulting from an Accident while the Covered Person is insured under this policy; circumcision; gynecomastia; hirsutism;

23. Expense incurred for any service, treatment or supply for the diagnosis or treatment of sexual dysfunction (including erectile dysfunction). This includes, but is not limited to, drugs, laboratory and x-ray tests, counseling, transsexual procedures or penile prostheses necessary due to any medical condition or organic disease. A penile prosthesis will be eligible for payment only after prostate surgery;

24. Expenses incurred for services or supplies for the diagnosis and treatment of sleep disorders, including but not limited to apnea monitoring and sleep studies;

25. Hearing aids, including exams for fitting, or other Treatment for hearing defects and problems, 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. “Hearing defects” means any physical defect of the ear that does or can impair normal hearing;

26. Services, supplies and facility that are provided mainly for a rest cure, maintenance or custodial care;

27. Care, treatment or supplies furnished by a program or agency funded by any government;
**EXCESS PROVISION**

The Company's liability for benefits due to Covered Expenses incurred for Treatments and services resulting from a covered Injury or Sickness will be limited. When a Covered Expense is subject to this Excess Provision, the Company's liability is limited to that part of the Expense, if any, which is in excess of the total benefits payable for the same loss, on a provision of service basis or on an expense incurred basis under any other collectible policy or service contract, unless otherwise herein provided.

**Important:** The Excess provision has no practical application if you do not have other medical insurance or if your other insurance does not cover the loss.

**REIMBURSEMENT AND SUBROGATION**

If the covered person is injured or becomes ill through the act or commission of another person, and if benefits are paid under this Policy due to that injury or Sickness, then to the extent the Covered Person recovers for the same Injury or Sickness from a third party, his insurer, or the Covered Person's uninsured motorist insurance, Companion Life Insurance Company will be entitled to a refund of all benefits it has paid up to the amount of such recovery. Further, Companion Life Insurance Company has the right to offset subsequent benefits payable to the Covered Person under the Policy against such recovery.

Companion Life Insurance Company’s right to recover under this subrogation provision is only effective if the Covered Person has received a full recovery from the applicable third party or source. In addition, any recovery on behalf of Companion Life Insurance Company may be reduced on a pro-rata basis by the costs, disbursements and reasonable attorneys’ fees and other expense incurred obtaining recovery.

**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 Covered 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 Covered Person should:

1. If at Carleton College, report immediately to the Student Health and Counseling (SHAC) so that proper treatment can be prescribed or referred; or
2. If away from Carleton College, or if the Student Health and Counseling (SHAC) is closed, consult a Physician 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. 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 on the back cover. Office hours are 9:00 a.m. to 6:00 p.m. (CST) Monday through Friday.