**STUDENT INSURANCE PLAN 2011-2012**

**POLICY # 124-125-090-P**

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### CLAIM PROCEDURE

In the event of injury or sickness, the Insured Student should:

1. **REPORT AT ONCE** to the STUDENT HEALTH SERVICE, when on campus.
2. If you are off campus and unable to report to the Health Service, then secure treatments at the nearest Hospital or Doctor’s office, pay the charges, if you wish, and obtain a receipt. Report immediately to the Health Service and follow instructions for filing your claim.
3. Obtain a claim form from the Health Service.

### ELIGIBILITY

The Company maintains the right to investigate student status and attendance records to verify that policy eligibility requirements have been met. If the Company discovers that the policy eligibility requirements have not been met, our only obligation is refund of premium. Eligibility requirements must be met each time a premium is paid to continue coverage. Eligible dependents shall be the student’s spouse and all dependent children under the age of 19 years and who reside with the Insured Student. Dependents can only enroll in this Plan at the time the student enrolls in the plan.

Newborn children are covered for injury or sickness from birth until 31 days old. Coverage may be continued for that child when we are notified in writing within 31 days from the date of birth and required premium is paid.

For students who are age 35 or over, the rates are increased by the following percentages:

- Students ages 35-44: 90%
- Students ages 45-54: 70%
- Students ages 55-64: 100%

**Premium Refunds**

No premium refunds are permitted except when the student enters full-time active military service in which case a pro-rata refund will be made upon request.

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**Notice of Privacy Practices For Protected Health Information:**

You have the right to request this notice in writing once every 3 years starting from the date of your initial enrollment at the school by writing to: First Agency, Inc., 5071 West H Avenue, Kalamazoo, MI 49009-8501.

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**Underwritten by:**

Guarantee Trust Life Insurance Company

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**Prairie State College**

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**STUDENT ACCIDENT AND SICKNESS INSURANCE PLAN**

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**2011-2012**

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**NOTE**

PLEASE BE SURE TO RETAIN THIS BROCHURE, AS IT OUTLINES THE PROVISIONS OF THE MASTER POLICY WHICH IS ON FILE AT THE COLLEGE.

ANY DISCREPANCY BETWEEN THIS BROCHURE AND THE MASTER POLICY WILL BE GOVERNED BY THE MASTER POLICY.

NO INDIVIDUALPOLICIES WILL BE ISSUED.
EXCESS PROVISION

Even if you have other insurance, the Policy may cover unpaid balances, deductibles and pay those eligible medical expenses not covered by other insurance. Benefits will be paid on the unpaid balances after your other insurance has paid. No benefits are payable for any expense incurred for Injury or Sickness which is paid or payable by any other valid and collectible insurance. However, this excess provision will not be applied to the first $100 of medical expenses incurred.

BASIC MEDICAL EXPENSE BENEFITS

When a covered Injury or Sickness requires treatment by a doctor, payment will be made for the medically necessary reasonable and customary expense, as allocated below, incurred while coverage is in force during the Policy year, up to a maximum benefit of $5,000. Treatment of Injury must begin within 30 days of covered accident. Covered Charges paid under the Basic Medical Expense Benefit of this Policy shall not be paid under the Major Medical Expense Benefit of this Policy.

COVERED CHARGES, PER INJURY OR SICKNESS

1. Daily Room and Board Semi-Private in a hospital confined at a rate per day of: $200.00 $300.00
2. Miscellaneous Hospital Charges for the use of operating room, anesthesia, X-ray examination (not treatment), laboratory tests, drugs or medicines, therapeutic services or supplies when hospital confined and while receiving Room and Board Benefits above payable at 80%, up to a maximum of $1,000.00 $1,500.00
3. Surgical Operations in accordance with the Schedule, using a $75 fee, up to a maximum of $1,000.00 $1,500.00
4. Assistant Surgeon, payable at 20% of the surgery fee paid, up to a maximum of $1,000.00 $1,500.00
5. Administration of Anesthetics payable at 25% of the amount of the surgical operation, payable at a maximum of $1,000.00 $1,500.00
6. Dental Treatment for injury to natural teeth up to $300.00 $500.00
7. Medical services, drugs and devices approved by the FDA (if prescription drug coverage is provided), clinical breast examinations, pain therapy and medications for the treatment of breast cancer, non-FDA approved drugs for certain types of cancer; HPV vaccines; amino acid based elemental formularies; habilitative services for children under 19; shingles vaccinations for persons 60 or older; prenatal care; prescription inhalants; physical therapy for treatment of multiple sclerosis; treatment of infertility. All Illinois mandates are paid the same as any other sickness
8. Immunizations for the treatment of breast cancer; non-FDA approved drugs for certain types of cancer; HPV vaccines; amino acid based elemental formularies; habilitative services for children under 19; shingles vaccinations for persons 60 or older; prenatal care; prescription inhalants; physical therapy for treatment of multiple sclerosis; treatment of infertility. All Illinois mandates are paid the same as any other sickness
9. Consultant requested and approved by the attending doctor, up to $50.00 $100.00
10. Diagnostic X-ray and Laboratory Services when prescribed by the attending doctor, up to a maximum of $100.00 $150.00
11. Hospital Emergency Care Outpatient Emergency Care at Ambulance Service Health Service (if available) not including transportation, up to $100.00 $150.00

MAJOR MEDICAL EXPENSE BENEFITS

ACCIDENT AND SICKNESS PER INJURY OR SICKNESS

When the insured person, because of covered injury or sickness, actually incurs, within the Policy year, medically necessary reasonable and customary medical expense in excess of $5,000.00 for medically necessary treatment by a doctor, services of a registered graduate nurse, X-ray service, ambulance, or any hospital care or service (hospital room and board limited to a semiprivate rate), the Company will pay 80% of such expense up to a maximum of $15,000.00, benefits under the policy.

No benefits are payable under the major medical expense benefit due to traveling in and as a result of an automobile accident.

Illinois mandates coverage for the following benefits: Hospital confinement for mother and child for 48 hours following vaginal delivery and 96 hours following caesarean delivery. If shorter length of hospital stay, coverage includes a post-discharge doctor office visit or in-home nurse visit in the first 48 hours after delivery, initial prosthetic device and reconstructive surgery incident to mastectomy; mammograms at certain intervals; annual cervical smear or pap test; prostate specific anti-gen test at age 40 and older; outpatient diabetes self-management training; diabetes equipment and pharmaceuticals; colorectal cancer exams as the Schedule, in accordance with American Cancer Society guidelines; treatment of serious mental illness; treatment of alcoholism while hospital confined; autism spectrum disorders and medically necessary home and mass measures and diagnosis and treatment of osteoporosis the same as any other sickness; Outpatient contraceptive services, drugs and devices approved by the FDA (if prescription drug coverage is provided); clinical breast examinations; pain therapy and medications for the treatment of breast cancer; non-FDA approved drugs for certain types of cancer; HPV vaccines; amino acid based elemental formularies; habilitative services for children under 19; shingles vaccinations for persons 60 or older; prenatal care; prescription inhalants; physical therapy for treatment of multiple sclerosis; treatment of infertility. All Illinois mandates are paid the same as any other sickness

EXCLUSIONS AND LIMITATIONS

The policy does not cover any loss caused by or contributed to by:

1. Treatment, services or supplies which are not medically necessary; are not prescribed by a doctor as necessary to treat a sickness or injury; are determined to be experimental or investigational by the Company; are received without charge or legal obligation to pay; would not reasonably be paid in the absence of insurance; are received after September 30 of any Policy year; or are not provided by a doctor, licensed in the State in which treatment is provided; or
2. Expenses incurred as a result of loss due to war, or any action of war, declared or undeclared by the United States of America, or armed forces of any country;
3. Expenses incurred as a result of committing or attempting to commit an assault or battery or any act of violence;
4. Expenses incurred as a result of suicide or intentionally self-inflicted injury while sane or insane;
5. Injury or sickness arising out of or in the course of employment or which is compensable under any Workers' Compensation or Occupational Diseases Act or Law;
6. Cosmetic surgery other than: Reconstructive surgery, incidental to or following a covered injury or sickness, and
7. Treatment of mental or nervous disorders, except as specifically stated;
8. Expenses for preventative medicines, serums or vaccines, except where required for the treatment of injury;
9. Eye examinations, contact lenses, eyeglasses, replacement of eyeglasses or prescription, or keratitis of laser surgery;
10. Injury sustained while participating in practice or play of intercollegiate, club or amateur sports;
11. Expenses for services rendered by employees or doctors or any other persons employed or retained by the policyholder for the use of persons employed or retained by the policyholder;
12. Routine physical examinations and routine testing; preventive testing or treatment; and screening exams except as specifically stated;
13. Loss due to voluntarily using any drug, narcotic or controlled substance, unless as prescribed by a Doctor;
14. Injury caused by or resulting from being legally intoxicated, as defined by the jurisdiction in which an Accident occurs;
15. Congenital conditions, except as specifically provided for newborns or adopted infants;
16. Air travel, except a fare-paying passenger on a regularly scheduled flight of a commercial airline, parachuting, or travel in or upon any two-wheeled vehicle;
17. Outpatient prescription drugs;
18. Physiotherapy, except as specifically stated;

Pre-existing Conditions are not covered for the first 12 months following a covered person's effective date of coverage under the Policy. The limitation will not apply if (1) the covered person has been covered under the policy for more than 12 months; or (2) the individual seeking coverage under the policy has an aggregate of 18 months of creditable coverage and becomes eligible and applies to the policy within 30 days of completion of termination of prior creditable coverage. We will credit the time the individual was covered prior to prior creditable coverage; and (b) whose most recent prior creditable coverage was under an employer group health plan; and (c) who accepted and used COBRA continuation of coverage or similar state coverage if it was offered to him or her.

Pre-Existing Conditions - A pre-existing condition is a sickness or injury for which medical treatment, diagnosis, treatment or advice was received or recommended within the 12 months prior to the covered person's effective date of coverage under the policy or pregnancy existing on the covered person's effective date of coverage under the policy.