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Introduction
The Middlebury College Student Health Insurance Plan has been developed especially for Middlebury College students. The Plan provides coverage for Sicknesses and Accidents that occur on and off campus and includes special cost saving features to keep the coverage as affordable as possible. Middlebury College is pleased to offer the Plan as described in this brochure.

This brochure is a brief description of the insurance coverage under the Middlebury College Student Health Insurance Plan. This plan is underwritten by Gallagher Student Health & Special Risk. The exact provisions governing this Student Health Insurance Plan are contained in the Master Policy which will be issued to the College.

Student Eligibility and Enrollment
All undergraduate students enrolled as full-time will be automatically enrolled in and billed for the Student Health Insurance Plan. Dependents are not eligible for coverage under this plan.

Online Waiver Process
Students who are currently enrolled in a Health Insurance Plan of comparable coverage that will be in effect until August 14, 2014 can elect to waive the Middlebury College Student Health Insurance Plan. Recognizing that health coverage may change, at the beginning of each academic year students will be asked to provide proof of comparable coverage in order to waive the Student Health Insurance Plan.

Waiver Process
To document proof of comparable coverage an Online Waiver Form must be completed and submitted by the deadline.
1. Go to www.gallagherstudent.com/Middlebury
2. Enter your Middlebury College student email as your User ID and your student ID as your password.
3. Select “Student Waive”, and then click on the red “I want to Waive” button. Please have your current insurance card ready as you will need this information in order to complete the Waiver Form.

Immediately upon submitting the Middlebury College Annual Waiver Form, you will receive a reference number indicating that the form has been successfully submitted. Print this reference number for your records. If you do not receive a reference number, you will need to correct any errors and resubmit the form. The online method is the only accepted process for waiving coverage.

Middlebury College reserves the right to audit and subsequently reject a waiver request. If it is determined that a student waived coverage with a health insurance plan that was not comparable coverage, the student will be automatically enrolled in the Student Health Insurance Plan, effective the date that the determination was made and there will be no pro-rata of premium.

In the event a student waives the Student Health Insurance Plan and then loses current coverage due to a qualifying event, (i.e. parent loss of coverage or the maximum age limit available is attained), the student has the right to petition to add coverage within 31 days of the qualifying event. If the petition is received within 31 days of the qualifying event, there will be no break in coverage. For petitions received after the 31 days, the effective date of coverage will be the date that the petition is received at Gallagher Student Health & Special Risk. If approved, the premium will not be prorated.

Waiver Deadline
The deadline for students to complete the Online Waiver Form for annual coverage is September 2, 2014 and January 13, 2015 for students newly enrolled for the Spring Semester. Students who waive the Student Health Insurance Plan in the Fall waive coverage for the entire policy year. The Online Waiver process is the only accepted process for making your insurance selection. Students who do not submit the Online Waiver Form by the deadline will be enrolled in and billed for the Student Health Insurance Plan.

Policy Term
The policy for the current year becomes effective 08/15/2014 at 12:01 AM and expires on 08/14/2015 at 11:59 PM. Coverage remains in effect during holiday and vacation periods. Should an Insured person graduate or withdraw from the institution, the insurance shall remain in effect until the end of the period for which premium has been paid.

Plan Costs

<table>
<thead>
<tr>
<th>Student Health Insurance Plan</th>
<th>Annual Coverage</th>
<th>Fall Coverage</th>
<th>Spring Semester</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>8/15/14 - 1/15/15</td>
<td>8/15/14 - 1/15/15</td>
<td>2/1/15 - 8/14/15</td>
</tr>
<tr>
<td>Student</td>
<td>$2,205</td>
<td>$933</td>
<td>$1,272</td>
</tr>
</tbody>
</table>

Premium Refund Policy
Except for medical withdrawal due to a covered Injury or Sickness, if an Insured Student withdraws from the College within the first 31 days of the first semester, and has not yet submitted a claim, he or she will receive a full refund of the insurance premium. If an Insured Student withdraws from the College after 31 days of the first semester, his or her coverage will remain in effect until the end of the term for which he or she was charged premium.

Those Insured Students withdrawing from school to enter military service will be entitled to a pro-rata refund of premium upon written request of the withdrawal from school, and coverage will end as of the date of such entry.

Parton Health and Counseling Center
Middlebury College offers a wide range of health services through Parton Health and Counseling Center, most of which are included in the cost of a student’s comprehensive fee (which is separate from the insurance plan cost).

During the academic year Health Service is staffed, weekdays 8:00 a.m. – 9:00 p.m. and weekends noon – 4:00 p.m., with a Registered Nurse. Prescriber appointments are scheduled with the doctor or nurse practitioner for weekdays, 9:00 a.m. to 4:00 p.m. You may schedule an appointment by telephone or walk-in.

The services provided at Health Service include but are not limited to:
- Acute care outpatient clinic
- Allergy shots
- Immunizations
- Men’s and women’s health care including contraceptive management
- Sexually transmitted infection testing and sexuality counseling
- Comprehensive travel clinic
- Limited laboratory services
- Limited over-the-counter medications
- Referrals to appropriate local practitioners.

Counseling Service provides psychological counseling. Four counselors provide short-term counseling, crisis intervention, educational and mental health programs, assessments and referrals to other professional therapists in the area. Students may be expected to pay for psychiatric assessment and follow-up psychiatric treatment.
Sports Medicine provides athletic training and sports medicine services to official team roster members of intercollegiate teams and club rugby and crew. For a complete list of services offered by Parton Health and Counseling Center visit our website at http://www.middlebury.edu/studentlife/services/health.

Health Center Charges
There is no charge for visits to Parton. Students will be charged through Health Services for certain lab tests, specifically STD and HIV testing, some vaccines and some medical supplies.

Gallagher Student Health Complements
Exclusively from Gallagher Student Health & Special Risk, enrolled students have access to the following menu of products at no additional cost. These plans are not underwritten by Companion Life Insurance Company. More information is available at www.gallagherstudent.com/Middlebury under the "Discounts and Wellness” link.

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

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

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

- Make an appointment with a contracted dentist. Contracted dentists and their fee schedules are listed on our website, www.basixstudent.com.
- Tell the dental office that you are an insured student and have the Basix program. Each dentist has an administrative person to assist you with any questions. You do not need a separate identification card for the Basix program, but you will need to show your student health insurance ID card to confirm your eligibility. If the office needs to check eligibility, call Gallagher Student Health & Special Risk at 1-800-430-0697.
- Remember, you must pay for the services you receive at the time of service, so make sure you understand what forms of payment (check, credit card, etc.) the dentist accepts.

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

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

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

CampusFit is available at no cost to students. To access CampusFit, go to www.gallagherstudent.com/Middlebury.

Network Providers
The Middlebury College Student Health Insurance Plan provides access to hospitals and health care providers throughout the country through the First Health Provider Network.

Network Providers are the Physicians, Hospitals, and other health care providers who are contracted to provide medical care at a negotiated fee, or Preferred Allowance. It is to the advantage of Insured Students to use Network Providers to help reduce out-of-pocket expenses, as any applicable coinsurance is based on the negotiated Preferred Allowance. Non-Network Providers have not agreed to a Preferred Allowance and consequently your out-of-pocket costs may be greater. Students should be aware that Network Hospitals may be staffed with Non-Network Providers. Receiving services or care from a Non-Network Provider at a Network Hospital does not guarantee that all charges will be paid at the Network Provider level of benefits. It is important that the Insured Person verify that his or her Doctors are Network Providers when calling for an appointment or at the time of service. The most efficient way to identify Network Providers in the First Health Network is to call First Health toll free at 1-800-226-5116 or visit their website at www.firsthealth.com. If you are unable to locate a First Health provider in your area, Multiplan is considered to be a Network Provider under this insurance plan.

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

Allowable Charge means the charge which is the lesser of: 1) The actual charge. 2) The negotiated charge that a Preferred Provider has agreed to accept for service, or 3) The Usual and Customary Charge for a covered service.

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

Complications of Pregnancy means conditions which require medical treatment before pregnancy ends, and whose diagnosis is distinct from, but are caused or affected by pregnancy. Such conditions are; acute nephritis or nephrosis, cardiac decompensation; missed abortion, hyperemesis gravidarum, pre-eclampsia; non-elective cesarean section; termination of ectopic pregnancy; and spontaneous termination when a live birth is not possible.
Complications of Pregnancy does not include: false labor, occasional spotting, voluntary abortion, Doctor prescribed rest during pregnancy, morning sickness, and similar conditions not medically distinct from a difficult pregnancy.

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

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

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

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

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

Dependent means: 1) An Insured’s lawful spouse; or 2) An Insured’s child, from the moment of birth through 25 years of age.

A "child", includes an Insured’s: 1) Natural child; 2) Stepchild; and 3) Adopted child, beginning with any waiting period pending finalization of the child’s adoption.

Coverage will continue for a child who is 26 or more years old, chiefly supported by his or her parent or dependent on other care providers and incapable of self-sustaining employment by reason of a handicapped condition that occurred before the attainment of the limiting age. Proof of the child’s condition and dependence will be requested by Us within 2 months prior to the date the child will cease to qualify as a child as defined above. Such proof must be submitted to Us within 31 days from the date of the request. We may, at reasonable intervals thereafter, require proof of the continuation of such condition and dependence. If proof is not submitted within the 31 days following any such request, coverage for the Dependent will terminate.

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

The term “spouse” also includes your domestic partner. You and your domestic partner must submit a complete domestic partner affidavit and meet the following criteria to qualify your domestic partner for insurance under this group policy. For at least six consecutive months prior to the effective date of your domestic partner insurance, you and your domestic partner:

1. Are and have been each other’s sole domestic partner, and have maintained the same principal place of residence and intend to do so indefinitely.
2. Are both at least 18 years of age.
3. Are not married or related by blood; and
4. Are jointly responsible for each other’s welfare and financial obligations.

The term also includes the child of your domestic partner. Any such child must be unmarried and under age 19, 24 if a full-time student.

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

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

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

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

Emergency Hospitalization and Emergency Medical Care means hospitalization or medical care that is provided for an Injury or a Sickness caused by the unexpected onset of a medical condition with acute symptoms of sufficient severity and pain that would cause a prudent layperson with an average knowledge of health and medicine to expect that the absence of immediate medical care will result in:

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

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

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

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

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

Essential health benefits has the meaning found in Section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services and includes ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services, preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

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

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

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

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

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

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

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

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

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

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

**Hospital** means an institution that:

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

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

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

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

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

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

**Medically Necessary** means a service, drug or supply which is necessary and appropriate for the diagnosis and treatment of a Covered Injury and Covered Sickness in accordance with generally accepted standards of medical practice in the United States at the time the service, drug or supply is provided. A service, drug or supply will not be considered as Medically Necessary if, it:

1. Is investigational, experimental or for research purposes;
2. Is provided solely for the convenience of the patient, the patient’s family Doctor, Hospital or any other provider;
3. Exceeds in scope, duration or intensity the level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment;
4. Could have been omitted without adversely affecting the person’s condition or the quality of medical care; or
5. Involves the use of a medical device, drug or substance not formally approved by the United States Food and Drug Administration.

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

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

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

**Policy year** means the 12-month period that is designated as the policy year in the contract. If there is no designation of a policy year in the contract, then the policy year is the deductible or limit year used under the contract. If deductibles or other limits are not imposed on a yearly basis under the contract, the policy year is the calendar year.
Preferred Allowance means the amount a Preferred Provider will accept as payment in full for covered medical expenses.

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

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

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

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

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

Extension of Benefits
If an Insured Person is confined to a Hospital on the day his or her insurance terminates, expenses incurred after such termination date and during the continuance of that hospital confinement shall be payable in accordance with the Plan, but only while they are incurred during the 90 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 be covered under this Plan, but only for an Injury or Sickness for which covered expenses were incurred before the termination date.

On Call International Assistance Program
The International Assistance Program (IAP) is supplemental to the Student Insurance Plan. The IAP provides access to a 24-hour worldwide assistance network, On Call International, for emergency assistance anywhere in the world. Simply call the assistance center at 800-407-7307 or collect at 603-898-9159. The IAP and On Call International are not affiliated with Companion Life Insurance Company. The multilingual staff will answer your call and immediately provide reliable, professional and thorough assistance. The following services are included in the IAP:

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

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

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

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

Contact: On Call International for any of the IAP services described above.
   Toll Free from U.S. and Canada: 1-800-850-4556
   Dial Direct/Call Collect Worldwide: 1-603-898-9159
   Website: www.oncallinternational.com

24-Hour Nurse Advice Line – Included in IAP
Wouldn’t you feel better knowing you could get health care answers from a Registered Nurse 24 hours a day? Students may utilize the Nurse Advice Line when the school health clinic is closed or anytime they need confidential medical advice. On Call International provides Members with clinical assessment, education and general health information. This service shall be performed by a registered Nurse Counselor to assist in identifying the appropriate level and source(s) of care for members (based on symptoms reported and/or health care questions asked by or on behalf of Members). Nurses shall not diagnose Member’s ailments. This program gives students access to a toll-free nurse information line 24-hours a day. 7 days a week. One phone call is all it takes to access a wealth of useful health care information at 1-866-525-1955.

Out-of-Pocket Maximum
After the Out-of-Pocket Maximum has been reached as shown in the Schedule of Benefits, benefits will be paid at 100% of the Preferred Allowance (In-Network) or 100% of U&C (Out-of-Network). The Out-of-Pocket limit is the most you could pay during the Policy Year for your share of the cost of covered services. This limit helps you plan for health care expenses. The Deductible does not apply to the Out-of-Pocket Maximum amount.
## Schedule of Benefits

<table>
<thead>
<tr>
<th>Policy Year Aggregate Maximum</th>
<th>Unlimited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>None, except as specifically provided</td>
</tr>
<tr>
<td>Co-insurance In-Network</td>
<td>80% of Preferred Allowance, unless indicated otherwise</td>
</tr>
<tr>
<td>Co-insurance Out-of-Network</td>
<td>80% of Usual &amp; Customary Charges (U&amp;C), unless indicated otherwise</td>
</tr>
<tr>
<td>Out-of-Pocket Expense Limit</td>
<td>Includes Deductibles, Co-payments, Co-insurances and internal essential benefit maximums</td>
</tr>
<tr>
<td></td>
<td>$6,350 per individual per Policy Year, $12,700 per family per Policy Year</td>
</tr>
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</table>

### COVERED BENEFITS

<table>
<thead>
<tr>
<th>In-Network Provider</th>
<th>Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INPATIENT EXPENSES</strong></td>
<td></td>
</tr>
<tr>
<td>Hospital Room &amp; Board - Limited to the semiprivate room rate</td>
<td>100% Preferred Allowance</td>
</tr>
<tr>
<td>Hospital Miscellaneous</td>
<td>100% Preferred Allowance</td>
</tr>
<tr>
<td>Intensive Care</td>
<td>100% Preferred Allowance</td>
</tr>
<tr>
<td>Surgery</td>
<td>80% Preferred Allowance</td>
</tr>
<tr>
<td>Anesthetist &amp; Assistant Surgeon Fees</td>
<td>30% of Surgical allowance</td>
</tr>
<tr>
<td>Doctor’s Visit - Limited to 1 per day and does not apply when related to surgery</td>
<td>80% Preferred Allowance</td>
</tr>
<tr>
<td>Emergency Room Care - Medical Emergency only</td>
<td>100% Preferred Allowance</td>
</tr>
<tr>
<td>Mental Health - payable on the same basis as any other Sickness</td>
<td>100% Preferred Allowance</td>
</tr>
<tr>
<td>Alcoholism - payable on the same basis as any other Sickness</td>
<td>100% Preferred Allowance</td>
</tr>
<tr>
<td>Drug Abuse - payable on the same basis as any other Sickness</td>
<td>100% Preferred Allowance</td>
</tr>
</tbody>
</table>
| Routine Well-Baby Care - payable on the same basis as any other Sickness. Charges for routine care of a newborn child as follows:  
• Hospital charges for routine nursery care during the mother’s confinement, but for not more than four days,  
• Doctor’s charges for circumcision, and  
• Doctor’s charges for visits to the newborn child in the Hospital and consultations, but for not more than 1 visit per day. | 100% Preferred Allowance | 100% U&C |
| Skilled Nursing Facility - to a maximum of 60 days per policy year, for treatment rendered:  
• In lieu of confinement in a hospital as a full time inpatient, or  
• Within 28 days following a hospital confinement and for the same or related cause(s) as such hospital confinement. | 100% Preferred Allowance | 100% U&C |

### OUTPATIENT EXPENSES

| Doctor’s Visits - Includes consultants and specialists. Does not apply when related to surgery or physiotherapy. | 100% Preferred Allowance, 100% U&C |
| Day Surgery including day surgery miscellaneous expenses | 80% Preferred Allowance | 80% U&C |
| Ambulatory Surgical Expense | 100% Preferred Allowance | 100% U&C |
| Anesthetist & Assistant Surgeon Fees | 30% of Surgical allowance | 30% of Surgical allowance |
| Outpatient Miscellaneous Expenses | 100% Preferred Allowance | 100% U&C |
| Physiotherapy/Occupational Therapy - payable on the same basis as any other Injury or Sickness | 100% Preferred Allowance | 100% U&C |
| Chiropractor care - payable on the same basis as any other Injury or Sickness | 100% Preferred Allowance | 100% U&C |
| Diagnostic X-ray and Laboratory Procedures | 100% Preferred Allowance | 100% U&C |
| Mental Health - payable on the same basis as any other Sickness | 100% Preferred Allowance | 100% U&C |
| Alcoholism - payable on the same basis as any other Sickness | 100% Preferred Allowance | 100% U&C |
| Drug Abuse - payable on the same basis as any other Sickness | 100% Preferred Allowance | 100% U&C |
| Radiation Therapy and Chemotherapy | 100% Preferred Allowance | 100% U&C |
| Hospice - by a licensed agency/provider for terminally ill patients with life expectancy of 6 months or less | 80% Preferred Allowance | 80% U&C |
| Home Health Care to a maximum of 40 visits per policy year | 80% Preferred Allowance | 80% U&C |

### OTHER EXPENSES

| Durable Medical Equipment | 100% Preferred Allowance | 100% U&C |
| Ambulance Service - ground or air ambulance | 100% Preferred Allowance | 100% U&C |
| Maternity (including Birthing Center services) payable on the same basis as any other Sickness | 100% Preferred Allowance | 100% U&C |
## COVERED BENEFITS (Con’t)

<table>
<thead>
<tr>
<th>In-Network Provider</th>
<th>Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complications of Pregnancy</td>
<td>100% Preferred Allowance</td>
</tr>
<tr>
<td>Elective Abortion</td>
<td>80% Preferred Allowance</td>
</tr>
<tr>
<td>Dental Treatment - Injury or Sickness</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Pediatric Dental Services - Subject to a $500 Deductible per policy year, pays for the following:</td>
<td>50% U&amp;C</td>
</tr>
<tr>
<td>- Preventive Services - including exams and cleanings (two per year), fluoride treatments and sealants to age 16;</td>
<td></td>
</tr>
<tr>
<td>- Basic Services - including fillings, X-rays, oral surgery and simple extractions;</td>
<td></td>
</tr>
<tr>
<td>- Major Services - including endodontics, periodontics, crowns, bridges and dentures; Orthodontia.</td>
<td></td>
</tr>
<tr>
<td>Pediatric Vision Services - Subject to a $20 Co-payment per exam, and a $40 Co-payment for materials and supplies</td>
<td>100% U&amp;C</td>
</tr>
<tr>
<td>Preventive Services - Benefits include preventive services such as screenings, exams and immunizations as specified by the Patient Protection and Affordable Care Act (PPACA). For more information visit: <a href="http://www.healthcare.gov/">http://www.healthcare.gov/</a></td>
<td>Not Covered</td>
</tr>
<tr>
<td>Prescription Drugs Expense - Limited to a 30-day supply per prescription. To locate a participating Express Scripts participating pharmacy, please call Express Scripts at 1-800-711-0917 or visit <a href="http://www.Express-Scripts.com">www.Express-Scripts.com</a></td>
<td>• Express Scripts Pharmacy: 100% of the Preferred Allowance subject to a per-prescription Co-payment of: $10 for generic and $20 for brand name. • Prescription filled at non-express Scripts Pharmacies are not covered</td>
</tr>
<tr>
<td>Craniofacial Disorders Expense - Covered Expenses include diagnosis and Medically Necessary treatment, including surgical and nonsurgical procedures, for a musculoskeletal disorder that affects any bone or joint in the face, neck, or head and is the result of accident, trauma, congenital defect, developmental defect, or pathology. Coverage shall be the same as that provided for any other musculoskeletal disorder in the body and may be provided when prescribed or administered by a Doctor or a dentist. Coverage does not include dental services for the diagnosis or treatment of dental disorders or dental pathology primarily affecting the gums, teeth or alveolar ridge.</td>
<td>100% Preferred Allowance</td>
</tr>
</tbody>
</table>

### STATE MANDATED ACCIDENT AND SICKNESS MEDICAL EXPENSE BENEFITS

<table>
<thead>
<tr>
<th>In-Network Provider</th>
<th>Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mammography Expense</td>
<td>100% Preferred Allowance</td>
</tr>
<tr>
<td>Annual Pap Smear - One Pap Smear per Policy Term or more frequently if recommended by a doctor. Covered at 100% if performed at the Student Health Center.</td>
<td>100% Preferred Allowance</td>
</tr>
<tr>
<td>Prostate Cancer Screening</td>
<td>100% Preferred Allowance</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>100% Preferred Allowance</td>
</tr>
<tr>
<td>Diabetes - payable on the same basis as any other Sickness. Includes all Medically Necessary equipment, supplies, medications, labs and outpatient self-management training and educational services</td>
<td>100% Preferred Allowance</td>
</tr>
<tr>
<td>Dental Anesthesia and Facility - Facility charges and general anesthesia services performed in connection with dental services for an Insured with special needs as specified in the Policy.</td>
<td>100% Preferred Allowance</td>
</tr>
</tbody>
</table>

### IMPORTANT NOTE ABOUT YOUR BENEFITS

Should state law and/or federal law require certain benefits to be included in the Master Policy that are not included in this brochure, such benefits shall be deemed to be included in this brochure to the extent necessary to satisfy the minimum requirements of such law. For more information about your benefits, please read the Summary of Benefits and Coverages available at www.gallagherstudent.com/Middlebury and the Glossary of Terms available at www.ccio.cms.gov or you may request a copy by calling 1-800-430-0697.
Description of Benefits

SECTION I
Basic Accident Benefits

When Your Accident requires: (a) Treatment by a Physician; (b) Hospital confinement; (c) Services of a licensed practical nurse or R.N.; (d) X-ray service; (e) Use of an operating room, anesthesia, including the administration thereof, laboratory service; (f) Use of an ambulance; (g) Use of an ambulatory surgical center or ambulatory medical center; (h) If ordered by a Physician, prescription medicines, drugs or any other therapeutic services or supplies; or (i) Home health care Services, We will pay the Expense at 80% up to the Policy Year Aggregate Maximum, subject to any copayments and deductibles listed on the schedule of benefits (page 6).

SECTION II
Accidental Death and Dismemberment Benefits

The company shall pay an indemnity, in addition to the medical expense benefits provided herein, if an insured Person sustains a loss, as listed below, within 180 days after the date of accident causing such loss. If more than one loss is sustained as the result of one accident, only the largest amount shall be payable.

Principal Sum: $10,000

<table>
<thead>
<tr>
<th>For Loss of:</th>
<th>Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>Principal Sum</td>
</tr>
<tr>
<td>Both Hands or Both Feet or Sight of Both Eyes</td>
<td>Principal Sum</td>
</tr>
<tr>
<td>One Hand and One Foot</td>
<td>Principal Sum</td>
</tr>
<tr>
<td>Either Hand or Foot and Sight of One Eye</td>
<td>Principal Sum</td>
</tr>
<tr>
<td>Either Hand or Foot</td>
<td>Half Principal Sum</td>
</tr>
<tr>
<td>Sight of One Eye</td>
<td>Half Principal Sum</td>
</tr>
</tbody>
</table>

SECTION III
Basic Sickness Benefits

When You suffer a Loss from Sickness, We will pay the Expense incurred at 80%, unless otherwise stated up to the Policy Year Aggregate Maximum, subject to any copayments and deductibles listed on the schedule of benefits (page 4). Benefits are allocated as follows:

Hospital Room and Board Expense: When Your Sickness requires Hospital confinement, We will pay the Hospital room and board Expense up to the semi-private rate. ICU will be paid at the ICU rate.

Hospital Miscellaneous Expense: We will pay the Expenses incurred by You during a Hospital confinement or as an outpatient for day surgery for services provided by a Hospital, ambulatory surgical center or ambulatory medical center for anesthesia, operating room, laboratory tests, x-rays, oxygen, drugs, medicines, dressings, and other necessary non-room and board Expenses.

Surgical Expense: When Your Sickness requires surgery, We will pay the Expense. Only one surgical procedure will be covered when multiple procedures are performed, unless Medically Necessary.

If the surgery requires the services of an anesthetist who is not employed or retained by the Hospital in which the surgery is performed, We will pay the Expense. If the surgery requires the services of an assistant surgeon, We will pay the Expense.

In-Hospital Physician’s Fees Expense: If, while confined to a Hospital, Your Sickness requires the services of a Physician, We will pay the Expense for such services.

Consultant or Specialist Expense: If while confined to a Hospital Your Sickness requires the services of a consultant or specialist, as requested by the attending Physician.

Outpatient Physician Fees Expense: When Your Sickness requires the services of a Physician, while not confined to a Hospital, We will pay the Expense for such services.

Ambulance Expense: When Your Sickness requires the use of an ambulance or air ambulance, We will pay the Expense at 100% up to the policy maximum.

Voluntary Termination of Pregnancy Expense: We will pay the Expense for the voluntary termination of Your pregnancy. This benefit is paid in lieu of all other benefits.

Outpatient Expense: When Your Sickness requires the use of outpatient facilities of an ambulatory surgical center, ambulatory medical center, Hospital or Physician’s office for the use of diagnostic x-ray, including ultrasound, MRI and CAT Scan, laboratory services, or an emergency room or operating room, under the Physician’s direction.

Home Health Care: When Your Sickness request Home Health Care, We will pay the Expense.

Skilled Nursing Facility: We will pay the Expense at 100% up to a maximum of 60 days.

Injectable Expense: All currently covered benefits that can be provided in the form of an injectable are covered in the Outpatient Prescribed Medicines Expense benefit.

Chiropractic Coverage: Coverage provided for medically necessary visits without an approved treatment plan and visits as medically necessary for an approved treatment plan.

Durable Medical Equipment: We will cover medical Expenses for a Sickness 100% of the Usual and Customary charges.

Craniofacial Disorders: We will cover for diagnosis and Medically Necessary treatment, including surgical and nonsurgical procedures, for a musculoskeletal disorder that affects any bone or joint in the face, neck or head and is the result of Accident, trauma, congenital defect, developmental defect, or pathology. This coverage will be the same as any other Injury or Sickness when prescribed or administered by a Physician or dentist.

Coverage mandated by this law does not include dental services for the diagnosis or treatment of dental disorders or dental pathology primarily affecting the gums, teeth or alveolar ridge.

Outpatient Prescribed Medicine Expense

The outpatient prescription drug program is available through the Express Scripts Pharmacy Program. The Express Scripts Pharmacy Network includes National pharmacy chains such as Brooks Pharmacy, Walgreens, Rite Aid, CVS, etc. as well as local independent pharmacies. After a $10.00 Copayment for a 30-day supply of a generic drug and a $20.00 Copayment for a 30-day supply of a brand name drug, prescriptions will be paid at 100% up to the policy year maximum. Insured persons use their student health insurance ID card to show to the pharmacy as proof of coverage. If a prescription needs to be filled prior to receiving the ID card, reimbursement will be made upon submitting a completed Rx claim form (claim forms can be obtained at www.gallagherstudent.com/Middlebury). To locate a Express Scripts participating pharmacy, please call Express Scripts at 1-800-711-0917 or visit www.Express-Scripts.com.

Mail Service Prescription Drug Program

Medications that are taken for a chronic condition can be filled for up to a 90-day supply using Express Scripts Mail Service Prescription Drug Program. Using the Mail Service Prescription Drug Program, a 90-day supply of a medication can be filled with a Copayment that is 2 times the Copayment of a 30-day supply. When you use the Mail Service Prescription Drug Program you will need to complete a “Express Scripts By Mail” Order Form and mail it directly to Express Scripts along with your doctor’s signed prescription form. After submitting your initial prescription, additional prescriptions can be filled by going online to www.Express-Scripts.com. A brochure describing the Mail Service Prescription Drug Program, order forms, and accompanying mailing
envelope are available at www.gallagherstudent.com/Middlebury. Not all medications are covered, for example vitamins or food supplements, smoking deterrents, drugs to promote hair growth or weight loss, immunizations, and experimental drugs. (See Exclusions Section). Benefits paid under the Mail Service Prescription Drug Program apply toward the prescription drug maximum per policy year.

**Mandated Benefits**

The following benefits are mandated by state regulation. These benefits are provided: 1) To the extent that the type of Expense is covered under the policy, and 2) At the same payment level as any other Sickness or Injury, unless otherwise stated below.

**Outpatient Mental Illness Expense:** The services of a licensed psychiatrist, licensed psychologist, licensed or certified mental health professional,

**Inpatient Mental Illness Expense:** Hospital confinement in a mental health facility qualified pursuant to rules adopted by the Secretary of Human Services or in an institution approved by the Secretary of Human Services that provides a program for the treatment of mental illness pursuant to a written plan.

**Outpatient Alcoholism or Substance Abuse Expense:** Treatment by a substance counselor or other person approved by the Secretary of Human Services.

**Inpatient Alcoholism or Substance Abuse Expense:** If, while confined to a Hospital, You require alcoholism or substance abuse treatment. We will pay the Expense for Hospital confinement in an institution approved by the Secretary of Human Services that provides a program for the treatment of alcohol or substance abuse pursuant to a written plan.

**Diabetes Expense:** Including gestational, insulin and non-insulin diabetes for the following:

a) Supplies, b) Equipment, c) Self-management training and education; and d) Medication.

**Maternity Expense:** Covers: a) Inpatient care for at least 48 hours for a covered mother and a newborn child after a vaginal delivery, and b) Inpatient care for at least 96 hours for a covered mother and a newborn child after a cesarean delivery. The length of stay may be longer when indicated by the attending Doctor and shall be based on the characteristics of each mother and newborn, health of mother and newborn, ability and confidence of mother to care for the baby, adequacy of support systems at home and access to follow-up care.

**Mammogram Expense:** We will pay the Expense incurred in connection with mammograms as follows: a) A baseline mammogram for any female who is at least 35 but less than 39 years of age; b) A mammogram every two years for any female who is at least 40 but less than 39 years of age; but not limited to: family planning, fertility tests, infertility (male or female), including any supplies rendered for the purpose or with the intention of achieving conception; premarital examinations. Examples of fertilization procedures are: ovulation induction, in vitro fertilization, embryo transplant, or similar procedures that augment or enhance the Covered Person’s reproductive ability; impotence organic or otherwise; 9. Expenses incurred in connection with voluntary sterilization except as specifically provided, or sterilization reversal, vasectomy except as specifically provided, or vasectomy reversal;

**Continuous Insurance**

This Policy may be replacing a Prior Plan with another insurer. Prior Plan means the Student Health Insurance policy or policies issued to the Policyholder immediately before the current Policy. Injury or Sickness shall include an Injury sustained, or a Sickness first manifesting itself, while the Insured Person is continuously insured under the Prior Plan and became insured under this Policy without a break in coverage. But no benefits shall be payable for such Injury or Sickness to the extent that such benefits are payable under the Prior Plan for the same expenses. This will apply even though the Prior Plan provided that it will not duplicate the benefits under another Policy. Also, the total amount of benefits payable for such Injury or Sickness under this Policy and the Prior Plan cannot exceed the Per Condition Aggregate Maximum. Nothing contained herein shall be held to vary, alter, waive, or extend any of the provisions, exclusions, and other terms of this Policy, except as provided above.

**Exclusions**

**Exclusion Disclaimer:** Any exclusion in conflict with the Patient Protection and Affordable Care Act will be administered to comply with the requirements of the Act.

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

1. Charges that are not Medically Necessary or in excess of the Usual and Customary charge;
2. Expense incurred for treatment of temporomandibular joint (TMJ) dysfunction and associated myofascial pain;
3. Expenses in connection with services and prescriptions for eye examinations, eye refractions, eye glasses or contact lenses, or the fitting of eyeglasses or contact lenses, except as provided under the Pediatric Vision Services benefit, radial keratotomy or laser surgery for vision correction or the treatment of visual defects or problems;
4. Nasal or sinus surgery;
5. Expenses in connection with cosmetic treatment or cosmetic surgery, except as a result of: a. A covered Injury that occurred while the Covered Person was insured; b. A covered child’s congenital defect or anomaly; or c. As specifically provided for in the Policy.
6. Injuries arising out of:
   a. Playing or participating in an interscholastic, intercollegiate, or professional sport, contest or competition;
   b. Traveling to or from such sport, contest or competition as a participant, or
c. Participation in any practice or conditioning program for such sport, contest, or competition.
7. Expenses incurred for birth control drugs, procedures, supplies or devices, including oral contraceptives used for birth control, except as provided under the Preventive Services benefit, drugs and medications for the treatment of impotence and/or sexual dysfunction;
8. Reproductive/Infertility procedures and fertility tests, including but not limited to: family planning, fertility tests, infertility (male or female), including any supplies rendered for the purpose or with the intention of achieving conception; premarital examinations. Examples of fertilization procedures are: ovulation induction, in vitro fertilization, embryo transplant, or similar procedures that augment or enhance the Covered Person’s reproductive ability; impotence organic or otherwise;
9. Expenses incurred in connection with voluntary sterilization except as specifically provided, or sterilization reversal, vasectomy except as specifically provided, or vasectomy reversal;
10. War, or any act of war, whether declared or undeclared; service in the Armed Forces of any country. Loss which occurs during or as a result of committing or attempting to commit an assault,
Routine physical examinations and routine testing; preventive testing
18. Immunizations, except as specifically provided in the Policy;
17. Hearing examinations or hearing aids; or other treatment for hearing
15. Elective Surgery or Elective Treatment as defined by the Policy;
13. Expenses incurred for dental care or treatment of the teeth, gums
12. Treatment, services, supplies, in a Veter an's Administration or
11. Expenses incurred for Injury or Sickness for which benefits are
10. A claim form is not required to submit a claim. However, an
9. Providers should submit claims within 90 days from the date of
8. If We pay covered expenses for an accident or sickness You incur as
7. Hearing examinations or hearing aids, or other treatment for hearing
6. Foot care including, flat foot conditions, supportive devices for
5. Immunizations, except as specifically provided in the Policy;
4. If you disagree with a claim payment decision, an Insured
3. Direct all questions regarding claim procedures, status of a
2. Providers should submit claims within 90 days from the date of
1. Reimbursement and Subrogation

Reimbursement and Subrogation
If We pay covered expenses for an accident or sickness You incur as a
result of any act or omission of a third party, and You later obtain
recovery from the third party, You are obligated to reimburse Us for the
expenses paid. We may also take subrogation action directly against
the third party. Our Reimbursement rights are limited by the amount
You recover. Our Reimbursement and Subrogation rights are subject
to deduction for the pro-rata share of Your costs, disbursements and reasonable attorney fees. You must cooperate with and assist
Us in exercising Our rights under this provision and do nothing to prejudice Our rights.

Claims Procedures
In the event of an Injury or Sickness the Insured Person should:
1. A claim form is not required to submit a claim. However, an
itemized bill, HCFA 1500, or UB92 form should be used to submit
expenses. If a referral was required, this form should accompany
this submission. The Insured Student/Person’s name and identification number need to be included.
2. Providers should submit claims within 90 days from the date of
Injury or from the date of the first medical treatment for a
Sickness, or as soon as reasonably possible. If a student is
submitting the claim, a copy should be retained and claims
should be mailed to the Claims Administrator, Health Smart
Benefit Solutions, Inc., at the address on the back cover.

Appeals Procedure
If a claim is wholly or partially denied, a written notice will be sent to the Insured Person containing the reason for the denial. The notice
will include a reference to the provision in the Plan description and
a description of any additional information which might be
necessary for reconsideration of the claim. The notice will also describe
the right to appeal. A written appeal, along with any additional
information or comments, may be sent within 6 months after notice
denial. In preparing the appeal, the Insured Person, or his or her
representative, may review all documents related to the claim and
submit written comments and issues related to the denial. After the
written notice is filed and all relevant information is presented, the
claim will be reviewed and a final decision sent within 60 days after receipt of the notice of the appeal. Under special circumstances, an
extension for further review will be granted, but not for longer than
60 additional days.

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

Our Privacy Promise
We understand the importance of handling your medical information
with care. We are committed to protecting the privacy of your medical information. State and federal laws require us to make sure that your
medical information is kept private. Federal law requires that we provide
you with this Notice of Privacy Practices, which describes our legal
duties and privacy practice 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 this notice at any time, as long as the law allows. These changes
will be effective for all medical information that we keep, including
medical information we created or received before we made the changes.
When we make a material change to our privacy practices, we will provide
a copy of a new notice (or information about the changes to our privacy
practices and how to obtain a new notice) in a mailing to members who
are covered under our health plans at that time.

Uses and Disclosures of Medical Information
Treatment, Payment, Health Care Operations:
We may use and disclose your medical information for purposes of
treatment, payment and health care operations.

Treatment:
We may disclose your medical information to a physician or other
health care professional to help him or her provide your treatment.
Payment:
We may use or disclose your medical information for these and other activities related to payment:
- Paying claims from physicians, hospitals and other health care providers.
- Obtaining premiums.
- Issuing explanations of benefits to the named insured.
- Providing information to health care professionals or other entities that are bound by the federal Privacy Rules for their payment activities.

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

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

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

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

Public Benefit
We may use or disclose our members’ medical information as authorized by law for the following purposes that are in the public interest or benefit:
- As required by law.
- For public health activities, including disease and vital statistics reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury.
- To report adult abuse, neglect or domestic violence.
- To health oversight agencies.
- In response to court and administrative orders and other lawful processes.

- To law enforcement officials in response to subpoenas and other lawful processes concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies and to identify or locate a suspect or other person.
- To coroners, medical examiners and funeral directors.
- To organ procurement organizations.
- To avert a serious threat to health or safety.
- In connection with certain research activities.
- To the military and to federal officials for lawful intelligence, counterintelligence and national security activities.
- To correctional institutions regarding inmates.
- As authorized by state workers’ compensation laws.

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

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

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

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

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

Confidential Communications
You have the right to request, in writing, that we communicate with you about your medical information by other means, or to another
location. We are not required to agree to your request unless you state that you could be in danger if we do not communicate to you in confidence. In that case, we must accommodate your request if it is reasonable, if it specifies the other means or location, and if it permits us to continue to collect premiums and pay claims under your health plan. We will not be bound to your request unless our agreement is in writing. Even if we agree to communicate with you in confidence, an explanation of benefits we issue to the named insured for health care services the named insured (or others covered by the health plan) received might contain sufficient information (such as deductible and out-of-pocket amounts) to reveal that you obtained health care services for which we paid.

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

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

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

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

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

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

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

Coordination of Benefits
If the Covered person is insured under more than one group health plan, the benefits of the plan that covers the insured student will be used before those of a plan that provides coverage as a dependent. When both parents have group health plans that provide coverage as a dependent, the benefits of the plan of the parent whose birth date falls earlier in the year will be used first. The benefits available under this Plan may be coordinated with other benefits available to the Covered person under any auto insurance, Workers’ Compensation, Medicare, or other coverage. The Plan pays in accordance with the rules set forth in the Policy.

Questions? Need More Information?
For general information on benefits, enrollment/eligibility questions, ID cards or service issues, please contact:

Gallagher Student Health & Special Risk
500 Victory Road
Quincy, MA 02171
1-800-430-0697
Email: Middleburystudent@gallagherstudent.com
www.gallagherstudent.com/Middlebury

If you need medical attention before the ID card is received, benefits will be payable according to the Policy. You do not need an ID card to be eligible to receive benefits. Call Gallagher Student Health & Special Risk to verify eligibility. For information on a specific claim, or to check the status of a claim, please contact:

HealthSmart Benefit Solutions (formerly Klais & Company, Inc.)
3320 West Market Street, Suite 100
Fairlawn, OH 44333
1-877-349-9017
Email: akronclaims@healthsmart.com

To review claims online, go to www.healthsmart.com and register for Status Link Group #SH52A4 subject to change

This Plan is Underwritten by:
Companion Life Insurance Company
Policy Number: 2014-S3-A02

Please keep this brochure as a general summary of the insurance. The Master Policy on file at the College contains all of the provisions, limitations, exclusions and qualifications of your insurance benefits some of which may not be included in this Brochure. If any discrepancy exists between this Brochure and the Policy, the Master Policy will govern and control the payment of benefits.