

# 2011 • 2012

## STUDENT ACCIDENT AND SICKNESS INSURANCE PLAN FOR DOMESTIC AND INTERNATIONAL STUDENTS



Policy Number: CLSP0020-11

**Direct all inquiries regarding enrollment to:  
Associated Insurance Plans International, Inc.**

Post Office Box 189  
Libertyville, IL 60048

**Pre-Certification is not required  
Policy benefits are not guaranteed**

(800) 452-5772 • Fax (847) 281-8813

email: [office@AIPStudentInsurance.com](mailto:office@AIPStudentInsurance.com)

Student Insurance Website: [www.SaintXavierInsurance.com](http://www.SaintXavierInsurance.com)

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

**Saint Xavier University 2011-2012  
Student Accident and Sickness Insurance Plan Identification Card  
Companion Life Insurance Company**

NOTE: In a life threatening emergency, go to the nearest emergency room for treatment.

Print name and school ID number

is entitled to the benefits provided under the policy issued by Companion Life Insurance Company for the entire period for which premium has been paid, 24 hours per day, anywhere in the world. Coverage expires at 11:59 p.m. local time on the last date for which premium has been paid. Possession of this card does not guarantee benefits. Contact the Plan Administrator to verify coverage at (800) 452-5772. *In a life threatening emergency, go to the nearest emergency room for treatment.*

Policy Number: CLSP0020-11

**Direct all claim inquiries and correspondence to:  
Administrative Concepts, Inc. Payor #: 22384**

994 Old Eagle School Road, Suite 1005  
Wayne, PA 19087-1802

(800) 452-5772 - 8 am-7 pm CST

[www.SaintXavierInsurance.com](http://www.SaintXavierInsurance.com)

\$25 for Physician's Visit  
\$25 for Urgent Care

\$250 for Emergency Room  
 PHCS [www.phcs.com](http://www.phcs.com)  
800-922-4362

Medco Health Prescription Services

\$25/\$45/\$60

[www.medcohealth.com](http://www.medcohealth.com)

Pharmacy Locations/Questions: (800) 400-0136

Detach and retain.

Please keep card in your possession at all times. Pre-Certification is not required.



SCAN for a direct link to your  
student insurance website.

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## PLAN HIGHLIGHTS

1. Coverage anywhere in the world.
2. \$250,000 maximum per condition.
3. Deductible waived and 100% reimbursement for covered treatment at the Student Health Center.
4. Benefits for Wellness and Immunizations.
5. Prescription Drug Card.
6. Coverage for all Illinois Mandated Benefits.
7. Benefits for Repatriation and Medical Evacuation and International Assistance.
8. Monthly payment option for Dependents.
9. Two Optional Dental and Vision Coverage Options.

### HOW DO I RECEIVE ASSISTANCE WITH A QUESTION OR PROBLEM?

Please call the Administrator, at (800) 452-5772, Monday through Friday, between the hours of 8:00 a.m. to 7:00 p.m. Central Standard Time, or email us through the Student Insurance website:

[www.SaintXavierInsurance.com](http://www.SaintXavierInsurance.com)

We appreciate hearing from you with your comments, questions, and concerns.

### POLICY TERM

The insurance under Saint Xavier University's Accident and Sickness Health Insurance Plan for the Annual Policy is effective 12:00 a.m., on August 11, 2011. The Annual Policy terminates at 11:59 p.m. on August 10, 2012 or at the end of the period through which the premiums are paid. Coverage is effective 24 hours a day on a worldwide basis.

### PERIODS OF COVERAGE FOR UNDERGRADUATES AND THEIR DEPENDENTS

Annual	August 11, 2011 to August 10, 2012
Waiver and Enrollment Deadline	September 16, 2011
Fall Semester One	August 11, 2011 to December 31, 2011
Waiver and Enrollment Deadline	September 16, 2011
Fall Semester Two	October 3, 2011 to December 31, 2011
Waiver and Enrollment Deadline	October 21, 2011
Spring & Summer-Semesters One	January 1, 2012 to August 10, 2012
Waiver and Enrollment Deadline	January 27, 2012
Spring & Summer-Semesters Two	March 1, 2012 to August 10, 2012
Waiver and Enrollment Deadline	March 9, 2012
Summer Semester (New Students Only)	May 19, 2012 to August 10, 2012
Waiver and Enrollment Deadline	June 15, 2012

## ELIGIBILITY

Enrolled **Undergraduate Students** and scholars under the age of 70 attending Saint Xavier University (the Participating Organization) who cannot produce evidence of insurance coverage will be automatically enrolled in this insurance plan.

Unless Undergraduate Students submit an insurance waiver which will provide information on their existing insurance, through [www.SaintXavierInsurance.com](http://www.SaintXavierInsurance.com), they will automatically receive the school's health insurance and the fee for health insurance coverage will be charged to the Student's account each semester.

The deadline for submission of a waiver is shown on page 3 of this brochure.

Enrolled Student/Scholar means a person: (1) who is a member of an eligible class of persons as described above; (2) has enrolled for coverage under this Plan, if required; (3) for whom premium has been paid; and (4) while covered under the Plan. However, an Insured Student does not include any person covered under this Plan solely as an enrolled Dependent.

Students must actively attend classes for at least the first 31 days from their effective date of coverage, or the entire period for which coverage is purchased, whichever is the lesser, except in the case of medical withdrawal (as verified and approved by the school). The Company maintains its right to investigate student (and dependents) status and attendance records to verify that the policy eligibility requirements have been met. If and whenever the Company discovers that the policy eligibility requirements have not been met, its only obligation is refund of premium less any claims paid.

This plan is optional for **Graduate Students** and premiums must be paid directly to the Plan Administrator.

### DEPENDENT ELIGIBILITY

Eligible students who enroll in the plan may also enroll their eligible dependents. Eligible dependents are the Insured Student's spouse residing with the Insured Student; or the Insured Student's unmarried Children under the age of 19 years or to age 23, if they are full-time students at an accredited school and dependent on the Insured Student for at least 50% of their financial support. Children must be fully supported by the Insured Student.

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

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

Any dependent on active duty in any military, naval, or air force of any country is not eligible for coverage under this Policy.

Dependent eligibility expires concurrently with that of the Insured Student.

## 2011-2012 INSURANCE RATES

Premiums are **NOT** pro-rated other than shown.

Coverage Available For	Annual	**Fall Semester Installment
Student Only	\$1,470	\$ 735
Additional for Spouse	\$2,940	\$1,470
Additional for each Child	\$2,205	\$1,103
Coverage Available For	**Spring & Summer Semester Installment	Spring & Summer For New Students Only
Student Only	\$ 735	\$ 911
Additional for Spouse	\$1,470	\$1,822
Additional for each Child	\$1,103	\$1,367
Coverage Available For	Summer	***Monthly Auto Debit Debited on the 11th of each month
Graduate Student Only	\$ 353	\$ 142
Additional for Spouse	\$ 706	\$ 275
Additional for each Child	\$ 530	\$ 208

An administrative fee has been added to all student rates except Annual.

\*\*The Fall and Spring/Summer installment method is for students purchasing annual coverage ONLY.

\*\*\*Monthly premium is available ONLY if purchasing annual coverage with an automatic debit from your checking, savings, or credit card account. Complete the enclosed auto debit form for this option.

### IMPORTANT REGARDING MONTHLY PAYMENT OPTION

Monthly premium payment is available for the full policy year, but on an automatic debit basis only. The initial payment is due at the time of enrollment and will be drafted on the 11th of each month through July 11, 2012. Students interested in coverage for a term other than the complete policy year should elect an option for payment other than monthly. Please note there is no provision for cancellation other than upon entrance into the Armed Forces.

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

### GRADUATE STUDENT AND DEPENDENT ENROLLMENT PROCESS

Enrollment applications may be obtained from the Student Insurance website at: [www.SaintXavierInsurance.com](http://www.SaintXavierInsurance.com).

1. You may enroll on-line at: [www.SaintXavierInsurance.com](http://www.SaintXavierInsurance.com) or you may access the website on CLAWS and pay with an electronic check, major credit card, or debit card.
2. Application and insurance payment may be mailed directly to:

**STUDENT INSURANCE PLAN**  
**Post Office Box 189, Libertyville, IL 60048**

3. You may call and enroll over the telephone using a Major Credit Card or Debit Card, (800) 452-5772.
4. You can email questions to us at: [office@AIPStudentInsurance.com](mailto:office@AIPStudentInsurance.com)

**NOTE:** Renewal notices will be mailed to the address you provide. However, it is your responsibility to submit payment prior to expiration date in order to avoid a lapse in coverage. You must re-enroll in the insurance plan. Automatic debit method of payment is available. Please call the administrator at (800) 452-5772 for details and an authorization form.

It is important to update all address changes with the Plan Administrator, (800) 452-5772, or by sending an email through the Student Insurance website at: [www.SaintXavierInsurance.com](http://www.SaintXavierInsurance.com).

## NEWBORN CHILDREN

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

### LATE ENROLLMENT FOR DEPENDENTS

An Eligible Student may add his or her Dependent as a late enrollee:

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

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

### TERMINATION DATE OF INSURED PERSON'S COVERAGE

The insurance for an Insured Person shall terminate on the first of the following dates:

- (a) On the date this Policy is terminated; or
- (b) On the payment due date if the required payment for the Insured Person is not paid, except as a result of inadvertent error; or
- (c) As of the date the Insured Person enters military service, in which case a pro-rata refund of insurance payment will be made to such Insured Person; or
- (d) On the date the Insured Person no longer qualifies under the Description of Class as shown in the Schedule of Eligible Classes.

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

### REFUND POLICY

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

**SAINT XAVIER UNIVERSITY**  
**STUDENT ACCIDENT AND SICKNESS INSURANCE PLAN**  
**SCHEDULE OF BENEFITS 2011-2012**

PLAN BENEFITS	In-Network	Out-of-Network
Lifetime Maximum Medical Expense Benefit - Per Accident or Sickness	\$250,000	\$250,000
Deductible: Per Person - Per Policy Year (waived at Student Health Center)	\$300/policy year	\$500/policy year
Student Health Center - The Deductible does not apply when covered services are received at the Student Health Center (SHC)	100%	N/A
HOSPITAL INPATIENT COVERED SERVICES AND BENEFIT LIMITS	In-Network	Out-of-Network
(a) Hospital Room and Board and Hospital Miscellaneous: \$100 copay per confinement	80%	50%
(b) Surgical Treatment	80%	50%
(c) Anesthesia	30% of Surgical Treatment	
(d) Assistant Surgeon	30% of Surgical Treatment	
(e) Private Duty Nurse: Paid under (a)	80%	50%
(f) Physician Non-Surgical Visits: 1 visit per day; not paid the day of surgery	80%	50%
(g) Physiotherapy: 1 visit per day; Paid under (a)	80%	50%
(h) Maternity Benefits: Benefits paid the same as any Sickness	80%	50%
(i) Mental & Nervous Disorders: Benefits paid the same as any Sickness; up to \$10,000 per Policy Year; \$50 copay per confinement	80%	50%
(j) Substance Abuse: Benefits paid the same as any Sickness; up to \$10,000 per Policy Year	80%	50%
(k) PreAdmission Testing	80%	50%
OUTPATIENT COVERED SERVICES AND BENEFIT LIMITS	In-Network	Out-of-Network
(a) Hospital Outpatient Surgical Miscellaneous: Day Surgery	80%	50%
(b) Surgical Treatment	80%	50%
(c) Anesthesia	30% of Surgical Treatment	
(d) Assistant Surgeon	30% of Surgical Treatment	
(e) Physician Non-Surgical Visits: 1 visit per day, not paid the day of surgery; \$25 copay per visit	80%	50%
(f) Urgent Care Treatment Center: \$25 copay per visit	80%	50%
(g) Physiotherapy: Includes occupational therapy; 1 visit per day, \$25 copay per visit; up to 10 visits	80%	50%
(h) Diagnostic X-rays, Radiology, and Laboratory Services: \$25 copay per visit; includes Ultrasound and Nuclear medicine, ECG, EEF and other Electronic Diagnostic procedures	80%	50%
(i) Hospital Emergency Room: \$250 copay per visit (waived if admitted)	80%	50%
(j) Maternity: Paid the same as any Sickness; includes Abortion if life threatening to mother	80%	50%
(k) Mental and Nervous Disorders: \$25 copay per visit; up to 20 visits per Policy Year	80%	50%
(l) Substance Abuse: \$25 copay per visit; up to 20 visits per Policy Year	80%	50%
(m) Prescription Drugs: 30 day supply per prescription; up to \$1,500 per policy year \$25 copay per Generic Drug; \$45 copay per Brand Drug; \$60 copay per Single Source	(Refer to Prescription Drug Program through Medco)	
OTHER COVERED SERVICES AND BENEFIT LIMITS	In-Network	Out-of-Network
(a) Ambulance: up to \$300	N/A	
(b) Dental Treatment: Xray and treatment of dental injury to sound, natural teeth	80%	80%
(c) Orthopedic Appliances and Durable Medical Equipment: up to \$200 per Policy Year	80%	50%
(d) Motor Vehicle Injury: Benefits paid the same as any Injury	80%	50%
(e) Home Health Care: 40 visits per Policy Year; \$50 Deductible/Policy Year, up to maximum \$300 per Policy Year	80%	50%
(f) Consultant Physician: when requested by the attending Physician	80%	50%
(g) Well Child Care: includes immunizations and age appropriate screening tests; subject to Deductible	80%	50%
(h) Immunizations: when received at Student Health Services only; \$200 per Policy Year; \$10 copay per immunization	100%	N/A
(i) Wellness Benefit; up to \$300 per Policy Year; subject to Deductible	80%	50%
(j) <i>Additional Benefits mandated by State of Illinois:</i>	Please see below	
Breast Reconstruction following Mastectomy and Post Mastectomy Treatment Benefits	80%	50%
Cervical Pap and Prostate Cancer Tests Benefit	80%	50%
Diabetes Benefit	80%	50%
Mammography Examination Benefit	80%	50%
HPV Vaccine	80%	50%
Maternity and Postpartum Care Benefit	80%	50%
Temporomandibular Joint Disorder and Craniomandibular Disorder Benefit	80%	50%

For questions or to enroll: [www.SaintXavierInsurance.com](http://www.SaintXavierInsurance.com) (800) 452-5772

## CONTINUATION OF COVERAGE

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

## CERTIFICATE OF COVERAGE

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

## PHCS PREFERRED PROVIDER NETWORK

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

When an Insured Person uses the services of a PHCS Preferred Provider Network provider, the covered expenses incurred will be payable at 80% of PPO Allowance. (Covered Medical Expenses incurred at the Student Health Center will be reimbursed at 100%). However, when treatment is rendered by providers outside the PHCS Preferred Provider Network, expenses will be payable at 50% of Reasonable and Customary Covered Charges.

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

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

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

A complete listing of participating providers are available on the web at: [www.SaintXavierInsurance.com](http://www.SaintXavierInsurance.com)

## MEDCO HEALTH - PRESCRIPTION DRUG CARD

Prescriptions purchased from the Medco Health Network of pharmacies will be covered. For a complete list of pharmacy providers, please visit [www.SaintXavierInsurance.com](http://www.SaintXavierInsurance.com).

**NOTE: The prescription drug benefit is through the MEDCO Pharmacy Program. The MEDCO Pharmacy Network includes national chains such as CVS and Walgreens, as well as local pharmacies. When you need to have a prescription filled, present your insurance ID card at a participating pharmacy. You will pay a co-payment for your medications. The pharmacy will submit additional charges to the Insurance Company. The plan pays a maximum of \$1,500.00 per policy year towards prescription medications.**

Medco Drug Card co-payments:  
\$25 co-pay generic medications.  
\$45 co-pay brand medications.  
\$60 for single source medications.

Co-payments are for a 30 day supply only.

## PHARMACY CO-PAYMENT DEFINITIONS

**Brand Drug:** A medication developed by a pharmaceutical company.

**Generic Drug:** A medication duplicated by another company once the patent expires.

**Single Source Drug:** A brand name drug without a generic equivalent.

## DEFINITIONS

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

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

**Claim Form** is a form that must be completed and sent to the claim office when any medical/dental expenses are incurred. This claim form is available at [www.SaintXavierInsurance.com](http://www.SaintXavierInsurance.com).

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

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

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

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

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

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

**Hospital** means a facility which meets all of these tests:

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

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

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

**Insured Person** means an Insured Student and his or her covered Dependent(s) while insured under this Policy.

**Insured Student** means a student of Saint Xavier University who is eligible and insured for coverage under this Policy.

**Loss** means medical expense covered by this Policy as a result of Injury or Sickness as defined in this Policy and other expenses specifically covered.

## DEFINITIONS (CONTINUED)

**Medical Emergency** means the sudden and, at the time, unexpected onset of an Injury or Sickness that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but is not limited to:

- (a) placing the person's health in sufficient jeopardy;
- (b) serious impairment to a bodily function;
- (c) serious dysfunction of any bodily organ or part;
- (d) inadequately controlled pain; or
- (e) with respect to a pregnant woman if she is having contractions:
  - a. that there is inadequate time to effect to safe transfer to another Hospital before delivery; or
  - b. that transfer to another Hospital may pose a threat to the health or safety of the woman or unborn child.

**Medically Necessary** means that a service or supply is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury based on generally accepted medical practice. A service or supply will not be considered as Medically Necessary if:

- (a) it is provided only as a convenience to the Insured Person or provider;
- (b) it is not the appropriate treatment for the Insured Person or provider;
- (c) it exceeds in scope, duration or intensity that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment.

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

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

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

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

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

**We, Us or Our** means Companion Life Insurance Company.

**You, Your or Yours** means the Insured Person.

## BENEFITS MANDATED BY THE STATE OF ILLINOIS

### ALCOHOL AND DRUG ABUSE EXPENSE BENEFIT

If an Insured Person requires treatment on account of alcoholism, Alcohol Abuse, Drug Abuse or drug dependency, We will pay for such treatment as follows:

### BENEFITS FOR INPATIENT HOSPITAL CONFINEMENT

When the Insured Person is confined as an inpatient in: (i) a Hospital; or (ii) a Detoxification Facility for the treatment of alcoholism, Alcohol Abuse, Drug Abuse, or drug dependency, We will pay the Covered Percentage of the Covered Charges incurred for such Hospital Confinement on the same basis as any other Sickness as described in Part A, Hospital Room and Board Expense of the Hospital Expense Benefit. Such confinement must be in a licensed or certified facility, including Hospitals.

## ILLINOIS MANDATES (CONTINUED)

### BENEFITS FOR OUTPATIENT SERVICES

We will pay the Covered Percentage of the Covered Charges incurred for covered outpatient services for the treatment of alcoholism, Alcohol Abuse, Drug Abuse, or Drug Dependency.

Outpatient Treatment and Doctor services include charges for services rendered in a Doctor's office or by an outpatient treatment department of a Hospital, community mental health facility or alcoholism treatment facility, so long as the Hospital, community mental health facility or alcoholism treatment facility is approved by the Joint Commission on the Accreditation of Hospitals or certified by the Department of Health. The services must be legally performed by or under the clinical supervision of a licensed Doctor or a licensed psychologist who certifies every three (3) months that the Insured Person needs to continue such treatment.

**Alcohol Abuse** This term means a condition that is characterized by a pattern of pathological use of alcohol with repeated attempts to control its use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

**Drug Abuse** This term means a condition which is characterized by a pattern of pathological use of a drug with repeated attempts to control its use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

**Detoxification Facility** This term means a facility that provides direct or indirect services to an acutely intoxicated individual to fulfill the physical, social, and emotional needs of the individual by:

- (a) monitoring the amount of alcohol and other toxic agents in the body of the individual;
- (b) managing withdrawal symptoms; and
- (c) motivating the individual to participate in the appropriate addictions treatment programs for Alcohol or Drug Abuse.

### MATERNITY EXPENSE BENEFIT

We will pay benefits for an Insured Person's Covered Charges for maternity care, including Hospital, surgical and medical care.

We cover charges for a minimum of forty-eight (48) hours of inpatient care following an uncomplicated vaginal delivery and a minimum of ninety-six (96) hours of inpatient care following an uncomplicated cesarean section for a mother and her newborn child in a health care facility, unless the attending Doctor in consultation with the mother, makes an alternative decision on the length of inpatient stay. The decisions must be based on accepted medical practice.

For a mother and newborn child who remain in the Hospital for the minimum length of time stated above, We will pay for one home health care visit if prescribed by the attending Doctor.

For a mother and newborn child who have a shorter Hospital stay, We will pay for one home visit scheduled within twenty-four (24) hours after Hospital discharge; and an additional home visit if prescribed by an attending provider.

**Newborn Infant Care** – Newborn infant care is covered when the infant is confined in the Hospital and has received continuous Hospital care from the moment of birth. This does include: (a) nursery charges; (b) charges for routine Doctor's examinations and tests; and (c) charges for routine procedures. This benefit does not include circumcision. This benefit also includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of newborn children covered from birth.

We cover such charges the same way We treat Covered Charges for any other Sickness.

## ILLINOIS MANDATES (CONTINUED)

### PEDIATRIC PREVENTIVE CARE EXPENSE BENEFIT

We cover charges for preventive services rendered to a child enrolled as a dependent including physical examinations, immunizations, history measurements, sensory screening, neuropsychiatric evaluation and development screening and assessment at the following intervals: (a) six times during the first year after birth; (b) up to a maximum of three times during the next year; and (c) annually until age 6.

Such charges will not be subject to a Deductible, if any.

### MAMMOGRAPHY EXAMINATION EXPENSE BENEFIT

We will pay the Covered Percentage of the Covered Charges incurred for screening by low-dose mammography exams for the presence of occult breast cancer. The charges must be incurred while the Insured Person is insured for these benefits.

Benefits will be paid for mammographic exam charges incurred for the following:

- (a) One baseline Mammogram for a woman thirty-five through thirty-nine years of age;
- (b) One Mammogram every twelve months for a woman forty years of age or older.

**Low Dose Mammography** means an X-ray examination of the breast using equipment dedicated specifically for mammography, including X-ray tube, filter, compression device, image receptor, with radiation exposure of less than one rad per breast with two views of an average size breast.

### MASTECTOMY EXPENSE BENEFIT

We cover charges for prosthetic devices; and reconstructive surgery incident to a mastectomy.

Coverage for prosthetic devices and reconstructive surgery will be subject to the Deductible and Covered Percentage provisions shown in the Plan of Insurance and is limited to two years after performance of a covered mastectomy which had revealed no evidence of malignancy.

**Mastectomy** means the removal of all or part of the breast for reasons that are determined by a licensed Doctor to be Medically Necessary.

### POST-MASTECTOMY EXPENSE BENEFIT

We cover charges for: (a) inpatient coverage following a mastectomy for a length of time determined by the attending Doctor to be Medically Necessary and in accordance with protocols and guidelines based on sound scientific evidence; and (b) a 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.

We cover such charges the same way We treat Covered Charges for any other Sickness.

### CYTOLOGIC SCREENING (PAP SMEAR) EXPENSE BENEFIT

If an Insured Person requires a Cytologic Screening (Pap smear), We will pay the Covered Percentage of the Covered Charges incurred for one annual Cytologic Screening. Such benefit will include the examination, laboratory fee and the Doctor's interpretation of the laboratory results.

### PROSTATE-SPECIFIC ANTIGEN EXPENSE BENEFIT

If an Insured Person requires a Prostate-Specific Antigen test, We will pay the Covered Percentage of the Covered Charges incurred for one annual digital rectal examination and a Prostate-Specific Antigen Test, for male insureds upon the recommendation of a Doctor licensed to practice medicine in all its branches for:

- (a) Asymptomatic men age 50 and over;
- (b) African-American men age 40 and over; and
- (c) Men age 40 and over with a family history of prostate cancer.

## ILLINOIS MANDATES (CONTINUED)

### DIABETES EXPENSE BENEFIT

We cover charges for Medically Necessary outpatient self-management training and education, equipment, and supplies for the treatment of type 1 diabetes, type 2 diabetes, and gestational diabetes mellitus.

Diabetes Self-Management Training, including medical nutrition education, shall be limited to the following:

- (a) up to three (3) Medically Necessary visits to a qualified provider upon initial diagnosis of diabetes by the patient's Doctor or, up to three (3) Medically Necessary visits to a qualified provider within one year after that effective date;
- (b) up to three (3) Medically Necessary visits to a qualified provider upon a determination by the patient's Doctor that a significant change in the patient's symptoms or medical condition has occurred. A "significant change" in condition means symptomatic hyperglycemia, severe hypoglycemia, onset or progression of diabetes, or a significantly different treatment regimen.

Covered Charges for the following equipment and supplies include: blood glucose monitors and blood glucose monitors for the legally blind; cartridges for the legally blind; lancets and lancing devices; insulin; syringes and needles; test strips for glucose monitors; FDA approved oral agents used to control blood sugar; and glucagons emergency kits.

Covered Charges also include regular foot care exams by a Doctor, or by a referral from a Doctor.

If authorized by a Doctor, Diabetes Self-Management Training may be provided as part of an office visit, group setting, or home visit.

We cover such charges the same way We treat Covered Charges for any other Sickness.

**Diabetes Self Management Training** means instruction in an outpatient setting which enables a diabetic patient to understand the diabetic management process and daily management of diabetic therapy as a means of avoiding frequent hospitalization and complications. Diabetes self-management training shall include the content areas listed in the National Standards for Diabetes Self Management Education Programs as published by the American Diabetes Association, including Medical Nutrition Therapy.

**Medical Nutrition Therapy** means "medical nutrition care" in the Dietetic and Nutrition Services Practice Act.

### COLORECTAL CANCER SCREENING EXPENSE BENEFIT

If an Insured Person requires a Colorectal Cancer Screening, We will pay the Covered Percentage of the Covered Charges incurred for such exams as follows:

- (a) Colorectal Cancer Screening with sigmoidoscopy or fecal occult blood testing once every 3 years for persons who are at least 50 years old; or
- (b) Colorectal Cancer Screening with sigmoidoscopy or fecal occult blood testing once every 3 years for persons who are at least 30 years old if the Insured Person is classified as high risk or Colorectal Cancer because the person or a first degree family member of the person has a history of Colorectal Cancer.

## REPATRIATION OF BODY REMAINS EXPENSE BENEFIT

This benefit applies only to Domestic Students while Studying Abroad, International Students, and their Dependents. In the event of the death of an Insured Person, We will pay the actual charges for the Covered Expenses for the preparation and transportation of the Insured Person's remains to his or her Home Country. This will be done in accordance with all legal requirements in effect at the time the body remains are to be returned to his or her Home Country. The death must occur while the person is insured for this benefit. The benefit will be paid up to a maximum of \$7,500. You must first seek approval from the Claim Office, (800) 452-5772.

## EMERGENCY MEDICAL EVACUATION

### EXPENSE BENEFIT

This benefit applies only to Domestic Students while studying abroad, International Students and their Dependents. This benefit will pay benefits for the Covered Percentage of the Covered Charges incurred, if any Injury or Sickness results in the Emergency Medical Evacuation of the Insured Person. The benefit will be paid up to a maximum of \$10,000. You must first seek approval from the Company Claim Office, (800) 452-5772.

### TRAVEL ASSISTANCE FOR ALL STUDENTS

Included in this health insurance plan is access to a 24-hour worldwide assistance network for emergency assistance anywhere in the world. Simply call the assistance center collect. The multilingual staff will answer your call and immediately provide reliable, professional and thorough assistance. The following services are included in this Plan:

1. Referral to the nearest, most appropriate medical facility, and/or Provider.
2. Medical monitoring by board certified emergency physicians in the United States.
3. Urgent message relay between family, friends, personal physician, school, and insured.
4. Guarantee of payment to Provider and assistance in coordinating insurance benefits.
5. Arranging and coordinating emergency medical evacuations and repatriations.
6. Emergency travel arrangements for disrupted travel as the consequence of a medical emergency.
7. Referral to legal assistance.
8. Assistance in locating lost or stolen items including lost ticket application processing.

Contact On Call International for any of these services:

Toll Free from U.S. and Canada: 1-800-850-4556, or collect outside the U.S. and Canada, 603-328-1713, 603-898-9159. [www.oncallinternational.com](http://www.oncallinternational.com)

**24-HOUR NURSE ADVICE LINE:** Wouldn't you feel better knowing you could get health care answers from a Registered Nurse 24 hours a day? Students may utilize the Nurse Advice Line when the school health clinic is closed or anytime they need confidential medical advice. ON CALL provides Members with clinical assessment, education and general health information. This service shall be performed by a registered Nurse Counselor to assist in identifying the appropriate level and source(s) of care for members (based on symptoms reported and/or health care questions asked by or on behalf of Members). Nurses shall not diagnose Member's ailments. Students must be enrolled in Saint Xavier University Student Accident and Sickness Insurance Plan in order to be eligible to utilize the Nurse Advice program, which is sponsored by the school. This program gives students access to a toll-free nurse information line 24-hours a day, 7 days a week. One phone call is all it takes to access a wealth of useful health care information at 1-800-850-4556 or collect outside the U.S. and Canada, 603-328-1713.

### EXCLUSIONS

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

1. Services normally provided without charge by the Participating Organization student health service center, infirmary, or Hospital, or by Health Care Providers employed by the Participating Organization;
2. Preventative medicines, serums, immunizations or vaccines, except as specifically provided;
3. Organ transplants, except as specifically provided;
4. Pre-existing Conditions as defined in this Policy.

### EXCLUSIONS (CONTINUED)

5. Injury sustained or Sickness contracted while in service of the Armed Forces of any country, except as specifically provided. Upon the Insured Person entering the Armed Forces of any country, We will refund the unearned pro-rata Premium to such Insured Person;
6. Illness, Accident, treatment or medical condition arising out of the play or practice of or traveling in conjunction with intercollegiate sports, intercollegiate club sports, and professional sports;
7. Injury resulting from motor vehicle accident to the extent that benefits are payable under any automobile medical expense insurance or automobile no-fault plans;
8. Cosmetic surgery, except as the result of covered Injury occurring while this Policy is in force as to the Insured Person. This exclusion shall also not apply to cosmetic surgery which is reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other disease of the involved body part, and reconstructive surgery because of congenital disease or anomaly of a covered Dependent child which has resulted in a functional defect;
9. Illness, Accident, treatment or medical condition arising out of hang-gliding, skydiving, glider flying, parasailing, sail planing, bungee jumping, racing or speed contests, skin diving, parachuting or bungi-cord jumping;
10. Injury or Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law;
11. Expense incurred as the result of dental treatment, except as provided in the Sickness Dental Expense Benefit, if included in this Policy. This exclusion does not apply to treatment resulting from Injury to sound natural teeth;
12. Injury or Sickness resulting from declared or undeclared war; or any act thereof;
13. Charges for treatment of any Injury or Sickness due to an Insured Person's commission of, or attempt to commit a felony, or a crime which would be considered a felony if prosecuted;
14. Injury due to participation in a riot;
15. Expense incurred for eye examinations or prescriptions, eyeglasses, and contact lenses (except for sclera shells which are intended for use of corneal bandages), eye refractions, vision therapy, multiphasic testing, or lasic or other vision procedures except as required for repair caused by a covered Injury;
16. Well baby care, including routine exams and immunizations, except as specifically provided;
17. Expenses incurred for allergy testing and allergy treatment;
18. An amount of a charge in excess of the Reasonable and Customary Expense;
19. Elective Treatment or elective surgery, except as specifically provided;
20. Services not Medically Necessary;
21. Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route;
22. Treatment of mental or nervous disorders except as specifically provided;
23. Treatment of alcohol and substance abuse except as specifically provided;
24. For International Students, expenses incurred within the Insured Person's Home Country or Country of regular domicile;
25. Suicide, attempted suicide, or intentionally self-inflicted injury, while sane or insane;
26. Voluntary or elective abortion, pregnancy of a dependent child, except as specifically provided;
27. Nicotine addiction;
28. Patient controlled anesthesia.

## PRE-EXISTING CONDITIONS LIMITATION

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

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

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

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

The Pre-existing Condition Waiting Period will not apply:

- (a) To pregnancy.
- (b) In the case of an Insured Person who, as of the last day of the 30-day period beginning on the date of his birth, is covered under Creditable Coverage.
- (c) In the case of a child who is adopted or placed for adoption before attaining the age of 18 years and who, as of the last day of the 30-day period beginning on the date of adoption or placement for adoption, whichever is earlier, is covered under Creditable Coverage. The provisions of this paragraph do not apply to coverage before the date of adoption or placement for adoption.
- (d) In the case of a condition for which medical advice, diagnosis, care or treatment was recommended or received for the first time while the Insured Person held Creditable Coverage, and the medical advice, diagnosis, care or treatment was a benefit under the plan, if the Creditable Coverage was continuous to a date not more than 63 days before the Effective Date of the new coverage.

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

### Definition

**“Creditable Coverage”** means health benefits or coverage provided to a person pursuant to:

- a) A group health plan;
- b) Health insurance coverage;
- c) Part A or Part B of Title XVIII of the Social Security Act;
- d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Sec. 1928 of that Title;
- e) The Civilian Health and Medical Program of Uniformed Services, CHAMPUS, Chapter 55 of title 10, U.S.C.;
- f) A medical care program of the Indian Health Service or of a tribal organization;
- g) A State health benefit risk pool;
- h) A health plan offered pursuant to the Federal Employees Health Benefits Program, FEHBP, under chapter 89 of title 5, U.S.C.;
- i) A public health plan as defined in 45 C.F.R. Sec. 146.113, authorized by the Public Health Service Act, 42 U.S.C. Sec. 300gg(c)(1)(I);
- j) A health benefit plan under Sec. 5(e) of the Peace Corps Act, 22 U.S.C. Sec. 2504(e).

## EXCESS PROVISION

No benefit under this Policy is payable for any Expense incurred for Injury or Sickness which is paid or payable by: (1) other valid and collectible medical, health or Accident insurance in excess of \$100 per Injury or Sickness; or (2) under an automobile insurance policy.

Covered Medical Expenses exclude amounts not covered by the primary carrier due to penalties imposed on the Insured Person for failing to comply with policy provisions or requirements.

## EXTENSION OF BENEFITS

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

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

## SUBROGATION AND RECOVERY RIGHTS

If, after payments have been made under this Policy, any person has the right to recover damages from a responsible third party, Our right will be subrogated to that person’s right to recover. The Insured Person will do what ever is necessary to enable Us to exercise Our right and will do nothing after Loss to prejudice it. If We are precluded from exercising Our Right to Subrogation, We may exercise Our Right to Reimbursement.

## APPEALS

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

## HOW DO I OBTAIN MY IDENTIFICATION CARD?

1. You may detach and retain the Identification Card provided on the brochure.
2. You may obtain your Identification Card on the Internet at:  
[www.SaintXavierInsurance.com](http://www.SaintXavierInsurance.com)  
Access Online Services and “Click” on Print ID Card. You will need to provide your name, Student Identification Number, and your birthdate. If you experience any difficulty, please call us at (800) 452-5772.
3. You may call (800) 452-5772 and request that your Identification Card be mailed to you.

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

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

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

**Administrative Concepts, Inc.**  
994 Old Eagle School Road, Suite 1005  
Wayne, PA 19087-1802  
(888) 293-9229

Please contact between 8:00 a.m. and 7:00 p.m. C.S.T.

6. You may check the status of a claim you have already filed at:  
[www.SaintXavierInsurance.com](http://www.SaintXavierInsurance.com)  
and click on “Check Claims Online”.

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

1. **Online Inquiry:**
  - a) go to: [www.SaintXavierInsurance.com](http://www.SaintXavierInsurance.com) to obtain your permanent identification card.
  - b) After obtaining your identification card, click on “Check Claims Online”.
  - c) You will need to set up an account by providing your first and last name, your birthdate, your student identification number and the policy number. This information should be taken directly from your permanent identification card.
2. **Telephone Inquiry:** Call Administrative Concepts, Inc. at (888) 293-9229 between the hours of 8:00 a.m. to 7:00 p.m. CST.

## COMPLAINT RESOLUTION

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

Any provisions of this Plan which, on its effective date, is in conflict with the statutes of the state in which the Insured Person resides on such date, is hereby amended to conform to the minimum requirements of such statutes.

This brochure is a brief description of the Plan Benefits. The exact provisions governing the insurance are contained in the Master Policy issued to Saint Xavier University. Any discrepancies between this brochure and the Policy will be governed by the Policy.

### Direct All Inquiries To:



ASSOCIATED  
INSURANCE PLANS  
INTERNATIONAL, INC.

Post Office Box 189

Libertyville, Illinois 60048

(800) 452-5772 • FAX (847) 281-8813

(e-mail) [office@aipstudentinsurance.com](mailto:office@aipstudentinsurance.com)

Visit us and **enroll on the Web** at:

[www.SaintXavierInsurance.com](http://www.SaintXavierInsurance.com)

# HIPAA NOTICE OF PRIVACY PRACTICES FOR PERSONAL HEALTH INFORMATION

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

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

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

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

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

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

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

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

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

**To Business Associates:** For example, We may disclose PHI to administrators who are contracted with Us who may use the PHI to administer health insurance benefits on our behalf and such administrators may further disclose PHI to their contractors or vendors as necessary for the administration of health insurance benefits.

If your state has adopted a more stringent standard regarding any of the above uses or disclosures of your PHI, those standards will be applied.

**Additional Uses or Disclosures:** We may also disclose PHI about you for the following purposes: To comply with legal proceedings, such as a court or administrative order, subpoena or discovery requests. To law enforcement officials for limited law enforcement purposes. To a family member, friend or other person, for the purpose of helping you with your health care or with payment for your health care, if you are in a situation such as a medical emergency and you cannot give your agreement to the Plan to do this. To your personal representatives appointed by you or designated by applicable law. For research purposes in limited circumstances. To a coroner, medical examiner, or funeral director about a deceased person. To an organ procurement organization in limited circumstances.

To avert a serious threat to your health or safety or the health or safety of others. To a governmental agency authorized to oversee the health care system or government programs. To the Department of Health and Human Services for the investigation of compliance with HIPAA or to fulfill another lawful request. To federal officials for lawful intelligence, counterintelligence, national security purposes and to protect the president.

To public health authorities for public health purposes. To appropriate military authorities, if you are a member of the armed forces. In accordance with a valid authorization signed by you.

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

You have the right to inspect and copy your PHI. If you request a copy of the information, We may charge a fee for the costs of copying, mailing or other supplies associated with your request. You have the right to ask Us to amend the PHI that is contained in a "designated record set", e.g., information used to make enrollment, eligibility, payment, claims adjudication and other decisions. You have the right to request an amendment for as long as we maintain the PHI. Requests must be made in writing and include the reason for the request. We may deny the request if the PHI is accurate and complete or if we did not create the PHI. You have the right to request a list of our disclosures of the PHI. Your request must state a time period, may not include dates before April 14, 2003 and may not exceed a period of six years prior to the date of your request. If you request more than one list in a year, We may charge you the cost of providing the list. We will notify you of the cost and you may withdraw or modify your request before any costs are incurred. Any list of disclosures provided by Us will not include disclosures made for payment, treatment or healthcare operations; made to you or persons involved in your care; incidental disclosures, authorized disclosures, for national security or intelligence purposes or to correctional institutions. You have the right to request to restrict the way We use or disclose PHI regarding treatment, payment or health care operations. You also have the right to request to restrict the PHI We disclose about you to someone who is involved in your care or the payment for your care. We are not required to agree to your request. If We do agree, We will comply with your request unless the information is needed to provide you emergency treatment. Your request must be in writing and state (1) what information you want to restrict; (2) whether you want to restrict our use, disclosure or both; and (3) to whom you want the restrictions to apply. Uses and disclosures of your PHI, other than those listed above, require prior written authorization from you. You may revoke that authorization at any time by writing to Us at the address at the end of this notice. You have the right to request that We communicate personal information to you in a certain way or at a certain location. Your request must specify how or where you wish to be contacted. We will comply with reasonable requests. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice upon request. You may request a paper copy of this notice by calling Us at 800-452-5772 or submitting the request to COMPANION LIFE INSURANCE COMPANY, c/o Associated Insurance Plans International, Inc., Post Office Box 189, Libertyville, IL 60048, Attn: HIPAA Privacy Office.

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

**Changes To This Notice:** We reserve the right to modify this Privacy Notice and our privacy policies at any time. If We make any modifications, the new terms and policies will apply to all PHI before and after the effective date of the modifications that We maintain. If We make material changes, We will send a new notice to insureds. If you have any questions regarding this notice, please call 800-452-5772 or send your written questions to the address at the end of this notice. Please include your name, the name of your insurance plan, your policy/ID number or copy of ID card, your address and telephone number and We will respond.

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

COMPANION LIFE INSURANCE COMPANY  
c/o Associated Insurance Plans International, Inc.  
Post Office Box 189, Libertyville, IL 60048  
Attn: HIPAA Privacy Office

## OPTIONAL DENTAL/VISION/PHARMACY DISCOUNT CARD

(Additional premium required)

- No Claim Forms
- No Waiting Periods
- No Pre-existing Conditions
- No Deductibles or Maximums
- No Age Restriction

**Discount is immediate at time of service**

Over 100,000 participating providers nationwide

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

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

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

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

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

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

**Annual Premiums - enroll anytime throughout the year at [www.SaintXavierInsurance.com](http://www.SaintXavierInsurance.com). You do not need to purchase health insurance to enroll in the optional dental/vision/pharmacy discount plan.**

ANNUAL PREMIUMS	Credit Card or Internet Payment	Check By Mail
<b>Dental/Vision/Pharmacy</b>		
Student Only	\$72.00	\$62.00
Family	\$88.00	\$78.00
<b>Dental &amp; Vision</b>		
Student Only	\$62.00	\$52.00
Family	\$79.00	\$69.00
<b>Dental &amp; Pharmacy</b>		
Student Only	\$62.00	\$52.00
Family	\$79.00	\$69.00
<b>Vision &amp; Pharmacy</b>		
Student Only	\$40.00	\$30.00
Family	\$50.00	\$40.00
<b>Vision</b>		
Student Only	\$25.00	\$15.00
Family	\$30.00	\$20.00
<b>Pharmacy</b>		
Student Only	\$25.00	\$15.00
Family	\$30.00	\$20.00

## OPTIONAL DENTAL AND VISION INSURANCE PLAN

(Additional premium required)

Underwritten by Security Life Insurance Company of America

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

### PERSONAL DENTAL PLANS

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

**PERSONAL DENTAL PLANS (CONTINUED)**

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

**☆Optional Feature**

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

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

**QUESTIONS? PLEASE CALL 800-452-5772.**

**You do not need to purchase health insurance to enroll in the optional dental and vision insurance plan.**

**Enroll online at [www.SaintXavierInsurance.com](http://www.SaintXavierInsurance.com).**

**PRIMESTAR PERSONAL DENTAL PREMIUM RATE TABLE  
FOR EFFECTIVE DATES**

**APRIL 1, 2011 THROUGH OCTOBER 1, 2011**

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

Zip Code / Other IL / 600-605 / 606-608

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

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

Call for rates if your permanent address is outside Illinois, or view online at [www.SaintXavierInsurance.com](http://www.SaintXavierInsurance.com).

**SAINT XAVIER UNIVERSITY  
AUTOMATIC PAYMENT AUTHORIZATION 2011-2012**

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

DRAFT DATE: \_\_\_\_\_ (Will be debited on the 11th of each month)

DRAFT AMOUNT: \_\_\_\_\_

Check One:  Checking Account  Savings Account

NAME OF BANK WHERE ACCOUNT IS AUTHORIZED \_\_\_\_\_

ADDRESS OF BANK \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_

NAME OF INSURED, APPLICANT (PRINT) \_\_\_\_\_

NAME(S) OF DEPOSITOR(S) IF OTHER THAN THE INSURED \_\_\_\_\_

DEPOSITOR SOCIAL SECURITY NUMBER \_\_\_\_\_

DEPOSITOR DRIVER'S LICENSE NUMBER \_\_\_\_\_

DEPOSITOR STATE \_\_\_\_\_

RELATIONSHIP TO INSURED \_\_\_\_\_

SIGNATURE OF DEPOSITOR \_\_\_\_\_ DATE \_\_\_\_\_

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

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

VISA  DISCOVER  MASTERCARD  AMEX

Credit/Debit Card Number \_\_\_\_\_ Expires: \_\_\_\_\_

Last 3 numbers on the reverse side of the credit card. Located within the signature box \_\_\_\_\_ (For Authorization Purposes)

Print name of cardholder \_\_\_\_\_

Cardholder phone number \_\_\_\_\_

Amount authorized to debit \_\_\_\_\_ for Student Health Insurance.

Cardholder signature \_\_\_\_\_  
Today's Date

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

**SAINT XAVIER UNIVERSITY GRADUATE STUDENT AND  
DEPENDENT ENROLLMENT CARD 2011-2012**

Please Print Legibly

Student's Name \_\_\_\_\_  
(First) (M) (Last)

Student I.D. # \_\_\_\_\_

Social Security # \_\_\_\_\_

Campus attending (important) \_\_\_\_\_

Billing Address:

Street \_\_\_\_\_ Apt. No. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Male  Female Date of Birth \_\_\_\_\_

Telephone No. \_\_\_\_\_

Alternate Telephone No. \_\_\_\_\_

Do you have any other medical insurance?  YES  NO

If yes, name of insurance company: \_\_\_\_\_

E-mail Address (important!) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Date of Birth (mm/dd/yy) \_\_\_\_\_

Social Security # \_\_\_\_\_

Child \_\_\_\_\_ Date of Birth (mm/dd/yy) \_\_\_\_\_

Social Security # \_\_\_\_\_

Child \_\_\_\_\_ Date of Birth (mm/dd/yy) \_\_\_\_\_

Social Security # \_\_\_\_\_

Child \_\_\_\_\_ Date of Birth (mm/dd/yy) \_\_\_\_\_

Social Security # \_\_\_\_\_

I wish to enroll my dependent in the Student Insurance Plan checked below. My check or money order for the amount shown is attached. Make check or money order payable to Student Insurance Plan. Mail premium and enrollment form to **Post Office Box 189, Libertyville, IL 60048.**

Coverage For	Annual 8/11/11 to 8/10/12	Fall 8/11/11 to 12/31/11	Spring & Summer Semesters 1/1/12 to 8/10/12	Spring & Summer Semester (New Students) 3/1/12 to 8/10/12	Summer Semester (New Students) 5/19/12 to 8/10/12	*Monthly Debited on the 11th of each month
Student	\$1,470	\$ 735	\$ 735	\$ 911	\$ 353	\$ 142
Spouse Only	\$2,940	\$1,470	\$1,470	\$1,822	\$ 706	\$ 275
Children	\$2,205	\$1,103	\$1,103	\$1,367	\$ 530	\$ 208

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

**\*MONTHLY ENROLLEES:** Monthly premium is available only if annual coverage is paid with an automatic debit. Please indicate which month you desire your coverage to begin \_\_\_\_\_ (Month). Monthly Enrollees: Please complete the Automatic Payment Authorization Form for full policy year coverage.

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

VISA  DISCOVER  MASTERCARD  AMEX

Card Number \_\_\_\_\_

3 or 4 digit security code \_\_\_\_\_ Expiration Date \_\_\_\_\_

Print name of cardholder \_\_\_\_\_

Cardholder signature \_\_\_\_\_

Please Charge \$ \_\_\_\_\_ for Student Health Insurance.

Student signature \_\_\_\_\_

**NOTE:** You may enroll "On-line" and pay your premium by electronic check or major credit card at [www.SaintXavierInsurance.com](http://www.SaintXavierInsurance.com)