**AMENDMENT NO. 2**

This Amendment forms a part of the Group Policy No. 2015U2A00 and Certificate of Coverage.

Policyholder: **Carleton College**

It is agreed that the following change is hereby made:

1. The Policy is reissued as a new Policy for the term August 15, 2016 through August 15, 2017 as Policy No. 2016U2A00.

2. The Annual Premium Basis for this term of coverage is:

| | |
|---|---|
| Student: | $1,165.00 |
| Spouse: | $2,652.00 |
| Child: | $1,477.00 |

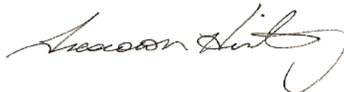
3. The Policy is amended to reflect the following benefit changes:

   - The Deductible is increased from $100.00 to $150.00.
   - The **Out-of-Pocket Maximum** is increased from $6,350.00 Individual/$12,700.00 Family to $6,600.00 Individual/$13,700.00 Family.
   - The **Pharmacy Benefit Manager** is changed from Catamaran to Optum.
   - The **Prescription Drug** Copayment for Generic/Preferred Brand/Brand from $15.00/$40.00/$75.00 to $20.00/$40.00/$60.00.

4. The Policy is amended to delete the **Coordination of Benefits** provision in its entirety.

The effective date of this change is August 15, 2016. All other terms and provisions of the Policy will apply other than stated in this Amendment.

Dated at Columbia, South Carolina, this 15th day of August 2016.



Trescott N. Hinton, Jr.
President

## SCHEDULE OF BENEFITS

### CLASSES OF ELIGIBLE PERSONS:

**Class I:** All full-time students attending Carleton College must participate in this Student Accident and Sickness Insurance Plan unless proof of alternate coverage is furnished. Students who have not provided proof of alternate coverage through the waiver process will be automatically enrolled in the Student Health Insurance Plan. **Waiver and enrollment must be submitted online by August 15, 2016 at www.cirstudenthealth.com/carleton.**

Dependents of Class I Insureds are eligible for coverage under this Policy.

Students must actively attend classes for 31 consecutive class days after the date of enrollment in this insurance program. Home study and auditing scholars do not qualify as a student for the purposes of purchasing insurance coverage.

A person may not be insured as a Dependent and an Insured at the same time.

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### ACCIDENT AND SICKNESS MEDICAL EXPENSE BENEFITS

***Unless otherwise specified, any Deductibles, Co-payments, Co-insurance Percentages and Benefit Maximums apply on a per Covered Person, per Covered Accident/Covered Sickness and Coverage Period basis.***

**Scope of Coverage:**
Benefits will be paid up to the Benefit Maximums shown for each service shown in the schedule below. After the Deductible is satisfied, if it applies, benefits will be paid based on the Provider selected.

**Policy Year Benefit Maximum per Injury or Sickness:**

| | |
|---|---|
| **Student** | **Unlimited** |
| **Dependents** | **Unlimited** |

After the Deductible and any Co-payments have been satisfied, benefits will be paid as shown in the Schedule of Benefits up to the Policy Year Benefit Maximum.

**Deductible:**

| | |
|---|---|
| **Per Person per Policy Year:** | **$150.00** |

The deductible is waived if a student first uses the Student Health and Counseling (SHAC). Dependents are not eligible to use the SHAC.

**Policy Term Out-of-Pocket Maximum per Covered Person*:**

| | |
|---|---|
| Per Individual | **$6,600.00** |
| Per Family | **$13,700.00** |

* After the Out-of-Pocket Maximum has been reached, benefits will be paid at 100% of the Preferred Allowance (In-Network) or 100% of U&C (Out-of-Network). The Out-of-Pocket limit 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 Medical Expenses 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 Co-payments and per service Deductibles.

| | |
|---|---|
| Preferred Provider Network: | First Health Network<br>Toll Free 800-226-5116<br>www.myfirsthealth.com |
| Participating Pharmacies: | Optum<br>800-248-1062<br>www.optumrx.com |

| SCHEDULE OF BENEFITS | | |
|---|---|---|
| **Covered Inpatient Expenses:** | **PPO Provider** | **Out-of-Network Provider** |
| | | |
| Hospital Room & Board – a) daily semi-private room rate when confined in a Hospital as an Inpatient; and b) general nursing care provided and charged for by the Hospital | 80% Preferred Allowance | 60% U&C |
| | | |
| Hospital Miscellaneous | 80% Preferred Allowance | 60% U&C |
| | | |
| Intensive Care | 80% Preferred Allowance | 60% U&C |
| | | |
| Surgery | 80% Preferred Allowance | 60% U&C |
| | | |
| Anesthetist & Assistant Surgeon Fees | 80% Preferred Allowance | 60 % U&C |
| | | |
| Preadmission Testing | 80% Preferred Allowance | 60% U&C |
| | | |
| Doctor's Visit – limited to one visit per day and does not apply when related to surgery | 80% Preferred Allowance | 60% U&C |
| | | |
| Urgent Care | 80% Preferred Allowance | 60% U&C |
| | | |
| Physical Therapy | 80% Preferred Allowance | 60% U&C |
| | | |
| Emergency Room Care – subject to $250.00 Copayment, waived if admitted as an Inpatient | 80% Preferred Allowance | 80% U&C |
| | | |
| Skilled Nursing Facility – up to 120 days per admission | 80% Preferred Allowance | 60% U&C |
| | | |
| Mental Health and Substance Use Disorders | Paid as any other Sickness | Paid as any other Sickness |

| **Covered Outpatient Expenses:** | **PPO Provider** | **Out-of-Network Provider** |
|---|---|---|
| | | |
| Doctor's Visits – does not apply when related to surgery or physiotherapy | 80% Preferred Allowance | 60% U&C |
| | | |
| Outpatient Surgery including day surgery miscellaneous expenses | 80% Preferred Allowance | 60% U&C |
| | | |
| Anesthetist & Assistant Surgeon Fees | 80% Preferred Allowance | 60% U&C |
| | | |
| Outpatient Miscellaneous Expense for services not otherwise covered, but excluding surgery | 80% Preferred Allowance | 60% U&C |

| SCHEDULE OF BENEFITS | | |
|---|---|---|
| **Covered Outpatient Expenses: (continued)** | **PPO Provider** | **Out-of-Network Provider** |
| | | |
| Physiotherapy/Occupational Therapy – limited to one visit per day | 80% Preferred Allowance | 60% U&C |
| | | |
| Rehabilitative and Habilitative Therapy | 80% Preferred Allowance | 60% U&C |
| | | |
| Chiropractor Care –limited to one visit per day | 80% Preferred Allowance | 60% U&C |
| | | |
| Diagnostic X-ray and Laboratory Procedures | 80% Preferred Allowance | 60% U&C |
| | | |
| Mental Health and Substance Use Disorders | Paid as any other Sickness | Paid as any other Sickness |
| | | |
| Radiation Therapy and Chemotherapy | 80% Preferred Allowance | 60% U&C |
| | | |
| Hospice – by a licensed agency/provider for terminally ill patients with life expectancy of 6 months or less | 80% Preferred Allowance | 60% U&C |
| | | |
| Home Health Care to a maximum of 120 visits per Policy Year. Other limitations apply. | 80% Preferred Allowance | 60% U&C |

| **Other Covered Expenses:** | **PPO Provider** | **Out-of-Network Provider** |
|---|---|---|
| | | |
| Durable Medical Equipment | 80% Preferred Allowance | 60% U&C |
| | | |
| Ambulance Service | 100% Preferred Allowance | 100% U&C |
| | | |
| Consultant Doctor's Fee – when requested and approved by the attending Doctor | 80% Preferred Allowance | 60% U&C |
| | | |
| Maternity (including Birthing Center services) | 80% Preferred Allowance | 60% U&C |
| | | |
| Complications of Pregnancy | Paid as any other Sickness | Paid as any other Sickness |
| | | |
| Routine Newborn Care | 80% Preferred Allowance | 60% U&C |
| | | |
| Accidental Dental Injury – to sound natural teeth only | 80% Preferred Allowance | 60% U&C |
| | | |
| Hearing Aid Expense – one per affected ear every 3 years | 80% Preferred Allowance | 60% U&C |

| SCHEDULE OF BENEFITS | | |
|---|---|---|
| **Other Covered Expenses: (continued)** | **PPO Provider** | **Out-of-Network Provider** |
| | | |
| Preventive Services Benefit – includes preventive services such as screenings, exams and immunizations as specified by the Patient Protection and Affordable Care Act (PPACA). To view a list of covered preventive services, log onto www.healthcare.gov. Such services will be paid 100% at the Student Health Center (Deductible waived), or 60% U&C Out-of-Network (Deductible waived). | 100% Preferred Allowance, no Deductible or Copay | 60% U&C, not subject to Deductible |
| | | |
| Pediatric Dental Service (as required by the Patient Protection and Affordable Care Act of 2010) for Covered Persons under the age of 19 years.<br><br>Pediatric Dental Service benefit pays for the following:<br>• Preventive Services – including exams and cleaning (two per year), fluoride treatments and sealants to age 16;<br>• Basic Services – including fillings, x-rays, oral surgery and simple extractions;<br>• Major Services – including endodontics, periodontics, crowns, bridges and dentures;<br>• Orthodontia | 100% U&C for Preventive Services<br><br>50% U&C<br><br>50% U&C<br><br>50% U&C<br><br>50% U&C | |
| | | |
| Pediatric Vision Service benefit pays for one vision examination per Policy Year, and related materials and supplies | 100% U&C for Preventive Services<br><br>80% U&C for all other Covered Services | |
| | | |
| Routine Eye Exam (Adult) | 80% Preferred Allowance | 60% U&C |
| | | |
| Prescription Drugs (Rx Card) | 100% U&C after a $20.00 Copay for each Generic prescription drug; a $40.00 Copay for each Preferred Brand prescription drug; and a $60.00 Copay for each Brand name prescription drug.<br>$0.00 Copay for Generic contraceptives | Prescriptions not filled at an Optum participating pharmacy are not covered. |
| | | |
| Sports Accident Expense incurred as a result of practice or play of Intercollegiate sports | 100% U&C up to $500.00, then 80% U&C up to $90,000.00 Deductible waived if Student first uses the Student Health Center | |

| SCHEDULE OF BENEFITS | | |
|---|---|---|
| **State Mandated Accident and Sickness Medical Expense Benefits:** | **PPO Provider** | **Out-of-Network Provider** |
| | | |
| Diabetes – includes all Medically Necessary equipment, supplies, medications, labs and outpatient self-management training and educational services | 80% Preferred Allowance | 60% U&C |
| | | |
| Dental Anesthesia and Facility – Facility charges and general anesthesia services performed in connection with dental services for dependent children with special needs as specified in the Policy | 80% Preferred Allowance | 60% U&C |
| | | |
| Temporomandibular Joint/Craniomandibular Disorder Expense Benefit | Paid as any other condition | Paid as any other condition |
| | | |
| Cleft Lip & Cleft Palate Treatment | Paid as any other condition | Paid as any other condition |
| | | |
| Lyme Disease Treatment Benefit | Paid as any other condition | Paid as any other condition |
| | | |
| Phenylketonuria (PKU) Treatment Expense Benefit | Paid as any other condition | Paid as any other condition |
| | | |
| Scalp Hair Prostheses Expense Benefit | Paid as any other condition | Paid as any other condition |
| | | |
| Coverage for Services to Ventilator Dependent Persons | Paid as any other condition | Paid as any other condition |
| | | |
| Off-label Drugs for Cancer Treatment | Paid as any other Prescription Drug | Paid as any other Prescription Drug |
| | | |
| Non-formulary Antipsychotic Drugs | Paid as any other Prescription Drug | Paid as any other Prescription Drug |
| | | |
| Ovarian Cancer Screening | Paid as any other condition | Paid as any other condition |
| | | |
| Reconstructive Surgery – see benefit for limitations | Paid as any other surgery | Paid as any other surgery |
| | | |
| Cosmetic Surgery due to complications from breast implants | Paid as any other surgery | Paid as any other surgery |

# NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN INSOLVENCY UNDER THE MINNESOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION LAW

If the insurer who issued your life, annuity or health insurance policy becomes impaired or insolvent you are entitled to compensation for your policy from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer.

In addition, residents of Minnesota who purchase life insurance, annuities, or health insurance from insurance companies authorized to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

Minnesota Life & Health Insurance Guaranty Association
4760 White Bear Parkway, Suite 101
White Bear Lake, Minnesota 55110
(651) 407-3149

The maximum amount the guaranty association will pay for all policies issued on one life by the same insurer is limited to $500.000. Subject to this $500.000 limit, the Guaranty Association will pay up to $500,000 in life insurance death benefits, $130,000 in net cash surrender and net cash withdrawal values for life insurance, $500,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values, $250,000 in annuity net cash surrender and net cash withdrawal values, $410,000 in present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant's lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be $500,000 in present value.

Unallocated annuity contracts issued to retirement plans, other then defined benefit plans, established under section 401, 403(b), or 457 of the Internal Revenue Code of 1986, as amended through December 31, 1992, are covered up to $250,000 in net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the association shall not be responsible for more than $10,000,000 in claims from all Minnesota residents covered by the plan. If the total claims exceed $10,000,000, the $10,000,000 shall be prorated among all claimants. These are the maximum claim amounts.

Coverage by the guaranty association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the Guaranty Association's limits you may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The Guaranty Association assesses insurers licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment.

THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY OR POLICY, YOU SHOULD NOT RELY ON COVERAGE BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF LIFE, ANNUITY OR HEALTH INSURANCE POLICIES OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE, ANNUITY AND HEALTH INSURANCE POLICIES ARE REQUIRED TO PROVIDE THIS NOTICE.

# Companion Life Insurance Company

**Companion Life Insurance Company (CL) is committed to protecting the privacy of the personal information we receive ("Information") about you. By choosing to do business with us, you have placed your trust in us and we take this responsibility very seriously. This notice states our privacy practices. Our pledge to you is "your privacy is our priority."**

**Why We Collect and How We Use Information:**

When you apply to any of our insurance companies for any product or service, you disclose to us a certain amount of Information about yourself. We collect only Information necessary or relevant to our business. We use the Information to evaluate, process and service your request for products and services and to offer you other CL products or services.

**Types of Information We Collect:**

We collect most Information directly from you on applications or from other communications with you during the application process.

Types of Information we could collect include, but are not limited to:

- name
- address
- age
- social security number
- beneficiary information
- other insurance coverage
- health information
- financial information
- occupation
- hobbies
- other personal characteristics

**We also may keep Information about your transactions with us:**

- types of products you buy
- your premium amount
- your account balances
- your payment history

Additional Information is received from:

- medical personnel
- medical institutions
- Medical Information Bureau (MIB, Inc.)
- other insurance companies
- agents
- employers
- public records
- consumer reporting agencies

**How We Disclose Your Information:**

Your Information as described above may be disclosed as permitted by law to our affiliates and nonaffiliated third parties. These disclosures include, but are not limited to the following purposes:

- To assess eligibility for insurance, benefits or payments
- To process and service your requests for our products and services
- To collect premium, pay benefits and perform other claims administration
- To print and mail communications from us such as policy statements
- For audit or research purposes
- To respond to requests from law enforcement authorities or other government authority as required by law
- To resolve grievances
- To find or prevent criminal activity, fraud, material misrepresentation or nondisclosure in connection with an insurance issue

CL also may disclose your Information as permitted by law to our affiliates without prior authorization in order to offer you other CL products or services. The law does not allow you to restrict such disclosures.

Except for the above disclosures or as authorized by you with respect to your Information, CL does not share Information about our customers or former customers with nonaffiliated third parties. Further, when Information is disclosed to any nonaffiliated third parties as permitted by law, we require that they agree to our privacy standards. Please note that Information we get from a report prepared by an insurance support organization may be retained by that insurance support organization and used for other purposes.

**Access to and Correction of Your Information:**

You have the right to access and correct your Information that we have on file. Generally, upon your written request, we will make your Information available for your review. Information collected in connection with or in anticipation of a claim or legal proceeding need not be disclosed to you.

If you notify us that your Information should be corrected, amended or deleted, we will review it. We will either make the requested change or explain our refusal to do so. If we do not make the requested change, you may submit a short written statement of dispute, which we will include in any future disclosure of Information. For a more detailed explanation of these rights to access and correction, please send us a written request.

**Massachusetts Policyholders**: You will be notified in writing of any adverse underwriting decisions, including the specific reason the adverse decision was made.

**How We Protect Your Information:**

CL has developed strong security measures to guard the Information of our customers.

We restrict access to your Information to designated personnel or service providers who administer or offer our products or services, or who may be responsible for maintaining Information security practices.

We maintain physical, electronic and procedural safeguards that comply with applicable laws to protect your Information.

Please keep a copy of this notice with your important papers. Additional copies of this notice are available upon written or verbal request. This notice is also available on CL's website, www.companionlife.com.

## NOTICE OF PRIVACY PRACTICES

COMPANION LIFE INSURANCE COMPANY

Columbia, SC

As Required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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)

COMPANION LIFE INSURANCE COMPANY
P.O. BOX 100102, COLUMBIA, SC 29202
800-753-0404 (Phone) ● 800-836-5433 (Fax)

# BLANKET STUDENT ACCIDENT AND SICKNESS INSURANCE COVERAGE

## SECTION I: Application Information

**Official School Name:** Carleton College

**Attn/Address:** One North College Street

**School Address:** ____________________

**City:** Northfield **State:** MN **Zip:** 55057

**School Phone:** ____________ **E-Mail Address:** ____________

**Contact Person (if different than above):** ____________

**Title:** ____________ **Dept:** ____________

**Contact's Phone:** ____________ **Contact's E-Mail Address:** ____________

**Select ONE Method for Receipt of Policy Confirmation:** __X__ **E-Mail** _____ **Fax** _____ **Mail**
*Confirmation will be sent by one method ONLY. If you check multiple options, we will send using the first method selected.*

| Section II: Coverage Period and Premium Rate | |
|---|---|
| **Eligible Class** | **Annual** |
| **Student** | **$1,165.00** |
| **Spouse** | **$2,652.00** |
| **Children** | **$1,477.00** |

**This application provides coverage for all eligible students and their dependents. Your premium is based upon the number of students enrolled during the selected coverage period and corresponding premium rate.**

## Section III: Please Read and Sign Below

**The applicant declares the information contained in the application is true and that no material facts have been suppressed or misstated. The applicant understands that incorrect information could void the insurance coverage. The signing of this application does not bind the undersigned to purchase this insurance, nor does the review of the application bind the insurance company to issue a policy. It is agreed that this application shall be the basis of the contract should a policy be issued. Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.**

**Signature:** ____________ **Today's Date (mm/dd/yyyy):** ____________

**Total Amount of Payment:** ____________ **Desired Effective Date:** 08/15/2016

## Section IV: Agent's Signature

**Agent/Broker (Please Print):** Kathleen Azman **License I.D. #:** 1436079

**Signature of Agent/Broker:** ____________ **Date:** ____________

**AMENDMENT NO. 1**

This Amendment forms a part of the Group Policy No. 2014S3A05 and certificate of coverage.

Policyholder: **Carleton College**

It is agreed that the following change is hereby made:

1. The Policy is reissued as a new Policy for the term August 15, 2015 through August 15, 2016 as Policy No. 2015U2A00.

2. The Annual Premium Basis for this term of coverage is:

| | |
|---|---|
| Student: | $1,010.00 |
| Spouse: | $2,298.00 |
| Child: | $1,280.00 |

3. The Policy is amended to remove Limitations from any Essential Health Benefit stated in the Schedule of Benefits or Description of Benefits section of the Policy. If additional care, treatment or services are added to the List of Essential Health Benefits by a governing authority, the Policy benefits will be amended to comply with such change.

4. Coverage under the Policy will include non-emergency care while traveling outside the United States.

5. The Policy is amended to reflect the following benefit changes:

   - Add coverage for Intercollegiate Sports at 100% of Usual & Customary Expense up to $500.00, then 80% of Usual and Customary up to $90,000.00 maximum per Covered Injury, subject to a $100.00 deductible per Policy Year as stated in the Schedule of Benefits. The deductible will be waived if the Student first uses the Student Health Center.
   - The Pharmacy Benefit Manager is changed from Express Scripts to Catamaran.
   - The Prescription Drug Copayment for Generic/Preferred Brand/Brand from $15.00/$30.00/$45.00 to $15.00/$40.00/$75.00.

6. The Policy is amended to replace the current **Sickness** definition with the following:

   **Covered Sickness** means Sickness, disease or trauma related disorder due to Injury which:
   1. causes a loss while the Policy is in force; and
   2. which results in Covered Medical Expenses.

   Covered Sickness includes Mental Health Disorders and Substance Use Disorders.

7. Coverage will be provided for **Mental Health and Substance Use Disorders** on the same basis as any other Covered Sickness as required by the Federal Mental Health Parity and Addiction Act (MHPAEA).

8. The **Pediatric Dental and Pediatric Vision Benefits** are amended to reflect coverage for In-Network preventive services at 100% of Usual and Customary and 50% of Usual and Customary for Pediatric Dental and 80% of Usual and Customary for Pediatric Vision, for all other Covered Services.

9. The Policy is amended to delete the current **Schedule of Benefits** in its entirety and replace it with the attached updated Schedule of Benefits.

10. The Policy is amended to include coverage for the following **Mandated Benefits** as required by the State of Minnesota:

    - **Diabetes** including all medically necessary equipment, supplies & service including medication, laboratory expense and self-management training and education services.
    - **Dental Anesthesia and Facility** charges including general anesthesia services performed in connection with dental services for dependent children with special needs.
    - **Lyme Disease Treatment**.
    - **Phenylketonuria Treatment** for special dietary treatment when recommended by a physician.
    - **Scalp Hair Prosthesis** – one per Policy Year for hair loss suffered as a result of alopecia areata.
    - **Temporomandibular Joint (TMJ) Disorder** benefit for surgical or non-surgical treatment for TMJ or craniomandibular disorder, same as any other treatment for a joint disorder of the body when treatment is administered by a Doctor or a Dentist.
    - Cosmetic Surgery due to **complications from breast implants**.
    - **Reconstructive Surgery** that is incidental to or follows a related surgery due to a Covered Injury or Sickness of a covered dependent child or due to congenital disease and reconstructive surgery after a mastectomy when medically necessary.
    - Coverage for **Emotionally Disabled Children** will be provided under the Mental Health Parity and Addiction Act (MHPAEA) on the same basis as Inpatient hospital coverage.
    - Coverage for **Services to Ventilator Dependent Persons**, up to 120 hours for service provided by a private duty nurse or personal care assistant during hospitalization.
    - **Off-label Drugs for Cancer Treatment** and **Non-Formulary Antipsychotic Drugs** will be paid as any other prescription drug under the Plan.
    - **Cleft Lip & Cleft Palate Treatment**.
    - **Ovarian Cancer Screening**.
    - **Hearing Aid Coverage** for one hearing aid every 36 months for covered children age 18 and under who have a hearing loss that is not corrected by other covered procedures.

11. The following Exclusion is amended to read:

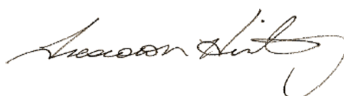
    6. Injuries arising out of:
        a. playing or participating in a professional sport, contest or competition;
        b. traveling to or from such sport, contest or competition as a participant; or
        c. participation in any practice or conditioning program for such sport, contest, or competition.

    18. Hearing examinations or hearing aids except as specifically provided by the Policy; or other treatment for hearing defects or problems. “Hearing defects” means any physical defect of the ear which does or can impair normal hearing apart from the disease process.

12. The **Exclusion Provision** is amended to reflect any Exclusion in conflict with the Patient Protection and Affordable Care Act or Mandated Benefits will be revised to comply and provide coverage as specifically stated in the Schedule of Benefits. Any Exclusion in direct conflict will be deleted in its entirety.

The effective date of this change is August 15, 2015. All other terms and provisions of the Policy will apply other than stated in this Amendment.

Dated at Columbia, South Carolina, this 15th day of August 2015.



Trescott N. Hinton, Jr.
President

| SCHEDULE OF BENEFITS | | |
|---|---|---|
| **Covered Inpatient Expenses:** | **PPO Provider** | **Out-of-Network Provider** |
| | | |
| Hospital Room & Board – a) daily semi-private room rate when confined in a Hospital as an Inpatient; and b) general nursing care provided and charged for by the Hospital | 80% Preferred Allowance | 60% U&C |
| | | |
| Hospital Miscellaneous | 80% Preferred Allowance | 60% U&C |
| | | |
| Intensive Care | 80% Preferred Allowance | 60% U&C |
| | | |
| Surgery | 80% Preferred Allowance | 60% U&C |
| | | |
| Anesthetist & Assistant Surgeon Fees | 80% Preferred Allowance | 60 % U&C |
| | | |
| Preadmission Testing | 80% Preferred Allowance | 60% U&C |
| | | |
| Doctor's Visit – limited to one visit per day and does not apply when related to surgery | 80% Preferred Allowance | 60% U&C |
| | | |
| Urgent Care | 80% Preferred Allowance | 60% U&C |
| | | |
| Physical Therapy | 80% Preferred Allowance | 60% U&C |
| | | |
| Emergency Room Care – subject to $250.00 Copayment | 80% Preferred Allowance | 80% U&C |
| | | |
| Skilled Nursing Facility – up to 120 days per admission | 80% Preferred Allowance | 60% U&C |
| | | |
| Mental Health and Substance Use Disorders | Paid as any other Sickness | Paid as any other Sickness |

| **Covered Outpatient Expenses:** | **PPO Provider** | **Out-of-Network Provider** |
|---|---|---|
| | | |
| Doctor's Visits – does not apply when related to surgery or physiotherapy | 80% Preferred Allowance | 60% U&C |
| | | |
| Outpatient Surgery including day surgery miscellaneous expenses | 80% Preferred Allowance | 60% U&C |
| | | |
| Anesthetist & Assistant Surgeon Fees | 80% Preferred Allowance | 60% U&C |
| | | |
| Outpatient Miscellaneous Expense for services not otherwise covered, but excluding surgery | 80% Preferred Allowance | 60% U&C |

| SCHEDULE OF BENEFITS | | |
|---|---|---|
| **Covered Outpatient Expenses: (continued)** | **PPO Provider** | **Out-of-Network Provider** |
| | | |
| Physiotherapy/Occupational Therapy – limited to one visit per day | 80% Preferred Allowance | 60% U&C |
| | | |
| Rehabilitative and Habilitative Therapy | 80% Preferred Allowance | 60% U&C |
| | | |
| Chiropractor Care –limited to one visit per day | 80% Preferred Allowance | 60% U&C |
| | | |
| Diagnostic X-ray and Laboratory Procedures | 80% Preferred Allowance | 60% U&C |
| | | |
| Mental Health and Substance Use Disorders | Paid as any other Sickness | Paid as any other Sickness |
| | | |
| Radiation Therapy and Chemotherapy | 80% Preferred Allowance | 60% U&C |
| | | |
| Hospice – by a licensed agency/provider for terminally ill patients with life expectancy of 6 months or less | 80% Preferred Allowance | 60% U&C |
| | | |
| Home Health Care to a maximum of 120 visits per Policy Year. Other limitations apply. | 80% Preferred Allowance | 60% U&C |

| **Other Covered Expenses:** | **PPO Provider** | **Out-of-Network Provider** |
|---|---|---|
| | | |
| Durable Medical Equipment | 80% Preferred Allowance | 60% U&C |
| | | |
| Ambulance Service | 100% Preferred Allowance | 100% U&C |
| | | |
| Consultant Doctor's Fee – when requested and approved by the attending Doctor | 80% Preferred Allowance | 60% U&C |
| | | |
| Maternity (including Birthing Center services) | 80% Preferred Allowance | 60% U&C |
| | | |
| Complications of Pregnancy | Paid as any other Sickness | Paid as any other Sickness |
| | | |
| Routine Newborn Care | 80% Preferred Allowance | 60% U&C |
| | | |
| Accidental Dental Injury – to sound natural teeth only | 80% Preferred Allowance | 60% U&C |
| | | |
| Hearing Aid Expense – one per affected ear every 3 years | 80% Preferred Allowance | 60% U&C |

| SCHEDULE OF BENEFITS | | |
|---|---|---|
| **Other Covered Expenses: (continued)** | **PPO Provider** | **Out-of-Network Provider** |
| | | |
| Preventive Services Benefit – includes preventive services such as screenings, exams and immunizations as specified by the Patient Protection and Affordable Care Act (PPACA). To view a list of covered preventive services, log onto www.healthcare.gov. Such services will be paid 100% at the Student Health Center (Deductible waived), or 60% U&C Out-of-Network (Deductible waived). | 100% Preferred Allowance, no Deductible or Copay | 60% U&C, not subject to Deductible |
| | | |
| Pediatric Dental Service (as required by the Patient Protection and Affordable Care Act of 2010) for Covered Persons under the age of 19 years.<br><br>Pediatric Dental Service benefit pays for the following:<br>• Preventive Services – including exams and cleaning (two per year), fluoride treatments and sealants to age 16;<br>• Basic Services – including fillings, x-rays, oral surgery and simple extractions;<br>• Major Services – including endodontics, periodontics, crowns, bridges and dentures;<br>• Orthodontia | 100% U&C for Preventive Services<br><br>50% U&C<br><br>50% U&C<br><br>50% U&C<br><br>50% U&C | |
| | | |
| Pediatric Vision Service benefit pays for one vision examination per Policy Year, and related materials and supplies | 100% U&C for Preventive Services<br><br>80% U&C for all other Covered Services | |
| | | |
| Routine Eye Exam (Adult) | 80% Preferred Allowance | 60% U&C |
| | | |
| Prescription Drugs (Rx Card) | 100% U&C after a $15.00 Copay for each Generic prescription drug; a $40.00 Copay for each Preferred brand prescription drug; and a $75.00 Copay for each Brand name prescription drug.<br><br>$0.00 Copay for Generic contraceptives | Prescriptions not filled at a Catamaran participating pharmacy are not covered. |
| | | |
| Sports Accident Expense incurred as a result of practice or play of Intercollegiate sports | 100% U&C up to $500.00, then 80% U&C up to $90,000.00 Deductible waived if Student first uses the Student Health Center | |

| SCHEDULE OF BENEFITS | | |
|---|---|---|
| **State Mandated Accident and Sickness Medical Expense Benefits:** | **PPO Provider** | **Out-of-Network Provider** |
| | | |
| Diabetes – includes all Medically Necessary equipment, supplies, medications, labs and outpatient self-management training and educational services | 80% Preferred Allowance | 60% U&C |
| | | |
| Dental Anesthesia and Facility – Facility charges and general anesthesia services performed in connection with dental services for dependent children with special needs as specified in the Policy | 80% Preferred Allowance | 60% U&C |
| | | |
| Temporomandibular Joint/Craniomandibular Disorder Expense Benefit | Paid as any other condition | Paid as any other condition |
| | | |
| Cleft Lip & Cleft Palate Treatment | Paid as any other condition | Paid as any other condition |
| | | |
| Lyme Disease Treatment Benefit | Paid as any other condition | Paid as any other condition |
| | | |
| Phenylketonuria (PKU) Treatment Expense Benefit | Paid as any other condition | Paid as any other condition |
| | | |
| Scalp Hair Prostheses Expense Benefit | Paid as any other condition | Paid as any other condition |
| | | |
| Coverage for Services to Ventilator Dependent Persons | Paid as any other condition | Paid as any other condition |
| | | |
| Off-label Drugs for Cancer Treatment | Paid as any other Prescription Drug | Paid as any other Prescription Drug |
| | | |
| Non-formulary Antipsychotic Drugs | Paid as any other Prescription Drug | Paid as any other Prescription Drug |
| | | |
| Ovarian Cancer Screening | Paid as any other condition | Paid as any other condition |
| | | |
| Reconstructive Surgery – see benefit for limitations | Paid as any other surgery | Paid as any other surgery |
| | | |
| Cosmetic Surgery due to complications from breast implants | Paid as any other surgery | Paid as any other surgery |

# NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN INSOLVENCY UNDER THE MINNESOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION LAW

If the insurer who issued your life, annuity or health insurance policy becomes impaired or insolvent you are entitled to compensation for your policy from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer.

In addition, residents of Minnesota who purchase life insurance, annuities, or health insurance from insurance companies authorized to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

Minnesota Life & Health Insurance Guaranty Association
4760 White Bear Parkway, Suite 101
White Bear Lake, Minnesota 55110
(651) 407-3149

The maximum amount the guaranty association will pay for all policies issued on one life by the same insurer is limited to $500.000. Subject to this $500.000 limit, the Guaranty Association will pay up to $500,000 in life insurance death benefits, $130,000 in net cash surrender and net cash withdrawal values for life insurance, $500,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values, $250,000 in annuity net cash surrender and net cash withdrawal values, $410,000 in present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant's lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be $500,000 in present value.

Unallocated annuity contracts issued to retirement plans, other then defined benefit plans, established under section 401, 403(b), or 457 of the Internal Revenue Code of 1986, as amended through December 31, 1992, are covered up to $250,000 in net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the association shall not be responsible for more than $10,000,000 in claims from all Minnesota residents covered by the plan. If the total claims exceed $10,000,000, the $10,000,000 shall be prorated among all claimants. These are the maximum claim amounts.

Coverage by the guaranty association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the Guaranty Association's limits you may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The Guaranty Association assesses insurers licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment.

THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY OR POLICY, YOU SHOULD NOT RELY ON COVERAGE BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF LIFE, ANNUITY OR HEALTH INSURANCE POLICIES OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE, ANNUITY AND HEALTH INSURANCE POLICIES ARE REQUIRED TO PROVIDE THIS NOTICE.

# Companion Life Insurance Company

**Companion Life Insurance Company (CL) is committed to protecting the privacy of the personal information we receive ("Information") about you. By choosing to do business with us, you have placed your trust in us and we take this responsibility very seriously. This notice states our privacy practices. Our pledge to you is "your privacy is our priority."**

**Why We Collect and How We Use Information:**

When you apply to any of our insurance companies for any product or service, you disclose to us a certain amount of Information about yourself. We collect only Information necessary or relevant to our business. We use the Information to evaluate, process and service your request for products and services and to offer you other CL products or services.

**Types of Information We Collect:**

We collect most Information directly from you on applications or from other communications with you during the application process.

Types of Information we could collect include, but are not limited to:

- name
- address
- age
- social security number
- beneficiary information
- other insurance coverage
- health information
- financial information
- occupation
- hobbies
- other personal characteristics

**We also may keep Information about your transactions with us:**

- types of products you buy
- your premium amount
- your account balances
- your payment history

Additional Information is received from:

- medical personnel
- medical institutions
- Medical Information Bureau (MIB, Inc.)
- other insurance companies
- agents
- employers
- public records
- consumer reporting agencies

**How We Disclose Your Information:**

Your Information as described above may be disclosed as permitted by law to our affiliates and nonaffiliated third parties. These disclosures include, but are not limited to the following purposes:

- To assess eligibility for insurance, benefits or payments
- To process and service your requests for our products and services
- To collect premium, pay benefits and perform other claims administration
- To print and mail communications from us such as policy statements
- For audit or research purposes
- To respond to requests from law enforcement authorities or other government authority as required by law
- To resolve grievances
- To find or prevent criminal activity, fraud, material misrepresentation or nondisclosure in connection with an insurance issue

CL also may disclose your Information as permitted by law to our affiliates without prior authorization in order to offer you other CL products or services. The law does not allow you to restrict such disclosures.

Except for the above disclosures or as authorized by you with respect to your Information, CL does not share Information about our customers or former customers with nonaffiliated third parties. Further, when Information is disclosed to any nonaffiliated third parties as permitted by law, we require that they agree to our privacy standards. Please note that Information we get from a report prepared by an insurance support organization may be retained by that insurance support organization and used for other purposes.

**Access to and Correction of Your Information:**

You have the right to access and correct your Information that we have on file. Generally, upon your written request, we will make your Information available for your review. Information collected in connection with or in anticipation of a claim or legal proceeding need not be disclosed to you.

If you notify us that your Information should be corrected, amended or deleted, we will review it. We will either make the requested change or explain our refusal to do so. If we do not make the requested change, you may submit a short written statement of dispute, which we will include in any future disclosure of Information. For a more detailed explanation of these rights to access and correction, please send us a written request.

**Massachusetts Policyholders**: You will be notified in writing of any adverse underwriting decisions, including the specific reason the adverse decision was made.

**How We Protect Your Information:**

CL has developed strong security measures to guard the Information of our customers.

We restrict access to your Information to designated personnel or service providers who administer or offer our products or services, or who may be responsible for maintaining Information security practices.

We maintain physical, electronic and procedural safeguards that comply with applicable laws to protect your Information.

Please keep a copy of this notice with your important papers. Additional copies of this notice are available upon written or verbal request. This notice is also available on CL's website, www.companionlife.com.

## NOTICE OF PRIVACY PRACTICES

COMPANION LIFE INSURANCE COMPANY

Columbia, SC

As Required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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)

COMPANION LIFE INSURANCE COMPANY
P.O. BOX 100102, COLUMBIA, SC 29202
800-753-0404 (Phone) • 800-836-5433 (Fax)

# BLANKET STUDENT ACCIDENT AND SICKNESS INSURANCE COVERAGE

## SECTION I: Application Information

**Official School Name:** Carleton College

**Attn/Address:** One North College Street

**School Address:** ______

**City:** Northfield **State:** MN **Zip:** 55057

**School Phone:** ______ **E-Mail Address:** ______

**Contact Person (if different than above):** Randie Johnson

**Title:** Purch + Risk Mgr **Dept:** Business Office

**Contact's Phone:** 507-222-4178 **Contact's E-Mail Address:** rajohnso@carleton.edu

**Select ONE Method for Receipt of Policy Confirmation:** X E-Mail ____ Fax ____ Mail

*Confirmation will be sent by one method ONLY. If you check multiple options, we will send using the first method selected.*

## Section II: Coverage Period and Premium Rate

| Eligible Class | Annual |
|---|---|
| Student | $1,010.00 |
| Spouse | $2,298.00 |
| Children | $1,280.00 |

**This application provides coverage for all eligible students and their dependents. Your premium is based upon the number of students enrolled during the selected coverage period and corresponding premium rate.**

## Section III: Please Read and Sign Below

**The applicant declares the information contained in the application is true and that no material facts have been suppressed or misstated. The applicant understands that incorrect information could void the insurance coverage. The signing of this application does not bind the undersigned to purchase this insurance, nor does the review of the application bind the insurance company to issue a policy. It is agreed that this application shall be the basis of the contract should a policy be issued. Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.**

**Signature:** [signature] **Today's Date (mm/dd/yyyy):** 07/01/2015

**Total Amount of Payment:** ______ **Desired Effective Date:** 08/15/2015

## Section IV: Agent's Signature

**Agent/Broker (Please Print):** Kathleen Azman **License I.D. #:** 1436079

**Signature of Agent/Broker:** ______ **Date:** ______

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**Total Amount of Payment:** ____________________ **Desired Effective Date:** 08/15/2015

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**Agent/Broker (Please Print):** Kathleen Azman **License I.D. #:** 1436079

**Signature of Agent/Broker:** ______________________________ **Date:** ____________________

COMPANION LIFE INSURANCE COMPANY
7909 PARKLANE ROAD, SUITE 200, COLUMBIA, SC 29223-5666
P.O. BOX 100102, COLUMBIA, SC 29202-3102
(803) 735-1251
(the "Company")

| | |
|---|---|
| **POLICYHOLDER:** | **Carleton College** |
| **POLICY NO.:** | **2014-S3-A05** |
| **EFFECTIVE DATE:** | **August 15, 2014** |
| **POLICY TERM:** | **August 15, 2014 to August 15, 2015** |
| **PREMIUM DUE DATE:** | **On or before the Policy Effective Date** |

**READ YOUR POLICY CAREFULLY**: This Policy is a legally binding contract between the Insured and Companion Life Insurance Company ("Company" or "Insurer"). The consideration for this Policy includes, but is not limited to, the Application and the payment of premiums as provided for herein. It is governed by the laws of the state in which it is issued.

The Company will pay the insurance benefits provided in this Policy. Payment is subject to the conditions, limitations and exceptions of this Policy.

The Insured agrees to pay premiums when due and to comply with the Policy provisions.

The sections set forth on the following pages are a part of this Policy and take effect on the Effective Date. All periods indicated in the Policy begin and end at 12:01 a.m. Standard Time at the Insured's principal place of business.

IN WITNESS WHEREOF the Companion Life Insurance Company has caused this Policy to be executed by its President at Columbia, South Carolina.

| | |
|---|---|
| Trescott N. Hinton, Jr. | Vivian B. Gray |
| **President** | **Secretary** |

**BLANKET STUDENT ACCIDENT AND SICKNESS INSURANCE POLICY**
**PLEASE READ THIS POLICY CAREFULLY**

## IMPORTANT NOTICE

Should any complaints arise regarding this insurance, you may contact the plan sponsor or any of the following offices:

The insurer who issued the group policy may be contacted by addressing:

Companion Life Insurance Company
7909 Parklane Road, Suite 200
Columbia, SC 29223-5666

or by calling the toll free number shown on your ID card.

The group policy is subject to the laws of Minnesota. The state may be contacted by addressing:

Minnesota Department of Commerce
85 7th Place East, Suite 500
St. Paul, Minnesota 55101

**WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED.**

Please be aware that when an election is made to utilize the services of a non-participating provider for a covered service in non-emergency situations, benefit payments to such non-participating provider are not based upon the amount billed. The basis of benefit payment will be determined according to the policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy.

**EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION.**

Non-participating providers may bill for any amount up to the billed charge after the plan has paid its portion of the bill. Participating providers have agreed to accept discounted payments for services with no additional billing other than co-insurance and deductible amounts. Further information about the participating status of professional providers and information on out-or-pocket expenses may be obtained by calling the toll free telephone number on the identification card.

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## SCHEDULE OF BENEFITS

### CLASSES OF ELIGIBLE PERSONS:

**Class I:** All full-time students attending Carleton College must participate in this Student Accident and Sickness Insurance Plan unless proof of alternate coverage is furnished. Students who have not provided proof of alternate coverage through the waiver process will be automatically enrolled in the Student Health Insurance Plan. **Waiver and enrollment must be submitted online by August 15, 2014 at www.cirstudenthealth.com/carleton.**

Dependents of Class 1 Insureds are eligible for coverage under this Policy.

Students must actively attend classes for 31 consecutive class days following the date of enrollment in this insurance program. Home study and auditing scholars do not qualify as a student for the purposes of purchasing insurance coverage.

A person may not be insured as a Dependent and an Insured at the same time.

---

### ACCIDENT AND SICKNESS MEDICAL EXPENSE BENEFITS

***Unless otherwise specified, any Deductibles, Co-payments, Co-insurance Percentages and Benefit Maximums apply on a per Covered Person, per Covered Accident/covered Sickness and Coverage Period basis.***

**Scope of Coverage:**
Benefits will be paid up to the Benefit Maximums shown for each service shown in the schedule below. After the Deductible is satisfied, if it applies, benefits will be paid based on the Provider selected.

**Policy Year Benefit Maximum per Injury or Sickness:**

| | |
|---|---|
| **Student** | **Unlimited** |
| **Dependents** | **Unlimited** |

After the Deductible and any Co-payments have been satisfied, benefits will be paid as shown in the Schedule of Benefits up to the Policy Year Benefit Maximum.

**Deductible:**

| | |
|---|---|
| **Per Person per policy year:** | **$100** |

The deductible is waived if a student first uses the Student Health and Counseling (SHAC). Dependents are not eligible to use the SHAC.

**Policy Term Out-of Pocket Maximum per Covered Person*:**

| | |
|---|---|
| Per Individual | **$6,350.00** |
| Per Family | **$12,700.00** |

* After the Out-of Pocket Maximum has been reached, benefits will be paid at 100% of the Preferred Allowance (In-Network) or 100% of U&C (Out-of-Network). The Out-of-Pocket limit 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, Copayments and any per-service Deductibles and

services that are not Covered Medical Expenses 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.

| | |
|---|---|
| Preferred Provider Network: | Preferred One Network<br>Toll Free 800-997-1750<br>www.preferredone.com |
| Participating Pharmacies: | Express Scripts<br>Toll Free 800-400-0136<br>www.express-scripts.com |

| SCHEDULE OF BENEFITS | | |
|---|---|---|
| **Covered Inpatient Expenses:** | **PPO Provider** | **Out-of-Network Provider** |
| Hospital Room & Board – a) daily semi-private room rate when confined in a Hospital as an Inpatient; and b) general nursing care provided and charged for by the Hospital. | 80% Preferred Allowance | 60% U&C |
| | | |
| Hospital Miscellaneous | 80% Preferred Allowance | 60% U&C |
| | | |
| Intensive Care | 80% Preferred Allowance | 60% U&C |
| | | |
| Surgery | 80% Preferred Allowance | 60% U&C |
| | | |
| Anesthetist & Assistant Surgeon Fees | 80% Preferred Allowance | 60% U&C |
| | | |
| Doctor's Visit – limited to one visit per day and does not apply when related to surgery | 80% Preferred Allowance | 60% U&C |
| | | |
| Emergency Room Care – Medical Emergency only, subject to a $250 copayment per visit, waived if admitted as an Inpatient | 80% Preferred Allowance | 80% U&C |
| | | |
| Serious Mental Health | Paid as any other Sickness | Paid as any other Sickness |
| | | |
| Mental Health (other than Serious Mental Illnesses) | Paid as any other Sickness | Paid as any other Sickness |
| | | |
| Alcoholism | Paid as any other Sickness | Paid as any other Sickness |
| | | |
| Drug Abuse | Paid as any other Sickness | Paid as any other Sickness |
| | | |

| **Covered Outpatient Expenses:** | **PPO Provider** | **Out-of-Network Provider** |
|---|---|---|
| Doctor's Visits – Does not apply when related to surgery or physiotherapy. | 80% Preferred Allowance | 60% U&C |
| | | |
| Day Surgery including day surgery miscellaneous expenses | 80% Preferred Allowance | 60% U&C |
| | | |
| Anesthetist & Assistant Surgeon Fees | 80% Preferred Allowance | 60% U&C |
| | | |
| Physiotherapy/Occupational Therapy | 80% Preferred Allowance | 60% U&C |

| HEALTH SERVICES<br>STUDENT INSURANCE LIST (Continued) | | |
|---|---|---|
| Chiropractor care – limited to one visit per day | 80% Preferred Allowance | 60% U&C |
| | | |
| Diagnostic X-ray and Laboratory Procedures | 80% Preferred Allowance | 60% U&C |
| | | |
| Serious Mental Health | Paid as any other Sickness | Paid as any other Sickness |
| | | |
| Mental Health (other than Serious Mental) | Paid as any other Sickness | Paid as any other Sickness |
| | | |
| Alcoholism and Drug Abuse | Paid as any other Sickness | Paid as any other Sickness |
| | | |
| Radiation Therapy and Chemotherapy | 80% Preferred Allowance | 60% U&C |
| | | |
| Hospice – by a licensed agency/provider for terminally ill patients with life expectancy of 6 months or less | 80% Preferred Allowance | 60% U&C |
| | | |
| Home Health Care to a maximum of 60 visits per policy year. Other limitations apply. | 80% Preferred Allowance | 60% U&C |

| **Other Covered Expenses:** | **PPO Provider** | **Out-of-Network Provider** |
|---|---|---|
| | | |
| Durable Medical Equipment | 80% Preferred Allowance | 60% U&C |
| | | |
| Ambulance Service | 100% Preferred Allowance | 100% U&C |
| | | |
| Consulting Doctor Fees – When requested and approved by the attending Doctor. | 80% Preferred Allowance | 60% U&C |
| | | |
| Maternity (including Birthing Center services) | 80% Preferred Allowance | 60% U&C |
| | | |
| Complications of Pregnancy | Paid as any other Sickness | Paid as any other Sickness |
| | | |
| Preventive Services Benefit – includes preventive services such as screenings, exams and immunizations as specified by the Patient Protection and Affordable Care Act (PPACA) To view a list of covered preventive services, log onto www.healthcare.gov. Such services will be paid 100% at the Student Health Center, Homeland and Northfield Clinics and In-Network, or 50% U&C Out-of-Network. | 100% Preferred Allowance, no Deductible or Copayment | 60% U&C, not subject to Deductible |
| | | |
| Pediatric Dental & Vision Services (as required by the Patient Protection and Affordable Care Act of 2010) for Covered Persons under the age of 19 years. | 80% of U&C | |

| | | |
|---|---|---|
| Pediatric Dental Service benefit pays for the following:<br>• Preventive Services - including exams and cleanings (two per year), fluoride treatments and sealants to age 16;<br>• Basic Services - including fillings, x-rays, oral surgery and simple extractions;<br>• Major Services - including endodontics, periodontics, crowns, bridges and dentures;<br>• Orthodontia.<br><br>Pediatric Vision Service benefit pays for one vision examination per Policy Year, and related materials and supplies. | | |
| | | |
| Sports Injury Expense Benefit: Injuries resulting from participating in an intercollegiate and club sport will be paid as any other Injury, but only up to a maximum of $500 per Injury per lifetime. | Paid as any other Injury | Paid as any other Injury |
| | | |
| Motor Vehicle Injury Expense Benefit: Expenses for treatment of Injuries sustained by reason of a Covered motor vehicle accident are covered as any other Injury, but are subject to an aggregate maximum of $10,000 per Accident. | n/a | n/a |
| | | |
| Prescription Drugs - Following a $15 copay for each generic prescription drug a $30 copay for each brand name prescription drug and $45 for single source, eligible expenses are payable at 100% to the plan maximum. | Prescriptions not filled at an Express Scripts participating pharmacy are not covered. | Prescriptions not filled at an Express Scripts participating pharmacy are not covered. |
| | | |
| Repatriation of Remains | Paid by On Call International as a third-party service (not insured under this Policy) | |
| | | |
| Emergency Medical Evacuation | Paid by On Call International as a third-party service (not insured under this Policy) | |

**SCHEDULE OF BENEFITS (Continued)**

| **State Mandated Accident and Sickness Medical Expense Benefits:** | **PPO Provider** | **Out-of-Network Provider** |
|---|---|---|
| | | |
| Diabetes – Includes all Medically Necessary equipment, supplies, medications, labs and outpatient self-management training and educational services. | 80% Preferred Allowance | 60% U&C |
| | | |
| Dental Anesthesia and Facility – Facility charges and general anesthesia services performed in connection with dental services for dependent children with special needs as specified in the Policy. | 80% Preferred Allowance | 60% U&C |
| | | |
| Temporomandibular Joint / Craniomandibular | Paid as any other condition | Paid as any other |

| Disorder Expense Benefit | | condition |
|---|---|---|
| | | |
| Port Wine Stain Benefit | Paid as any other condition | Paid as any other condition |
| | | |
| Lyme Disease Treatment Benefit | Paid as any other condition | Paid as any other condition |
| | | |
| Phenylketonuria Treatment Expense Benefit | Paid as any other condition | Paid as any other condition |
| | | |
| Scalp Hair Prostheses Expense Benefit | Paid as any other condition | Paid as any other condition |

Should state law and/or federal law require certain benefits to be included in the Master Policy that are not included in this Policy, such benefits shall be deemed to be included in this Policy 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.cirstudenthealth.com/carleton and the Glossary of Terms available at www.cciio.cms.gov, or you may request a copy by calling 800-3229901.

## ACCIDENTAL DEATH AND DISMEMBERMENT BENFIT

**Loss of Life Limb or Sight – Maximum Benefit**

Life ..................................................................$1,000
Two hands ........................................................$1,000
Two feet.............................................................$1,000
Sight of two eyes..............................................$1,000
One hand and one foot .....................................$1,000
One hand and sight of one eye .........................$1,000
One foot and sight of one eye ..........................$1,000
One hand or one foot or one eye ......................$ 500

## COVERAGE PERIOD & PREMIUM RATES:

August 15, 2014 to August 15, 2015

Student Only............................................................$1,028.00

Spouse Only............................................................$2,230.00

Each Child..............................................................$1,269.00

Administrative fee included.

## 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, 2) the negotiated charge that a Preferred Provider has agreed to accept for service, or 3) 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.

**"Complications of Pregnancy"** means conditions which require medical treatment before pregnancy ends, and whose diagnosis is distinct from, but are caused or affected by pregnancy. Such conditions are; acute nephritis or nephrosis, cardiac decompensation; missed abortion; hyperemesis gravidarum; pre-eclampsia; non-elective cesarean section; termination of ectopic pregnancy; and spontaneous termination when a live birth is not possible.

Complications of Pregnancy does not include: false labor; occasional spotting; voluntary abortion; Doctor prescribed rest during pregnancy; morning sickness; and similar conditions not medically distinct from a difficult pregnancy.

**"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.

## DEFINITIONS (Continued)

**"Dependent"** means: 1) an Insured's lawful spouse; or 2) an Insured's unmarried child, from the moment of birth to age 19, 24 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 25 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.

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 26.

**"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.

**"Elective Surgery or Elective Treatment"**: means those health care services or supplies that do not meet the health care need for a Sickness or Injury. Elective surgery or elective treatment includes any service, treatment or supplies that:

1. are deemed by the Insurer to be research, investigative, or experimental;
2. are not generally recognized and accepted medical practices in the United States.

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

That is provided for an Injury 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:

1. The Covered Person's health or in the case of a pregnant woman, the health of the woman and her unborn child, being placed in serious jeopardy.
2. Serious impairment of the Covered Person's bodily functions.
3. Serious dysfunction of any of the Covered Person's bodily organs or parts.

**"Experimental or Investigational"**: means any procedure, treatment, facility, supply, device, or drug that:

1. is not generally accepted by the United States medical community as effective for diagnosis, care or treatment; or
2. is subject to research protocols indicating that the procedure, treatment, facility, supply, device, or drug is "experimental or investigational;" or
3. requires the patient to sign a consent form which indicates that the procedure, treatment, supply, device, or drug is "experimental or investigational" or is part of a research or study program; or
4. requires the provider's institutional review board to acknowledge that the procedure, treatment, facility, supply, device, or drug is "experimental or investigational," and subject to the board's approval.

**Important Notice** - The insurer may rely upon the advice of medical and dental peer review groups and other medical and dental experts to determine which services and/or supplies are experimental or investigational. The decision whether there is enough scientific data, and the decision whether a service or supply is "experimental or investigational" will be made by the insurer.

The insurer will determine, in its discretion, whether a procedure, treatment, facility, supply, device, or drug is "experimental or investigational"

**"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.

**"Home Health Care"** means nursing care and treatment and Daily Living Services provided to a Covered Person in His home as part of an overall extended treatment plan. To qualify for Home Health Care Benefits:

1. the Home Health Care plan must be established and approved in writing by a Covered Person's attending Doctor, including certification in writing by the attending Doctor that confinement in a Hospital or extended care facility would be required in the absence of Home Health Care;
2. nursing care and treatment must be provided by a Hospital certified to provide Home Health Care services or by a certified Home Health Care agency; and
3. Daily Living Services must be approved in writing by the attending Doctor or by the provider of the nursing care services.

"Daily Living Services" means cooking, feeding, bathing, dressing and personal hygiene services performed by a Home Health Aide, and which are necessary to the care and health of the Covered Person.

**"Hospice"**: means a public or private agency or facility which:

1. administers medically supervised written plans of physical, psychological, social and spiritual care for terminally ill individuals and their immediate family;
2. has its own staff doctors, nurses and medical and social counseling services on call 24 hours a day, 7 days a week or contracts and monitors this staff if not furnished by the hospice itself;
3. is supervised on a full-time basis by a doctor or registered nurse (RN);
4. keeps a written record of all hospice services furnished to its patients and families;
5. makes use of trained volunteers and keeps written records of their use and cost savings;
6. is licensed or certified according to the laws of the state in which it is located; and
7. provides bereavement and medical social services.

**"Hospital"** means an institution that:

1. operates as a Hospital pursuant to law for the care, treatment, and providing of in-patient services for sick or injured persons;
2. provides 24-hour nursing service by Registered Nurses on duty or call;
3. has a staff of one or more licensed Doctors available at all times;
4. provides organized facilities for diagnosis, treatment and surgery, either:
   a. on its premises; or
   b. in facilities available to it, on a pre-arranged basis;
5. is not primarily a nursing care facility, rest home, convalescent home, or similar establishment, or any separate ward, wing or section of a Hospital used as such.

Hospital also means a licensed alcohol and drug abuse rehabilitation facility or a mental hospital. Alcohol and drug abuse rehabilitation facilities and mental hospitals are not required to provide organized facilities for major surgery on the premises on a prearranged basis.

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

**"Immediate Family"** means a Covered Person's parent, spouse, child, brother or sister.

**DEFINITIONS (Continued)**

**“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.

**"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.

**"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.

## ELIGIBILITY FOR INSURANCE

Each person in one of the Classes of Eligible Persons shown in the Schedule of Benefits is eligible to be insured under the Policy. This includes anyone who may become eligible on the Policy Effective Date, and after the Policy Effective Date while the Policy is in force. Students must actively attend class for at least the first 31 days after the date for which coverage is purchased. Home study, correspondence, on-line, and television (TV) courses do not fulfill the eligibility requirements. We maintain the right to investigate student status and attendance records to verify eligibility requirements have been met. If We discover the eligibility requirements have not been met, Our only obligation is to refund any premium paid for that person.

A person may be insured under only one class of Eligible Persons shown in the Schedule of Benefits, even though the person may be eligible under more than one Class.

An Insured's Dependent is eligible on the date:
1. the Insured is eligible, if the Insured has Dependents on that date; or
2. the date the person becomes a Dependent of the Insured, if later.

In no event will a Dependent be eligible if the Insured is not enrolled.

## EFFECTIVE DATE OF INSURANCE

Insurance for an Eligible Person who enrolls during the enrollment period established by the school is effective on the latest of the following dates:
1. the Policy Effective Date;
2. the date We receive the completed enrollment form;
3. the date the required premium is paid; and
4. the date the student enters the Eligible Class.

Coverage for a student's eligible Dependent who enrolls:
1. during the enrollment period established by the Policyholder; or
2. within 31 days after the student acquires a new Dependent; or
3. within 31 days after a Dependent terminates coverage under another Health Care Plan,

is effective on the latest of the following dates:
1. the first day of the Coverage Period;
2. the date the student enters the Eligible Class;
3. the date We receive the completed enrollment form; and
4. the date the required premium is paid.

After the time periods described above, the student must wait until the next enrollment period, except for a newborn or a newly adopted child and involuntary loss of coverage under another Health Care Plan.

We will pay benefits for a newborn child of the Insured until that child is 31 days old. Coverage may be continued beyond 31 days if the Insured notifies US of the child's birth and pays the required premium, if any.

Adopted children will be covered on the same basis as a newborn child from the date of the child is placed for adoption with the Insured. Coverage will cease on the date the child is removed from placement and the Insured's legal obligation terminates. An adopted child is one who has not yet attained 18 years of age.

*EFFECTIVE DATE OF INSURANCE (Continued)*

"Placed for adoption" means circumstances under which the Insured assumes or retains a legal obligation to partially or totally support a child in anticipation of the child's adoption. A placement ends at the time such legal obligation ends.

Coverage for newborn and adopted children will consist of coverage for covered Injury or covered Sickness including the necessary care and treatment of medically diagnosed congenital defects, prematurity, well born care, birth abnormalities, and routine nursery care related with a covered Sickness.

# TERMINATION

## TERMINATION DATE OF INSURANCE

An Insured's coverage will end on the earliest of the date:
1. the Policy terminates;
2. the Insured is no longer eligible; or
3. the period ends for which premium is paid.

A Dependent's coverage will end on the earliest of the date:
1. he or she is no longer a Dependent;
2. the Insured's coverage ends; or
3. the period ends for which premium is paid; or 4. the Policy terminates

## REFUND OF PREMIUM

In the event the insured student withdraws from school or reduces his/her semester hours to less than 6, within the first 30 days of the semester. We will refund any premiums 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.

## EXTENSION OF BENEFITS

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 obtains other coverage; or
3. the Covered Expenses are incurred more than 3 months following termination of insurance

## CONTINUATION OF COVERAGE

A Covered Person who has been insured under the Policy may continue to be insured under the Policy when coverage terminates subject to the following:

1. Continuation of Coverage is available to Insureds, and their covered Dependents, when the Insured leaves school, dies, or when the covered Dependent no longer qualifies as an eligible Dependent.

2. The Covered Person requesting coverage must have been insured under the Policy for at least 6 months.

*CONTINUATION OF COVERAGE (Continued)*

3. Requests for Continuation of Coverage, with the applicable premium, must be mailed to the Plan Administrator, before the termination of existing coverage and while the Covered Person still meets the eligibility criteria.

4. Coverage and benefits will be the same as those, which are applicable prior to continuation.

5. Premium rates for Continuation of Coverage are higher than student rates. Rates, and forms to request Continuation of Coverage, are available in the Student Insurance Office.

6. The maximum period for which coverage may be continued is 12 months.

7. Continuation of Coverage is not available to persons who are eligible for coverage under another Health Care Plan, including Medicare.

## DESCRIPTION OF BENEFITS

The following provisions explain the benefits available under the Policy. Please see the Schedule of Benefits for the applicability of these benefits on a class level.

## ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Life ..................................................................$1,000
Two hands .......................................................$1,000
Two feet...........................................................$1,000
Sight of two eyes.............................................$1,000
One hand and one foot ....................................$1,000
One hand and sight of one eye .........................$1,000
One foot and sight of one eye ..........................$1,000
One hand or one foot or one eye .....................$ 500

Loss of hand or foot means complete Severance through or above the wrist or ankle joint.
Loss of Entire Sight means the total, permanent loss of sight of the eye. The loss of sight must be unrecoverable by natural, surgical or artificial means. "Severance" means the complete separation and dismemberment of the part from the body.

This benefit will be payable in addition to any other benefit payable under this Policy, subject to all the terms and conditions of this Policy.

The Insurer will pay the stated benefit if death or one of the specified losses occurs under the following conditions:

1. loss is, directly and independently of disease or any bodily infirmity, the result of the accidental injury; and
2. the Injury occurred while the Covered Person insured by this policy; and
3. the death or loss occurred within 365 days of the Injury.

If the accidental Injury results in more than one of the specified losses, benefits will be paid only for the greatest. The total benefit payment under this coverage in combination with any benefits payable under the medical expense portion of this policy will not exceed the Policy Maximum Benefit as stated in the Schedule of Benefits.

**Exclusions**

No benefit will be paid by this coverage for a death or loss that results from, or that is caused by or is the result of a disease or mental illness, or the treatment of these conditions. Coverage is also subject to all exclusions or limitations shown in the General Exclusion section of this Policy.

## ACCIDENT & SICKNESS MEDICAL EXPENSE BENEFITS

We will pay the Covered Expenses as shown in the Schedule of Benefits if a Covered Person requires treatment by a Doctor. We will consider the Usual and Customary Charges incurred for Medically Necessary Covered Expenses. Benefit payments are subject to the deductibles, co-insurance factors and benefit maximums, if any, shown in the Schedule of Benefits.

### *ACCIDENT & SICKNESS MEDICAL EXPENSE BENEFITS (Continued)*

**Covered Expenses include:**

**Inpatient Expenses**

1. Hospital Room and Board Expenses: daily semi-private room rate when Hospital Confined as shown in the Schedule of Benefits; and general nursing care provided and charged for by the Hospital.
2. Intensive Care as shown in the Schedule of Benefits. We will make this payment in lieu of the semi-private room expenses.
3. Hospital Miscellaneous Expenses: expenses incurred while Hospital Confined or as a precondition for being Hospital Confined, for services and supplies such as the cost of operating room, laboratory tests, X-ray examinations, anesthesia, drugs (excluding take home drugs) or medicines, physical therapy, therapeutic services and supplies. In computing the number of days payable under this benefit, the date of admission will be counted but not the date of discharge.
4. Surgery: Doctor's fees for inpatient surgery. If an Injury or Sickness requires multiple surgical procedures through the same incision, We will pay only one benefit, the largest of the procedures performed. If multiple surgical procedures are performed during the same operative session but through different incisions, We will pay as shown in the Schedule of Benefits for the most expensive procedure and 50% of covered expenses for the additional surgeries.
5. Assistant Surgeon Fees: in connection with inpatient surgery as shown in the Schedule of Benefits.
6. Anesthetist Services: in connection with inpatient surgery.
7. Doctor's Visits: when Hospital Confined. Benefits are limited to one visit per day. Benefits do not apply when related to surgery.
8. Organ Transplant: including non-investigative and non-experimental human organs and tissue transplants that are Medically Necessary.

**Outpatient Expenses**

9. Day Surgery (Outpatient): Surgeon's and Assistant Surgeon's fees for outpatient surgery. If an Injury or Sickness requires multiple surgical procedures through the same incision, We will pay only one benefit, the largest of the procedures performed. If multiple surgical procedures are performed during the same operative session but through different incisions, We will pay as shown in the Schedule of Benefits for the most expensive procedure and 50% of covered expenses for the additional surgeries.
10. Day Surgery Miscellaneous Expenses: Includes services related to scheduled surgery performed in a Hospital, ambulatory surgical center, operating room expenses, laboratory tests and diagnostic test expense, examinations, including professional fees, anesthesia; drugs or medicines; therapeutic services and supplies. Benefits will not be paid for: surgery performed in a Hospital emergency room, Doctor's office, or clinic.
11. Anesthetist Services: in connection with outpatient surgery.
12. Doctor's Visits: Includes well visits and routine GYN exams; benefits are limited to one visit per day. Benefits will not be paid when related to surgery.

***ACCIDENT & SICKNESS MEDICAL EXPENSE BENEFITS (Continued)***

13. Physical Therapy and Chiropractic Expenses: benefits are limited to one visit per day.
14. Diagnostic X-ray Services: Includes diagnostic services and medical procedures performed by a Doctor, other than Doctor's visits, X-ray and lab procedures.
15. Medical Emergency Expenses: only in connection with a Medical Emergency as defined. Benefits will be paid for the use of the emergency room and supplies. Treatment must be rendered within 48 hours from time of Injury or first onset of Sickness.
16. Radiation & Chemotherapy: as shown in the Schedule of Benefits.
17. Laboratory Procedures: as shown in the Schedule of Benefits.

**Other Expenses**

18. Ambulance Service. Payment will be made to the provider as shown in the Schedule of Benefits.
19. Braces and Appliances: 1) when prescribed by a Doctor; and 2) a written prescription accompanies the claim when submitted. Replacement braces and appliances are not covered. Braces and appliances include durable, medical equipment which is equipment that:
    a. is primarily and customarily used to serve a medical purpose;
    b. can withstand repeated use; and
    c. generally is not useful to person in the absence of Injury.

    No benefits will be paid for rental charges in excess of the purchase price.
20. Consultant Doctor Fees: when requested and approved by the attending Doctor. Covered Expenses will be paid under this benefit or under the Doctor's Visits benefit, but not for the same day.

21 Dental Treatment (Injury Only): when performed by a Doctor and made necessary by Injury to sound, natural teeth. If there is more than one way to treat a dental problem, We will pay based on the least expensive procedure if that procedure meets commonly accepted dental standards of the American Dental Association.

22. The Insurer will pay the actual expenses incurred as a result of pregnancy, childbirth, miscarriage, or any Complications resulting from any of these, to the extent shown in the Schedule of Benefits, Certain maternity testing may not be covered under the Policy. The following maternity routine tests and screening exams may be payable if all of the terms and conditions of the Policy are met: a pregnancy test, CBC, Hepatitis B, Surface Antigen, Rubella Screen, Syphilis Screen, Chlamydia, HIV, Gonorrhea, Toxoplasmosis, Blood Typing ABO, RH Blood Antibody Screen, Urinalysis, Urine Bacterial Culture, Microbial Nucleic Acid Probe, Pap Smear, and Glucose Challenge Test (at 24 - 28 weeks gestation), one ultrasound (subsequent ultrasounds only if they are ordered by a Doctor as Medically Necessary and if a claim is submitted with the pregnancy record and ultrasound report confirming the Medical Necessity), and for a Covered Person over age 35, AFP Blood Screening, Amniocentesis/AFP Screening, Chromosome Testing, Fetal Stress/Non-Stress tests. Pre-natal vitamins are not covered.

    Pregnancy benefits will also cover a period of hospitalization for maternity and newborn infant care for:
    a. a minimum of 48 hours of inpatient care following a vaginal delivery; or
    b. a minimum of 96 hours of inpatient care following delivery by cesarean section.

*Other Expenses (Continued)*

If the Doctor, in consultation with the mother, determines that an early discharge is medically appropriate, the Insurer shall provide coverage for post-delivery care, within the above time limits, to be delivered in the patient's home, or, in a provider's office, as determined by the Doctor in consultation with the mother. The at-home post-delivery care shall be provided by a registered professional nurse, Doctor, nurse practitioner, nurse midwife, or physician's assistant experienced in maternal and child health, and shall include:

a. Parental education;
b. Assistance and training in breast or bottle feeding; and
c. Performance of any Medically Necessary and clinically appropriate tests. including the collection of an adequate sample for hereditary and metabolic newborn screening.

23. Routine Well-Baby Care: 1) while the baby is Hospital Confined; and 2) for routine nursery care provided immediately after birth, including treatment of diagnosed congenital and birth abnormalities.
24. Hospice Care: as shown in the. Schedule of Benefits.
25. Durable Medical Equipment. Prosthetic Appliances and Medical Services: for Medically Necessary services.

**ADDITIONAL BENEFITS**

**Emergency Services Prior to Stabilization**

Coverage for emergency services as provided under this Policy is not dependent upon whether the services are performed by a Preferred Provider or an out of network provider and without regard to prior authorization. Benefits for the services of an out of network provider, if payable, will be at the same benefit level as if the services or treatment had been rendered by a Preferred Provider.

The medical director's or his or her designee's determination of whether the condition Covered Person meets the standards of an emergency medical condition shall be based solely upon the presenting symptoms documented in the medical record at the time care was sought. Only a clinical peer may make an adverse determination.

The appropriate use of the 911 emergency telephone system or its local equivalent shall not be discouraged or penalized by the health care plan when an emergency medical condition exists.

Note: This provision shall not imply that the use of 911 or its local equivalent is a factor in determining the existence of an emergency medical condition.

**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.

*ADDITIONAL BENEFITS (Continued)*

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);

*ADDITIONAL BENEFITS (Continued)*

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; and
9. Panic disorder.

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."

*ADDITIONAL BENEFITS (Continued)*

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.

*ADDITIONAL BENEFITS (Continued)*

**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.

*ADDITIONAL BENEFITS (Continued)*

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 60 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.

**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.

*ADDITIONAL BENEFITS (Continued)*

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.

## GENERAL POLICY EXCLUSIONS

The Policy does not provide coverage for loss caused by or resulting from:

1. Charges that are not Medically Necessary or in excess of the Usual and Customary charge.
2. Suicide, or any attempt thereat or self-inflicted Injuries while sane;
3. 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, or as specifically provided under the Pediatric Dental and Vision benefit, radial keratotomy or laser surgery for vision correction or the treatment of visual defects or problems;
4. Skeletal irregularities of one or both jaws including orthognathia and mandibular retrognathia, except as specifically provided; nasal or sinus surgery;
5. 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.
6. 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.
7. Expenses incurred for birth control drugs, procedures, supplies or devices, including oral contraceptives used for birth control, except as provided under the Preventive Services benefit. Drugs and medications for the treatment of impotence and/or sexual dysfunction;
8. Reproductive/Infertility procedures and fertility tests, including but not limited to: family planning, fertility tests, infertility (male or female), including any supplies rendered for the purpose or with the intention of achieving conception; premarital examinations. Examples of fertilization procedures are: ovulation induction; in vitro fertilization; embryo transplant; or similar procedures that augment or enhance the Covered Person's reproductive ability; impotence organic or otherwise.
9. Expenses incurred in connection with voluntary sterilization, except as specifically provided for women under the Preventive Services benefit, or sterilization reversal, vasectomy or vasectomy reversal and sexual reassignment;
10. War, or any act of war, whether declared or undeclared; service in the Armed Forces of any country. Loss which occurs during or as a result of committing or attempting to commit an assault, felony, or participation in a riot or insurrection, engaging in an illegal occupation;
11. 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.
12. Treatment, services, supplies, in a Veteran's Administration or Hospital owned or operated by a national government or its agencies unless there is a legal obligation for the Covered Person to pay for the treatment.
13. 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 caused by a covered Injury, and except as specifically provided in the Hospitalization and Anesthesia for Dental Procedures expense benefit or as specifically provided under the Pediatric Dental and Vision benefit;
14. Expenses incurred for acupuncture;
15. Autistic disease of childhood, hyperkinetic syndromes, milieu therapy, conceptual handicap, developmental delay or disorder, or mental retardation;
16. Elective Surgery or Elective Treatment as defined by the Policy;
17. Foot care including: flat foot conditions, supportive devices for the foot, subluxations, care of corns, bunions (except capsular or bone surgery), calluses, toenails, fallen arches, week feet, foot strain, and symptomatic complaints of the feet, except those related to diabetic care;

18. Hearing examinations or hearing aids; or other treatment for hearing defects or problems. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;
19. 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;
20. Hirsutism, alopecia;
21. 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.
22. Routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of any Injury or Sickness, except as specifically provided by the Policy.

**NON-DUPLICATION OF BENEFITS LIMITATION**

If benefits are payable under more than one (1) benefit provision contained in the Policy, benefits will be payable only under the provision providing the greater benefit.

## COORDINATION OF BENEFITS (COB)

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.

## CLAIM PROVISIONS

**Notice of Claim:** Written (or authorized electronic or telephonic) notice of a claim under the Policy must be given to the Insurer or the Administrator within 30 days after any loss covered by the Policy occurs, or as soon thereafter as is reasonably possible. The notice should identify the Covered Person and the Policy number.

**Claim Forms:** Upon receipt of a written notice of claim, the Insurer or Administrator will send claim forms to the claimant within 15 days. If the forms are not furnished within 15 days, the claimant will satisfy the Proof of Loss requirements of the Policy by submitting written proof describing the occurrence, nature and extent of the loss for which claim is made.

**Proofs of Loss:** Written (or authorized electronic or telephonic) proof of loss must be furnished to the Insurer or its Administrator within 90 days after the date of loss. Failure to furnish proof within the time required will not invalidate nor reduce any claim if it is not reasonably possible to give proof within 90 days, provided:

1. it was not reasonably possible to provide proof in that time; and
2. the proof is given within one year from the date proof of loss was otherwise required. This one year limit will not apply in the absence of legal capacity

**Time for Payment of Claim:** Benefits payable under the Policy, other than for any periodic payments, will be paid within 30 days after the receipt of due written proof of loss; or the Insured, the Insured's assignee, health care professional, or health care facility will be notified that additional documentation is needed. All other benefits will be paid as soon as the required proof of loss is received.

Claims paid 30 or more days following the date of receipt of satisfactory proof of loss will be subject to the payment of interest at a rate of 9% per year. Interest is calculated from the 30$^{th}$ day following receipt of proof of loss until the date of the late payment. No interest payment is due for any amount of interest, which is less than $1.00.

**Payment of Claims:** All benefits payable under the Policy shall be payable to the Covered Person or to his or her designated beneficiary or beneficiaries, or to his or her estate. If the Covered Person is a minor, benefits may be payable to the parents, guardian, or other person actually supporting him or her, or to a person or persons upon whom such minor is chiefly dependent for support and maintenance.

If any benefits are payable to the estate of a Covered Person, or to a Covered Person's beneficiary who is a minor or otherwise not competent to give valid release, the Insurer may pay up to $1,000 to any relative, by blood or by marriage, of the Covered Person or beneficiary who is deemed by the Insurer to be equitably entitled to payment. Any payment made by the Insurer in good faith pursuant to this provision will fully discharge the Insurer of any obligation to the extent of the payment.

# PREMIUMS

**Premiums:** The premiums for this Policy will be based on the rates currently in force, the plan and amount of insurance in effect.

**Changes In Premium Rates:** We may change the premium rates from time to time with at least 31 days advanced written, or authorized electronic or telephonic notice. No change in rates will be made until 12 consecutive months after the Policy Effective Date. An increase in rates will not be made more often than once in a 12-month period. However, We reserve the right to change rates at any time if any of the following events take place.

1. The terms of the Policy change.
2. A division, subsidiary, affiliated organization or eligible class is added or deleted from the Policy.
3. There is a change in the factors bearing on the risk assumed.
4. Any federal or state law or regulation is amended to the extent it affects Our benefit obligation.

If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a pro rata adjustment will apply from the date of the change to the next Premium Due Date.

**Payment of Premium:** The first Premium is due on the Policy Effective Date. After that, premiums will be due monthly unless We agree with the Policyholder on some other method of premium payment.

If any premium is not paid when due, the Policy will be canceled as of the Premium Due Date, except as provided in the Policy Grace Period section.

**Policy Grace Period:** A Policy Grace Period of 31 days will be granted for the payment of the required premiums. The Policy will remain in force during the Grace Period. If the required premiums are not paid during the Policy Grace Period, insurance will end on the last Premium Due Date on which required premiums were paid. The Policyholder will be liable to Us for any unpaid premium for the time the Policy was in force.

**Currency:** All premiums for and claims payable pursuant to the Policy are payable only in the currency of the United States of America.

# GENERAL PROVISIONS

**Entire Contract:** The entire contract consists of the Policy (including any endorsements or amendments), and the signed application of the Policyholder. All statements contained in the application will be deemed representations and not warranties. No such statements will be used to void the insurance, reduce the benefits, or be used in defense of a claim for loss incurred unless it is contained in a written application.

No agent has the authority to modify or waive any part of the Policy, or to extend the time for payment of premiums, or to waive any of the Insurer's rights or requirements. No modifications of the Policy will be valid unless evidenced by an endorsement or amendment of the Policy, signed by one of the Insurer's officers and delivered to the Policyholder.

**Policy Effective Date:** The Policy begins on the Policy Effective Date at 12:01 AM, Standard Time at the address of the Policyholder.

**Policy Termination:** We may terminate this Policy by giving 31 days written (authorized electronic or telephonic) notice to the Policyholder. Either We or the Policyholder may terminate this Policy on any Premium due date by giving 31 day advance written (authorized electronic or telephonic) notice to the other. This Policy may be terminated at anytime by mutual written or authorized electronic/telephonic consent of the Policyholder and Us.

This Policy terminates automatically on the earlier of:

1. the Policy Termination Date shown in the Schedule of Benefits; or
2. the Premium due date if Premiums are not paid when due.

Termination takes effect at 12:01 AM, Standard Time at the address of the Policyholder on the date of termination.

**Assignment:** At the request of the Covered Person or his or her parent or guardian, medical benefits may be paid to the provider of service. No assignment of benefits will be binding on the Insurer until a copy of the assignment has been received by the Insurer or its Administrator. The Insurer assumes no responsibility for the validity of the assignment. Any payment made in good faith will end our liability to the extent of the payment.

**Physical Examination and Autopsy:** We have the right to have a Doctor of our choice examine the Covered Person as often as is reasonably necessary. This section applies when a claim is pending or while benefits are being paid. We also have the right to request an autopsy in the case of death, unless the law forbids it. Such examinations or autopsy will be at the expense of the Insurer.

**Right of Reimbursement**

If a Covered Person incurs expenses for Sickness or Injury that occurred due to the negligence of a third party: (a) We have the right to reimbursement for all benefits We have paid from any and all damages collected from the 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, and (b) We are assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits paid for that Sickness or Injury.

We shall have the right to reimbursement out of all funds that the Covered Person, the Covered person's parents, if the Covered Person is a minor, or the Covered Person's legal representative, is or was able to obtain for the same expenses we have paid as a result of that Sickness or Injury.

The Covered Person or the Covered Person's parents if the Covered Person is a minor is required to furnish any information or assistance or provide any documents that we may reasonably require in order to obtain our rights under this provision. This provision applies whether the third party admits liability or not.

**Right of Recovery:** If We make payments with respect to benefits payable under the Policy in excess of the amount necessary, We shall have the right to recover such payments. We shall notify the Covered Person of such overpayment and request reimbursement from the Covered Person. However, should the Covered Person not provide such reimbursement, We shall have the right to offset such overpayment against any other benefits payable to the Covered Person under the Policy to the extent of the overpayment.

**Examination of Records and Audit:** We shall be permitted to examine and audit the Policyholder's books and records at any time during the term of the Policy and within 2 years after final termination of the Policy as they relate to the Premiums or subject matter of this insurance.

**Clerical Error:** A clerical error in record keeping will not void coverage otherwise validly in force, nor will it continue coverage otherwise validly terminated. Upon discovery of the error an equitable adjustment of premium shall be made.

**Legal Actions:** No action at law or in equity may be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action may be brought after the expiration of 3 years (5 years in Kansas, 6 years in South Carolina, and the applicable statute of limitations in Florida) after the time written proof of loss is required to be furnished.

**Incontestability.** We cannot contest the validity of this Policy after two years from the date of issue except for non-payment of premiums. We cannot contest the validity of coverage with respect to a Participating Employer under this Policy after two years from the Participating Employer's Effective Date except for non-payment of premiums. We cannot contest an Insured's insurability after his or her insurance has been in force for two years while the Insured is alive. Any of the Insured's statements that we contest must be in written application signed by the Insured.

**Conformity with State Statutes:** Any provision of the Policy which, on its effective date, is in conflict with the statutes of the state in which it is delivered, is hereby amended to conform to the minimum requirements of those statutes.

**Not in Lieu of Workers' Compensation**. This Policy is not a Workers' Compensation policy. It does not provide any Worker's Compensation benefit.

COMPANION LIFE INSURANCE COMPANY
7909 PARKLANE ROAD, SUITE 200, COLUMBIA, SC 29223-5666
P.O. BOX 100102, COLUMBIA, SC 29202-3102
(803) 735-1251
(the "Company")

AMENDMENT

This amendment forms a part of the Group Policy No. 2014-S3-A05 and certificate of coverage.

Policyholder: Carleton College

**DEFINITIONS**

The following definitions have the following meanings:

**"Emergency Services"** means, with respect to an emergency medical condition:

1) A medical screening examination (as required under Section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and
2) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under Section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

**"Emergency medical condition"** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2) Serious impairment to bodily functions; or
3) Serious dysfunction of any bodily organ or part.

**"Essential health benefits"** has the meaning found in Section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services and includes 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.

**“Non-participating provider”** means a health care practitioner or health care facility that has not contracted directly with Companion Life Insurance Company or an entity contracting on behalf of Companion Life Insurance Company to provide health care services to Companion Life Insurance Company’s enrollees.

**“Participating provider”** means a health care practitioner or health care facility that has contracted directly with Companion Life Insurance Company or an entity contracting on behalf of Companion Life Insurance Company to provide health care services to the Company’s enrollees.

**“Policy year”** means the 12-month period that is designated as the policy year in the contract. If there is no designation of a policy year in the contract, then the policy year is the deductible or limit year used under the contract. If deductibles or other limits are not imposed on a yearly basis under the contract, the policy year is the calendar year.

**BENEFITS**

It is agreed that the following changes are hereby made:

**Lifetime Dollar Limits**
Any lifetime dollar limit on any essential health benefits in the contract is deleted. The contract is amended to provide that if an individual’s coverage under the contract had terminated due to reaching a lifetime dollar limit, the individual may enroll during the first 30 days of a policy year that begins on or after September 23, 2010, and coverage will begin on the first day of the policy year that begins on or after September 23, 2010.

**Annual Dollar Limits**
Any annual dollar limit on any essential health benefits in the group contract or certificate is amended to be the greater of (1) the annual dollar limit permitted under 45 CFR 147.126 of the Patient Protection and Affordable Care Act; and (2) the annual dollar limit described in the group contract or certificate.

**Rescissions**
Any provision of the contract that describes the right of Companion Life Insurance Company to rescind or void the contract is amended to permit Companion Life Insurance Company to rescind or void the coverage of an individual only if (1) the individual performs an act, practice, or omission that constitutes fraud; or (2) the individual makes an intentional misrepresentation of material fact. Any provision of the contract that describes notice of rescission of coverage and that provides less than 30-days advance written notice of rescission is amended to provide 30-days advance written notice of any rescission of coverage.

**Preventive Services**
In addition to any other preventive benefits described in the contract, Companion Life Insurance Company shall cover the following preventive services and shall not impose any cost-sharing requirements, such as deductibles, copayment amounts or coinsurance amounts to any covered individual receiving any of the following benefits for services received from participating providers:

1) Evidenced-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force, except that the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention of breast cancer shall be considered the most current other than those issued in or around November 2009;
2) Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;

3) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4) With respect to women, such additional preventive care and screenings not described in paragraph 1) above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Companion Life Insurance Company shall update new recommendations to the preventive benefits listed above at the schedule established by the Secretary of Health and Human Services.

**Prohibition on Pre-existing Conditions for Covered Persons**
The following provisions of the group contract or certificate shall not apply to Covered Persons of any age:

1) Any provision that describes a pre-existing condition exclusion or limitation;
2) Any provision that indicates that a pre-existing condition exclusion or limitation is applicable;
3) Any provision that indicates that benefits are contingent on an injury occurring or a sickness first manifesting itself while the individual is covered under the group contract or certificate; and
4) Any provision of the group contract or certificate that describes possible denial or rejection of coverage due to underwriting.

**Emergency Services**
Any provision of the group contract or certificate that provides benefits with respect to services in an emergency department of a hospital is amended to provide emergency services

1) Without the need for any prior authorization determination, even if the emergency services are provided by a non-participating provider;
2) Without regard to whether the health care provider furnishing the emergency services is a participating provider with respect to the services; and
3) If the emergency services are provided by a non-participating provider, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers.

**Cost-Sharing Requirements for Emergency Services**
If any copayment amount or coinsurance percentage described in the group contract or certificate for emergency services is different for a service received from a participating provider than a non-participating provider, the copayment amount and coinsurance percentage for emergency services provided by a non-participating provider is amended to be identical to the copayment amount and coinsurance percentage listed in the group contract or certificate for emergency services provided by a participating provider.

Companion Life Insurance Company shall pay the greater of the following amounts for emergency services received from non-participating providers:

1) The amount set forth in the group contract or certificate to which this amendment is attached;
2) The amount negotiated with participating providers for the emergency service provided, excluding any copayment or coinsurance that would be imposed if the service had been received from a participating provider. If there is more than one amount negotiated with participating providers for the emergency service provided, the amount paid shall be the median of these negotiated amounts, excluding any copayment or coinsurance that would be imposed if the service had been received from a participating provider.
3) The amount for the emergency service calculated using the same method Companion Life Insurance Company generally used to determine payments for services provided by a non-

participating provider (such as usual, customary and reasonable amount), excluding any copayment or coinsurance that would be imposed if the service had been received from a participating provider; or

4) The amount that would be paid under Medicare (part A or part B of Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.) for the emergency service, excluding any copayment or coinsurance that would be imposed if the service had been received from a participating provider.

Any other provision of the group contract or certificate that describes cost-sharing for services received from non-participating providers, other than copayment amounts or coinsurance responsibilities, continue to apply to emergency services received from non-participating providers. Examples of these cost-sharing requirements include deductibles and out-of-pocket limits. Any out-of-pocket limit described in the group contract or certificate that generally applies to services received from non-participating providers is applicable to emergency services received from non-participating providers.

**Extension of Adult Dependent Coverage**

For purposes of eligibility for coverage under this group contract or certificate, a dependent child is the Member's natural child, adopted child, foster child, stepchild or child for whom the Member has legal custody or legal guardianship and who is under 26 years of age. Any reference to requirements other than age and relationship to the Member are hereby removed. This provision is applicable only if the group contract or certificate includes dependent coverage.

**Appeal Process**

If you are dissatisfied with the resolution reached through the Company's appeal process, you may contact the Insurance Commissioner at: Minnesota Department of Commerce, 85 7th Place East, Suite 500, St. Paul, Minnesota 55101.

The effective date of this change is August 1, 2014. All other terms and provisions of the policy will apply other than stated in this amendment.

Dated at Columbia, South Carolina, this 1st day of August, 2014.

Trescott N. Hinton, Jr.
President

**Companion Life Insurance Company**
**7909 Parklane Road, Suite 200**
**Columbia, South Carolina 29223-5666**

**AMENDATORY ENDORSEMENT**
**PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010**
**WOMEN'S PREVENTIVE SERVICES**

Notwithstanding anything in Your Policy or Certificate to the contrary, it is hereby understood and agreed that Your Policy or Certificate to which this Amendatory Endorsement is attached is amended as follows:

To ensure compliance with federal health care reform's Patient Protection and Affordable Care Act (the "Act") pertaining to Women's Preventive Services, including any amendments, regulations, rules or other guidance issued with respect to the Act, certain benefits, terms, conditions, limitations and exclusions in your Policy or certificate are being amended to comply with the Act. The following provisions apply under Your Policy or Certificate effective on August 15, 2014 or Your coverage Effective Date whichever is later.

**Women's Preventive Services**
In addition to any other preventive screening services described in Your Policy or Certificate including any Riders attached thereto, we will cover the following preventive screening services for Insured/Covered Persons who are women, without regard to any cost-sharing requirements, such as Deductible, Copay or Coinsurance requirements that would otherwise apply. If You are covered under a PPO Network Plan, as shown on Your Schedule of Benefits, these services must be received from In-Network/Participating Providers to be covered unless otherwise specifically stated in Your Policy or Certificate:

1. Well-woman visits: benefits are payable for one well-woman preventive care visit per Benefit Year for an adult woman to obtain the recommended preventive screening services that are age appropriate and developmentally appropriate, including preconception and one visit for prenatal care. This benefit does not include coverage for routine pregnancy, delivery and well-baby charges.

   More than one visit may be needed to obtain all the recommended preventive screening services, depending on a woman's health status, health needs and other risk factors. Additional well-woman visits will be covered if the doctor determines they are necessary to help establish what preventive screening services are appropriate and to set up a plan to help the woman get the care she will need to be healthy.

   For covered preventive screening services, Deductible, Copay and/or Coinsurance cost-sharing requirements may apply to the office visit if (a) the preventive screening service is billed separately from the office visit, or (b) the primary purpose of the office visit is other than the delivery of preventive screening services and the preventive screening service is not billed separately from the office visit.

   For covered preventive screening services cost-sharing requirements will not be applied to the office visit if (a) the preventive screening service is not billed separately from the office visit and (b) the primary purpose of the office visit is the delivery of the preventive screening service.

As provided for in the Act's interim final regulations, for a recommendation or guideline for recommended preventive screening services or items that does not specify a frequency, method, treatment or setting for the provision of that service, We may use reasonable medical management to determine any coverage limitations. We may rely on established techniques and the relevant evidence base to determine the frequency, method, treatment, or setting for which a recommended preventive screening service will be covered without cost-sharing requirements to the extent not specified in a recommendation or guideline.

2. Screening for gestational diabetes: benefits are payable for one screening for gestational diabetes for pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be high risk for diabetes. This benefit does not include coverage for routine pregnancy, delivery and well-baby charges.

3. Human papillomavirus testing: high-risk human papillomavirus DNA testing in women with normal cytology results. One screening is covered for females 30 years of age and over and will be covered no more frequently than once every 3 years.

4. Counseling for sexually transmitted infections: benefits are payable for one counseling session per Benefit Year for counseling on sexually transmitted infections for all sexually active women.

5. Counseling and screening for human immune-deficiency virus: benefits are payable for one counseling session and screening per Benefit Year for human immune-deficiency virus infection for all sexually active women.

6. Contraceptive methods and counseling: when prescribed by Your Physician, benefits are payable for all Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. This benefit does not include coverage for abortifacient drugs. Any exclusions under Your Policy or Certificate that excludes coverage for contraceptive drugs and devices, or tubal ligation for the purpose of voluntary sterilization, are deleted. Covered charges paid under the Prescription Medication Benefit Rider will not be covered under this benefit.

7. Breastfeeding support, supplies and counseling in conjunction with each birth: benefits are payable for comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postpartum period. Coverage includes the costs for the rental of breastfeeding equipment. This benefit does not include coverage for routine pregnancy, delivery and well-baby charges.

8. Screening and counseling for interpersonal and domestic violence: benefits are payable for one screening and counseling for interpersonal and domestic violence per Benefit Year.

Benefits paid under this Amendatory Endorsement will not be paid under Your Policy or Certificate including any Riders attached thereto pertaining to preventive screening services or other wellness benefits.

This Amendatory Endorsement is endorsed and made part of the Policy/Certificate to which it is attached. This Endorsement terminates concurrently with the date Your coverage under the Policy ends.

This Amendatory endorsement is subject to all provisions of the Policy/Certificate which are not in conflict with the provisions of this Endorsement. Nothing in this Endorsement will be held to vary, alter, waive, or extend any of the terms, conditions, provisions, agreements, or limitations of the Policy other than stated above.

IN WITNESS WHEREOF, the Insurance Company has caused this Endorsement to be signed by its President.

**COMPANION LIFE INSURANCE COMPANY**

Trescott N. Hinton, Jr.
President

**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.**

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**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.

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## 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.

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**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)

**2014-15 STUDENT HEALTH INSURANCE COVERAGE APPLICATION & AGREEMENT**
**COMPANION LIFE INSURANCE COMPANY**

THE UNDERSIGNED SCHOOL HEREBY APPLIES FOR A BLANKET STUDENT ACCIDENT & SICKNESS STUDENT HEALTH INSURANCE COVERAGE BASED ON THE STATEMENTS SET FORTH BELOW:

NAME OF APPLICANT (SCHOOL): Carleton College

ADDRESS: One N College St

CITY, STATE, ZIP (+4): NorthField, MN 55057

NAME OF INSURANCE PLAN: ____________________

POLICY PERIOD: EFFECTIVE DATE: August 15, 2014 EXPIRATION DATE: August 15, 2015

INDIVIDUAL INSURED'S TERM OF COVERAGE

- ☒ Full Year
- ☐ School Year
- ☐ Other ____________________

METHOD OF ENROLLMENT:

- ☐ Mandatory (Student)
- ☒ Mandatory/Hard Waiver (Student)
- ☐ Voluntary (Student)
- ☐ Dependent Enrollment
- ☐ Other ____________________

INSURANCE COST: See next page(s).

COVERAGE AGREEMENT: This policy will provide benefits only for those coverages quoted by Companion Life Insurance Company and accepted by the Applicant.

AMENDMENT(S) AND ENDORSEMENT(S) EXECUTED AT THE SAME TIME AS THIS APPLICATION: None

**IT IS UNDERSTOOD THAT THIS INSURANCE IS DESIGNED TO SUPPLEMENT, RATHER THAN REPLACE, FACILITIES AND SERVICES AVAILABLE AT THE STUDENT HEALTH CENTER.**

AGENCY: ____________________

BY: ____________________
Signature

Agent's Name: ____________________

Date: ____________________

APPLICANT: Carleton College

BY: Randy Johnson
Signature

Name: Randie Johnson

Title: Purchasing + Risk Mgr

Date: 11/4/14

COVERAGE WILL NOT BE EFFECTIVE UNLESS THIS APPLICATION HAS BEEN ACCEPTED BELOW BY COMPANION LIFE INSURANCE COMPANY THROUGH ITS AUTHORIZED REPRESENTATIVE.

APPLICATION ACCEPTED:

BY: ____________________
Name: ____________________

Date: ____________________

POLICY NUMBER ASSIGNED: 2014-S3-A05

Student Accident and Sickness Insurance Plan
Designed for Students of
Carleton College
2014-15

Policy No. 2014-S3-A05
Insurance Plan Cost: 2014-2015

**August 15, 2014 to August 15, 2015**

**Student Only.........................................................$1,028.00**

**Spouse Only.........................................................$2,230.00**

**Each Child.............................................................$1,269.00**

**Administrative fee included.**