Wheaton College

For Christ and His Kingdom

Student Health Insurance Plan

designed for

Wheaton College

Wheaton, IL

2014-2015

~ Non-Renewable One Year Term Insurance ~

Policy Number: 2014-S3-A27

Underwritten by Companion Life Insurance Company
Form Number: BSHP-PPO-POL

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Important: Please see the Notice on the Inside Cover of this plan material concerning student health insurance coverage.

Your student health insurance coverage, offered by Companion Life Insurance Company, may not meet the minimum standards required by health care reform.

NOTICE TO STUDENT ENROLLEES AND THEIR COVERED DEPENDENTS

This 2014-2015 Student Health Insurance Plan does not include coverage of all contraceptive services.

Contraceptive methods and counseling: when prescribed by Your Physician, benefits are payable for certain Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity, as required under the Patient Protection and Affordable Care Act of 2010; provided, however, that this benefit does not include coverage for voluntary termination of pregnancy or elective abortion (including but not limited to abortifacient drugs and devices such as the placement of IUDs with and without hormone impregnation, the use of abortifacient drugs including Ella and Plan B, but not the removal of IUDs).

If you have questions, please contact the Claims Administrator:

HealthSmart Benefit Solutions, at 1-877-349-9017
Email: akronclaims@klais.com

Student Health Insurance Plan

This is a brief description of the Student Health Insurance Plan available for Wheaton College students. The plan is underwritten by Companion Life Insurance Company and is managed by Gallagher Student Health & Special Risk. Claims are paid by HealthSmart Benefit Solutions. The exact provisions governing this insurance are contained in the Master Policy issued to the College; the Policy may be viewed during normal business hours at the Wheaton College Risk Management Department. The Master Policy will control in the event of any conflict with this brochure.

Eligibility

The following students are eligible for the student insurance:

1. Degree-seeking students regardless of the number of credit hours for which they are registered (exception for degree-seeking modular students).
2. Non-degree seeking or 'Special' Students taking 9 or more credits.
3. Students on Deferred Enrollment (Consortium, HNGR, Internship) unless they are entering their home country for the semester in which universal health care is provided.
4. Psy-D students registered for classes on campus. Students completing their thesis or dissertation studies are not required to meet the health insurance requirements but have the option of enrolling in the plan.
5. Consortium students from other colleges.
6. Eastern European Tutorial students.
7. Honey Rock students registered for credit hours.
8. International students (including Canadian students) and their dependents who are residing with the student in the United States.
   - First year International students (including Canadian students) are enrolled on a mandatory basis and the six month premium will be charged to their student account each semester.
   - Second year International students (including Canadian students) are automatically enrolled unless proof of comparable coverage is provided by the deadline. Foreign plans and travel policies are not accepted as they are not considered comparable to the Wheaton College student plan and do not meet the Wheaton College health insurance requirements.
9. Wheaton College allows students who are on an approved semester Leave of Absence to enroll in coverage for up to one semester they will not be on campus.
10. Eligible dependents of insured students can also be enrolled in the Student Health Insurance Plan for an additional cost. Students who are interested in enrolling their dependents need to submit their dependent enrollment application to Student Health Services, and a charge will be placed on their account.

The Company maintains the right to investigate student status and attendance records to verify the Policy eligibility requirements have been and continue to be met. If the Company discovers that the Policy eligibility requirements have not been met, the Company's only obligation is to refund the premium, unless claims have been paid.

In the event students waive the Wheaton Student Health Insurance Plan and then lose current coverage due to a qualifying event, (i.e. parent loss of coverage or the maximum age limit available is attained), students 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 the 31 days, the effective date of coverage will be the date that the petition is received at Gallagher Student. If approved, the premium will be prorated on a monthly basis.

Enrollment/Waiver Process

To enroll or document proof of comparable coverage, an Online Enrollment or Waiver Form must be completed and submitted by the deadline.

1. Go to www.gallagherstudent.com/WheatonIL.
2. Click on "Student Waive/Enroll".
3. Create a user account or log in (if a returning user).
4. Select either the Red "I want to Waive" or Green "I want to Enroll" button. If waiving the insurance, have your current health insurance ID card ready as you will need this information in order to complete the Waiver Form. Upon completing the form you will be asked for review your information for accuracy and click submit. Immediately upon submitting your online Waiver Form you will receive a reference number. **Please save this number and print a copy of your confirmation for your records**.

International Students Please Note: Only second year international students are eligible to waive the Student Health Insurance Plan if they are covered by a health insurance plan comparable to the Student Health Insurance Plan. Foreign plans and travel policies are not accepted as they are not considered comparable to the Wheaton College student plan and do not meet the Wheaton College health insurance requirements.

Enrollment/Waiver Deadline

The deadline for students to submit a Waiver or Enrollment Form for annual coverage is **September 11, 2014.** For students newly enrolled for the Spring Semester, or annual students who missed the September deadline, coverage can still be waived for the spring semester. The deadline to submit a Waiver or Enrollment form for the spring semester period is **January 29, 2015.** Students who waive the Wheaton College Student Health Insurance Plan in the fall waive coverage for the entire policy year. **Students who do not submit the Waiver Form by the deadline will be enrolled in and billed for the Wheaton College Student Health Insurance Plan.**

Dependent Eligibility and Enrollment

Eligible dependents of students enrolled in the Plan may participate on a voluntary basis. Dependents must be enrolled at the time of the Participant's enrollment or within 31 days of birth of a newborn. Eligible dependents are the spouse and unmarried children under 26 years of age and who are not self-supporting. Dependent Eligibility expires concurrently with that of the Insured student. It is the student's responsibility to enroll eligible dependents by the deadline each year.

1. The Effective Date for an Insured's eligible spouse or dependents enrolled with an Insured is the Insured's Effective Date provided we receive the required premium for the spouse or dependent by the enrollment deadline. If a spouse or dependent becomes eligible after an Insured's Effective Date, the Insured has at least 30 days from the date such spouse or dependent first becomes eligible to enroll them and pay the applicable premium.
2. Automatic Coverage for Newly Acquired Dependents. A newborn child, of an Insured, will be automatically covered for the first 31 days after birth. An adopted child or child placed with an Insured in anticipation of adoption will be automatically covered for 31 days from the date of placement. The automatic coverage of a newborn child or child placed for adoption will end on the 32nd day after

birth or placement. Coverage for such a child will be the same as any other dependent, including medically diagnosed congenital defects, birth abnormalities, premature birth care and nursery care. An Insured will have the right to continue such coverage for the child beyond the first 31 days. To continue the coverage the Insured must, within the 31 days after the date of birth, adoption, or placement for adoption: a) Enroll such dependent; and b) Pay the required additional premium for the continued coverage. If the Insured does not use this right as stated here, all coverage as to that child will terminate at the end of the first 31 days after the child's birth, adoption, or placement for adoption.

To enroll a dependent, a student needs to submit a dependent enrollment application to Student Health Services, and an additional charge will be placed on their account.

Effective and Termination Dates

The Master Policy becomes effective August 1, 2014 and terminates on July 31, 2015 for annual term coverage and becomes effective on January 1, 2015 and terminates on July 31, 2015 for the Spring term coverage. This policy is a Non-Renewable One Year Term Policy. It is the Insured's responsibility to obtain coverage the following year in order to maintain continuity of coverage. Insured persons, who have not received information regarding a subsequent plan prior to the Policy's Termination Date, should inquire regarding such coverage with the school or its agent.

Plan Costs and Period of Coverage

Coverage Period	Annual* 8/1/14 - 7/31/15	Fall Only/ First Semester* 8/1/14 - 1/31/15	Spring Second Semester* 2/1/15 - 7/31/15	Spring* 1/1/15 - 7/31/15
Student Through 21	$2,042	$1,021	$1,021	$1,244.50
Student 22 & Over	$2,459	$1,229.50	$1,229.50	$1,487.75
Spouse	$6,317	$3,158.50	$3,158.50	$3,684.92
Child(ren)	$3,427	$1,713.50	$1,713.50	$1,999.08

***Please note – the rates listed above include administrative fees charged by the school through which you are receiving coverage as well as new Federal fees and taxes imposed by health care reform. Coverage Ends:** An Insured's coverage ends on the earliest of the following: 1) The date the Insured ceases to be eligible for coverage; or 2) The end of the Insured's term of coverage. An Insured's spouse or dependent coverage will end at the earliest of: 1) The end of the period for which the premium is paid for such spouse or dependent coverage; 2) The date a spouse or dependent is no longer eligible for coverage; or 3) The end of the Insured's term of coverage.

Premium Refund Policy

Any Insured Student withdrawing from the College during the first 45 days of the period for which coverage is purchased shall not be covered under the Plan and a full refund of premium will be made. Insured Students withdrawing after 45 days will remain covered under the Plan for the full period for which premium has been paid and no refund will be made available. This is true for students on leave for medical or academic reasons, graduating students, and students electing to enroll in a separate comparable plan during the policy year. Premiums received by the Company are non-refundable except as specifically provided. Coverage for an Insured Student entering the Armed Forces of any country will terminate as of the date of such entry. Those Insured Students withdrawing from the school to enter military service will be entitled to a pro-rata of premium upon written request.

Preferred Provider Network

The Student Health Insurance Plan provides access to hospitals and health care providers locally and across the country through the Private Healthcare System (PHCS) Network.

You are not required to use a Network Provider. However, the advantage to using a Network Provider is that Network Providers have agreed to accept as payment for their services a negotiated fee or Preferred Allowance. Non-Network Providers have not agreed to a Preferred Allowance and consequently your out-of-pocket costs may be greater.

Students should be aware that Network Hospitals may be staffed with Non-Network Providers. Receiving services or care from a Non-Network Provider at a Network Hospital means that those charges will not be paid at the Network Provider level of benefits. It is important that the Insured Student verify that his or her Doctors are Network Providers when calling for an appointment or at the time of service. The most efficient and accurate way to identify Network Providers is to call Private Healthcare System (PHCS) toll-free at 1-800-922-4362 or visit their website at www.PHCS.com.

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.

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

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.

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.

Dependent means: 1) an Insured's lawful spouse; or 2) an Insured's unmarried child, from the moment of birth until the age of 26, 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.

With respect to a handicapped child, "dependent on other care providers" means such child requires a Community Integrated Living Arrangement, group home, supervised apartment, or other residential services licensed or certified by the Department of Human Services, the Department of Public Health, or the Department of Public Aid.

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.

Emergency Hospitalization and Emergency Medical Care means hospitalization or medical care:

That is provided for an Accident or a Sickness caused by the unexpected onset of a medical condition with acute symptoms of sufficient severity and pain that would cause a prudent layperson with an average knowledge of health and medicine to expect that the absence of immediate medical care to result in:

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.

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

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.

Prescription Drugs mean 1) prescription legend drugs; 2) compound medications of which at least one ingredient is a prescription legend drug; 3) any other drugs that under the applicable state or federal law may be dispensed only upon written prescription of a Doctor; and 4) injectable insulin.

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.

On Call International Assistance Program

The International Assistance Program (IAP) is supplemental to the Student Insurance Plan. The IAP provides access to a 24-hour worldwide assistance network, On Call International, for emergency assistance anywhere in the world. Simply call the assistance center at 800-407-7307 or collect at 603-898-9159. The IAP and On Call International are not affiliated with Companion Life Insurance Company.

The multilingual staff will answer your call and immediately provide reliable, professional and thorough assistance. The following services are included in the IAP:

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.

Students must be enrolled in the Student Health Insurance Plan in order to be eligible to utilize the IAP. Other services included in the IAP are listed below:

Repatriation of Remains – Included in IAP

In the event of the death of an Insured Person, On Call International will arrange for and pay the actual expenses incurred for preparing and transporting the Insured Person's remains to his or her home country. Covered expenses include expenses for embalming, cremation, coffins, and transportation. All expenses for repatriation of remains must be approved in advance by On Call International. Repatriation of remains is a service provided by On Call International; it is not insurance but it is included as a service in your Student Health Insurance Policy.

Emergency Medical Evacuation – Included in IAP

In the event of a serious Injury or Sickness, On Call International will arrange for and pay the actual expenses incurred to evacuate an Insured Person if: (a) the Insured Person's medical condition warrants immediate transportation from the place where the Insured Person is injured or sick to the nearest hospital where appropriate medical treatment can be obtained; or (b) after being treated at a local hospital, the Insured Person's medical condition warrants transportation to the Insured Person's home country to obtain further medical treatment to recover. All expenses for emergency medical evacuation must be approved in advance by On Call International. Emergency medical evacuation is a service provided by On Call International; it is not insurance but it is included as a service in your Student Health Insurance Policy.

Contact: On Call International for any of the IAP services described above.

Toll Free from U.S. and Canada: 1-800-850-4556
Dial Direct/Call Collect Worldwide: 1-603-898-9159
Website: www.oncallinternational.com

24-Hour Nurse Advice Line – Included in IAP

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 International 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. This program gives students access to a toll-free nurse information line 24-hours a day, 7 days a week. One phone call is all it takes to access a wealth of useful health care information at 1-866-525-1955.

SCHEDULE OF BENEFITS

MEDICAL BENEFITS **NOTE: In the event treatment is needed for a Covered Medical Expense due to a Medical Emergency while the student is traveling abroad, benefits will be paid at the Network level.**	**NETWORK**	**NON-NETWORK**
Annual Deductible – (*non*-SHS *services*) applies to all benefits unless indicated otherwise	$300 per person, limit of 3 per family per year	$300 per person, limit of 3 per family per year
Coinsurance	80% of the Preferred Allowance (PA)	60% of Usual and Customary Expenses (U&C)
Out-of-Pocket Maximum	$5,950 per individual, $12,700 per family	$8,000 per individual
Per Policy Year Maximum	Unlimited	
Pre-Existing Conditions	Covered as any other Injury or Sickness	
COVERED SERVICES	**NETWORK**	**NON-NETWORK**
HOSPITAL SERVICES		
Hospital Room & Board	80% of PA	60% of U&C
Intensive Care	80% of PA	60% of U&C
Inpatient Hospital Miscellaneous (includes pre-admission testing) & Inpatient Medical Care	80% of PA	60% of U&C
Hospice care	80% of PA $5,000 annual maximum	60% U&C, $5,000 annual maximum
Home health care	100% of PA, 100 visits annual maximum	60% of U&C, 100 visits annual maximum
PHYSICIAN MEDICAL SERVICES		
Hospital and skilled nursing facility visits	80% of PA	60% of U&C
Surgeon and surgeon assistant; anesthesiologist or anesthetist	80% of PA	60% of U&C
Office visits – Student Health Service	$25 copayment, then 100%	60% of U&C
Office visits – other primary care, specialists and consultants	$30 copayment, then 100%	60% of U&C
Physical therapy, physical medicine, occupational therapy, speech therapy	$20 copayment, then 100%	60% of U&C
Chiropractic, osteopathic manipulation	80% of PA, $20 copayment 20 visit annual maximum	60% of U&C, 20 visit annual maximum
GENERAL MEDICAL SERVICES		
X-Ray, radiology and laboratory testing	80% of PA	60% of U&C
Durable medical equipment	80% of PA	60% of U&C
Hearing aids	80% of PA. Once every two years	Not Covered
PREVENTIVE CARE		
Preventive Services Includes preventive services such as screenings, exams and immunizations as specified by the Patient Protection and Affordable Care Act (PPACA). For more information visit: http://www.healthcare.gov	100% of PA, no deductible or copayment	60% of U&C
Routine physical exams, including appropriate blood exams	100% of PA, pursuant to SHS protocols	60% of U&C
Routine gynecological exams, including Pap Smears and mammograms	100% of PA, within frequency guidelines	60% of U&C
Cancer screening	80% of PA	60% of U&C

SCHEDULE OF BENEFITS (Con't)

COVERED SERVICES (Con't)	NETWORK	NON-NETWORK
PREVENTIVE CARE (Con't)		
Pediatric Dental Services - subject to a $300 Deductible per policy year, covers the following: • Preventive Services - including exams and cleanings (two per year), fluoride treatments and sealants to age 16; • Basic Services - including fillings, x-rays, oral surgery and simple extractions; • Major Services - including endodontics, periodontics, crowns, bridges and dentures; • Orthodontia	50% of U&C	
Pediatric Vision Services - subject to a $20 co-pay per exam, and a $40 co-pay for materials and supplies.	100% of U&C	
EMERGENCY CARE, AMBULANCE AND URGENT CARE		
Emergency services and supplies	$100 copayment then 80% of PA Waived if admitted	$100 copayment then 80% of U&C. Waived if admitted
Urgent care center	80% of PA after $50 copayment	60% of U&C (80% if true Medical Emergency)
Ambulance – ground	80% of PA	80% of U&C
Ambulance – air	80% of PA	80% of U&C
PREGNANCY AND MATERNITY CARE		
Physician office visits (pre-natal)	$25 copayment (first office visit only); Subsequent visits covered at 100% of PA	60% of U&C
Inpatient services	80% of PA	60% of U&C
BEHAVIORAL HEALTH / SUBSTANCE USE DISORDER		
Outpatient services	$15 copayment, then 100% of PA	60% of U&C
Inpatient services	80% of PA	60% of U&C
Psychotherapy	Paid the same as any other Sickness	
PRESCRIPTION BENEFIT		
Prescription Drugs (*Pharmacy benefits are managed through Express-Scripts*) Prescriptions filled at non-Express Scripts Pharmacies (other than the SHS Pharmacy) are not covered.	**SHS Pharmacy:** Generic: $5 copayment to the Student Health Service **Retail:** Generic: $15 Brand Formulary: $25 Non-Formulary: $50 Mail-Order (90-day supply) Copayments: $30/$50/$100	No coverage
OTHER BENEFIT		
Essential Health Benefits – per the Patient Protection and Affordable Care Act. Benefits are included in the following categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.	Coverage is subject to limits on the number of visits, specific dollar amounts paid by the issuer, deductibles, copayments, coinsurances in and out of network, as shown in this Schedule of Benefits, and age requirements in accordance with the terms of the policy and state and federal guidelines.	
Emergency Medical Evacuation	Unlimited benefit, paid by On Call International under a separate agreement	
Repatriation of Remains	Unlimited benefit, paid by On Call International under a separate agreement	

IMPORTANT NOTE ABOUT YOUR BENEFITS

Should state law and/or federal law require certain benefits to be included in the Master Policy that are not included in this brochure, such benefits shall be deemed to be included in this brochure to the extent necessary to satisfy the minimum requirements of such law. For more information about your benefits, please read the Summary of Benefits and Coverages available at www.gallagherstudent.com/wheatonil and the Glossary of Terms available at www.cciio.cms.gov, or you may request a copy by calling 855-275-3700.

OUT-OF-POCKET MAXIMUM

After the Out-of Pocket Maximum has been reached as shown in the Schedule of Benefits, benefits will be paid at 100% of the Preferred Allowance (In-Network) or 100% of U&C (Out-of-Network). The Out-of-Pocket Maximum is the most you could pay during the Policy Year for your share of the cost of covered services. This limit helps you plan for health care expenses. The policy Deductible, Co-payments and any per-service Deductibles, and services that are not Covered Charges do not count toward meeting the Out-of-Pocket Maximum. Even when the Out-of-Pocket Maximum has been satisfied, the Covered Person will still be responsible for Copayments and per service Deductibles.

Additional Benefits

Benefits are payable subject to the Policy limitations for the following additional benefits: Inpatient Alcoholism Treatment Benefit; Cervical Cancer Screening Test Benefit; Colorectal Cancer Screening Benefit; Diabetes Treatment Services and Supplies Benefit; General Anesthesia Benefit; Osteoporosis Testing and Treatment Benefit; Prenatal HIV Testing Benefit; Prostate Cancer Screening Tests Benefit; Mammography Benefit; Clinical Breast Exams Benefit; Reconstructive Surgery following Mastectomy Benefit; Follow-up Care Following a Mastectomy Benefit; Contraceptives Benefit; Amino acid-based Elemental Formulas Benefit.

Benefits will be payable on the same basis as any other **sickness** for **Covered Persons** for treatment of serious mental illness. "Serious mental illness" means the following psychiatric illnesses as defined in the most current edition of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association:

a) schizophrenia;
b) paranoid and other psychotic disorders;
c) bipolar disorders (hypomanic, manic, depressive, and mixed);
d) major depressive disorders (single episode or recurrent);
e) schizoaffective disorders (bipolar or depressive);
f) pervasive developmental disorders;
g) obsessive-compulsive disorders;
h) depression in childhood and adolescence; and
i) panic disorder.

Coordination of Benefits

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.

For a complete description, please see the Master Policy.

Termination of Insurance

Benefits are payable under the Policy only for that covered expense incurred while the Policy is in effect as to the Insured. No benefits are payable for expense incurred after the date the insurance terminates, except as may be provided under the Extension of Benefits provision.

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 13-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.

Definitions

"Home Health Aide" means a person who:

1. Provides care of a medical or therapeutic nature, or who provides Daily Living Services; and
2. Reports to and is under the direct supervision of a Home Health Care Agency.

Home Health Agency: means an organization, or its distinct part, that meets all these tests:

1. its' primary purpose is providing skilled nursing and other therapy for, and in the private homes of, persons recovering from an Injury or Sickness.
2. it is licensed or approved under any state or local standards that apply; it is run under policies established by a professional staff that includes Doctors and registered nurses.
3. its' services are supervised by a Doctor or registered nurse; it keeps clinical records on all patients.
4. it does not, except incidentally, provide care or treatment of the mentally ill or care of a custodial nature.

Exclusions and Limitations

The Policy does not cover nor provide benefits for:

1. Charges that are not Medically Necessary or in excess of the Usual and Customary charge;
2. Expenses in connection with services and prescriptions for eye examinations, eye refractions, eye glasses or contact lenses, or the fitting of eyeglasses or contact lenses, except as specifically provided under the Pediatric Vision Services benefit; radial keratotomy or laser surgery for vision correction or the treatment of visual defects or problems;
3. Expenses in connection with cosmetic treatment or cosmetic surgery, except as a result of:
   a. a covered Injury that occurred while the Covered Person was insured;
   b. a covered child's congenital defect or anomaly; or
   c. as specifically provided for in the Policy.
4. Injuries arising out of:
   a. playing or participating in an interscholastic, intercollegiate, or professional sport, contest or competition;
   b. traveling to or from such sport, contest or competition as a participant; or
   c. participation in any practice or conditioning program for such sport, contest, or competition.
5. Expenses incurred for Injury or Sickness for which benefits are paid or payable under any Worker's Compensation or Occupational Disease Law or Act, or similar legislation;
6. Expenses incurred for dental care or treatment of the teeth, gums or structures directly supporting the teeth, including surgical extractions of teeth. This exclusion does not apply to the repair of Injuries to sound natural teeth caused by a covered Injury, and except as specifically provided in the Hospitalization and Anesthesia for Dental Procedures expense benefit and the Pediatric Dental Services benefit;
7. Elective Surgery or Elective Treatment as defined by the Policy;
8. Immunizations, except as specifically provided in the Policy; preventive medicines or vaccines, except when required for treatment of a covered Injury or as specifically provided in the Policy;
9. Weight management, weight reduction, treatment for obesity, surgery for the removal of excess skin or fat, or nutrition programs, except as related to treatment for diabetes;
10. Voluntary termination of pregnancy or elective abortion (including but not limited to abortifacient drugs and devices such as the placement of IUDs with and without hormone impregnation, the use of abortifacient drugs including Ella and Plan B, but not the removal of IUDs).

Gallagher Student Complements

Exclusively from Gallagher Student, the following menu of products is provided to all students currently enrolled in this Plan. These plans are not underwritten by Companion Life Insurance Company. For more information on all of the products & services listed below, visit your school's page at www.gallagherstudent.com under the "Discounts and Wellness" tab.

EYEMED Vision Care

The discount vision plan is available through EyeMed Vision Care.EyeMed's provider network offers access to over 45,000 independentproviders and retail stores nationwide, including LensCrafters, SearsOptical, Target Optical, JC Penney Optical, and most Pearle Vision locations. You can purchase prescription eyeglasses, conventional contact lenses or even non-prescription sunglasses at savings between 15% and 45% off regular retail pricing. In addition, you can receive discounts off laser correction surgery at some of the nation's most highly-qualified laser correction surgeons. You can take advantage of the savings immediately using your EyeMed ID card, which can be printed from the "Discounts and Wellness" tab on your school's page at www.gallagherstudent.com.

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 at reduced costs for students enrolled in a Gallagher Student Insurance Plan. 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 the Gallagher Student plan.

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:

1. Find a contracted dentist from the Basix website.
2. Make an appointment with a contracted dentist- be sure to tell the dental office that you have access to the Basix Dental Savings program. You do not need a separate identification card for the Basix program, but you will need to show your student health insurance ID card to confirm your eligibility.
3. Payment must be made at the time of service in order to receive the negotiated rate.

Full details of the program including lists of contracted dentists and fee schedules can found at www.basixstudent.com.

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.

1. The Energy Management section of the site allows a student to assess how much energy they are consuming, and expending on a daily basis and offers ways to improve food choices.
2. The Fitness Works section offers 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.
3. The Wellness Support section has downloadable mp3 files for guided imagery relaxation, and dozens of recordings to reinforce fundamental diet and nutrition ideas.

The CampusFit website can be accessed at
http://campusfit.basixwellness.com.
Registration is fast, free and completely confidential.

Subrogation and Reimbursement

In the event that an Insured Person suffers an Accident or Sickness for which another party may be responsible, such as someone injuring the Insured Person in an Accident, and We pay benefits as a result of that Accident or Sickness, We will be subrogated and succeed to the Insured Person's right of recovery against the responsible party to the extent of the benefits We have paid. This means that We have the right independently of the Insured Person to proceed against the responsible party to recover the benefits We paid.

If benefits are paid under this Policy and any person recovers from a responsible third party by settlement, judgment or otherwise, We have a right to recover from that person an amount equal to the amount We paid. However, We will reimburse the Insured Person for any charges on a pro-rata basis for any expense incurred in securing the settlement, judgment or otherwise.

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

Claims Procedures

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

1. Students seeking care at from Student Health Services will need to submit a custom claim to HealthSmart Benefit Solutions for reimbursement. Such claim forms are available at Student Health Services or online.
2. A claim form is not required to submit a claim for services outside of Student Health Services. However, an itemized medical bill, HCFA 1500, or U B-92 form should be used to submit expenses. The Insured Student/Person's name and identification number need to be included.
3. 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, HealthSmart Benefit Solutions, at the address on the back cover.

Direct all questions regarding claim procedures, status of a submitted claim or payment of a claim, or benefit availability to the Claims Administrator, HealthSmart Benefit Solutions.

Right to Appeal

An Insured Person has a right to file an appeal or grievance on any coverage decision or adverse decision rendered while insured under this policy. An Insured Person may contact our Claim Administrator, HealthSmart Benefit Solutions and Company, Inc., at 1-877-349-9017. HealthSmart Benefit Solutions address concerns and attempt to resolve them satisfactorily. If HealthSmart Benefit Solutions is unable to resolve a concern over the phone, they will request submission of the concern in writing to pursue a formal appeal.

Privacy Practices

Notice of Privacy Practices

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.

Our Privacy Promise

We understand the importance of handling your medical information with care. We are committed to protecting the privacy of your medical information. State and federal laws require us to make sure that your medical information is kept private. Federal law requires that we provide you with this Notice of Privacy Practices, which describes our legal duties and privacy practices with respect to your medical information and your legal rights with respect to our use and disclosure of your medical information. We are required by law to follow the terms of the Notice currently in effect. This Notice is effective September 23, 2013, and will remain in effect until it is changed or replaced.

We reserve the right to change our privacy practices and the terms of this notice at any time, as long as the law allows. These changes will be effective for all medical information that we keep, including medical information we created or received before we made the changes. When we make a material change to our privacy practices, we will provide a copy of a new notice (or information about the changes to our privacy practices and how to obtain a new notice) in a mailing to members who are covered under our health plans at that time.

Uses and Disclosures of Medical Information

Treatment, Payment, Health Care Operations:

We may use and disclose your medical information for purposes of treatment, payment and health care operations.

Treatment:

We may disclose your medical information to a physician or other health care professional to help him or her provide your treatment.

Payment:

We may use or disclose your medical information for these and other activities related to payment:

- Paying claims from physicians, hospitals and other health care providers.
- Obtaining premiums.
- Issuing explanations of benefits to the named insured.
- Providing information to health care professionals or other entities that are bound by the federal Privacy Rules for their payment activities.

Health Care Operations:

We may use or disclose your medical information in the normal course of conducting health care operations, including such activities as:

- Quality assessment and improvement activities.
- Reviewing the qualifications of health care professionals.
- Compliance and detection of fraud and abuse.
- Underwriting, enrollment and other activities related to creating, renewing or replacing a plan of benefits. We may not, however, use or disclose genetic information for underwriting purposes.
- Providing information to another entity bound by the federal Privacy Rules for its health care operations, in limited circumstances.

You and Your Family and Friends

We may use and disclose your medical information to communicate with you for purposes of customer service or to provide you with information you request. We may disclose your medical information to a family member, friend or other person to the extent necessary for him or her to assist with your health care or payment for your health care. Before we disclose your medical information to that person, we will give you a chance to object to us doing so. If you are not available, or if you are incapacitated or in an emergency situation, we may, in the exercise of our professional judgment, determine whether the disclosure would be in your best interest. We may also use or disclose your medical information to notify (or help notify, including identifying and locating) a family member, a personal representative or other person responsible for your care of your location, general condition or death.

Your Employer or Organization Sponsoring Your Group Health Plans

We may disclose summary information and enrollment information to your employer (or other plan sponsor). Summary information is a summary of the claims history, claims expenses or types of claims that members of your group health plan have filed. The summary information will not include demographic information about you or others in the group health plan, but your employer or plan sponsor may be able to identify individuals from the summary information provided.

Disaster Relief

We may use or disclose your medical information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit

We may use or disclose our members' medical information as authorized by law for the following purposes that are in the public interest or benefit:

- As required by law.
- For public health activities, including disease and vital statistics reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury.
- To report adult abuse, neglect or domestic violence.
- To health oversight agencies.
- In response to court and administrative orders and other lawful processes.
- To law enforcement officials in response to subpoenas and other lawful processes concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies and to identify or locate a suspect or other person.
- To coroners, medical examiners and funeral directors.
- To organ procurement organizations.
- To avert a serious threat to health or safety.
- In connection with certain research activities.
- To the military and to federal officials for lawful intelligence, counterintelligence and national security activities.
- To correctional institutions regarding inmates.
- As authorized by state workers' compensation laws.

Your Authorization

We may not use or disclose your medical information without your written authorization, except as described in this notice. You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it at any time by notifying us of your revocation in writing. Your revocation will not affect any use or disclosure permitted by the authorization while it was in effect. We need your written authorization to use or disclose psychotherapy notes, except in limited circumstances such as when a disclosure is required by law. We also must obtain your written authorization to sell your medical information to a third party or, in most circumstances, to send you communications about products and services. We do not need your written authorization, however, to send you communications about health-related products or services, as long as the products or services are associated with your coverage or are offered by us.

Individual Rights

You have certain rights with respect to the medical information we maintain about you. To exercise any of these rights or to obtain more information about these rights (including any applicable fees), contact us using the information listed at the end of this notice.

Access

You have the right to inspect or receive a paper or electronic copy of your medical information, with some exceptions. To inspect or receive your medical information, you must submit the request in writing. If you request to receive a copy of your records, we are allowed to charge a reasonable, cost-based fee.

Disclosure Accounting

You have the right to request, in writing, a record of instances in which we (or our business associates) disclosed your medical information for purposes other than treatment, payment, health care operations, and as allowed by law. We will provide you with a record of such disclosures for up to the previous six years. If you request a record of disclosures more than once in a 12-month period, we may charge you a reasonable, cost-based fee for each additional request.

Restriction

You have the right to request, in writing, that we place additional restrictions on our use or disclosure of your medical information. By law, we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement to additional restrictions will be made in writing and signed by a person authorized to make such an agreement for us.

Confidential Communications

You have the right to request, in writing, that we communicate with you about your medical information by other means, or to another location. We are not required to agree to your request unless you state that you could be in danger if we do not communicate to you in confidence. In that case, we must accommodate your request if it is reasonable, if it specifies the other means or location, and if it permits us to continue to collect premiums and pay claims under your health plan. We will not be bound to your request unless our agreement is in writing.

Even if we agree to communicate with you in confidence, an explanation of benefits we issue to the named insured for health care services the named insured (or others covered by the health plan) received might contain sufficient information (such as deductible and out-of-pocket amounts) to reveal that you obtained health care services for which we paid.

Amendment

You have the right to request, in writing, that we amend your medical information. Your request must explain why we should amend the information. We may deny your request if we did not create the information you want amended and the person or entity that did create it is available, or we may deny your request for certain other reasons. If we deny your request, we will send you a written explanation.

Notice of Breach

We are required to notify affected individuals following a breach of unsecured medical information.

Electronic Notice

You may request a written copy of this notice at any time or download it from our website.

Questions and Complaints

If you want more information about our privacy practices, or if you have questions or concerns, please contact us using the information below.

If you believe we may have violated your privacy rights, you may submit a complaint to us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with that address upon request.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Information

Attn: Bruce Honeycutt, Privacy Officer
I 20 East @ Alpine Road (AX-E01)
Columbia, SC 29219
(803) 264-7258 (telephone)
(803) 264-7257 (fax)

Questions? Need More Information?

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

Gallagher Student Health & Special Risk
500 Victory Rd.
Quincy, MA 02171
855-275-3700
Email: WheatonILstudent@gallagherstudent.com
www.gallagherstudent.com/WheatonIL

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 Student to verify eligibility.

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

HealthSmart Benefit Solutions
3320 West Market Place
Suite 100
Fairlawn, OH 44333-3306
1-877-349-9017
Email: akronclaims@klais.com

For pharmacy card information or questions about pharmacy claims, please contact:
Express-Scripts
www.express-scripts.com
1-800-344-3405

This plan is underwritten by:
Companion Life Insurance Company
Policy Number 2014-S3-A27

Please keep this as a general summary of the insurance policy. The Master Policy on file at the College contains all the provisions, exclusions and qualifications of your insurance benefits, some of which may not be included in this certificate. The Master Policy is the contract and will govern and control the payment of benefits.