

IMPORTANT NUMBERS

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► **GENERAL INSURANCE QUESTIONS**



Phone.....800-322-9901

Website.....
.....www.cirstudenthealth.com/scholastica

The Plan is Underwritten by:
BCS Insurance Company
No. BSA-00143

Claims Administration
Administrative Concepts, Inc.
994 Old Eagle School Road, Suite 1005
Wayne, PA 19087-1802
Phone:888-293-9229
Fax:610-293-9299
www.visit-aci.com

For a list of Preferred One Providers
Call 1-800-451-9597 or
Visit the website: www.preferredone.com

**INTERNATIONAL
STUDENT
ACCIDENT
&
SICKNESS
INSURANCE
PLAN**

**Designed Especially
for the Students of**



The College of
St. Scholastica

Duluth, MN

2010-2011

Policy No. BSA-00143

STUDENT ELIGIBILITY AND ENROLLMENT

All International students are required to participate in this Student Accident and Sickness Insurance Plan.

Previously Covered 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.

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 reside with the Covered Student and are under the age of the age of nineteen years; and (c) a child born to or adopted by an 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 for the first 31 days from the moment of birth. To continue the child's dependent benefits past the first 31 days, the Covered Student must notify the Claims Administrator in writing within 31 days of the child's birth. 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.

POLICY TERM

The insurance under The College of St. Scholastica's International Student Accident and Sickness Insurance Plan is effective 12:01 a.m. on August 2, 2010. 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 Coverage terminates at 12:01 a.m. on August 2, 2011 or at the end of the period through which the premiums are paid.

COST OF INSURANCE

Age	Term 1	Term 2
	08/02/10-02/02/11	02/02/11-08/02/11
0-24	\$ 310.00	\$ 310.00
25-29	\$ 336.00	\$ 336.00
30-39	\$ 372.00	\$ 372.00
40-45	\$ 564.00	\$ 564.00
46-54	\$ 636.00	\$ 636.00
Spouse	\$1476.00	\$1476.00
Child	\$ 486.00	\$ 486.00

The above costs include an administrative fee.

Dependent enrollment forms and rates can be obtained from Collegiate Insurance Resources at 1-800-322-9901.

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 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

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 CONDITIONS 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 Covered 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 an insured has maintained continuous and uninterrupted coverage for a period of twelve (12) consecutive months.

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.

MEDICAL EXPENSE BENEFITS -ACCIDENT AND SICKNESS

Benefit Schedule: If as the result of an Injury or Illness, a Covered Person incurs medical expenses, we will pay the covered percentage of the Covered Medical Expense incurred as described below and subject to the limitations and exclusions, within 52 weeks from the date of the Injury or Illness or commencement of the first expense up to a Maximum of \$200,000, per Injury or Illness. A Covered Person must receive treatment for an Injury or Illness within 30 days of the date of the Injury or Illness.

*The deductible will be waived if medical service is first received from the Student Health Center. Otherwise, the Covered Person must pay the deductible. The Deductible shall not exceed \$250 per Covered Person per Program year. If there is no Student Health Center, the deductible will be waived only if medical services are received from a Preferred Provider Network member.

Medical Benefit Schedule	In-Network or Outside the U.S.	Out of Network
	After a \$50 Deductible* / incident	After a \$150 Deductible* / incident
Up to \$25,000	The Program Pays Covered Medical Expenses: 80%	
\$25,000.01 - \$200,000	The Program Pays Covered Medical Expenses: In Network or outside U.S.: 100%, Out of Network: 80%	
Out-Patient Doctor Visit Copay ** (includes outpatient physiotherapy visits)	Insured Pays: \$10	
Emergency Room Visit Copay ** For Outpatient Only	Insured Pays: \$50	

** The co-pay is in addition to the deductible above.

COVERED EXPENSES

1. Room and Board Expense: 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.
2. Inpatient Surgery: Physician’s fees for Inpatient surgery. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed the benefit for the one of such procedures for which the largest benefit is payable. Covered Expenses for surgery will be paid under this Inpatient surgery benefit or under the outpatient surgery benefit, but not both

3. Inpatient Anesthetist Services: In connection with Inpatient surgery.
4. Inpatient Physician's 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 Physician's visits benefit or under the outpatient Physician's visits benefit, but not both on the same day.
5. Inpatient Psychotherapy: As noted on the Schedule of Benefits.
6. Outpatient Surgery: Physician's fees for outpatient surgery. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed the benefit for the one of such procedures for which the largest benefit is payable. Covered Expenses for surgery will be paid under this outpatient surgery benefit or under the Inpatient surgery benefit, but not both.
7. Outpatient Anesthetist Services In connection with scheduled outpatient surgery.
8. Outpatient Physician's Visits: Benefits are limited to one visit per day. Benefits do not apply when related to surgery or physiotherapy.
9. Outpatient Test and Procedures: Diagnostic services and medical procedures when performed by a Physician (excluding Physician's visits; physiotherapy; X-rays; and laboratory procedures).
10. Inpatient and outpatient Consultant Physician Fees: When requested and approved by the attending Physician.
11. 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.
12. Inpatient Physiotherapy.
13. Outpatient Physiotherapy: Benefits are limited as shown on the Schedule of Benefits. Service must be prescribed by a licensed physician, and such prescription is for a stated number of visits.
14. Scheduled Outpatient Surgery Miscellaneous: In connection with outpatient surgery that is scheduled prior to its being performed. Benefits will be paid for services and supplies such as: the cost of the operating room; anesthesia; drugs or medicines; therapeutic services; and supplies, for such surgery performed in a Hospital, an Outpatient Surgical Facility, or Physician's office. Non-scheduled surgery is not covered under this benefit.
15. 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.
16. Outpatient Radiation Therapy.
17. Outpatient Laboratory Procedures: Laboratory procedures are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 80000 - 89999 inclusive.
18. Outpatient Injections: a) when administered in a Physician's office; and b) charged on the Physician's statement.
19. Outpatient Chemotherapy.
20. Dental Treatment: The Program will pay for treatment of Injury to sound natural teeth as any other injury up to \$250.00 per tooth to a maximum of \$1,000 per Injury.
21. Termination of Pregnancy: The Program will pay on the same basis as any Sickness.
22. Expenses for Manual Manipulation through Subluxation of the Vertebrae: When it is medically necessary, the Program will pay up to a maximum of \$35.00 per visit up to a maximum of 3 visits per week, for a maximum benefit of \$1,000 per year.
23. Tuberculosis Expense Benefit: We will pay the Covered Percentage of the Covered Charge for testing and treatment (pre-existing condition stipulation will be waived).
24. Outpatient Non-Resident Mental Health Benefit: We will pay the preferred allowance for treatment rendered in a non-resident treatment program approved or licensed by the State of Minnesota pursuant to diagnosis or recommendation by a Physician of Medicine.

SPORTS INJURY EXPENSE BENEFIT

Injuries resulting from participating in an intercollegiate or club sport are excluded under the Student Health Plan. Students enrolled for the Accident and Sickness plan are eligible to enroll for Intercollegiate Sports coverage. By enrolling for and paying the additional cost toward the Intercollegiate Sports coverage, each injury occurring while participating in Intercollegiate Sports will be covered for a maximum of \$90,000 and payable at 100% after satisfaction of a \$25 deductible. Students who purchase the

St. Scholastica students who are enrolled in the student health plan are eligible to purchase the voluntary sports accident plan for an additional premium.

Please go to www.cirstudenthealth.com/scholastica to enroll in the sports plan.

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 lymph edemas, 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 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.

"Home Health Care Services" means any of the following services which are Medically Necessary to achieve the plan of care referred to in condition (3) above and are provided for the care of the Covered Person: nursing care (furnished by or under the supervision of a Registered Nurse); physical therapy; occupational therapy; medical social work; nutrition services; speech therapy; home health aide services; medical appliances and equipment, drugs and medications, laboratory services and special meals, to the extent such items and services would be covered by this Policy if the Covered Person were in a Hospital; and any diagnostic or therapeutic service, including surgical services performed in a Hospital outpatient department, a Physician's office or any other licensed health care facility, to the extent such service would be covered by this Policy if performed while the Covered Person was confined in a Hospital as an Inpatient, provided that service is performed as part of the plan of care.

Limitations - Home Health Care Benefits are subject to the following limitations:

1. Services must follow a Hospital confinement of at least 3 consecutive days. Services must begin not more than 3 days after the end of that confinement.
2. Any visit by a member of a home health care team on any day will be considered one home health care visit. Benefits will be provided for no more than 60 home health care visits in any period of 12 consecutive months.

3. The amount payable for a home health care visit will not exceed for each of the first three days on which services are provided the daily room and board benefit provided by this Policy during the prior Hospital confinement; for each subsequent day of such services, the amount payable will not exceed one-half of the daily room and board benefit provided by this Policy during the prior Hospital confinement.
4. The services and supplies must be furnished and charged for by a Home Health Care Provider.

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

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 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.

Pre-admission Testing: Limited to routine tests such as completed blood count; urinalysis; and chest X-rays. If otherwise payable under this Policy, major diagnostic procedures such as cat-scans and blood chemistries will be paid under the “Hospital Miscellaneous” benefit. Pre-admission testing must occur within 7 working days prior to Hospital admission for this benefit to be payable.

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 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.

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.

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 Protheses 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 co-payment required under the Policy and is limited to a maximum benefit of \$350 in any Policy year.

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) - LIMIT: \$10,000

When Benefits Are Payable: 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 the Covered 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.

For Loss of:	Benefit Amount
Life	\$10,000
Both Hands, Both Feet or Sight of Both Eyes	\$10,000
Either One Hand or One Foot and Sight of One Eye	\$10,000
One Hand and One Foot	\$10,000
Either Hand or Foot	\$ 5,000
Sight of One Eye	\$ 5,000

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

The Plan does not cover nor provide benefits for:

1. Treatment, services or supplies provided by the School's infirmary or its employees, or Physicians who work for the School; unless specifically provided;
2. Treatment of allergies, including allergy testing;
3. Expenses for treatment of Injuries sustained as a result of a 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;
4. Cosmetic Surgery, except cosmetic surgery which the Covered Person needs as a result of an Accident which happens while he is insured under the Policy or reconstructive surgery as a result of a congenital disease or abnormality of a covered newborn dependent child which has resulted in a functional defect, as determined by the attending physician;
5. Skydiving, parachuting, hang gliding, glider flying, parasailing, sail planning, bungee jumping, or flight in any type of aircraft, except while riding as a fare-paying passenger on a regularly-scheduled airline;
6. 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;
7. Injury or Sickness covered by Worker's Compensation or Employer's Liability Laws, or by any coverage provided or required by law (including, but not limited to group, group type, and individual automobile "No-Fault" coverage);
8. War or any act of war, declared or undeclared; or while serving in the armed forces of any country (a pro-rata premium will be refunded for such period of service);
9. Participation in a riot or civil disorder; fighting or brawling, except in self-defense; commission of or attempt to commit a felony;
10. Treatment or services provided by any member of the Covered Person's immediate family; or for which no charge is normally made;
11. Routine foot care, including the treatment of corns, calluses and bunions;
12. The diagnosis and treatment of Infertility;

13. Eye examinations; prescriptions or fitting of eyeglasses and contact lenses; eyeglasses, contact lenses or other Treatment for visual defects and problems, except as required as a result of a covered Injury. "Visual defects" means any physical defect of the eye that does or can impair normal vision;
14. Routine physical examinations and routine testing; preventive testing or Treatment; screening examinations or testing in the absence of Injury or Sickness. This exclusion does not apply to benefits for mammography or cytologic screening as provided by the policy, unless as specified in the policy;
15. Treatment, services or supplies provided or paid for by any governmental program or law, except Medicaid;
16. Charges used to meet any deductible, or in excess of the coinsurance level, or in excess of those considered Usual, Customary, and Reasonable Charges;
17. Elective Treatments and voluntary testing;
18. Birth Control, including surgical procedures and devices;
19. Suicide, attempted suicide or intentionally self-inflicted Injury while sane or insane;
20. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, other than as specifically provided in the Policy. Conditions caused by the adverse effects of breast implants will be considered a Covered Expense subject to the same terms and conditions applicable to other Covered Expenses;
21. Impotence, whether organic or otherwise;
22. The diagnosis and treatment of acne;
23. Nasal or Sinus Surgery or, surgery to correct a deviated nasal septum (unless required due to an Injury resulting from an Accident while the Covered Person is insured under this Policy);
24. Circumcision;
25. Gynecomastia;
26. Hirsutism;
27. Sleeping disorders, including testing thereof;
28. Hearing examinations or hearing aids; or other Treatment for hearing defects and problems, except as required as a result of a covered injury. "Hearing defects" means any physical defect of the ear that does or can impair normal hearing;
29. Rest cures or custodial care (whether or not prescribed by a Physician), or transportation.

PREFERRED PROVIDER NETWORK

The College of St. Scholastica 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 co-payment 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 Covered Person verifies 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:

medco

After a co-payment of \$10.00 for generic or \$30.00 for a brand name drug per prescription, the cost of prescription drugs is paid in full, up to a maximum of \$1000.00 per condition per policy year. Prescriptions must be filled at a Medco Participating Pharmacy. Covered Persons will be given an insurance ID card to show to the Pharmacy as proof of coverage.

Coverage includes insulin and supplies, but not equipment.

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 Medco contracted discount rate and will be less than the rate charged by the pharmacy. Not all medications are covered. Before you receive your insurance ID card you may contact Administrative Concepts, Inc. for a list of participating pharmacies and covered medications or exclusions.

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 15-digit Member Number printed on your insurance ID card.

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

TRAVEL ASSISTANCE SERVICES

TRAVEL ASSISTANCE

The following TRAVEL ASSISTANCE, EMERGENCY MEDICAL EVACUATION/REPATRIATION, BEDSIDE VISIT BY FAMILY MEMBER OR FRIEND and REPATRIATION OF MORTAL REMAINS benefits are not insured by BCS Insurance Company and are provided by Europ Assistance.

WHAT IS TRAVEL ASSISTANCE?

Your travel assistance program is designed to help you along the way before and during your travels. If you encounter a medical or other emergency during your trip of 90 days or less when you are at least 100 miles away from home, emergency assistance is available to you any time of day. Information services (such as “Cultural Information” – details about a location you are planning to visit, visa or passport information, etc) are available at any time, even if you don’t travel.

ABOUT THE SERVICE PROVIDER

Founded in 1963 Europ Assistance (EA) was the first company to offer assistance services to travelers. Now, EA provides help to customers throughout the world utilizing 36 assistance centers operating around the clock. Further support comes from an extensive international provider network and local agents in over 200 countries and territories allowing EA to offer local support in virtually any location. Headquartered in Bethesda, Maryland just outside of Washington, DC, EA-USA’s International Assistance Coordinators, Case Managers, doctors and nurses are available 24 hours a day to take care of virtually any assistance need. EA-USA may be reached by phone at 877-319-4387 (toll free) or at their website, www.europassistance-usa.com.

► KEY SERVICES

EMERGENCY MEDICAL TRANSPORTS

Should the patient’s conditions require a medical transport based on the evaluation and recommendation of one of EA-USA’s physicians, EA-USA will take care of all required arrangements to either move the patient to the needed level of medical care (“evacuation”) or return him/her to his/her place of residence for the purpose of recuperation, rehabilitation or further care (“repatriation”). EA-USA will pay up to \$1,000,000 CSL (“Combined Single Limit” for all transport related eligible expenses).

All services **must be arranged** by EA-USA.

REPATRIATION OF MORTAL REMAINS

In the event a Covered Person dies, EA-USA will arrange for the deceased to be returned to their place of residence for the purpose of burial or cremation. EA-USA will also take care of ancillary requirements such as government authorization, death certificates and so forth as governed by the policy. EA-USA will pay up to \$1,000,000 CSL for eligible transport expenses and ancillary services.

All services **must be arranged** by EA-USA.

BEDSIDE VISIT BY FAMILY MEMBER OR FRIEND

Should the Covered Person be hospitalized for seven or more consecutive days, be likely to be hospitalized for seven or more days or is in critical condition, EA-USA will arrange and pay for the economy class round-trip transportation of one family member or friend from his/her home to the place where the covered person is hospitalized. EA-USA will pay for eligible expenses up to \$1,000,000 CSL.

The benefit includes meals and accommodations reimbursement for up to 5 days with a maximum benefit of \$150 per day while visiting the hospitalized Covered Person.

All services **must be arranged or approved** by EA-USA.

► OTHER BENEFITS:

- Medical Provider Search and Referral
- Medical Monitoring
- Return of Travel Companion Assistance
- Dependent Child Return Assistance
- Emergency Cash Advance (credit card guarantee required)
- Legal Assistance/Bail (credit card guarantee required)
- Prescription Transfer/Shipment of Medication
- Emergency Travel Arrangements (credit card guarantee required)

In all cases, the medical professionals, medical facilities or legal counsel suggested by EA-USA to provide direct services to the eligible person are not employees or agents of EA-USA or BCS Insurance Group, and the final selection of any such medical professional, medical facility, or legal counsel is your choice alone. Neither EA-USA nor BCS Insurance Group assumes any responsibility for the quality or content of any such medical or legal advice or services. Neither EA-USA nor BCS Insurance Group shall be liable for the negligence or other wrongful acts or omissions of any of the healthcare or legal professionals providing direct services pursuant to this Agreement. The Covered Person shall not have any recourse against EA-USA or BCS Insurance Group by reason of its suggestion of or contract with any medical professional or attorney.

The services described above currently are available in every country of the world. Due to political and other situations in certain areas of the world, EA-USA may not be able to respond in the usual manner. EA-USA also reserves the right to suspend, curtail or limit its services in any area in the event of rebellion, riot, military uprising, war, terrorism, labor disturbance, strikes, nuclear accidents, Acts of God or refusal of authorities to permit EA-USA to fully provide services.

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 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.

CLAIM PROCEDURES

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

1. If at The College of Scholastica, report immediately to the Student Health Service so that proper treatment can be prescribed or referred, and obtain a Claim Form; or
2. If away from The College of Scholastica, or if the Student Health Service 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. 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, 994 Old Eagle Road, Suite 1005, Wayne, PA 19087-1802; Phone: 1-888-293-9229; Fax: 610-293-9229; www.visit.aci.com.
6. Itemized medical bills must be attached to the claim format 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 Covered 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, 994 Old Eagle Road, Suite 1005, Wayne, PA 19087-1802; Phone: 1-888-293-9229; Fax: 610-293-9229; www.visit.aci.com. 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 CONDITION.

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.

APPEALS

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.

AN IMPORTANT MESSAGE ABOUT HIPAA AND YOUR PRIVACY

If you want more information about our privacy practices or have concerns, please contact us using the information listed at the end of this notice. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information or in response to a request you made to amend or restrict the use or disclosure of your medical information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

BCS Privacy Officer:	Privacy Officer
Telephone:	630-472-7752
Fax:	630-472-7754
E-mail:	privacyofficer@bcsgroup.com
Address:	BCS Insurance Company 2
	Mid America Plaza, Suite 200
	Oakbrook Terrace, IL 60181

REIMBURSEMENT AND SUBROGATION

Company will be entitled to a full refund of all Benefits it has paid up to the amount of such recovery. Further, BCS Insurance Company has the right to offset subsequent benefits payable to the Covered Person under the Policy against such recovery. BCS 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 BCS Insurance Company may be reduced on a pro-rata basis by the costs, disbursements and reasonable attorney's fees and other expense incurred obtaining recovery.