Student Accident and Sickness Insurance Plan

designed for

The Chicago School of Professional Psychology and Pacific Oaks College 2011-2012

Policy Number: CLSP0014-11

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The Student Accident and Sickness Insurance Plan

This brochure describes the insurance coverage under the Student Accident and Sickness Insurance Plan available to Insured Students through The Chicago School of Professional Psychology and Pacific Oaks College.

This Plan is underwritten by Companion Life Insurance Company. The exact provisions governing this Student Accident and Sickness Insurance Plan are contained in the Master Policy issued to the Chicago School of Professional Psychology and Pacific Oaks College.

Student Eligibility

All domestic students taking 9 credit hours or are actively enrolled and designated by The Chicago School of Professional Psychology or Pacific Oaks College as full full-time are eligible to enroll in this insurance plan.

International students are automatically enrolled in this insurance plan at registration unless proof of comparable coverage is furnished. International students may waive the health insurance coverage if the student presents evidence of other health insurance. Students must document evidence of coverage and make an on-line waiver decision by the waiver deadline at your respective school www.gallagherkoster.com/CSPP or

www.gallagherkoster.com/PacificOaks.

Covered students may also enroll their spouse, and/or the insured's unmarried dependent children under the age of 19 or 23 if a full-time student.

Domestic and International students must actively attend classes for at least the first 31 days after the date for which coverage is purchased or enrolled into. Home study, correspondence, Internet, and television (TV) courses do not fulfill the eligibility requirements that the student actively attend classes.

International students can waive the student accident and sickness coverage only if they are covered by a US based insurance carrier.

Online Waiver/Enrollment Process

Domestic Students Online Enrollment Process

To voluntarily enroll in the Student Accident and Sickness Insurance Plan and have your student account charged, an online enrollment form must be completed and submitted before the August 24, 2011 deadline.

1. Log on to: www.gallagherkoster.com/CSPP or www.gallagherkoster.com/PacificOaks
2. Click on "Student Waive/Enroll" and create your own unique username and password.
3. Click the Green "I want to ENROLL - Domestic" button.

Immediately upon submitting the online Enrollment Form, you will receive a confirmation number confirming that the online Enrollment Form has been submitted.

To voluntarily enroll in the Student Accident and Sickness Insurance Plan and directly pay for the insurance plan in full, an online direct pay or hard copy enrollment form must be completed and submitted before the September 16, 2011 deadline.

1. Log on to: www.gallagherkoster.com/CSPP or www.gallagherkoster.com/PacificOaks
2. Click on "Student Direct Pay Enroll" and complete the online enrollment form.

International Students can waive the Student Accident and Sickness Insurance plan if they can document proof of comparable coverage from another health insurance plan that will be in effect until August 5, 2011. Recognizing that health insurance coverage may change, at the beginning of each academic year students will be asked to notify the college of their insurance selection. To document proof of comparable coverage, international students need to complete the Online Waiver Form and submit it by the August 5, 2011 deadline.

To Waive:

1. Log onto: www.gallagherkoster.com/CSPP or www.gallagherkoster.com/PacificOaks
2. Click on "Student Waive/Enroll" and create your own unique username and password.
3. Click the Red "I want to Waive - International" button. Please have your current health insurance ID card ready as you will need this information in order to complete the form.

Immediately upon submitting the online Waiver Form, you will receive a confirmation number confirming that the Online Waiver Form has been submitted. The Online Waiver process is the only accepted process for making your insurance selection.

Waiver/Enrollment Deadline

The deadline for domestic students to complete the Online Enrollment Form for annual or fall only coverage is August 28, 2011, if they would like their student accounts charged. The deadline for domestic students to complete the Online direct pay or hard copy Enrollment Form for annual or fall only coverage is September 16, 2011. The deadline for international students to complete the Online Waiver Form for annual coverage is August 5, 2011. International students who waive the Student Accident and Sickness Insurance Plan in the fall, waive coverage for the entire policy year.

International students who do not submit the Online Waiver Form by the deadline will remain enrolled in the Student Accident and Sickness Insurance Plan and the fee will be charged to their Student Account.

In the event that you waive the Student Accident and Sickness Insurance Plan or lose your current coverage due to a qualifying event, i.e. your parent loses coverage or you reach the maximum limit available under a parent's plan, you have the right to petition to add coverage within 31 days of the qualifying event. If the petition is received within 31 days of the qualifying event, there will be no break in coverage. For petitions received after 31 days, the effective date of coverage will be the date that the petition is received at Gallagher Koster. If the petition is approved, the premium will not be prorated. **If it is later determined that a student who waived coverage, waived coverage with a plan that was not comparable to the Student Accident and Sickness Insurance Plan, that student will be automatically enrolled in the student insurance plan, effective the date that the determination was made and there will be no pro-rata of premium.**

Domestic Plan Costs and Periods of Coverage

	Annual 8/15/2011 - 8/14/2012	**Fall** 8/15/2011 - 12/31/2011	**Spring** 1/01/2012 - 08/14/2012
Students Only	$1,348.00	$ 528.00	$ 825.00
Spouse	$3,638.00	$1,419.00	$2,224.00
Child(ren)	$2,330.00	$ 910.00	$1,425.00

International Plan Costs and Periods of Coverage

	Annual 8/15/2011 - 8/14/2012	Fall 8/15/2011 - 12/31/2011	Spring 1/01/2012 - 08/14/2012
Students Only	$1,192.00	$ 467.00	$ 730.00
Spouse	$3,638.00	$1,419.00	$2,224.00
Child(ren)	$2,330.00	$ 910.00	$1,425.00

Dependent Eligibility and Enrollment

Students enrolled in the Student Accident and Sickness Insurance Plan may also enroll their dependent(s) as defined. "Dependent" means: 1) an Insured's lawful spouse; or 2) an Insured's unmarried child, from the moment of birth to age 19, 23 if a full-time student, who is chiefly dependent on the Insured for support. A "child", includes an Insured's: 1) natural child; 2) stepchild; and 3) adopted child, beginning with any waiting period pending finalization of the child's adoption. Coverage will continue for a child who is 19 or more years old, chiefly supported by his or her parent or dependent on other care providers and incapable of self-sustaining employment by reason of a handicapped condition that occurred before the attainment of the limiting age. Proof of the child's condition and dependence will be requested by Us within 2 months prior to the date the child will cease to qualify as a child as defined above. Such proof must be submitted to Us within 31 days from the date of the request. We may, at reasonable intervals thereafter, require proof of the continuation of such condition and dependence. If proof is not submitted within the 31 days following any such request, coverage for the Dependent will terminate. The term "spouse" also includes your domestic partner. You and your domestic partner must submit a complete domestic partner affidavit and meet the following criteria to qualify your domestic partner for insurance under this group policy. For at least six consecutive months prior to the effective date of your domestic partner insurance, you and your domestic partner: 1. are and have been each other's sole domestic partner, and have maintained the same principal place of residence and intend to do so indefinitely; 2. are both at least 18 years of age; 3. are not married or related by blood; and 4. are jointly responsible for each other's welfare and financial obligations. The term also includes the child of your domestic partner. Any such child must be unmarried and under age 19, 24 if a full-time student. To continue the child's dependent benefits past the first 31 days, the Insured Student must complete a Dependent Enrollment Form and submit it and any applicable premium to Gallagher Koster within 31 days of the child's birth or date of placement for adoption. Students can also enroll their dependents online. To submit a dependent enrollment form online, go to your respective school www.gallagherkoster.com/CSPP or www.gallagherkoster.com/PacificOaks and then click on "Dependent Enroll". Payment for Dependent coverage is in addition to the fee for your individual student coverage. Coverage is not effective until the start date shown in the Plan Costs and Period of Coverage section or if the deadline is not met, the effective date will be the postmark date on the envelope, or the date the Online Dependent Enrollment Form was submitted. Previously Insured Students and their Dependents must be re-enrolled by September 15, 2011 in order to avoid a break in coverage. If this deadline is not met, the effective date of coverage will be the postmark date on the envelope. An Insured Person who has a break in continuous coverage will not be covered for any Pre-existing Condition that originated before or during such break subject to policy terms and conditions.

Policy Term

The Chicago School of Professional Psychology and Pacific Oak College Student Accident and Sickness Insurance Plan for the Annual Policy is effective at on August 15, 2011. An eligible student's coverage becomes effective on that date or the date the application and full premium are received by the College or Gallagher Koster, whichever is later. The Annual Policy terminates on August 14, 2012 or at the end of the period through which the premiums are paid, whichever is earlier.

The insurance for the Spring Semester is effective on January 11, 2012 or the date the application and full premium are received by the College or Gallagher Koster, whichever is later and terminates on August 14, 2012, whichever is earlier.

Premium Refund Policy

In the event the insured student withdraws from school or reduces his/her semester hours to less than 9, within the first 30 days of the semester and has not yet submitted a claim, then he/she will receive a full refund for any premium paid for the student and any covered Dependents.

A pro-rata refund of premium will be made only in the event:

1. the Covered Person enters full-time active duty in any Armed Forces; and
2. We receive proof of such active duty service.

Gallagher Koster Complements

Exclusively from Gallagher Koster, enrolled students have access to the following menu of products at no additional cost. More information is available at www.gallagherkoster.com/CSPP or www.gallagherkoster.com/PacificOaks.

EyeMed Vision Care

The discount vision plan is available through EyeMed Vision Care. EyeMed's provider network offers access to over 45,000 independent providers and retail stores nationwide, including LensCrafters, Sears Optical, Target Optical, JC Penney Optical, and most Pearle Vision locations. You will receive a separate EyeMed ID card. There is no waiting period; you can take advantage of the savings immediately upon receipt of your EyeMed ID card. You can purchase prescription eyeglasses, conventional contact lenses or even non-prescription sunglasses at a savings of 15% to 45% off regular retail pricing. In addition, you can receive discounts from 5% to 15% off laser correction surgery at some of the nation's most highly qualified laser correction surgeons. You can call 1-866-8EYEMED or go online to www.eyemedvisioncare.com and choose the Access network from the drop down network option.

Basix Dental Savings

Maintaining good health extends to taking care of your teeth, gums and mouth. The Basix Dental Savings Program provides a wide range of dental services. It is important to understand the ***Dental Savings Program is not dental insurance***. Basix contracts with dentists that agree to charge a negotiated fee to students covered under your Gallagher Koster plan. You must pay for the services received at the time of service to receive the negotiated rate.

Savings vary but can be as high as 50% depending upon the type of service received and the contracted dentist providing the service. To use the program, simply:

- Make an appointment with a contracted dentist. Contracted dentists and their fee schedules are listed on our website, www.basixstudent.com.

- Tell the dental office that you are an insured student and have the Basix program. Each dentist has an administrative person to assist you with any questions. You do not need a separate iden-tification card for the Basix program, but you will need to show your student health insurance ID card to confirm your eligibility. If the office needs to check eligibility, call Gallagher Koster at 877-320-4347.
- Remember, you must pay for the services you receive at the time of service, so make sure you understand what forms of payment (check, credit card, etc.) the dentist accepts.

Full details of the program can be viewed at the website: www.basixstudent.com. Once at the home page, select the link for your school. You may also contact us via email from our website, or by telephone at (888) 274-9961.

CampusFit

College health is all about helping students develop healthy habits for a lifetime. To support your efforts, CampusFit "digitizes" knowledge from registered dieticians and certified fitness instructors to help teach and reinforce mainstream ideas about diet, nutrition, fitness and general wellness.

- The Energy Management section of the site allows a student to easily assess how much energy they are consuming, and expending on a daily basis. It also displays the results in the context of the Food Pyramid so students can see how to improve their food choices.
- The Fitness Works section has dozens of downloadable mp3 files and written exercise routines to help students get more active. Want to run your first 5K? We've got a nine week, step-by-step plan to get you there.
- The Wellness Support section has downloadable mp3 files for guided imagery relaxation, and dozens of recordings to reinforce fundamental diet and nutrition ideas – we've even got a 20 minute discussion on the "Freshman 15".

CampusFit is available at no cost to students. To access CampusFit, go to your respective school's website at www.gallagherkoster.com/CSPP or www.gallagherkoster.com/PacificOaks. This plan is not underwritten by Companion Life Insurance Company.

Network Providers

The Chicago School of Professional Psychology and Pacific Oaks College Student Accident and Sickness Insurance Plan provides access to Hospitals and health care providers locally and nationally through the PHCS Preferred Provider Network. The advantage to using a Network Provider is that Network Providers have agreed to accept a predetermined fee or Preferred Allowance as payment for their services. Consequently, when Insured Students use Network Providers, Out-of-Pocket expenses will be less because any applicable co-payments or Deductibles will be based on a Preferred Allowance. The easiest and most efficient way to find a PHCS Preferred Provider is to contact PHCS toll-free at 1-800-922-4362 or visit www.multiplan.com. Preferred provider participation is subject to change, so be sure to verify with the provider that they are participating in PHCS when calling for an appointment or at the time of your appointment.

Definitions

"Accident" means a, unexpected and unintended event, which is the direct cause of an Injury. The Accident must occur while the Covered Person is insured under the Policy.

"Allowable Charge" means the charge which is the lesser of: 1) The actual charge, or 2) the Usual and Customary Charge for a covered service.

"Benefit Period" means a period commencing on the first date of treatment for a covered Accident or covered Sickness and continuing for a maximum period shown in the Schedule of Benefits. The term, Benefit Period; includes any Extension of Benefits shown in the Policy.

"Co-payment" means a fixed dollar amount that the Covered Person must pay before benefits are payable under the Policy.

"Covered Accident" means an Accident that occurs while coverage is in force for a Covered Person and results in a loss or Injury covered by the Policy for which benefits are payable.

"Covered Expenses" means expenses actually incurred by or on behalf of a Covered Person for treatment, services and supplies not excluded or limited by the Policy. Coverage under the Policy must remain continuously in force from the date the Accident or Sickness occurs until the date treatment, services or supplies are received for them to be a Covered Expense. A Covered Expense is deemed to be incurred on the date such treatment, service or supply, that gave rise to the expense or the charge, was rendered or obtained.

"Covered Person" means any eligible person or an eligible Dependent who applies for coverage, and for whom the required premium is paid to Us.

"Deductible" means the dollar amount of Covered Expenses that must be incurred as an out-of-pocket expense by each Covered Person on a Policy Term basis before benefits are payable under the Policy.

"Doctor": means a Doctor licensed to practice medicine. It also means any other practitioner of the healing arts who is licensed or certified by the state in which his or her services are rendered and acting within the scope of that license or certificate.

It will not include a Covered Person or a member of the Covered Person's Immediate Family or household.

"Home Country" means the Covered Person's country of domicile or citizenship named on the enrollment form or the roster, as applicable. However, the Home Country of an eligible Dependent who is a child is the same as that of the eligible participant.

"Injury" means accidental bodily harm sustained by a Covered Person that results directly and independently of disease and any bodily infirmity from a Covered Accident. All injuries sustained by one person in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury.

"Insured" means a person in a Class of Eligible Persons who enrolls for coverage and for whom the required premium is paid making insurance in effect for that person. An Insured is not a Dependent covered under the Policy.

"Medically Necessary" means a service, drug or supply which is necessary and appropriate for the diagnosis and treatment of a Covered Injury and Covered 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 will not be considered as Medically Necessary if, it:

1. is investigational, experimental or for research purposes;
2. is provided solely for the convenience of the patient, the patient's family Doctor, Hospital or any other provider:
3. exceeds in scope, duration or intensity the level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment;
4. could have been omitted without adversely affecting the person's condition or the quality of medical care; or

5. involves the use of a medical device, drug or substance not formally approved by the United States Food and Drug Administration.

"Out-of-Network" means a provider who has not agreed to any prearranged fee schedules. We will not pay charges in excess of the Usual and Customary Charges.

"Pre-Existing Condition" means any injury sustained in an accident that occurred, or a sickness that first manifested itself, before the Insured Person's effective date of coverage under this Policy and for which the Insured Person has received any diagnosis, medical advice, care or treatment within the 12-month period immediately preceding his effective date of coverage. A pregnancy that existed on an Insured Person's effective date will not be considered a Pre-Existing Condition.

"Preferred Allowance"; means the amount a Preferred Provider will accept as payment in full for covered medical expenses.

"Preferred Provider" means the Doctors, Hospitals and other health care providers who have contracted to provide specific medical care at negotiated prices.

"Sickness" means an illness, disease or condition of the Covered Person that causes a loss for which a Covered Person incurs medical expenses while covered under the Policy. All related conditions and recurrent symptoms of the same or similar condition will be considered one Sickness.

"Usual and Customary Charge" means the average amount charged by most providers for treatment, service or supplies in the geographic area where the treatment, service or supply is provided.

"We, Our, Us" means Companion Life Insurance Company, Inc., or its authorized agent.

Emergency Medical Evacuation

This benefit is available to International Students or students participating in a Elizabethtown College Study Abroad Program. Combining this benefit with the Repatriation of Remains benefit, we will pay for benefits for the Covered Expenses incurred, up to $10,000 if any Injury or Sickness results in the Emergency Medical Evacuation of the Insured Person. Emergency Medical Evacuation means: a) the Insured Person's medical condition warrants immediate Transportation from the place where the Insured Person is injured or ill to the nearest Hospital or home residence where appropriate medical treatment can be obtained; orb) for International Students after being treated at a local Hospital; the Insured Person's medical condition warrants Transportation to his/her Home Country to obtain further medical treatment to recover. All Transportation arrangements made for evacuating the Insured Person must be: (a) by the most direct and economical conveyance; and (b) approved in advance by the Company (On Call International). Expenses for special transportation must be: (a) recommended by the attending Physician; or (b) required by the standard regulations of the conveyance transporting the Insured Person. Special transportation includes, but is not limited to: air ambulance, land ambulance, and private motor vehicle. Expenses for medical supplies and services must be recommended by the attending Physician.

Repatriation of Remains

This benefit is available to International Students or students participating in a Elizabethtown College Study Abroad Program. In the event of the death of an Insured Person, we will pay the actual charges up to a maximum of $10,000 (in conjunction with the Medical Evacuation Benefit) for preparation and transportation of the Insured Person's remains to his or her home country. This will be in accord 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. Covered expenses include expenses for embalming, cremation, coffins, and transportation. Repatriation of remains must be approved in advance by the Company.

Travel Assistance Services

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
6. repatriations.
7. Emergency travel arrangements for disrupted travel as the consequence
8. of a medical emergency.
9. 7. Referral to legal assistance.
10. 8. Assistance in locating lost or stolen items including lost ticket
11. application processing.

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 or

www.oncallinternational.com.

SCHEDULE OF MEDICAL EXPENSE BENEFITS
PLAN FEATURES

Maximum Benefit	$ 100,000 per Accident or Sickness	
MEDICAL BENEFITS	**NETWORK**	**NON-NETWORK**
Annual Deductible	$250 per Policy Year	$500 per Policy Year
Coinsurance	90% of the Preferred Allowance (PA)	70% of Reasonable and Customary (R&C) Expenses
COVERED SERVICES - INPATIENT		
Hospital Miscellaneous Expenses (Cost of the operating room, laboratory tests, x-ray examinations, drugs (excluding take-home drugs) or medicines, therapeutic services and supplies and other necessary non-Room and Board expenses)	90% of Preferred Allowance	70% of Reasonable and Customary
Room and Board Expense (Daily semi-private room rate, general nursing care provided by the Hospital, or intensive care unit)	90% of Preferred Allowance	70% of Reasonable and Customary
Routine Newborn Care 48 hours vaginal/96 hours cesarean Hospital Confinement expense maximum. While Hospital Confined; and routine nursery care provided immediately after birth.	90% of Preferred Allowance	70% of Reasonable and Customary
Surgery $5,000 *maximum* (Including Surgery performed in a Doctor's office, will be paid in accordance with data provided by Ingenix, Inc. No more than one (1) surgical procedure will be covered when multiple procedures are performed)	90% of Preferred Allowance	70% of Reasonable and Customary
Anesthetist	90% of Preferred Allowance	70% of Reasonable and Customary
Registered Nurse's Services	90% of Preferred Allowance	70% of Reasonable and Customary
Pre-Admission Testing Payable within 3 working days prior to admission.	90% of Preferred Allowance	70% of Reasonable and Customary
Assistant Surgeon	No Benefits	
Physician Visits Benefits are limited to one (1) visit per day and do not apply when related to surgery.	90% of Preferred Allowance	70% of Reasonable and Customary
Physiotherapy	90% of Preferred Allowance	70% of Reasonable and Customary
Psychotherapy Benefits are limited to one (1) visit per day. Psychiatric Hospitals are not covered.	Paid the same as any other Sickness	
COVERED SERVICES - OUTPATIENT		
Day Surgery Miscellaneous Related to scheduled surgery performed in a Hospital, including the cost of the operating room; laboratory tests and x-ray examinations, including professional fees; anesthesia; drugs or medicines; and supplies.	90% of Preferred Allowance	70% of Reasonable and Customary
Surgery $5,000 *maximum* (Including Surgery performed in a Doctor's office, will be paid in accordance with data provided by Ingenix, Inc. No more than one (1) surgical procedure will be covered when multiple procedures are performed)	90% of Preferred Allowance	70% of Reasonable and Customary
Anesthetist Expense	90% of Preferred Allowance	70% of Reasonable and Customary
Assistant Surgeon	No Benefits	
Physician's Visits Benefits are limited to one (1) visit per day for the diagnosis, medical advice, care or treatment of a Condition. Benefits for outpatient Physician's Visits do not apply when related to surgery or physiotherapy.	90% of Preferred Allowance	70% of Reasonable and Customary
Medical Emergency Expenses $400 max if not admitted. Use of emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness.	90% of Preferred Allowance	90% of Reasonable and Customary
Physiotherapy Benefits are limited to one visit per day. Outpatient Physiotherapy benefits are payable only for a condition that required surgery or Hospital Confinement: 1) within the 30 days immediately preceding such Physiotherapy; or 2) within 30 days immediately following the attending Physician's release for rehabilitation.	90% of Preferred Allowance	70% of Reasonable and Customary

SCHEDULE OF MEDICAL EXPENSE BENEFITS (Con't)		
COVERED SERVICES - OUTPATIENT (Con't)	**NETWORK**	**NON-NETWORK**
Diagnostic X-Ray and Laboratory Services $950 *max if not admitted.*	90% of Preferred Allowance	70% of Reasonable and Customary
Chemotherapy & Radiation Therapy	90% of Preferred Allowance	70% of Reasonable and Customary
Tests and Procedures Diagnostic services and medical procedures by a Physician, other that Physician's visits, Physiotherapy, X-rays and Lab Procedures.	90% of Preferred Allowance	70% of Reasonable and Customary
Psychotherapy $100 per day/10 visit max. Benefits are limited to one visit per day. Including all related or ancillary charges incurred as a result of Mental & Nervous Disorder, including Prescription Drugs.	Paid as any other sickness	
Prescription Drugs (30-day supply per prescription) $2,000 *maximum per policy year*	$15.00 co-pay for a 30-day supply of generic drugs, $30.00 co-pay for a 30-day supply of a brand name drugs and $45 co-pay for a 30-day supply of non-preferred brand name drugs up to a $2,000 maximum per policy year. Mail order is available for a 90-day supply at the cost of a 60-day co-pay. Prescriptions must be filled at a Medco participating pharmacy.	
ADDITIONAL BENEFITS		
Ambulance Expense	90% of Preferred Allowance	90% of Reasonable and Customary
Consultant Physician Fees When requested by attending physician	90% of Preferred Allowance	70% of Reasonable and Customary
Dental Treatment Made necessary by Injury to Sound, Natural Teeth	90% of Preferred Allowance	90% of Reasonable and Customary
Durable Medical Equipment A written prescription must accompany the claim when submitted. Replacement equipment is not covered.	90% of Preferred Allowance	90% of Reasonable and Customary
Accidental Death & Dismemberment	$5,000 maximum	

State Mandated Benefits

Mammography Examinations and Pap Smear Test Expense Benefit

Benefits payable under the group policy include covered expenses incurred by a Covered Person for mammography examinations for the presence of occult breast cancer.

Benefits payable for routine mammography screenings, however, will be limited to the following schedule:

1. one baseline mammography examination for women age 35 through age 39;
2. an annual mammography examination for women age 40 and older.

Benefits are also payable under the group policy for expenses incurred by a covered person for annual cervical or Pap Smear test.

The benefits payable for mammography screening and Pap Smears are payable to the same extent as any other screening or test, and are subject to all of the provisions and limitations of the Policy.

Bone Mass Measurement and Osteoporosis Treatment Expense Benefit

We will pay covered Expenses incurred by a Covered Person for bone mass measurement, and the diagnosis and treatment of osteoporosis.

Benefits are payable to the same extent as for any other covered sickness and subject to all of the provisions and limitations of the Policy.

Mental and Nervous Conditions Expense Benefit

We will pay the Covered Expenses incurred by a Covered Person for Medically Necessary treatment of Mental and Nervous Conditions furnished, as described below.

Benefit payments for Mental and Nervous Conditions will be subject to any Deductible, Coinsurance rate, Benefit Maximum, lifetime Aggregate Benefit Maximum, and Benefit Period shown in the Schedule of Benefits.

The Covered Person may select any Doctor, clinical psychologist or clinical social worker, who is licensed by the state in which services are rendered, to treat such ailments. The Insurer will pay the Covered Expenses for such treatment up to the limits stated in the Schedule of Benefits, provided that: (a) the ailment treated is covered by this Policy; and (b) the Doctor, psychologist or social worker is acting within the scope of his or her license in rendering such treatment.

Serious Mental Illness Expense Benefit

Benefits payable under the group policy include covered expenses incurred by a covered person for Medically Necessary care and treatment of a serious mental illness.

For the purposes of this provision, the term "serious mental illness" means those psychiatric illnesses as defined in the most current edition of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association, including:

1. Schizophrenia;
2. Paranoid and other psychotic disorders;
3. Bipolar disorders (hypomanic, manic, depressive, and mixed);
4. Major depressive disorders (single episode or recurrent);
5. Schizoaffective disorders (bipolar or depressive);
6. Pervasive developmental disorders;
7. Obsessive-compulsive disorders;
8. Depression in childhood and adolescence;
9. Panic disorder;
10. Post-traumatic stress disorders (acute, chronic, or with delayed onset); and
11. Anorexia nervosa and bulimia nervosa.

Coverage for the care and treatment of serious mental illness are subject to all of the provisions that would apply to any other hospital or medical expense covered under the policy.

Benefits will be payable as shown in the Schedule of Benefits. An outpatient visit for the purpose of medication management will not be counted toward the outpatient limit shown in the Schedule of Benefits.

This provision does not provide coverage for treatment of:

1. Addiction to a controlled substance or cannabis that is used in violation of the law; or
2. Mental illness resulting from the use of a controlled substance or cannabis in violation of the law.

Inpatient Care Following Mastectomy

Inpatient benefits following a mastectomy will be provided for a length of time determined by the attending Doctor to be Medically Necessary. The length of time will be based on the evaluation of the patient and the availability of post-discharge doctor's office visit or in-home nurse visit to verify the condition of the patient in the first 48 hours after discharge.

Benefits will be payable on the same basis as any other illness under the Policy.

"Mastectomy" means the surgical removal of all or part of a breast.

Breast Reconstructive Surgery after Mastectomy

The federal Women's Health and Cancer Rights Act requires coverage for certain treatment related to mastectomy. If you are eligible for mastectomy benefits under this Policy and you elect breast reconstruction in connection with such mastectomy, you also are covered for the following:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment for physical complications of all stages of mastectomy, including Lymphedemas.

Coverage for breast reconstructive surgery may not be denied or reduced on the grounds that it is cosmetic in nature or, that it otherwise does not meet the group policy definition of "Medically Necessary" or "medically required."

Benefits will be payable on the same basis as any other illness or injury under the Policy, including the application of appropriate deductibles and coinsurance amounts.

Hospitalization and Anesthesia Related to Dental Procedures

We will pay the Covered Expenses incurred for Hospital or Ambulatory Surgical Center services and for anesthetics in conjunction with dental procedures for a Covered Person who:

1. Is a dependent child age 6 or under; or
2. Has a medical condition that requires hospitalization or general anesthesia for dental care; or
3. Is disabled.

For purposes of this provision, "disabled" means a person, regardless of age, with a chronic disability that meets all of the following conditions:

1. It is attributable to a mental or physical impairment or combination of both;
2. It is likely to continue; or
3. It results in substantial functional limitations in 1 or more of the following areas of major life activity:
   a. self-care;
   b. receptive and expressive language;
   c. learning;
   d. mobility;
   e. capacity for independent living; or
   f. economic self-sufficiency.

Coverage will be subject to all conditions and limitations of the Policy. Benefits for these services will be payable to the same extent as when they are provided for any other covered Sickness or Injury.

Services for dental care are not covered except as may otherwise be provided by the Policy.

Prostate Cancer Screening Expense Benefit

We will pay the Covered Expenses incurred by a Covered Person for an annual Prostate Cancer Screening for covered men upon the recommendation of a Doctor, for prostate cancer screening tests as follows.

Benefits cover an annual digital rectal exam and a prostate-specific antigen ("PSA") blood test for:

1. asymptomatic men age 50 and over;
2. African-American men age 40 and over; and
3. men age 40 and over with a family history of prostate cancer.

These benefits are payable to the same extent as any other diagnostic exam; and are subject to all of the provisions and limitations of the Policy.

Colorectal Cancer Screening Expense Benefit

We will pay the Covered Expenses incurred by a Covered Person for colorectal cancer examinations and laboratory tests when ordered or authorized by a Doctor. Such examinations and testing must be consistent with the American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies.

These benefits are payable to the same extent as any other diagnostic exam, and are subject to all of the provisions and limitations of the Policy.

Diabetes Coverage

Benefits will be paid for Covered Expenses incurred by a Covered Person for Medically Necessary equipment and related supplies for the treatment of diabetes when prescribed by a Doctor or other licensed health care provider.

Benefits for such charges will be payable on the same basis as any other illness under the Policy.

Equipment and related supplies which may be Medically Necessary include, but are not limited to, the following:

1. Blood glucose monitors;
2. Blood glucose monitors for the visually impaired;
3. Diabetes data management systems for management of blood glucose;
4. Insulin pumps and equipment for the use of the pump including batteries;
5. Insulin infusion pumps; and
6. Podiatric appliances and therapeutic footwear.

Coverage is also provided for the regular foot care exams of a diabetic patient when provided by a licensed Doctor.

Benefits are payable on the same basis as any other covered Sickness under the Policy.

Diabetic Self-Management Education Programs

Benefits are payable for Covered Expenses incurred for a program of instruction in the self-care of diabetes that enables a diabetic to understand the disease and to manage its daily therapy.

Such a program must be prescribed by a Doctor. The program must be taught by a "qualified provider," which means a licensed Doctor or a certified, registered or licensed health care professional with expertise in diabetes management to whom the diabetic has been referred by a Doctor.

Coverage includes Medically Necessary visits to a "qualified provider" after the diabetic's Doctor has made an initial diagnosis of diabetes up to the maximum shown in the Schedule of Benefits and after the diabetic's Doctor has determined that a significant change in the diabetic's symptoms or medical condition has occurred. A "significant change" in condition means symptomatic hyperglycemia {greater than 250 mg/dl on repeated occasions}, severe hypoglycemia {requiring the assistance of another person}, onset or progression of diabetes, or a significant change in medical condition that would require a significantly different treatment regimen.

Diabetic self-management education benefits are payable to the same extent as any other covered Sickness and subject to all of the terms and conditions of the Policy.

Home Health Care Expense Benefit

We will pay the Covered Expenses incurred for care and treatment rendered to a Covered Person by a Home Health Care Agency for the following Home Health Care Services:

1. Nursing care furnished by or under the supervision of a registered nurse;
2. Certified nurse aide service under the supervision of a registered nurse or a qualified therapist;
3. Physical therapy, occupational therapy, speech therapy and audiology; respiratory and inhalation therapy;
4. Medical social service by a qualified social worker licensed by the jurisdiction in which services are rendered;
5. Nutrition counseling by a nutritionist or dietician;
6. Home Health Aide services;
7. Medical appliance and equipment, drugs and medicines, and laboratory services;
8. Any diagnostic and therapeutic service, including surgical services, performed in a Hospital outpatient department, ambulatory surgical facility, Doctor's office, or any other licensed health care facility, to the extent such service would have been covered under the Policy, and provided that such service is delivered as part of the Home Health Care Plan.

Home Health Care Agency visits are limited to 40 visits in any continuous 12-month period. Services up to 4 hours by a Home Health Agency team will be considered as one Home Health Care Agency visit.

Benefit payments will be subject to any Deductible, Co-payment, Coinsurance rate, Benefit Maximum, Lifetime Aggregate Benefit Maximum, and Benefit Period shown in the Schedule of Benefits.

Excess Provision

This provision applies to persons covered by the Policy and one or more other medical or dental plans. This Plan is excess to any other plan of medical or dental insurance the Covered Person may have.

No benefit is payable for any Covered Expense incurred, which is paid or payable by any other valid and collectible insurance. Covered Expenses does not include any amount not covered by the primary carrier due to penalties for failure to comply with policy provisions or requirements.

This provision will not apply to the first $100.00 of incurred Covered Expense.

Pre-existing Condition Limitation

The Policy does not provide coverage for a Pre-Existing Condition until the Covered Person's coverage has been in force for a period of not less than 12 months. This limitation will not apply to pregnancy or coverage provided to newborn or adopted children.

The Pre-existing Conditions Limitation will be waived if:

1. the Covered Person was insured under Creditable Coverage; and
2. Such coverage was continuous to a date not more than 63 days prior to the effective date of coverage under this Policy; and
3. the Covered Person previously met the pre-existing conditions limitation of such policy.

"**Pre-existing Conditions**" means any condition, Injury or Sickness for which the Covered Person incurred expenses, received medical treatment, or consulted a health care professional within the 12 months immediately preceding the effective date of coverage.

"**Qualifying Previous Coverage**" means: (1) Medicare or Medicaid; (2) an employee welfare plan or group health insurance or health benefit plan; (3) an individual health benefit plan; (4) a state health benefits risk pool; (5) CHAMPUS or CHAMPUS/TRICARE; (6) a medical care program of the Indian Health Service or of a tribal organization; (7) a health plan offered under the federal employees health benefits program (FEHBP); (8) a public health plan; (9) a health benefit plan of the Peace Corps Act, or (10) a State Children's Health Insurance Program.

Qualifying Previous Coverage does not include accident only, credit, dental, vision, Medicare supplement, long-term care, disability income insurance, coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, automobile medical payment insurance, specified diseases, hospital indemnity, or limited benefit health insurance.

Exclusions and Limitations

This Plan does not cover nor provide benefits for:

1. Services normally provided without charge by the Policyholder's student health service center, infirmary, or Hospital, or by Health Care Providers employed by the Policyholder;
2. Preventative medicines, serums, immunizations, or vaccines, except as specifically provided;
3. Speech therapy treatment, except as specifically provided;
4. Care and/or treatment in skilled nursing facility, except as specifically provided;
5. Organ transplants, except as specifically provided;
6. Pre-existing Conditions as defined in this Policy;
7. Illness, Accident, treatment or medical condition arising out of the play or practice of or traveling in conjunction with intercollegiate sports, intercollegiate club sports, and professional sports;
8. 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, reconstructive surgery following a mastectomy as provided for in the *Breast Reconstruction Expense Benefit* and reconstructive surgery because of congenital disease or anomaly of a covered Dependent newborn child which has resulted in a functional defect or to the extent specifically covered under this Policy;
9. Correction of congenital defects except as specifically provided;

10. Injury or Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law;
11. 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 natural teeth;
12. Expense incurred for treatment of temporomandibular joint dysfunction and associated myofacial pain;
13. Injury or Sickness resulting from declared or undeclared war; or any act thereof;
14. Charges for treatment of any Injury or Sickness due to an Insured Person's commission of, or attempt to commit a felony, or a crime which would be considered a felony if prosecuted;
15. Injury due to participation in a riot;
16. Expenses incurred in connection with foot care only to improve comfort or appearance such as care for weak, strained or flat feet; subluxation; corns; calluses; bunions, except open cutting operations; routine care of toenails, except for the removal of the nail root and necessary services in treatment of metabolic or peripheral-vascular disease; treatment of the instability and imbalance of the feet; and any tarsalgia, metatarsalgia. Expenses incurred for the care and treatment of Injury, infection, or disease are not excluded;
17. Screening examinations, including X-ray examinations made without film, except as specifically provided;
18. Expenses incurred in connection with family planning, the enhancement of fertility, fertility tests, correction of infertility, in-vitro fertilization, artificial insemination, and services or supplies for inducing conception;
19. Expenses incurred in connection with a voluntary sterilization procedure or any sterilization reversal process;
20. Treatment of obesity, including any care which is primarily dieting or exercise for weight loss, except for surgical treatment of morbid obesity;
21. Expenses incurred for transsexual surgery or any treatment leading to or in connection with transsexual surgery;
22. Expense incurred for eye examinations or prescriptions, eyeglasses, and contact lenses (except for sclera shells which are intended for use of corneal bandages), eye refractions, vision therapy, multiphasic testing, or lasix or other vision procedures except as required for repair caused by a covered Injury;
23. Well baby care, including routine exams and immunizations, except as specifically provided;
24. Routine periodical physical examinations and routine chest x-rays, except as specifically provided;
25. Expenses incurred for allergy testing and allergy treatment;
26. Treatment provided in a governmental Hospital unless there is a legal obligation to pay such charges in the absence of insurance;
27. Expenses for any service or supply not specified in this Policy as a covered service;
28. Elective Treatment or elective surgery, except as specifically provided;
29. Services not Medically Necessary;
30. Expense incurred for: tubal ligation; vasectomy; breast implants; breast reduction; sexual reassignment surgery; impotence (organic or otherwise); non-cystic acne; non-prescription birth control; submucus resection and/or other surgical correction for deviated nasal septum, other than for required treatment of acute purulent sinusitis; circumcision; gynecomastia; hirsutism;
31. Voluntary or elective abortion;
32. Expense incurred for: topical acne treatments, moles, non-malignant warts or lesions, fertility medication; legend vitamins or food supplements; smoking deterrents; immunization agents; biological sera; drugs to promote or stimulate hair growth; experimental drugs; drugs dispensed in a rest home or hospital, except as provided under the Hospital Expense Benefit;
33. Testing, treatment, or services for any condition in the absence of Sickness or Injury except as specifically provided;
34. Alternative health care, including (but not limited to) acupuncture, except as specifically provided, acupressure, biofeedback, reflexology, and rolfing type services;
35. Expenses incurred for services or supplies for the diagnosis and treatment of sleep disorders, including but not limited to apnea monitoring and sleep studies;
36. Hearing aids, including exams for fitting, except as required to correct damage caused by an Injury which occurs while the patient is covered by this Plan, provided they are obtained within four months of the date of the Injury;
37. Services, supplies and facility that are provided mainly for a rest cure, maintenance or custodial care;
38. Any treatment, service or supply in excess of the maximum benefit specified in this Policy;
39. Nicotine addiction.

Reimbursement and Subrogation

Subrogation: We are assigned the right to recover from the negligent third party, or his or her insurer, to the extent of the benefits we paid for that sickness or injury. You are required to furnish any information or assistance, or provide any documents that we may reasonably require in order to exercise our rights under this provision. This provision applies whether or not the third party admits liability.

Right of Reimbursement: If a Covered Person recovers expenses for sickness or injury that occurred due to the negligence of a third party, we have the right to reimbursement for all benefits we paid from any and all damages collected from the negligent third party for those same expenses whether by action at law, settlement, or compromise, by the Covered Person, Covered Person's parents if the Covered Person is a minor, or Covered Person's legal representative as a result of that sickness or injury. You are required to furnish any information or assistance, or provide any documents that we may reasonably require in order to exercise our rights under this provision. This provision applies whether or not the third party admits liability.

Extension of Benefits after Termination

If a Covered Person is confined in a Hospital for a medical condition on the date his insurance ends, expenses Incurred during the continuation of that Hospital stay will be considered a Covered Expense, but only while such expenses are incurred during the 90 day period following the termination of insurance. We will not continue to pay these Covered Expenses if:

1. the Covered Person's medical condition no longer continues;
2. the Covered Person reaches the Lifetime Aggregate Maximum per covered Accident or covered Sickness; or
3. the Covered Person obtains other coverage.
4. the Covered Expenses are incurred more than 3 months following termination of insurance.

Inquiry and Grievance Procedures

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

If an Insured Person or the Insured Person's provider would like additional information or has any complaints concerning the basis upon which payment was made, they may contact Us or Our Third Party Administrator ("TPA") at 1-800-349-9017. The TPA will address concerns and attempt to resolve them satisfactorily. If the TPA is unable to resolve a concern over the phone, it will request submission of the concern in writing to pursue a formal appeal.

A formal appeal must be submitted, in writing to Us or Our Administrator at the following address:

Combined Insurance Company
c/o Klais & Company, Inc.
1867 West Market Street
Akron, OH 44313-6977

A formal appeal should include:

- The Insured Person's name, security number, and home address;
- policy number; and
- any other information, documentation, or evidence to support the appeal.

A formal appeal must be submitted within sixty (60) days of the event that resulted in the complaint. The TPA will acknowledge a formal appeal within ten (10) working days of its receipt or within seventy-two (72) hours if the appeal involves a life-threatening situation. A decision will be sent to the Insured Person in writing within thirty (30) days following receipt of the formal appeal. If there are extraordinary circumstances requiring a more extensive review, the TPA may take up to an additional sixty (60) days to review the formal appeal before rendering a decision.

Claims Procedures

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

1. A claim form is not required to submit a claim. However, an item-ized bill, HCFA 1500, or UB92 form should be used to submit expenses. The Insured Student/Person's name and identification number need to be included.
2. Providers should submit claims 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. If a student is submitting the claim, a copy should be retained and claims should be mailed to the Claims Administrator, Klais & Company, Inc., at the address on the back cover.
3. Direct all questions regarding claim procedures, status of a submitted claim or payment of a claim, or benefit availability to the Claims Administrator, Klais & Company, Inc.
4. If You disagree with a claim payment decision, an Insured Person has the right to file an appeal. The process to file an appeal is as follows: (a) you must notify Klais & Company, Inc. within 30 days of the denial. Your claim appeal must be in writing, and clearly state that You are appealing the decision and requesting another review of your claim; and (b) Your written appeal should provide specific documentation as to why You believe the decision to be in error, and any new medical information that will be helpful to Klais & Company, Inc. in considering the claim. Klais & Company, Inc. will respond in writing as to their decision.

Any provisions of this Policy, which on its effective date, 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.

HIPAA Notice of Privacy Practices for Personal Health Information

Under HIPAA's Privacy Rule, We are required to provide you with notice of our legal duties and privacy practices with respect to personal health information. You should receive a copy of this notice with your enrollment materials. If, at anytime, you wish to request a copy of Companion Life Insurance Company's Privacy Notice, write to Companion Life Insurance Company, P.O. Box 100102, Columbia, SC 29202-3102. To view it online, go to http://www.companionlife.com/privacypractices.aspx.

Questions? Need More Information?

For general information on benefits, on enrollment/ eligibility questions, ID Cards or service issues, please contact:

Gallagher Koster
500 Victory Road
Quincy, MA 02171
877-320-4347
Email: TCSstudent@gallagherkoster.com or
www.gallagherkoster.com/CSPP and
www.gallagherkoster.com/PacificOaks

If you need medical attention before the ID card is received, benefits will be payable according to the Policy. You do not need an ID card to be eligible to receive benefits. Call Gallagher Koster to verify eligibility.

For information on a specific claim or to check the status of a claim, please contact:

Klais and Company, Inc.
1867 West Market Street
Akron, OH 44313-6977
877-349-9017
Email: KlaisClaims@klais.com
To review claims online, go to www.klais.com and register for StatusLink
The Chicago School GROUP #: SH516A1
Pacific Oaks College GROUP #: SH517A1

CLAIM INFORMATION RECEIVED REGARDING MEDICAL TREATMENT IS STRICTLY CONFIDENTIAL

This Policy is Underwritten by:

Companion Life Insurance Company
Policy Number: CLSP0014-11

A Master Policy is available for review at the either The Chicago School of Professional Psychology or Pacific Oaks College. In the event of any conflict between this description of services provided and the Policy, the Master Policy will govern.