COMPANION LIFE INSURANCE COMPANY
1301 GERVAIS STREET, SUITE 900, COLUMBIA SC 29201
P.O. Box 100102, Columbia, South Carolina 29202-3102
(803) 735-1251

Policy Number:	907-14-01224	**Certificate Effective Date:**	January 01, 2018
Certificateholder:	BEVERLY S BALLIOT	**Policyholder:**	HAYWOOD COMMUNITY COLLEGE

This Certificate is issued to the Certificateholder and subject to the laws of the jurisdiction within which the Policy has been issued.

In consideration of the application made by the Policyholder, the enrollment of the Certificateholders and receipt of any and all premiums when due, the Company agrees to provide the coverage described herein subject to all provisions of the Policy and any amendments added to the Policy.

The Policy may be amended or cancelled without the consent of the Insured.

This Certificate replaces all certificates previously issued to the Insured under the Policy.

Important Cancellation Information – Please Read The Provision Entitled "Termination of Insurance" Found On Page 9.

TEN DAY FREE LOOK
The Company urges the Certificateholder to examine this Certificate closely. If the Certificateholder is not satisfied with it, the Certificateholder may send it back to the Company or its Administrator for any reason within 10 days after the date the Certificateholder receives it. If returned, the Certificateholder's insurance will be canceled, and any premium paid will be refunded in full.

In witness whereto, Companion Life Insurance Company has caused this Certificate to be signed and shall take effect on the Certificate Effective Date specified above.

Signed for by the Company

John Wilbur
President

GROUP VISION INSURANCE CERTIFICATE
OPTIONALLY RENEWABLE AS
DESCRIBED WITHIN

Please read your Certificate carefully. This is a legal contract.

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CERTIFICATE. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from the Company.

For service or questions about the Policy, please address any inquiries to Companion Life, P.O. Box 1535, Dubuque, IA 52004-1535, call 1-877-676-5789 or via website www.companionlife.com.

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SECTION 2 - SCHEDULE OF BENEFITS

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Benefits are payable as shown on the Schedule of Benefits for expense incurred for each Insured Individual while this Certificate is in force. Benefits provided by this Certificate will be compensated according to the following schedule:

Routine Eye Examination **Benefit Period**	$20 Copayment 12 months*
Contact Lens Fitting A contact lens fitting refers to a new fit, re-fit, or evaluation **Benefit Period**	$0 Copayment 12 months*
Allowance For Eyewear The allowance can be applied to frames, spectacle lenses, contact lenses, special lens options, or any combination **Benefit Period**	Reimbursement for cost of eyewear, up to $175 minus $0 Copayment 12 months*

**Once in a 12-month period defined by last date of service.

SECTION 3 - DEFINITIONS

ACTIVE EMPLOYEE means an Employee who works for the Employer on a regular basis in the usual course of the Employer's business. The Employee must work the number of hours as defined in the Eligibility provision.

ACTIVE SERVICE means the performance in the customary manner by an Active Employee of all the regular duties of their employment with their Employer at one of the Employer's business establishments or at some location to which the Employer's business requires the Employee to travel.

ACTIVELY AT WORK means a day, which is one of the Employee's scheduled workdays if they are performing, in the usual way, all of the regular duties of their job. The Employee will be deemed to be Actively at Work on a day, which is not one of the Employees' scheduled workdays only if the Employee was Actively at Work on the preceding scheduled workday.

ADMINISTRATOR means an organization or entity that processes all or certain administrative functions for the Company.

ALLOWANCE FOR EYEWEAR means the maximum dollar amount of coverage for eyewear under this Certificate. The allowance acts like a credit. It can be applied to frames, lenses, contact lenses, special lens options, or any combination. So long as the Covered Individual selects Eyewear having a retail price that's less than or equal to the allowance, they incur no out-of-pocket expense for Eyewear at the time of service, apart from any applicable Copayment. If the selected Eyewear has a retail price that exceeds the allowance, the Covered Individual is responsible only for the balance (i.e., retail minus the allowance). Under selected plans, the balance may be discounted.

CALENDAR YEAR means the 12 month period commencing on January 1st and ending on December 31st of the same year.

CERTIFICATE means a document that describes the benefits provided to the Insured by the Policy.

CERTIFICATEHOLDER means the Employee who is eligible for benefits provided by the Policyholder's policy and who has been provided a Certificate of insurance.

COMPANY is Companion Life Insurance Company. Our home office mailing address is P.O. Box 100102, Columbia, SC 29202-3102.

COPAYMENT or COPAY means the amount You are required to pay the provider for the benefits shown in the Schedule of Benefits.

DEPENDENT means:

1) an Insured's Spouse;
2) each Insured's Dependent Child under 26 years of age; and
3) each child over 26 who is incapable of self-sustaining employment because of mental incapacity or physical handicap and primarily dependent on the Insured for support and maintenance.

Proof of the incapacity and dependency must be furnished upon request, to the Company within 31 days of the child's attainment of the limiting age and subsequently as may be required by Us, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

DEPENDENT CHILD means: (a) the Insured's natural child from moment of birth; (b) the Insured's adopted child from the date of a final court order granting adoption of the child or, if earlier, the date the child is placed by a court in the Insured's home pending such an order; (c) any foster child from the moment of placement in the foster home, for which the Insured has assumed legal obligation to support the foster child; (d) any child living with the Insured in a regular parent-child relationship and primarily dependent on the Insured for support and maintenance, or (e) any child for whom We have notice, pursuant to a medical support order, that the Insured must provide support in the form of vision insurance from the date of such notice. For the purpose of this definition, "medical support order" is a valid order of a court, judicial department or government agency at the local, state, or federal level that obligates the Insured to provide a child financial support in the form of vision insurance.

EFFECTIVE DATE for the Employer means the first date coverage under the Policy becomes effective. The Effective Date is on the Policy cover page. The Effective Date for an Insured is shown on the Certificate. All insurance will begin at 12:01 A.M. standard time, at the Policyholder's address on the Effective Date. It will end at 12:01 A.M., standard time, at the Policyholder's address on the termination date.

EYEWEAR means frames, spectacle lenses, contact lenses, and special lens options.

ELIGIBILITY WAITING PERIOD means a period of continuous Active Service with an Employer that an Employee must serve in order to qualify for coverage under the Policy. The length of any Eligibility Waiting Period is shown on the Schedule of Benefits.

EMPLOYEE means a person permanently employed by the Employer for wages or salary and working for the Employer on a regular basis.

EMPLOYER means the business organization listed on the Schedule of Benefits which provides vision insurance available through the Policy to its eligible Employees and has executed an application for vision insurance acceptable to Us.

FAMILY means an Insured and his or her Dependents.

FAMILY MEMBER means anyone related to an Insured Individual by blood, marriage, or adoption.

INSURED means a person who is an eligible , who has qualified for insurance by completing the Eligibility Waiting Period, if any; as shown on the Schedule of Benefits and for whom coverage under the Policy has become effective.

INSURED INDIVIDUAL means the Insured and any Dependent covered under the Policy.

LATE ENTRANT means an Insured Individual whose Effective Date of Insurance is more than 31 days from the date the person qualifies for insurance, or who has elected to become insured again after the premium contribution is stopped for reasons other than loss of eligibility for insurance.

OPHTHALMOLOGIST means a Physician or a doctor of medicine or osteopathy (M.D. or D.O.) who specializes in the comprehensive care of the eyes and visual system to prevent, diagnose, and treat any eye disease, disorder, or injury.

OPTICIAN means an individual who is licensed to fit, adjust, and dispense eyeglasses and other optical devices on the written prescription of a licensed Ophthalmologist or Optometrist.

OPTOMETRIST means a doctor of optometry (O.D.) who is trained to detect and correct vision problems primarily by prescribing eyeglasses or contact lenses and specializes in the comprehensive care of the eyes and visual system.

OVERSIZED LENS means any lens with an eyesize of 61 mm or greater.

PHYSICIAN means any person, including an Ophthalmologist, who is licensed by the law of the state in which treatment, within the scope of his or her license, is given for sickness or injury causing the expenses or loss for which claim is made.

POLICY means the contract of insurance made by the Company and the Policyholder.

POLICYHOLDER means the firm or other organization to which the Policy is issued. The term Policyholder will also include those subsidiaries, divisions, and affiliates listed in the Policy.

PROVIDER means a healthcare professional, including Optician and Optometrist, who is professionally licensed by the appropriate state agency and who provides services within the scope of that license. A Provider's services are not covered if the Provider resides in the Insured's home or is a Family Member.

SCHEDULE OF BENEFITS means the document showing the eligible class, the amounts of insurance, and other relevant information about the plan of insurance applied for by the Employer under the Policy. It is made a part of the Policy for the purposes of defining Employer coverage under the Policy.

SPOUSE means a lawfully recognized partner of the Insured, who is not a relative, is of legal age, is not currently married to someone else, is in a committed relationship with the Insured and shares financial obligations and can provide legal proof of marriage. Spouse also includes the Insured's domestic partner or civil union partner as defined by state law. The Insured must provide the Policyholder and Company with proof of such legal domestic partnership or legal civil union partnership required by state law or the Company

including as applicable, but not limited to, a declaration of such partnership, license of such partnership or registration of such partnership, or other documentation as required by state law.

VISION EXAMINATION means a comprehensive ophthalmological service as defined in the Current Procedural Technology (CPT) and the Documentation Guidelines listed under "Eyes-examination items." Comprehensive ophthalmological service describes a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but need not be performed at one session. This service includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields and basic sensorimotor examination. It often includes, as indicated: biomicroscopy, examination with cyclopedia or mydriasis and tonometry. It always includes initiation of diagnostic and treatment programs.

WE, OUR, US means Companion Life Insurance Company or its Administrator.

YOU, YOUR, YOURS means the Insured.

SECTION 4 - ELIGIBILITY AND ENROLLMENT

Eligible Employee Means You

1) are an Active Employee working 30 hours or more per week who is a legal resident or citizen of the U.S.; and
2) qualify as an eligible Employee as shown in the Schedule of Benefits

Eligible Dependents Include

1) an Insured's Spouse; and/or
2) each Insured's Dependent Child under 26 years of age.
3) each child over 26 who is incapable of self-sustaining employment because of mental incapacity or physical handicap and primarily dependent on the Insured for support and maintenance.

Proof of the incapacity and dependency must be furnished upon request, to the Company within 31 days of the child's attainment of the limiting age and subsequently as may be required by Us, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

No one can be insured as a Dependent of more than one eligible Employee.

No one on active duty in the armed forces of any country can be insured as a Dependent.

No one can be insured as a Dependent if eligible for insurance as an eligible Employee.

If both the eligible Employee and Spouse are eligible Employees of the Policyholder, only one of them may insure the Dependent Child for vision care expenses.

Dependents Acquired After Coverage Is Effective

All Dependents except for newborn children will be covered from the date they meet the definition of Dependent if written request and payment of any required premium is submitted within 31 days. Newborn children will be covered from the moment of birth for a period of 31 days. To continue coverage beyond 31 days, written request and payment of any required premium must be submitted within such 31-day period.

Eligibility Waiting Period

Employees are eligible under this Certificate after completing the Eligibility Waiting Period as described on the Schedule of Benefits, if any, as established by the Policyholder.

An Insured whose eligibility terminates and is established again within 12 month(s) will not have to complete a new Eligibility Waiting Period before becoming eligible for coverage.

If We receive an eligible Employee's enrollment more than the 31 days after completing any Eligibility Waiting Period, they will be considered a Late Entrant.

Enrollment If A Section 125 Plan

If the Policy is provided as part of the Employer's Section 125 Plan, each eligible Employee has the option under the Section 125 Plan of participating or not participating in the Policy. If an eligible Employee does not elect to participate when initially eligible, the eligible Employee may elect to participate at a subsequent election period. This election period will be held each year and those who elect to participate in the Policy at that time will have their insurance become effective on January 01. An eligible Employee who elects to participate during the election period who did not elect to participate when initially eligible will be considered a Late Entrant and is subject to the waiting periods associated with the Policy. Eligible Employees may change their election option only during the election period, except for a change in family status. Family status changes would be marriage, divorce, birth of a child, death of a Spouse/child, or termination of employment of a Spouse.

Eligible Employee Effective Date

The Effective Date for an eligible Employee covered by the Policy, subject to payment of the required premium and satisfaction of the waiting period, will be the later of:

1) the Effective Date of the Policy if We receive the eligible Employee request for coverage prior to the Effective Date; or
2) after We receive the eligible Employee request for coverage if that date is after the date they have met the qualifications of an

eligible Employee.

Eligible Employees must be Actively at Work on the Effective Date for coverage, or any increase in coverage to take effect. If not, the coverage or increase in coverage will take effect when the eligible Employee returns to work and meets the definition of Actively at Work.

Benefit Classification Change

If an Insured's status changes so they become an eligible Employee of a different class, as shown in the Schedule of Benefits, any change in amounts of insurance because of the new class will take effect immediately following the change..

Eligible Dependent Effective Date

The Effective Date for each eligible Dependent covered by the Policy except for newborn children will be the first day of the month after:

1) the Company's acceptance of the signed request for coverage that includes Dependent coverage; and
2) receipt of the first premium.

However, if on such date the coverage for the eligible Employee has not yet taken effect, the Effective Date for Dependent coverage will be the same as the Effective Date for such eligible Employee.

The Effective Date for each eligible Dependent who is a newborn child covered by the Policy will be the date of birth and will continue for a period of 31 days. Coverage will continue to be effective beyond 31 days provided written request and payment of any required premium is submitted within such 31-day period.

SECTION 5 – TERMINATION/CONTINUATION

Termination of Insurance

The Insured's insurance provided under the Policy will terminate at 12:01A.M., standard time, at the Policyholder's address on the earliest of the following:

1) the date the Policy terminates;
2) the date the Policy is amended or changed to exclude coverage for the class of eligible individuals to which the Insured belongs;
3) the date that the Insured ceases to be a member of the classes for whom insurance is provided;
4) the end of the period for which any required contribution is made, or/ as negotiated by Us and the Policyholder;
5) the date on which an Insured Individual enters the armed forces, other than for reserve duty of 30 days or less.

The Dependent's insurance provided under the Policy will terminate at 12:01A.M., standard time, at the Policyholder's address on the earliest of the following:

1) the date the Policy terminates;
2) the date the Insured's coverage terminates;
3) the date We are notified to terminate the Dependent's coverage;
4) the date that the Dependent ceases to qualify as an eligible Dependent;
5) the end of the period for which any required contribution is made, or as negotiated by Us and the Policyholder;
6) the date on which an Insured Individual enters the armed forces, other than for reserve duty of 30 days or less.

Continuation of Coverage

The Policyholder may, but is not required to, consider Employees as eligible Employees and continue insurance even though they are:

1) temporarily laid-off and the Policyholder expects to call them back to work;
2) put on approved leave of absence; or
3) unable to work because of injury or sickness.

The Policyholder must treat all Insureds the same for purposes of continuing insurance. If insurance is so continued, it will end on the earliest of:

1) the date the Policyholder notifies the Company that the Insured is no longer a member of an eligible class; or
2) the date that ends the period for which the Policyholder last paid the premium for the Insured and their Dependents.

Any Insured Individual has the right to continue their coverage for a limited time after it would otherwise terminate. Below explains certain instances when an Insured Individual's coverage may be continued. Please contact the Policyholder's benefits Administrator for additional information. If insurance is continued, it must be according to a plan which does not allow individual selection.

Cobra Continuation Rights

If coverage for an Insured Individual ends, they may qualify for continuation of such coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985, amended (COBRA). For more information, contact the Policyholder's benefits Administrator. The following groups are not subject to this regulation:

1) groups of less than 20 Employees; or
2) certain church plans.

Death or Divorce – For Dependents Only

The Insured's Spouse may continue coverage under the Policy if the Insured dies or the marriage is dissolved provided the Spouse makes an election to continue coverage within 90 days of such occurrence and premium is paid within 90 days of notification of continuation. Coverage may include any Dependent Child whose insurance would end at the same time.

Coverage will terminate under continuation due to death or divorce on the earliest of:

1) the last day of the period for which the premium is paid;
2) the date coverage would normally stop under the terms of the Policy, except coverage must not be changed or stopped during the first 90 days of continuation unless coverage is changed or stopped for all Employees covered under the Policy;
3) the date the Spouse becomes insured under another vision plan;
4) the date the Spouse remarries;
5) the date coverage has been continued for 3 years, for Spouse under age 65 when continuation started;
6) the date the Spouse or Dependent Child is eligible for coverage under Medicare, Title XVIII of the Federal Social Security Act; or
7) the date the Policy terminates.

SECTION 6 - LIMITATIONS AND EXCLUSIONS

Limitations

Oversized Lenses are not a covered benefit. An Insured Individual requesting these lenses will be required to pay the difference in charges.

Exclusions

No benefits will be paid for services or materials connected with or charges arising from:

1) orthoptic or vision training, sub-normal vision aids, and any associated supplemental testing;
2) aniseikonia lenses;
3) medical and/or surgical treatment of the eye, eyes or supporting structure;
4) corrected eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under plan;
5) services provided according to a final adjudication of the claim under Worker's Compensation, Article 1 of Chapter 97 of the General Statutes or an order of the North Carolina Industrial Commission approving a settlement agreement entered into under that Article;
6) plain non-prescription lenses and non-prescription sunglasses (except for 20% discount);
7) services or materials provided by any other group benefit providing for vision care;
8) two pair of glasses in lieu of bifocals.

SECTION 7 - GENERAL PROVISIONS

Entire Contract
The contract between the parties consists of:

1) the Policy;
2) the application of the Policyholder, which is made a part of the Policy when issued;
3) this Certificate;
4) any endorsements, amendments, or riders; and
5) the enrollment forms, if any, of each Insured.

All statements made by the Policyholder and Insured shall be deemed representations and not warranties and no statement made by an Insured shall void the insurance or be used in defense to a claim hereunder unless a copy of the instrument containing such statement is or has been furnished to such Insured.

Clerical Error
Clerical errors or delays in keeping records for the Policy:

1) will not deny insurance which would otherwise have been granted;
2) will not continue insurance which otherwise would have ceased; and
3) may call for an adjustment of premium benefits to correct the error.

Certificates
The Company will supply individual Certificates for each Insured. This Certificate will describe:

1) the insurance benefits;
2) to whom benefits will be paid;
3) any limitations of the Policy; and
4) all other essential features of the Policy.

If more than one Certificate is issued under the Policy to an Insured, only the last one issued will be in effect. If requested, the Certificates will be provided electronically at no additional cost.

Legal Action
No legal action can be brought against Us until at least 60 days after the Insured sends Us the required proof of loss. No such action may be brought against Us after three years after proof of loss is required.

Conformity with State Laws
If any provision of the Policy is contrary to the law of the jurisdiction in which it is delivered, such provision is hereby amended to conform to that law. If any change to state or federal law affects the Company's liability under the Policy, the Company may change the Policy, the premiums or both. Such change:

1) will be effective as of the date of change to the state or federal law; and
2) will not be made until the Company gives the Policyholder 31 days' notice.

Incontestability
The validity of the Policy cannot be contested after two years from its date of issue, except for nonpayment of premiums. After coverage for an Insured Individual has been in force for two years, the Company cannot: (a) void the coverage; or (b) deny a claim for loss that starts after the two-year period, because of statements in the application.

Nothing herein should be construed to prevent the Company from denying any claim on the basis that an individual was not eligible for coverage.

Not in Lieu of Workers' Compensation
The Policy is not in lieu of and does not affect any requirement for coverage by workers' compensation.

Physical Examination
We, at Our expense, will have the right to and opportunity to examine any Insured Individual for whom a claim is pending when and as often as We may reasonably require during the pendency of a claim.

SECTION 8 - CLAIMS PROVISIONS

Notice of Claim
Written notice of claim must be given to Us within 30 days after the incurred date of the services provided for which benefits are payable or as soon as reasonably possible. Notice must be given to the Company, its Administrator, or to one of Our agents. Notice should include the Policyholder's name, Insured Individual's name, and Policy Number. If it will not be reasonably possible to give written notice within the 30-day period stated above, We will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

Claim Forms
When We receive the notice of claim, We will send the claimant forms for filing proof of loss. If these forms are not furnished within 15 days after We have received the notice, the claimant will meet Our proof of loss requirements by giving Us a written statement of the nature and extent of loss within the time limit for filing proofs of loss.

Proof of Loss
Written proof of loss must be given to Us within 180 days after the date for which services were provided. If it was not reasonably possible to give written proof within the 180-day period, We will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible. In any event, We must receive proof no later than one year from the time specified, except in the absence of legal capacity.

Time of Payment
We will pay all benefits upon receipt of due proof.

Payment of Claims
All benefits will be paid to the Insured, unless an assignment of benefits has been requested by the Insured or We have the obligation to pay the facility or Provider directly. If the Insured dies before all payments due have been made, all remaining amounts payable will be paid to the Insured’s estate. Any payment made by Us in good faith pursuant to this provision will fully release Us from liability to the extent of such payment.

STATEMENT OF ERISA RIGHTS
As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all Plan participants shall be entitled to:

1. Receive Information About Your Plan and Benefits

a) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

b) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form5500 Series) and updated summary Plan description. The administrator may make a reasonable charge for the copies.

c) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

2. Prudent Actions by Plan Fiduciaries
In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

3. Enforce Your Rights
If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If the Plan requires you to complete administrative appeals prior to filing in court, your right to file suit in state or Federal court may be affected if you do not complete the required appeals. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

4. Assistance with Your Questions
If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200
Constitution Avenue N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

A. Claims Filing PROCEDURES

Written notice of claim must be furnished to Companion Life Insurance Company, 1301 Gervais Street, Suite 900, Columbia, SC 29201, within twenty (20) days after the event on which the claim is based, or as soon thereafter as is reasonably possible. Notice of claim should include the Employer's name, Insured's name, and Employer's Group Number. Failure to give notice within the time does not invalidate nor reduce any claim if the claimant can show that it was not reasonably possible to give the notice within the required time frame and if notice was given as soon as reasonably possible. Upon receipt of the notice, Companion Life will furnish or cause a claim form to be furnished to the claimant. If the claim form is not furnished within fifteen (15) days after Companion Life receives the notice, the claimant will be deemed to have complied with our proof of loss requirements. The claimant must submit written proof covering the nature and extent of the claim within the policy time limit for filing proof of loss.

PROOF OF CLAIM

1. Companion Life must receive the claim within ninety (90) days after the beginning of services. Failure to file the claim within the ninety (90) day period, however, will not prevent payment of Covered Expenses if the Insured Employee shows that it was not reasonably possible to file the claim timely, provided the claim is filed as soon as is reasonably possible. In any event, except in the absence of legal capacity, claims must be filed by the end of the calendar year after the calendar year in which the loss occurred or the claim will be denied.

2. Receipt of a claim by Companion Life will be deemed written proof of loss and will serve as written authorization from the Insured Employee to Companion Life to obtain any medical or financial records and documents useful to Companion Life. Companion Life, however, is not required to obtain any additional records or documents to support payment of a claim and is responsible to pay claims only on the basis of the information supplied at the time the claim was processed. Any party who submits medical or financial reports and documents to Companion Life in support of an Insured's claim will be deemed to be acting as the agent of the Insured Employee.

3. There are four (4) types of claims: Pre-Service Claims, Urgent Care Claims, Post-Service Claims, and Concurrent Care Claims. Companion Life will make a determination for each type of claim within the following time periods:

    a. Pre-Service Claim.

        i. A determination will be provided in writing or in electronic form within a reasonable period of time, appropriate to the medical circumstances, but no later than fifteen (15) days from receipt of the claim.

        ii. If a Pre-service Claim is improperly filed, or otherwise does not follow applicable procedures, the Insured Employee will be sent notification within five (5) days of receipt of the claim.

        iii. An extension of fifteen (15) days is permitted if Companion Life determines that, for reasons beyond the control of Companion Life, an extension is necessary. If an extension is necessary, Companion Life will notify the Insured Employee within the initial fifteen (15) day time period that an extension is necessary, the circumstances requiring the extension, and the date Companion Life expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The Insured Employee will have at least forty-five (45) days to provide the required information. If Companion Life does not receive the required information within the forty-five (45) day time period, the claim will be denied. Companion Life will make its determination within fifteen (15) days of receipt of the requested information, or, if earlier, the deadline to submit the information.

    b. Urgent Care Claim.

i. A determination will be sent to the Insured Employee in writing or in electronic form as soon as possible taking into account the medical exigencies, but no later than seventy-two (72) hours from receipt of the claim.

ii. If the Insured Employee's Urgent Care Claim is determined to be incomplete, the Insured Employee will be sent a notice to this effect within twenty-four (24) hours of receipt of the claim. The Insured Employee will then have forty-eight (48) hours to provide the additional information. Failure to provide the additional information within forty-eight (48) hours may result in the denial of the claim.

iii. If the Insured Employee requests an extension of Urgent Care Benefits beyond an initially determined period and makes the request at least twenty-four (24) hours prior to the expiration of the original determination period, the Insured Employee will be notified within twenty-four (24) hours of receipt of the request for an extension.

c. Post-Service Claim.

i. A determination will be sent within a reasonable time period, but no later than thirty (30) days from receipt of the claim.

ii. An extension of fifteen (15) days may be necessary if Companion Life determines that, for reasons beyond the control of Companion Life, an extension is necessary. If an extension is necessary, Companion Life will notify the Insured Employee within the initial thirty (30) day time period that an extension is necessary, the circumstances requiring the extension, and the date Companion Life expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The Insured Employee will have at least forty-five (45) days to provide the required information. If Companion Life does not receive the required information within the forty-five (45) day time period, the claim will be denied. Companion Life will make its determination within fifteen (15) days of receipt of the requested information, or, if earlier, the deadline to submit the information.

d. Concurrent Care Claim.

The Insured Employee will be notified if there is to be any reduction or termination in coverage for ongoing care sufficiently in advance of such reduction or termination to allow the Insured Employee time to appeal the decision before the Benefits are reduced or terminated.

4 Notice of Determination.

a. If the Insured Employee's claim is filed properly, and the claim is in part or wholly denied, the Insured Employee will receive notice of an Adverse Benefit Determination that will:

i. State the specific reason(s) for the Adverse Benefit Determination;

ii. Reference the specific Plan of Benefits provisions on which the determination is based;

iii. Describe additional material or information, if any, needed to complete the claim and the reasons such material or information is necessary;

iv. Describe the claims review procedures and the Plan of Benefits and the time limits applicable to such procedures, including a statement of the Insured Employee's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on review;

v. Disclose any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination (or state that such information is available free of charge upon request); and,

vi. If the reason for denial is based on a lack of Medical Necessity or Investigational or Experimental Services exclusion or similar limitation, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request).

b. The Insured Employee will also receive a notice if the claim is approved.

B. Appeal procedures for an ADVERSE BENEFIT DETERMINATION

1. Insured Employee has one hundred eighty (180) days from receipt of an Adverse Benefit Determination to file an appeal. An appeal must meet the following requirements:

   a. An appeal must be in writing; and,

   b. An appeal must be sent (via U.S. mail) to Companion Life Insurance Company at the address on the Insured's Identification Card; and,

   c. The appeal request must state that a formal appeal is being requested and include all pertinent information regarding the claim in question; and,

   d. An appeal must include the Insured's name, address, social security number and any other information, documentation or materials that support the Insured's appeal.

2. The Insured Employee will have the opportunity to submit written comments, documents, or other information in support of the appeal, and will have access to all documents relevant to the claim. A person other than the person who made the initial decision will conduct the appeal. No deference will be afforded to the initial determination.

3. If the appealed claim involves an exercise of medical judgment, Companion Life will consult with an appropriately qualified health care practitioner with training and experience in the relevant field of medicine. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on the appeal.

4. Companion Life will make a final decision on the appeal within the time periods specified below:

   a. Pre-Service Claim.

   Companion Life will decide the appeal within a reasonable period of time, taking into account the medical circumstances, but no later than fifteen (15) days after receipt of the appeal. If the Insured Employee disagrees with Companion Life's decision, the Insured Employee can submit a second appeal within ninety (90) days after receipt of the final decision of the first appeal. Companion Life will decide the second appeal within a reasonable period of time, taking into account the medical circumstances, but no later than fifteen (15) days after receipt of the second appeal.

   b. Urgent Care Claim.

   The Insured Employee may request an expedited appeal of an Urgent Care Claim. This expedited appeal request may be made orally, and Companion Life will communicate with the Insured Employee by telephone or facsimile. Companion Life will decide the appeal within a reasonable period of time, taking into account the medical circumstances, but no later than seventy-two (72) hours after receipt of the Request for an expedited appeal.

   c. Post-Service Claim.

   Companion Life will decide the appeal within a reasonable period of time, but no later than thirty (30) days after receipt of the appeal. If the Insured Employee disagrees with Companion Life's decision, the Insured Employee can submit a second appeal within ninety (90) days after receipt of the final decision of the first appeal. Companion Life will decide the second appeal within a reasonable period of time, but no later than thirty (30) days after receipt of the second appeal.

d. Concurrent Care Claim.

Companion Life will decide the appeal of Concurrent Care Claims within the time frames set forth in (B)(4)(a-c) depending on whether such claim is also a Pre-Service Claim, an Urgent Care Claim or a Post-Service Claim.

5. Notice of Appeals Determination.

   a. If an Insured Employee's appeal is denied in whole or in part, the Insured Employee will receive notice of an Adverse Benefit Determination that will:

      i. State specific reason(s) for the Adverse Benefit Determination;

      ii.. Reference specific provision(s) of the Plan of Benefits on which the benefit determination is based;

      iii. State that the Insured Employee is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for Benefits;

      iv. Describe any voluntary appeal procedures offered by Companion Life and the Insured Employee's right to obtain such information;

      v. Disclose any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination (or state that such information will be provided free of charge upon request);

      vi. If the reason for an Adverse Benefit Determination on appeal is based on a lack of Medical Necessity, Investigational or Experimental Services or other limitation or exclusion, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request); and

      vii. Include a statement regarding the Insured Employee's right to bring an action under section 502(a) of ERISA.

   b. The Insured Employee will also receive a notice if the claim on appeal is approved.

NOTICE OF PROHIBITIONS

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-260.3, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR HEALTH CARE PLAN PREMIUMS, FOR WHICH PAYMENT WAGES OR OTHER FUNDS ARE WITHHELD FROM THE PERSONS INSURED, SHALL: (1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE PLAN, OR HEALTH CARE PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY SUCH PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND (2) WILLFULLY FAIL TO DELIVER, AT LEAST 30 DAYS PRIOR TO THE TERMINATION OF SUCH COVERAGES, TO EACH NAMED INSURED A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO THE NAMED INSUREDS OF THEIR RIGHTS TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 26C OF GENERAL STATUTES CHAPTER 58. VIOLATION OF THIS LAW IS A FELONY IF THE INSURANCE IS, IN WHOLE OR IN PART, PAID FOR OUT OF WAGES WITHHELD OR OTHER FUNDS COLLECTED FROM THE PERSONS INSURED. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE. (1985, c.507,s.1.)

COMPANION LIFE INSURANCE COMPANY
1301 Gervais Street, Suite 900, Columbia, South Carolina 29201
P.O. Box 100102, Columbia, South Carolina 29202-3102
(803) 735-1251

NOTICE CONCERNING COVERAGE
LIMITATIONS AND EXCLUSIONS UNDER THE NORTH CAROLINA
LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies and Health Maintenance Organizations (HMOs) licensed in this state to write these types of insurance are members of the North Carolina Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer or HMO becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of the insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted in *the box* below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The North Carolina Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in North Carolina. You should not rely on coverage by the North Carolina Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

The North Carolina Life and Health Insurance Guaranty Association
Post Office Box 10218
Raleigh, North Carolina 27605-0218

North Carolina Department of Insurance, Consumer Services Division
1201 Mail Service Center
Raleigh, North Carolina 27699-1201

The state law that provides for this safety-net coverage is called the North Carolina Life and Health Insurance Guaranty Association Act. *On the next page* is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE

Generally, individuals will be protected by the life and health insurance guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer or HMO. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy was issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.
- They acquired rights to receive payments through a structured settlement factoring transaction.

The association also does not provide coverage for:

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed the average rate specified in the law;
- Dividends;
- Experience or other credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contract holders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered.
- A policy or contract commonly known as Medicare Part C, Medicare Part D, Medicaid or any regulations issued pursuant thereto.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out as follows:

(1) The guaranty association cannot pay out more than the insurance company would owe under the policy or contract.
(2) Except as provided in (3), (4), and (5) below, the guaranty association will pay a maximum of $300,000 per individual, per insolvency, no matter how many policies or types of policies issued by the insolvent company.
(3) The guaranty association will pay a maximum of $500,000 with respect to a health benefit plan.
(4) The guaranty association will pay a maximum of $1,000,000 with respect to the payee of a structured settlement annuity.
(5) The guaranty association will pay a maximum of $5,000,000 to any one unallocated annuity contract holder.

NOTICE OF PRIVACY PRACTICES

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

Our Privacy Promise

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

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

Uses and Disclosures of Medical Information Treatment,

Payment, Health Care Operations

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

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

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

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

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

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

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

Your Employer or Organization Sponsoring Your Group Health Plan
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.

Privacy 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: Privacy Officer
I 20 East@Alpine Road (AX-E0l) Columbia,
SC 29219

(803) 264-7258 (telephone) (803)
264- 7257 (fax)

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation or health status in our health plans, when we enroll or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice (TDD: 711).

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance by emailing contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD)

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥 1-844-396-0188。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đỡ với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건강보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187로 연락해 주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839 . (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Rvs 3/13/2017

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions à propos de ce plan médical, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 1-844-396-0190. (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سوالاتی در باره‌ی این برنامه‌ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره‌ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)

Ni da doodago t'áá háída bíká'aná nílwo'igíí dií Béeso Ách'ąąh naa'nilígi háá'ida yi na' idił kidgo, nihá'áhóót'i' nihí ká'a'doo wolgo kwii ha'át'ishíį bí na'idołkidígi doo bik'é'azlâagóó. Ata' halne'é la' bich'į' ha desdzih nínízingo, kojį' béésh bee hólne' 1-844-516-6328. (Navajo)

Revised 08/27/2019

Companion Life

Companion Life Insurance Company
P.O. Box 100102
Columbia, SC 29202

NOTICE OF OUR PRIVACY POLICIES AND PRACTICES

This Privacy Notice has been prepared to inform you of our practices related to information we collect about you. When necessary to provide our products and services to you, we may disclose the information we collect, as described below, (a) to companies that provide services on our behalf and (b) to affiliated and nonaffiliated third parties, such as to health care providers and those who process insurance applications, pay claims, coordinate benefits and administer premiums. Otherwise, we do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted by law. If you are a plan sponsor or group policyholder, this Privacy Notice describes our practices for safeguarding nonpublic personal financial information that we collect about participants and beneficiaries of your employee benefit plan(s).

Information we collect and maintain: We collect information about you from the following sources:

- Information we receive from you on applications or on other forms
- Information we obtain from your transactions with us, our affiliates or others
- Information we receive from consumer-reporting agencies

How we protect information: We restrict access to nonpublic personal information about you to those who need to know the information to provide our products and services to you and as permitted by law. We maintain physical, electronic and procedural safeguards that comply with applicable legal requirements to guard your nonpublic personal financial information. We have installed usernames, passwords and other safety features on web applications to help ensure that the information about you that we collect and maintain remains safe and secure.

Changes to this notice: We may amend our privacy policies and practices at any time, and we will inform you of any material changes, as required by law.

YOU DO NOT NEED TO DO ANYTHING IN RESPONSE TO THIS NOTICE.

THIS NOTICE IS MERELY TO INFORM YOU ABOUT OUR PRIVACY POLICIES AND PRACTICES.