2011 • 2012

STUDENT ACCIDENT AND SICKNESS INSURANCE PLAN FOR THE STUDENTS OF

Indiana State University
More. *From day one.*

Policy Number
CLSP0019-11

Direct all inquiries regarding enrollment to:
ASSOCIATED INSURANCE PLANS INTERNATIONAL, INC.
Post Office Box 189
Libertyville, Illinois 60048

Pre-Certification is not required
Policy benefits are not guaranteed

Student Insurance Website:
www.MyISUInsurance.com
(800) 452-5772 • Fax (847) 281-8813
email: office@AIPStudentInsurance.com

Please contact us between the hours of 8:00 a.m. to 7:00 p.m. Central Standard Time.

Indiana State University 2011-2012
Student Accident and Sickness Plan Insurance Identification Card
Companion Life Insurance Company
NOTE: In a life threatening emergency, go to the nearest emergency room for treatment.

_____
Print name and school ID number

may be entitled to the benefits provided under the policy issued by Companion Life Insurance Company for the entire period for which premium has been paid, 24 hours per day, anywhere in the world. Coverage expires at 11:59 p.m. local time on the last dates for which premium has been paid. For term dates, see page 2, Periods of Coverage. Possession of this card does not guarantee benefits. Contact the Plan Administrator to verify coverage at (800) 452-5772.

Policy Number: CLSP0019-11
Direct all claim inquiries and correspondence to:
Administrative Concepts, Inc. Payor #: 22384
994 Old Eagle School Road, Suite 1005
Wayne, PA 19087-1802
(800) 452-5772 - 8 am-7 pm CST
www.MyISUInsurance.com

Office visits: $10 co-pay
Emergency Room: $100 co-pay

PHCS www.phcs.com 800-922-4362
Medco Health Prescription Services
$15/$25
www.medcohealth.com
Pharmacy Locations/Questions: (800) 400-0136

SCAN for a direct link to your student insurance website.

POLC11-12
COC 11-12

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ELIGIBILITY

Undergraduate students taking 6 or more credit hours (3 credits in the summer), graduate students taking 6 or more credit hours, international students, students on internship, graduate assistants, fellows and students working on completing their thesis or dissertation are eligible to enroll in the plan. Coverage will become invalid for students who leave school within 31 days of their Effective Date of coverage. The Servicing Agent should be notified at that time by the student. Students who enroll in the plan may secure family coverage. Dependents must enroll in the plan when the student first enrolls in the plan, and must enroll for the same coverage as the student. Eligible dependents means the insured student's legal spouse and unmarried children (as defined in the Master Policy) under 23 years old who are residing with the student and not self-supporting.

The Plan Administrator reserves the right to determine if the student has met the Eligibility requirements. If the Plan Administrator later determines the Eligibility requirements have not been met, its only obligation is to refund premium.

DEPENDENT ELIGIBILITY

Eligible students who enroll in the plan may also enroll their eligible dependents. Eligible dependents are the Insured Student's spouse residing with the Insured Student; or the Insured Student's unmarried Children if they are full-time students at an accredited school and dependent on the Insured Student for at least 50% of their financial support. Children must be fully supported by the Insured Student.

A child's coverage will not end because the child (a) is not able to earn his or her own living as a result of physical handicap or mental retardation; (b) became so handicapped before reaching the age limit; and (c) is chiefly dependent on the Insured Student for support and maintenance.

Within 31 days after the child reaches the age limit, the Insured Student must send us proof of the child's dependency or handicap. We may ask for more proof of the child's dependency and handicap, but We will not ask for proof more frequently than annually after the two year period following the child's attainment of the limiting age.

Any Dependent on active duty in any military, naval, or air force of any country is not eligible for coverage under this Policy. Dependent eligibility expires concurrently with that of the Insured Student.

EFFECTIVE DATES

The coverage takes effect as of August 22, 2011. It continues in force until August 21, 2012. Subject to Our consent, this coverage may be renewed for like periods by the payment, within the grace period provided in the General Provisions Section, of the renewal premium at the premium rate then in force. We reserve the right to adjust the premium rate on the first anniversary of the Policy Effective Date. We will give Indiana State University at least sixty days prior written notice. We also reserve the right to refuse to renew this Policy.

You must meet the Eligibility Requirements listed in the Eligibility Section to continue insurance coverage. To avoid a lapse in coverage, your premium payment must be received within 14 days after the date your coverage terminates, based upon the premium payment method selected.

EFFECTIVE DATES (CONTINUED)

NOTE: Renewal premium notices will be mailed to the address provided however, it is your responsibility to submit premium prior to expiration date in order to avoid a lapse in coverage. You must re-enroll in the insurance plan. We do not automatically debit your card.

It is important to update all address changes with the Plan Administrator, (800) 452-5772, or by sending an email through the Internet Site: **www.MyISUInsurance.com**

EFFECTIVE AND TERMINATION DATES OF INDIVIDUAL COVERAGE

EFFECTIVE DATE OF INSURED PERSON'S COVERAGE

The insurance of each Eligible Student shall take effect as follows: (a) If an Eligible Student enrolls on or before the Policy Effective Date, coverage will begin on the Policy Effective date; (b) If an Eligible Student enrolls after the Policy Effective Date but within the Allowed Application Period, coverage will begin on the Policy Effective Date or the start of the term or semester in which the student has enrolled; (c) If an Eligible Student enrolls after the Allowed Application Period, coverage will begin on the day after the enrollment card is received; or (d) If an Eligible Student enrolls on or before the Policy Effective Date and such student is a participant in intercollegiate sports or a school sponsored activity or requirement, coverage will begin on the date the eligible student is required to be on campus.

PERIODS OF COVERAGE

If paying premiums other than Annual, coverage will be in effect as shown below.

Full Policy Year:	August 22, 2011 through August 21, 2012
Enrollment Ends:	October 15, 2011
Policy Year Paid by Semester Fall Semester:	August 22, 2011 through January 8, 2012
Enrollment Ends:	October 15, 2011
Policy Year Paid by Semester Spring Semester:	January 9, 2012 through May 15, 2012
Enrollment Ends:	March 15, 2012
Policy Year Paid by Semester Spring & Summer:	January 9, 2012 through August 21, 2012
Enrollment Ends:	March 15, 2012
Policy Year Paid by Semester Summer Semester:	May 16, 2012 through August 21, 2012
Enrollment Ends:	June 15, 2012
Monthly Payment for Full Policy Year Coverage (Auto Debit Only)	Initial payment due at the time of enrollment into the plan. Subsequent payments debited from your account on the 22nd of each month through July 22, 2012.
Enrollment Ends:	October 15, 2011 for Annual/ Fall Semester March 15, 2012 for Spring/Summer Semester

HOW DO I ENROLL IN THE INDIANA STATE UNIVERSITY STUDENT ACCIDENT AND SICKNESS INSURANCE PLAN

1. You may enroll via the Internet at: www.MyISUInsurance.com using an electronic check or major credit card.
2. You may complete the attached application, along with your credit card number and expiration date, or you may include a check/money order made payable to:

   Student Insurance Plan
   Post office box 189
   LIBERTYVILLE, ILLINOIS 60048

3. You may call us at (800) 452-5772 and pay by phone.

We accept American Express, Discover, Mastercard, and Visa credit cards, as well as your personal check.

TERMINATION DATE OF INSURED PERSON'S COVERAGE

The insurance for an Insured Person shall terminate on the first of the following dates: (a) on the date this Policy is terminated; or (b) on the premium due date if the required premium for the Insured Person is not paid, except as a result of inadvertent error; or (c) as of the date the Insured Person enters military service, in which case a pro-rata refund of premium will be made to such Insured Person; or (d) on the date the Insured Person no longer qualifies under the Description of Class as shown in the Schedule of Eligible Classes; or (e) on the last day the Insured Student is required to be on campus at Indiana State University or, if the Indiana State University has so elected, the anniversary of the Indiana State University's Policy.

Termination of Insurance for an Insured Person shall be without prejudice to any claim which starts prior thereto.

LATE ENROLLMENT FOR DEPENDENTS

An Eligible Student may add his or her Dependent as a late enrollee:
(a) when he or she marries. The application for coverage must be submitted within 31 days of the date of marriage. Coverage will be effective on the date of the marriage. Payment for the full semester is required even if the spouse is enrolled after the term has begun; (b) when he or she acquires a Dependent child through birth, adoption or guardianship decree. The application must be submitted within 31 days of the date the child is born, adopted or acquired through decree. Coverage will be effective as of the date of birth, adoption or guardianship; and (c) when his or her Dependent arrives from a foreign homeland. The application for coverage must be submitted within 31 days of the date of the Dependent's arrival from the foreign homeland. Coverage will be effective as of the date of the Dependent's arrival following direct travel from the homeland.

If the Eligible Student does not add a new Dependent within 31 days of the date the Dependent becomes eligible for coverage, he or she must wait until the following school term to add the Dependent for coverage.

IMPORTANT FOR ANNUAL ENROLLEES WHO ELECT MONTHLY PAYMENT

Monthly premium payment is available for policy year coverage, but on an AUTOMATIC DEBIT basis only, for the ENTIRE policy year. Students interested in coverage for a term other than the complete policy year should elect an option for payment other than monthly. Please note there is no provision for cancellation other than upon entrance into the Armed

IMPORTANT FOR ANNUAL ENROLLEES WHO ELECT MONTHLY PAYMENT (CONTINUED)

Forces. Students who elect monthly payment, whose coverage lapses (because of insufficient funds) during the Policy Year, WILL NOT be permitted to continue the monthly payment option, and will be required to wait until the next open enrollment period to reapply for these benefits.

NEWBORN CHILDREN

Coverage for newborn children will consist of coverage for Sickness or Accident, including necessary care or treatment of congenital defects, birth abnormalities, or premature birth. Such coverage will start from the moment of birth, if the Insured Student is already insured for dependent coverage when the child is born. If the Insured Student does not have dependent coverage when the child is born, We cover the newborn child for dependent benefits from and after the moment of birth, or any minor child placed with an Insured Student for adoption for dependent benefits from and after the moment the child is placed in the physical custody of the Insured Student for adoption. To continue the newborn child's dependent benefits past the first 31 days, the Insured Student must notify Associated Insurance Plans International, Inc. in writing within 31 days of the child's birth.

REFUND POLICY

There is no provision for cancellation other than upon entry into the Armed Forces or for medical withdrawal due to a covered Injury or Sickness. Any student withdrawing from school during the first 31 days of the period for which coverage is purchased (annual, fall, spring, or summer) shall not be covered under the Policy and a full refund of the payment will be made. Such a student will not be entitled to any benefits during the days preceding withdrawal, and no claims received will be honored. Students withdrawing after such 31 days will remain covered under the Policy for the full period for which the payment has been paid and no refund will be available. Pro-rata refunds will be made upon the entry of any insured person into the Armed Forces of any country. **NO OTHER REFUNDS WILL BE PERMITTED.**

CONTINUATION OF COVERAGE

Continuation of coverage is offered to students and their dependents should they become ineligible to continue the Indiana State University Student Health Insurance Plan for up to 9 months. The benefits and Provisions will be similar to the Student Health Insurance Plan, but premium will be higher. Application must be made within 31 days of termination of the Student Health Insurance. Please contact (800) 452-5772 for information.

CERTIFICATE OF HEALTH PLAN COVERAGE

If your coverage terminates, the Insured should request a Certificate of Health Plan Coverage from Associated Insurance Plans International, Inc. This request can be made by phone or in writing through the Student Insurance website: **www.MyISUInsurance.com**. This request must include the name of the school and the name of each person who is no longer eligible under the Plan. If mailed, direct your request to Associated Insurance Plans International, Inc., Post Office Box 189, Libertyville, IL 60048, (800) 452-5772.

Indiana State University
More. From day one.

STUDENT HEALTH INSURANCE PLAN
SCHEDULE OF BENEFITS 2011-2012

OPTION 1: INJURY AND SICKNESS COVERAGE TO $500 EACH POLICY YEAR

Injury and Sickness Coverage to $500 each policy year. This plan has been developed to provide "first dollar" coverage for students and is designed to coordinate with the insurance benefits provided under Option 2, which contains a $500 deductible. Option 1 is available on a stand-alone basis, or Option 1 may be purchased in addition to Option 2.

COVERED SERVICES (Provided under Option I)

a. Zero Deductible.
b. Benefits are paid at 80% when treatment is received by a Preferred Provider and at 60% when treatment is received by a Non-Preferred Provider.
c. Covered medical expenses are those expenses for doctors and surgeons, hospital confinement, physical therapy, x-rays, laboratory tests, nurses, casts, surgical dressings, use of an ambulance, and other medically necessary expenses incurred during the term Insured.
d. Outpatient visit to a Physician will be subject to a $10 co-payment.
e. Prescription Drugs are covered to $100 each policy year. Please submit receipts and claim form for reimbursement.
f. Maximum Benefit provided under Option 1 is $500 each policy year.

OPTION 2: INJURY AND SICKNESS BENEFITS COVERAGE: $250,000 PER ACCIDENT OR SICKNESS

When your covered Injury or Sickness requires treatment by a Physician or Hospital, the policy will provide benefits while your coverage is in force for the percentage shown of the PPO negotiated fee for covered services received from a Preferred Provider, or the percentage shown of the Reasonable and Customary Charges (R&C) incurred for covered services received from a Non-Preferred Provider, or as scheduled below, **up to a Lifetime Maximum Benefit of $250,000** for Each Injury or Sickness. Eligible expenses are subject to $500 Deductible per person, per Policy year unless benefits under Option 1 have been purchased. Benefits will not be provided for services which are not listed in the Medical Benefits Schedule or the Master Policy.

COVERED SERVICES (Provided under Option 2)	IN NETWORK (Preferred Provider)	OUT OF NETWORK (Non-Preferred Provider)
I. INPATIENT		
a. HOSPITAL ROOM AND BOARD AND HOSPITAL MISCELLANEOUS (semi-private room rate including general nursing care)	80%	60%
b. SURGICAL TREATMENT up to $2,500	80%	60%
c. ANESTHETIST AND ASSISTANT SURGEON	30% of Surgical Treatment Benefit	30% of Surgical Treatment Benefit
d. PHYSICIAN'S NON-SURGICAL VISITS 1 visit per day, not paid day of surgery	80%	60%
e. MENTAL AND NERVOUS DISORDERS $50 copay per confinement, up to $10,000 per Policy Year	Same as any Sickness	Same as any Sickness
f. SUBSTANCE ABUSE $50 copay per confinement, up to $10,000 per Policy Year	Same as any Sickness	Same as any Sickness
g. PRE-ADMISSION TESTING	80%	60%
COVERED SERVICES (Provided under Option 2)	**IN NETWORK (Preferred Provider)**	**OUT OF NETWORK (Non-Preferred Provider)**
II. OUTPATIENT		
a. HOSPITAL OUTPATIENT SURGICAL MISCELLANEOUS, up to $2,500	80%	60%
b. SURGICAL TREATMENT, up to $2,500	80%	60%
c. ANESTHETIST AND ASSISTANT SURGEON	30% of Surgical Treatment Benefit	30% of Surgical Treatment Benefit
d. PHYSICIAN'S NON-SURGICAL VISITS 1 visit per day, not paid day of surgery $10 copay per visit; plus an additional $15 deductible applies per visit.	80%	60%
e. PHYSIOTHERAPY 1 visit per day, $25 copay per visit, up to 10 visits	80%	60%
f. HOSPITAL EMERGENCY ROOM (copay is waived if admitted) $100 copay per visit, up to $1,000	80%	60%
g. DIAGNOSTIC X-RAY AND LAB SERVICES up to $1,000	80%	60%
h. MENTAL AND NERVOUS DISORDERS $25 copay per visit, up to 20 visits	80%	60%
i. SUBSTANCE ABUSE $25 copay per visit, up to 20 visits	80%	60%
j. PRESCRIPTION DRUGS: 30 day supply per prescription; not subject to deductible; (refer to the Medco Prescription Drug Card) up to $600 per Policy Year	$15 copay per Generic Drug; $25 copay per Brand Drug	No Benefit
COVERED SERVICES (Provided under Option 2)	**IN NETWORK (Preferred Provider)**	**OUT OF NETWORK (Non-Preferred Provider)**
III. OTHER		
a. AMBULANCE SERVICES (professional ground service)	$300	$300
b. ORTHOPEDIC BRACES AND DURABLE MEDICAL EQUIPMENT up to $200 per Policy Year	80%	80%
c. HIGH COST PROCEDURE (CAT Scans and MRI)	80%, up to $1,250 per procedure	60%, up to $1,000 per procedure
d. CONSULTANT PHYSICIAN (when requested by the attending physician) after $25 copay per visit	80%	60%
e. DENTAL TREATMENT (Injury to sound, natural teeth, includes X-rays, does not up to $1,000/Policy Year include biting or chewing injuries)	80%	80%
f. WELL BABY CARE (immunizations and screening tests)	80%	60%
g. MATERNITY BENEFITS	Same as any Sickness	Same as any Sickness
h. MOTOR VEHICLE INJURY	Same as any Injury	Same as any Injury
i. IMMUNIZATIONS (administered at Student Health Center only for Student only; not subject to deductible)	80% after $10 copay per immunization up to $200 per Policy Year	No Benefit

NOTE: Enrollment deadlines, Definitions, and Exclusions outlined in this brochure apply to both Option 1 and Option 2.

PHCS PREFERRED PROVIDER NETWORK

Persons insured under this Plan may choose to be treated within, or out of, the Preferred Provider Network. The Preferred Provider Network consists of hospitals, doctors, and other health care providers, which are organized into a network for the purpose of delivering quality health care at a preferred fee. Reimbursement rates will vary according to the source of care, as described under the Description of Benefits herein.

When an Insured Person uses the services of a PHCS Preferred Provider Network provider, the covered expenses incurred will be payable at 80% of PPO Allowance. However, when treatment is rendered by providers outside the PHCS Preferred Provider Network, expenses will be payable at 60% of Reasonable and Customary Covered Charges.

Assignment of a network Doctor does not guarantee eligibility or the right to Student Health Benefits.

In order to use the services of a participating provider, you must present your Companion Life Insurance Company Medical Identification Card that is provided to all students insured under the Indiana State University Student Accident and Sickness Insurance Plan.

You should always confirm that a Preferred Provider is participating at the time services are required (by asking the provider when you make an appointment for service).

A complete listing of participating providers are available on the Student Insurance website: **www.MyISUInsurance.com.**

PRE-EXISTING CONDITIONS LIMITATION

"Pre-existing Condition" means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the Effective Date of the Insured Person's coverage under this Policy. The term does not include genetic information in the absence of a diagnosis of the condition related to such information.

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

The Pre-existing Condition Waiting Period will be reduced by the aggregate period of Creditable Coverage of the Insured Person, if the Creditable Coverage was continuous to a date not more than 63 days before the Effective Date of the coverage.

Payment will be in accord with the provisions of this Policy. If the Insured Person has a lapse in coverage of more than 63 days, the Pre-existing Condition Waiting Period will have to be satisfied again.

PRE-EXISTING CONDITIONS LIMITATION (CONTINUED)

The Pre-existing Condition Waiting Period will not apply:

(a) To pregnancy.

(b) In the case of an Insured Person who, as of the last day of the 30-day period beginning on the date of his birth, is covered under Creditable Coverage.

(c) In the case of a child who is adopted or placed for adoption before attaining the age of 18 years and who, as of the last day of the 30-day period beginning on the date of adoption or placement for adoption, whichever is earlier, is covered under Creditable Coverage. The provisions of this paragraph do not apply to coverage before the date of adoption or placement for adoption.

(d) In the case of a condition for which medical advice, diagnosis, care or treatment was recommended or received for the first time while the Insured Person held Creditable Coverage, and the medical advice, diagnosis, care or treatment was a benefit under the plan, if the Creditable Coverage was continuous to a date not more than 63 days before the Effective Date of the new coverage.

The provisions of paragraphs (b) and (c) do not apply to an Insured Person after the end of the first 63-day period during all of which the Insured Person was not covered under any Creditable Coverage.

Definition:

"Creditable Coverage" means health benefits or coverage provided to a person pursuant to:

(a) A group health plan;
(b) A health benefit plan;
(c) Part A or Part B of the Title XVIII of the Social Security Act, 42 U.S.C. Sec, 1395c et seq., also known as Medicare;
(d) Title XIX of the Social Security Act, 42 U.S.C. Sec. 1396 et esq., also known as Medicaid, other than coverage consisting solely of benefits under Sec. 1928 of that Title, 42 U.S.C. Sec.1392s;
(e) The Civilian Health and Medical Program of Uniformed Services, CHAMPUS, 10 U.S.C. Sec. 1071 et seq.;
(f) A medical care program of the Indian Health Service or of a tribal organization;
(g) A state health risk pool;
(h) A health plan offered pursuant to the Federal Employees Health Benefits Program, FEHBP, 5 U.S.C. Sec. 8901 et seg.;
(i) A public health plan. A public health plan means any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in this plan, as defined in 45 C.F.R. Sec. 146.113, authorized by the Public Services Act, 42 U.S.C. Sec. 300 gg(c)(1)(I);
(j) A health benefit plan under insurance program established pursuant to 42 U.S.C. Sec. 2504(e);
(k) The children's health insurance program established pursuant to 42 U.S.C. Sec 1397aa 1397jj, inclusive;
(l) A short-term health insurance policy; or
(m) A blanket accident and health insurance policy.

MEDCO HEALTH – PRESCRIPTION DRUG CARD

Prescriptions purchased through the Medco Health Network including contraceptive medication, will be covered, subject to the applicable co-payment. For a complete list of pharmacy providers, please visit the Student Insurance website: **www.MyISUInsurance.com**.

NOTE: The prescription drug card benefit is through the Medco Pharmacy Program. The Medco Pharmacy Network includes national chains such as CVS and Walgreens, as well as local pharmacies. When you need to have a prescription filled, present your insurance ID card at a participating pharmacy. You will pay a co-payment for your medications. The pharmacy will submit additional charges to the Insurance Company. The plan will pay a maximum of $600 per Policy Year towards prescription medication filled through the Medco Pharmacy Benefit.

Medco Drug Card co-payments applicable per prescription:
$15 generic medication
$25 brand medication

PHARMACY CO-PAYMENT DEFINITIONS

GENERIC DRUG: A medication duplicated by another company once the patent expires.

BRAND DRUG: A medication developed by a pharmaceutical company.

TRAVEL ASSISTANCE FOR ALL STUDENTS

Included in this health insurance program is access to a 24-hour worldwide assistance network for emergency assistance anywhere in the world. Simply call the assistance center collect. 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.

TRAVEL ASSISTANCE FOR ALL STUDENTS (CONTINUED)

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 Indiana State University Student Accident and Sickness 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 1-800-850-4556, in the U.S. or Canada, or collect outside the U.S. and Canada, 603-328-1713.

Contact On Call International for any of these services:
Toll Free from U.S. and Canada: 1-800-850-4556
Dial Direct or Call Collect Worldwide: 1-603-898-9159
Contact us online: www.MyISUInsurance.com
and "Click" on On Call International.

REPATRIATION OF BODY REMAINS EXPENSE BENEFIT

This benefit applies only to Domestic Students while Studying Abroad, International Students, and their Dependents. In the event of the death of an Insured Person, We will pay the actual charges for the Covered Expenses for the preparation and transportation of the Insured Person's remains to his or her Home Country. This will be done in accordance with all legal requirements in effect at the time the body remains are to be returned to his or her Home Country. The death must occur while the person is insured for this benefit. The benefit will be paid up to a maximum of $7,500. You must first seek approval from the Company Claim Office, (888) 293-9229.

EMERGENCY MEDICAL EVACUATION EXPENSE BENEFIT

This benefit applies only to Domestic Students while studying abroad, International Students and their Dependents. This benefit will pay benefits for the Covered Percentage of the Covered Charges incurred, if any Injury or Sickness results in the Emergency Medical Evacuation of the Insured Person. The benefit will be paid up to a maximum of $10,000. You must first seek approval from the Claim Office, (888) 293-9229.

DEFINITIONS FOR OPTION 1 & 2

Accident means a specific unforeseen event, which happens while the Insured Person is covered under this Policy and which directly, and from no other cause results in an Injury.

Children includes an Insured Student's biological children; step-children; adopted children from the date of placement in the Insured Student's home and who depend on the Insured Student for their full support.

Claim Form is a form that must be completed and sent to the claim office when any medical/dental expenses are incurred. This claim form is available at **www.MyISUInsurance.com**.

Coinsurance means the percentage of Reasonable and Customary Expenses for which the Insured Person is responsible for a covered service.

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

Co-payment means the specified dollar amount an Insured Person must pay for specified charges. The co-payment is separate from and not a part of the Deductible or Coinsurance.

Covered Percentage means that part of the Covered Charge that is payable by the Company after the Deductible or Co-payment has been met.

Deductible means the amount of Expenses for covered services and supplies which must be incurred by the Insured Person before specified benefits become payable.

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

Elective Treatment means medical treatment, which is not necessitated by a pathological change in the function or structure in any part of the body occurring after the Insured Person's Effective Date of coverage. Elective Treatment includes, but is not limited to: tubal ligation; vasectomy; breast reduction; breast implants; sexual reassignment surgery; impotence (organic or otherwise); submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered chronic purulent sinusitis; treatment for weight reduction; learning disabilities; immunizations; treatment of infertility and routine physical examination.

Hospital means a facility which meets all of these tests:

(a) it provides inpatient services for the care and treatment of injured and sick people; and (b) it provides room and board services and nursing services 24 hours a day; and (c) it has established facilities for diagnosis and major surgery; and (d) it is supervised by a Doctor; and (e) it is run as a Hospital under the laws of the jurisdiction in which it is located. Hospital does not include a place run mainly: (a) for alcoholics or drug addicts; (b) as a convalescent home; (c) as a nursing or rest home; or (d) as a hospice facility.

DEFINITIONS FOR OPTION 1 & 2 (CONTINUED)

Hospital Confinement means a stay of 18 or more consecutive hours as a resident bed-patient in a Hospital.

Injury means bodily injury caused by an accident, which is the sole cause of the Loss. All injuries due to the same or related cause are considered one Injury.

Insured Person means an Insured Student and their covered Dependent(s) while insured under this Plan.

Insured Student means a student of Indiana State University who is eligible and insured for coverage under this Plan.

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

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

Medically Necessary means that a service, drug or supply is needed for the diagnosis or treatment of an Injury or Sickness in accordance with generally accepted standards of medical practice in the United States at the time the service, drug or supply is provided. A service, drug or supply shall be considered "needed" if it: (a) is ordered by a licensed Doctor; and (b) is commonly and customarily recognized through the medical profession as appropriate for the particular Injury or Sickness for which it was ordered. A service, drug or supply shall not be considered as Medically Necessary if it is investigational, experimental, or educational.

Non-Network Providers have not agreed to any pre-arranged fee schedules.

Policyholder means the institution indicated on the face page of this Policy.

Policy Year means the 12 month period beginning on the Policy Effective Date.

Reasonable and Customary Expense means fees and prices generally charged within the locality where performed for medically necessary services and supplies required for treatment of cases of comparable severity and nature.

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

We, Us or Our means Companion life Insurance Company.

You, Your or Yours means the Insured Student.

REIMBURSEMENT & SUBROGATION

If We pay covered expenses for an accident or injury You incur as a result of any act or omission of a third party, and You later obtain recovery from the third party, You are obligated to reimburse Us for the expenses paid. We may also take subrogation action directly against the third party. Our Reimbursement rights are limited by the amount You recover. Our Reimbursement and Subrogation rights are subject to deduction for the pro-rata share of Your costs, disbursements and reasonable attorney fees. You must cooperate with and assist Us in existing Our rights under this provision and do nothing to prejudice Our rights.

EXTENSION OF BENEFITS

If an Insured Person is confined to a Hospital on the date his or her insurance terminates, charges incurred during the continuation of that Hospital Confinement shall also be included in the term "Expense", but only while they are incurred during the 30 day period following such termination of insurance.

If an Insured Person is not confined to a Hospital on the date his or her insurance terminates, charges incurred during the next 31 days shall also be payable under this Plan, but only for a Sickness or Injury for which covered expenses were incurred before the termination date.

EXCLUSIONS FOR OPTIONS 1 & 2

The Plan does not cover nor provide benefits for unless otherwise provided within the Schedule of Benefits or Master Policy:

1. Services normally provided without charge by Indiana State University's student health service center, infirmary, or Hospital, or by Health Care Providers employed by Indiana State University;
2. Organ transplants, except as specifically provided;
3. Pre-existing Conditions as defined in this Policy.
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. Illness, Accident, treatment or medical condition arising out of the play or practice of or traveling in conjunction with intercollegiate sports and professional sports;
6. Injury resulting from motor vehicle accident to the extent that benefits are payable under any automobile medical expense insurance or automobile no-fault plans;
7. 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 child which has resulted in a functional defect;
8. Illness, Accident, treatment or medical condition arising out of hang-gliding, skydiving, glider flying, parasailing, sail planing, bungee jumping, racing or speed contests, skin diving, parachuting or bungi-cord jumping;
9. Injury or Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law;
10. Expense incurred as the result of dental treatment, except as provided in the Sickness Dental Expense Benefit, if included in this Policy. This exclusion does not apply to treatment resulting from Injury to sound natural teeth;
11. Injury or Sickness resulting from declared or undeclared war; or any act thereof;

EXCLUSIONS FOR OPTIONS 1 & 2 (CONTINUED)

12. 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 Lasic or other vision procedures except as required for repair caused by a covered Injury;
13. An amount of a charge in excess of the Reasonable and Customary Expense;
14. Elective Treatment or elective surgery, except as specifically provided;
15. Services not Medically Necessary;
16. Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route;
17. Intentionally self-inflicted injury;
18. Voluntary or elective abortion, except as specifically provided;
19. Nicotine addiction;
20. Patient controlled anesthesia.

COORDINATION OF BENEFITS

The Policy will coordinate benefits as outlined in the Master Policy on file at the University's Business Office.

COMPLAINT RESOLUTION

Insured persons or their representatives may call the Customer Service Department with questions or complaints at (800) 452-5772. If the question or complaint is not resolved to the satisfaction of the complainant, the complainant may submit a written request to the claims review committee, which will make a thorough investigation and respond to the complainant in a timely manner. The Company will not retaliate against the complainant because of the complaint.

APPEALS

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

HOW DO I OBTAIN MY IDENTIFICATION CARD?

1. You may detach and retain the temporary Identification Card provided on the brochure.
2. You may obtain your permanent Identification Card on the internet at: **www.MyISUInsurance.com** "Click" on Print ID Card. You will need to provide your name, student identification number, and birth date. If you experience any difficulty, please call us at (800) 452-5772.
3. You may call (800) 452-5772 and request that your permanent Identification Card be mailed to you.

HOW DO I FILE A CLAIM UNDER MY STUDENT ACCIDENT AND SICKNESS INSURANCE PLAN?

Should an Injury or Sickness occur, the following steps should be taken:

1. Secure the necessary medical treatment. A listing of Preferred Providers is available at: **www.MyISUInsurance.com**
2. Obtain itemized bills from your physician or provider.
3. You must complete a claim form. Claim forms may be obtained on the Student Insurance website: **www.MyISUInsurance.com**
4. Please make certain all additional medical bills submitted show your name, school ID number, school, and description of medical condition. **Only one claim form, per condition, needs to be mailed.**
5. Mail the completed claim form and medical bills as soon as possible to:

Administrative Concepts, Inc.
994 Old Eagle School Road, Suite 1005
Wayne, PA 19087-1802
(800) 452-5772
Please contact between 8:00 a.m. and 7:00 p.m. C.S.T.

6. You may check the status of a claim you have already filed at **www.MyISUInsurance.com** and click on "Check Claims Online".

HOW DO I CHECK THE STATUS OF A CLAIM I HAVE ALREADY FILED?

1. Online Inquiry:

a.) go to: **www.MyISUInsurance.com** obtain your permanent Identification Card.

b.) After obtaining your Identification Card, click on "Check Claims Online."

c.) You will need to set up an account by providing your first and last name, your birthdate, your student identification number and the Policy number. This information should be on taken directly from your permanent Identification Card.

2. Telephone Inquiry: Call Administrative Concepts, Inc. at (888) 293-9229 between the hours of 8 a.m. to 4 p.m. CST.

HOW CAN I RECEIVE ASSISTANCE WITH A QUESTION OR PROBLEM?

Please call the Administrator, at (800) 452-5772, Monday through Friday, between the hours of 8:00 a.m. to 7:00 p.m. Central Standard Time, or email us through the Student Insurance website, **www.MyISUInsurance.com**. We appreciate hearing from you with your comments, questions, and concerns.

Any provision of the Policy, or the brochure, which is in conflict with the statutes of the state in which the Policy is issued, will be administered to conform with the requirements of the state statutes.

Please keep this brochure as a general summary of the insurance. The Master Policy contains all of the provisions, limitations, exclusions and qualifications of your insurance benefits, some of which may not be included in this brochure. If any discrepancy exists between the brochure and the Policy, the Master Policy will govern and control the payment of benefits. This brochure is based on Policy CLSP0018-11.

Medical Benefits Underwritten by:

Companion Life

Companion Life Insurance Company
Policy Number: CLSP0018-11

Claims should be mailed to:
Administrative Concepts, Inc.
994 Old Eagle School Road, Suite 1005
Wayne, PA 19087-1802
(800) 452-5772

Direct All Inquiries To:

AIP Associated Insurance Plans International, Inc.

Post Office Box 189
Libertyville, Illinois 60048
(800) 452-5772 • FAX (847) 281-8813
(e-mail) office@aipstudentinsurance.com
*Visit us and **enroll on the Web** at:*
www.MyISUInsurance.com

This brochure is a brief description of the Plan Benefits. The exact provisions governing the insurance are contained in the Master Policy issued to Indiana State University, on file at the Business Office.

HIPAA NOTICE OF PRIVACY PRACTICES FOR PERSONAL HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This is your Health Information Privacy Notice from COMPANION LIFE INSURANCE COMPANY (referred to as We or Us). This notice is effective April 14, 2003. This notice provides you with information about the way in which We protect Personal Health Information ("PHI") that We have about you. PHI includes individually identifiable information which relates to your past, present or future health, treatment or payment for health care services. This notice also explains your rights with respect to PHI. The Health Insurance Portability and Accountability Act ("HIPAA") requires Us to: Keep PHI about you private; provide you this notice of our legal duties and privacy notices with respect to your PHI; and follow the terms of the notice that are currently in effect.

Use and Disclosure of PHI

We obtain PHI in the course of providing and/or administering health insurance benefits for you. In administering your benefits, We may use and/or disclose PHI about you and your dependents. The following are some examples, however, not every use or disclosure in a category will be listed:

• **For Health Care Payment Purposes:** For example, We may use and disclose PHI to administer and process payment of benefits under your insurance coverage, determine eligibility for coverage, claims or billing information, conduct utilization reviews, or to another entity or health care provider for its payment purposes.

• **For Health Care Operations Purposes**: For example, We may use and disclose PHI for underwriting and rating of the plan, audits of your claims, quality of care reviews, investigation of fraud, care coordination, investigate and respond to complaints or appeals, provider treatment review and provision of services.

• **For Treatment Purposes.** For example, We may use and disclose PHI to health care providers to assist in their treatment of you. We do not provide health care treatment to you directly.

• **For Health Services.** For example, We may use your medical information to contact you to give you information about treatment alternatives or other health related benefits and services that may be of interest to you as part of large case management or other insurance related services.

• **For Data Aggregation Purposes.** For example, We may combine PHI about many insureds to make plan benefit decisions, and the appropriate premium rate to charge.

• **To You About Dependents**. For example, We may use and disclose PHI about your dependents for any purpose identified herein. We may provide an explanation of benefits for you or any of your dependents to you.

• **To Business Associates.** For example, We may disclose PHI to administrators who are contracted with Us who may use the PHI to administer health insurance benefits on our behalf and such administrators may further disclose PHI to their contractors or vendors as necessary for the administration of health insurance benefits. If your state has adopted a more stringent standard regarding any of the above uses or disclosures of your PHI, those standards will be applied.

Additional Uses or Disclosures. We may also disclose PHI about you for the following purposes:

- To comply with legal proceedings, such as a court or administrative order, subpoena or discovery requests.
- To law enforcement officials for limited law enforcement purposes.
- To a family member, friend or other person, for the purpose of helping you with your health care or with payment for your health care, if you are in a situation such as a medical emergency and you cannot give your agreement to the Plan to do this.
- To your personal representatives appointed by you or designated by applicable law.
- For research purposes in limited circumstances.
- To a coroner, medical examiner, or funeral director about a deceased person.
- To an organ procurement organization in limited circumstances.
- To avert a serious threat to your health or safety or the health or safety of others.
- To a governmental agency authorized to oversee the health care system or government programs.
- To the Department of Health and Human Services for the investigation of compliance with HIPAA or to fulfill another lawful request.
- To federal officials for lawful intelligence, counterintelligence, national security purposes and to protect the president.
- To public health authorities for public health purposes.
- To appropriate military authorities, if you are a member of the armed forces.
- In accordance with a valid authorization signed by you.

Your Rights Regarding PHI That We Maintain About You

You have various rights as a consumer under HIPAA concerning your PHI. You may exercise any of these rights by writing to Us in care of Associated Insurance Plans International, Inc., Post Office Box 189, Libertyville, IL 60048, Attn: HIPAA Privacy Office.

• You have the right to inspect and copy your PHI. If you request a copy of the information, We may charge a fee for the costs of copying, mailing or other supplies associated with your request.

• You have the right to ask Us to amend the PHI that is contained in a "designated record set", e.g., information used to make enrollment, eligibility, payment, claims adjudication and other decisions. You have the right to request an amendment for as long as we maintain the PHI. Requests must be made in writing and include the reason for the request. We may deny the request if the PHI is accurate and complete or if we did not create the PHI.

• You have the right to request a list of our disclosures of the PHI. Your request must state a time period, may not include dates before April 14, 2003 and may not exceed a period of six years prior to the date of your request. If you request more than one list in a year, We may charge you the cost of providing the list. We will notify you of the cost and you may withdraw or modify your request before any costs are incurred. Any list of disclosures provided by Us will not include disclosures made for payment, treatment or healthcare operations; made to you or persons involved in your care; incidental disclosures, authorized disclosures, for national security or intelligence purposes or to correctional institutions.

• You have the right to request to restrict the way We use or disclose PHI regarding treatment, payment or health care operations. You also have the right to request to restrict the PHI We disclose about you to someone who is involved in your care or the payment for your care. We are not required to agree to your request. If We do agree, We will comply with your request unless the information is needed to provide you emergency treatment. Your request must be in writing and state (1) what information you want to restrict; (2) whether you want to restrict our use, disclosure or both; and (3) to whom you want the restrictions to apply.

• Uses and disclosures of your PHI, other than those listed above, require prior written authorization from you. You may revoke that authorization at any time by writing to Us at the address at the end of this notice.

• You have the right to request that We communicate personal information to you in a certain way or at a certain location. Your request must specify how or where you wish to be contacted. We will comply with reasonable requests.

• You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice upon request. You may request a paper copy of this notice by calling Us at 800-452-5772 or submitting the request to COMPANION LIFE INSURANCE COMPANY, c/o Associated Insurance Plans International, Inc., Post Office Box 189, Libertyville, IL 60048, Attn: HIPAA Privacy Office.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with Us. When filing a complaint, include your name, address and telephone number and We will respond. All complaints must be submitted in writing to COMPANION LIFE INSURANCE COMPANY, c/o Associated Insurance Plans International, Inc., Post Office Box 189, Libertyville, IL 60048, Attn: HIPAA Privacy Office. You may also contact the Secretary of the Department of Health and Human Services. You will not be retaliated against for filing a complaint.

Changes To This Notice

We reserve the right to modify this Privacy Notice and our privacy policies at any time. If We make any modifications, the new terms and policies will apply to all PHI before and after the effective date of the modifications that We maintain. If We make material changes, We will send a new notice to insureds.

If you have any questions regarding this notice, please call 800-452-5772 or send your written questions to the address at the end of this notice. Please include your name, the name of your insurance plan, your policy/ID number or copy of ID card, your address and telephone number and We will respond.

ALL QUESTIONS AND REQUESTS REGARDING YOUR RIGHTS UNDER THIS NOTICE SHOULD BE SENT TO:

COMPANION LIFE INSURANCE COMPANY

c/o Associated Insurance Plans International, Inc.,
Post Office Box 189, Libertyville, IL 60048

Attn: HIPAA Privacy Office

OPTIONAL - ADDITIONAL PREMIUM REQUIRED DENTAL/VISION/PHARMACY *DISCOUNT PLAN*

Additional premium required (see rates listed below).

No Claim forms
No Waiting Periods
No Pre-existing Conditions
No Deductibles or Maximums
No Age Restriction
Discount is immediate at time of service
Over 100,000 participating providers nationwide

The Co-Health Group Collegiate plan has been specifically designed to meet the needs of today's College and University students, whether they are incoming freshmen, graduate, evening students, international or domestic students attending Indiana State University.

The Co-Health Benefit Plan provides discounts in certain health care areas not normally reimbursed by insurance. In the "Collegiate Plan" we are offering the Vision, Dental and Pharmacy Discount Program as a single package of Benefits, or you may purchase discounts for pharmacy or vision separately. Here's how the plan works.

This is not an Insurance Plan. The Co-Health Group Collegiate Plan is a Discount Care Plan offering discounts and savings for Vision, Dental and Prescription Pharmacy expenses.

Each of the benefit programs (Vision, Dental, and Prescription Pharmacy) has a network of Providers (for example, the participating dentists in the Dental Plan.) As a member of the Plan you can go to any of the providers listed and purchase their products or services on a negotiated discount basis. You receive your discount/savings on the spot. There are no exclusions for "pre-existing"conditions. There are no claim forms to fill out and no paperwork to be filed. Simply show your Co-Health membership card at the time of your scheduled appointment or at a participating pharmacy.

The discounts you will receive are substantial and these savings can be very important to you. The services that make up the Collegiate Plan (Vision, Dental and Pharmacy) are also the three most common areas where you will have unexpected expenses. With our Benefits, you can substantially reduce your out of pocket expenses, and as an added bonus, you can use our plan benefits anywhere in the United States, except the State of Washington.

You simply show your Co-Health ID Card and get your discount on the spot.

Annual Coverage Premiums - enroll anytime throughout the year at www.dentalvisionrxdiscount.com.

ANNUAL PREMIUMS Dental/Vision/Pharmacy	Credit Card or Internet Payment	Check by mail
Student Only	$72.00	$62.00
Family	$98.00	$88.00
Vision & Pharmacy		
Student Only	$50.00	$40.00
Family	$71.00	$61.00
Vision		
Student Only	$25.00	$15.00
Family	$30.00	$20.00
Pharmacy		
Student Only	$25.00	$15.00
Family	$30.00	$20.00

OPTIONAL, ADDITIONAL PREMIUM DENTAL AND VISION *INSURANCE PLAN*

(Additional premium required)

Underwritten by Security Life Insurance Company of America

- **Freedom to Use Dentist of Your Choice**
- **Up to $2,000 Annual Maximum**
- **Coverage for Adult Sealants**
- **Three Plan Design Options**
- **No Waiting Periods for Most Services**
- **Optional Vision Coverage for Additional Premium**

PERSONAL DENTAL PLANS

Dental Benefits	Elite Plan	Premier Plan	Select Plan
Class A - Preventive Services Initial & Periodic Exams (2 per year), Cleanings (2 per year), Fluoride Treatments (to age 16), Sealants (no age limitation)			
Benefit Year One	100%	100%	75%
Benefit Year Two	100%	100%	85%
Benefit Year Three and Each Benefit Year Thereafter	100%	100%	100%
Deductible - Lifetime per Insured	$50	$50	$50
Waiting Period	None	None	None
Class B - Basic Services X-rays, Fillings, Simple Extractions			
Benefit Year One	35%	35%	25%
Benefit Year Two	65%	50%	35%
Benefit Year Three and Each Benefit Year Thereafter	80%	65%	50%
Deductible - Lifetime per Insured	$50/year	$50/year	$50/year
Waiting Period	None	None	None
Class C - Major Services Oral Surgery, Endodontics, Periodontics, Crowns, Bridges, Dentures			
Benefit Year One	15%	10%	10%
Benefit Year Two	50%	25%	25%
Benefit Year Three and Each Benefit Year Thereafter	50%	50%	50%
Deductible - Lifetime per Insured	$50/year	$50/year	$50/year
Waiting Period	None	None	None
Class D - Orthodontic Services Straightening of Teeth (for children under age 19)			
Benefit Year One	N/A	0%	N/A
Benefit Year Two	N/A	0%	N/A
Benefit Year Three and Each Benefit Year Thereafter	N/A	50%	N/A
Deductible - Lifetime per Insured	—	None	—
Waiting Period	—	24 months	—

PERSONAL DENTAL PLANS (CONTINUED)

Dental Benefits	Elite Plan	**Premier Plan	Select Plan
Calendar Year Maximum for Classes A, B and C Combined	$1,000	$1,000	$1,000
Calendar Year Max. for Class C-Major Services	$500	$500	$500
Calendar Year Max. for Class D	—	$500	—
Lifetime Max. Per Child for Class D	—	$1,000	—
* Class B & C Deductible is combined for each calendar year. A maximum of three (3) individual deductibles per family shall apply.			
☆CALENDAR YEAR MAXIMUM INCREASE OPTIONS			
Option One (1) $1,500/Class C - Major Services limited to $750	☆$1,500	☆$1,500	☆$1,500
Option Two (2) $2,000/Class C - Major Service limited to $1,000	☆$2,000	☆$2,000	☆$2,000
**Optional Vision Benefits Rider (Not a Stand-Alone Benefit)			
Class A - Vision Exams - 1/year Benefit Year One and Each Benefit Year Thereafter No Waiting Period	100%	85%	85%
Class B - Lenses and Frames - 1 pair every 2 years Benefit Year One and Each Benefit Year Thereafter 15 Month Waiting Period	50%	50%	50%
Class C - Contact Lenses - 1 pair every 2 years (in lieu of frames and lenses) Benefit Year One and Each Benefit Year Thereafter 15 Month Waiting Period	50%	50%	50%
Calendar Year Deductible	$50/year	$50/year	$50/year
Calendar Year Maximum for Classes A, B and C	$200	$150	$150

☆Optional Feature

You may increase your Calendar Year Maximum Benefit, per individual, for an additional monthly fee. If you elect this feature, your Calendar Year Maximum for Major Services (Class C) will also increase. You must indicate your election of this feature on the enrollment form.

The above plans provide for an increase in coinsurance levels based upon each Benefit Year of coverage. Benefit Year begins with each insured's effective date and continues for 12 months. Each primary insured and dependent will have their own Benefit Year beginning with their specific effective date of coverage. This plan reimburses at the above percentages for covered dental expenses based upon the Reasonable and Customary (R&C) fees for those covered expenses.

QUESTIONS? PLEASE CALL 800-452-5772.
You do not need to purchase health insurance to enroll in the optional dental and vision insurance plan. Enroll online at www.MyISUInsurance.com.

PRIMESTAR PERSONAL DENTAL PREMIUM RATE TABLE FOR EFFECTIVE DATES APRIL 1, 2011 THROUGH OCTOBER 1, 2011

Monthly premiums illustrated are guaranteed for the initial twelve (12) months of coverage. Thereafter, premiums are likely to increase on a semi-annual basis.

Zip Code / Other IN / 463-464 / 473

RATE CHART			Area 1	Area 2	Area 3
UNDER AGE 65	ELITE	Applicant Only	$ 30.00	$ 33.00	$ 36.00
		Applicant+Spouse	$ 63.00	$ 69.00	$ 76.00
		Applicant+ Child(ren)	$ 69.00	$ 76.00	$ 83.00
		Applicant + Family	$ 106.00	$ 116.00	$ 128.00
	PREMIER	Applicant Only	$ 26.00	$ 28.00	$ 31.00
		Applicant+Spouse	$ 53.00	$ 58.00	$ 64.00
		Applicant+ Child(ren)	$ 62.00	$ 68.00	$ 75.00
		Applicant + Family	$ 94.00	$ 103.00	$ 113.00
	SELECT	Applicant Only	$ 24.00	$ 26.00	$ 29.00
		Applicant+Spouse	$ 46.00	$ 50.00	$ 55.00
		Applicant+ Child(ren)	$ 47.00	$ 52.00	$ 57.00
		Applicant + Family	$ 76.00	$ 84.00	$ 92.00
65 AND OVER	ELITE	Applicant Only	$ 34.00	$ 37.00	$ 41.00
		Applicant+Spouse	$ 71.00	$ 77.00	$ 85.00
	PREMIER	Applicant Only	$ 28.00	$ 31.00	$ 34.00
		Applicant+Spouse	$ 60.00	$ 66.00	$ 72.00
	SELECT	Applicant Only	$ 25.00	$ 27.00	$ 30.00
		Applicant+Spouse	$ 53.00	$ 58.00	$ 64.00

Optional Vision Rates for Under Age 65		
Elite Plan	Applicant Only	$ 6.00
	Applicant + Spouse	$ 13.00
	Applicant + Child(ren)	$ 13.00
	Applicant + Family	$ 17.00
Premier & Select Plans	Applicant Only	$ 5.00
	Applicant + Spouse	$ 10.00
	Applicant + Child(ren)	$ 10.00
	Applicant + Family	$ 13.00
Optional Vision Rates for Age 65 and Over		
Elite Plan	Applicant Only	$ 6.00
	Applicant + Spouse	$ 12.00
Premier & Select Plans	Applicant Only	$ 5.00
	Applicant + Spouse	$ 10.00

Call for rates if your permanent address is outside Indiana, or view online at **www.MyISUInsurance.com**.

Yes, I wish to participate in the Indiana State University Student Insurance Plan. I understand that I may purchase Option 1, Option 2, or Option 1 & 2 as oulined below. My check or money order payable to Student Insurance Plan for the coverage selected below is enclosed. Note: You may also enroll online at www.MyISUInsurance.com by using your checking, savings, debit or credit card accounts.

ANNUAL 8/22/2011-8/21/2012	**OPTION 1▲** *$500 PER POLICY YEAR	**OPTION 2❖** $500 TO $250,000 PER CONDITION	**OPTION 1 & 2** $500 PER POLICY YEAR AND $250,000 PER CONDITION
Student Only	☐ $96	☐ $ 955	☐ $1,051
Additional for Spouse	N/A	☐ $2,865	N/A
Additional for Child(ren)	N/A	☐ $1,910	N/A
Additional for Spouse and Child(ren)	N/A	☐ $4,775	N/A

FALL 8/22/2011-1/8/2012	**OPTION 1▲** *$500 PER POLICY YEAR	**OPTION 2❖** $500 TO $250,000 PER CONDITION	**OPTION 1 & 2** $500 PER POLICY YEAR AND $250,000 PER CONDITION
Student Only	☐ $48	☐ $ 377	☐ $425
Additional for Spouse	N/A	☐ $1,100	N/A
Additional for Child(ren)	N/A	☐ $ 733	N/A
Additional for Spouse and Child(ren)	N/A	☐ $1,833	N/A

SPRING & SUMMER 1/9/2012-8/21/2012	**OPTION 1▲** *$500 PER POLICY YEAR	**OPTION 2❖** $500 TO $250,000 PER CONDITION	**OPTION 1 & 2** $500 PER POLICY YEAR AND $250,000 PER CONDITION
Student Only	☐ $48	☐ $ 598	☐ $646
Additional for Spouse	N/A	☐ $1,765	N/A
Additional for Child(ren)	N/A	☐ $1,177	N/A
Additional for Spouse and Child(ren)	N/A	☐ $2,942	N/A

SUMMER ONLY 5/16/2012-8/21/2012	**OPTION 1▲** *$500 PER POLICY YEAR	**OPTION 2❖** $500 TO $250,000 PER CONDITION	**OPTION 1 & 2** $500 PER POLICY YEAR AND $250,000 PER CONDITION
Student Only	☐ $48	☐ $ 266	☐ $314
Additional for Spouse	N/A	☐ $ 767	N/A
Additional for Child(ren)	N/A	☐ $ 512	N/A
Additional for Spouse and Child(ren)	N/A	☐ $1,280	N/A

****MONTHLY FOR FULL POLICY YEAR (AUTO DEBIT ONLY ON THE 22ND OF EACH MONTH)**	**OPTION 1▲** *$500 PER POLICY YEAR	**OPTION 2❖** $500 TO $250,000 PER CONDITION	**OPTION 1 & 2** $500 PER POLICY YEAR AND $250,000 PER CONDITION
Student Only	N/A	☐ $ 95	☐ $105
Additional for Spouse	N/A	☐ $ 239	N/A
Additional for Child(ren)	N/A	☐ $ 169	N/A
Additional for Spouse and Child(ren)	N/A	☐ $ 398	N/A

▲OPTION 1: INJURY AND SICKNESS COVERAGE TO $500 EACH POLICY YEAR

Injury and Sickness Coverage to $500 each policy year. This plan has been developed to provide "first dollar" coverage for students and is designed to coordinate with the insurance benefits provided under Option 2, which contains a $500 deductible. Option 1 is available on a stand-alone basis, or Option 1 may be purchased in addition to Option 2.

❖OPTION 2: INJURY AND SICKNESS BENEFITS COVERAGE: $250,000 PER ACCIDENT OR SICKNESS

When your covered Injury or Sickness requires treatment by a Physician or Hospital, the policy will provide benefits while your coverage is in force for the percentage shown of the PPO negotiated fee for covered services received from a Preferred Provider, or the percentage shown of the Reasonable and Customary Charges (R&C) incurred for covered services received from a Non-Preferred Provider, or as scheduled below, **up to a Lifetime Maximum Benefit of $250,000** for Each Injury or Sickness. Eligible expenses are subject to $500 Deductible per person, per Policy year unless benefits under Option 1 have been purchased. Benefits will not be provided for services which are not listed in the Medical Benefits Schedule or the Master Policy.

* This benefit may be added at initial payment only. Once you have selected either Option 1 or Option 1 & 2, you must continue with the coverage selected for the entire policy year.

** This option is for full policy year coverage via an automatic debit from your checking, savings or credit card account. There is NO provision for cancellation unless admitted into the Armed Forces.

Renewal premium notices will be mailed to the address provided, however, it is your responsibility to submit premium prior to expiration date in order to avoid a lapse in coverage.

Insurance costs shown include an administrative fee.

THE INDIANA STATE UNIVERSITY STUDENT INSURANCE PLAN
ENROLLMENT CARD 2011-2012

Please Print Legibly

Student's Name _____
(First) (M) (Last)

Student I.D. # _____

Social Security # _____

Campus attending (important) _____

Billing Address:

Street _____ **Apt. No.** _____

City _____ **State** _____ **Zip** _____

☐ **Male** ☐ **Female** **Date of Birth** _____

Telephone No. _____

Alternate Telephone No. _____

Do you have any other medical insurance? ☐ YES ☐ NO.

If yes, name of insurance company: _____

E-mail Address (important!) _____

Spouse's Name _____

Date of Birth (mm/dd/yy) _____

Social Security # _____

Child _____ **Date of Birth (mm/dd/yy)** _____

Social Security # _____

Child _____ **Date of Birth (mm/dd/yy)** _____

Social Security # _____

Child _____ **Date of Birth (mm/dd/yy)** _____

Social Security # _____

☐ I have carefully read the brochure and elect to enroll as indicated. Rates are not pro-rated other than as listed. PLEASE MAKE SURE TO INDICATE COVERAGE DESIRED ON PAGE 13. My remittance in the amount of $_____is enclosed.

MONTHLY ENROLLEES…Please indicate which month you desire your coverage to begin _____(Month). Monthly enrollees: please complete Automatic Payment Authorization Form

Make check or money order payable to Student Insurance Plan.
Mail this enrollment card along with premium to:
Post Office Box 189, Libertyville, IL 60048

☐ **Please charge my Student Health Insurance: (Minimum charge of $25). You must re-enroll in the insurance plan each term.**

☐ **VISA** ☐ **DISCOVER** ☐ **MASTERCARD** ☐ **AMEX**

Card Number _____

3 or 4 digit security code _____ **Expiration Date**_____

Print name of cardholder _____

Cardholder signature _____

Please Charge $_____ **for Student Health Insurance.**

Student signature _____

Today's Date

NOTE: You may enroll "On-line" and pay your premium by electronic check or major credit card at **www.MyISUInsurance.com**

THE INDIANA STATE UNIVERSITY STUDENT INSURANCE PLAN
AUTOMATIC PAYMENT AUTHORIZATION 2011-2012

☐ I request and authorize **COMPANION LIFE INSURANCE COMPANY** and/or its designee to obtain payment of amounts becoming due the Company by initiating charges to my account in the form of checks, share drafts, or electronic debit entries, and I request and authorize the Financial Institution named below to accept and honor the same to my account. I understand that there is no provision for cancellation unless admitted into the Armed Forces.

DRAFT DATE: _____ **(Will be debited on the 22th of each month)**

DRAFT AMOUNT:_____

Check One: ☐ Checking Account ☐ Savings Account

_____
NAME OF BANK WHERE ACCOUNT IS AUTHORIZED

_____
ADDRESS OF BANK

_____
CITY **STATE**

_____
NAME OF INSURED, APPLICANT (PRINT)

_____
NAME(S) OF DEPOSITOR(S) IF OTHER THAN THE INSURED

_____
DEPOSITOR SOCIAL SECURITY NUMBER

_____
DEPOSITOR DRIVER'S LICENSE NUMBER

_____
DEPOSITOR STATE

_____
RELATIONSHIP TO INSURED

_____
SIGNATURE OF DEPOSITOR **DATE**

AUTOMATIC PAYMENT FROM YOUR CHECKING ACCOUNT REQUIRES A COPY OF A VOIDED CHECK (PLEASE DO NOT SEND A DEPOSIT SLIP)

☐ ***Please automatically charge my Student insurance premiums to my account identified below for this entire policy year.***

☐ **VISA** ☐ **DISCOVER** ☐ **MASTERCARD** ☐ **AMEX**

Card Number _____ **Expires:**_____
Last 3 numbers on the reverse side of the credit card. Located within the signature box _____ ***(For Authorization Purposes)***

Print name of cardholder _____

Cardholder phone number _____

Amount authorized to debit_____for Student Health Insurance.

Cardholder signature _____
Today's Date

FOR HOME OFFICE USE ONLY
BANK TRANSIT NUMBER _____
DEPOSITOR'S ACCOUNT NUMBER _____