Middlebury

Student Health Insurance Plan

Designed for

Middlebury College
2016-2017

— Please keep this outline of coverage for future reference —

Policy Number: 2016K1A09

Underwritten by Companion Life Insurance Company
As Policy Form Number: BSHP-POL VT 2015

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Middlebury College offers a wide range of health services through Parton Center for Health and Wellness, 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 weekend’s 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. For a complete list of services offered by Parton Center for Health and Wellness visit our website at http://www.middlebury.edu/studentlife/services/health.

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.

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 Companion Life Insurance Company, serviced by Gallagher Student Health & Special Risk and claims are administered by Health Smart Benefit Solution. 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

Enrollment in a health insurance plan is required for all full-time undergraduate students at Middlebury College. Only students that actively enroll in the plan will be enrolled and have their student account billed. Dependents are not eligible for coverage under this plan.

Online Decision Form Process

Students who are currently enrolled in a Health Insurance Plan of comparable coverage that will be in effect until August 14, 2017 can elect to waive the Middlebury College Student Health Insurance Plan. 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 enroll or document proof of comparable coverage an Online Decision Form must be completed and submitted by the deadline.

1. Go to www.gallagherstudent.com/Middlebury.
2. On the left toolbar, click on ‘Student Waive/Enroll’.
3. Log in (if you haven’t already).
4. Click the ‘I want to Waive/Enroll’ button.

Immediately upon submitting the Middlebury College Decision 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 Decision Form for annual coverage is September 30, 2016. Students who waive the Student Health Insurance Plan in the Fall waive coverage for the entire policy year. The Online Decision Form process is the only accepted process for making your insurance selection.

Policy Term

The policy for the current year becomes effective 08/15/2016 at 12:01 AM and expires on 08/14/2017 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 8/15/16-8/14/17</th>
<th>Spring 2/1/17-8/14/17</th>
<th>Summer 6/1/17-8/31/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student*</td>
<td>$1,949</td>
<td>$1,041</td>
<td>$486</td>
</tr>
</tbody>
</table>

*The above rates may include an administrative fee.

Refund of Premium

Except in the event of a certified medical leave of absence, if the insured student withdraws from school or reduces his/her semester hours to less than six (6), within the first thirty (30) days of the semester, We will refund any premiums paid for the student and any covered Dependents and coverage will be Terminated. A refund of premium will be made only in the event:
1. The covered Person enters full-time active duty in any Armed Forces; and We receive proof of such active duty service.

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

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 Doctors, 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 services 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. Multiplan is considered to be a Network Provider under this plan.

Definitions
Accident means an, 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.

Emergency Services means health care Items and services furnished or required to evaluate and treat an emergency medical condition. Emergency Services include the following:

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 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.

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 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 Provider that confinement in a Hospital or skilled nursing 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

**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 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. is operated pursuant to law;

2. is primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and

3. provides 24 hour nursing service by or under the supervision of registered graduate professional nurses (R.N.’s).

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

**Hospital Confinement** 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 health care services, including diagnostic testing, treatments, drugs preventive services and aftercare, that are appropriate in terms of type, amount, frequency, level, setting, and duration to the Insured's diagnosis or condition. Medically-necessary care must be informed by generally accepted medical or scientific evidence and consistent with generally accepted practice parameters as recognized by health care professions in the same specialties as typically provide procedure or treatment, or diagnose or manage the medical condition; must be informed by the unique needs of each individual patient and each presenting situation; and

1. help restore or maintain the member's health; or

2. prevent deterioration of or palliate the member's condition; or

3. prevent the reasonably likely onset of a health problem or detect an incipient problem

A service, drug or supply will not be considered as Medically Necessary if, it:

1. Is investigational, experimental or for research purposes;

2. exceeds in scope, duration or intensity the level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment;

3. could have been omitted without adversely affecting the person's condition or the quality of medical care; or

4. involves the use of a medical device, drug or substance not formally approved by the United States Food and Drug Administration.

**Out-of-Network** means a provider who has not entered into a contract with the Insurer. We will not pay any charges in excess of the Usual and Customary Charges for Out-of-Network benefits, unless otherwise provided herein. If Medically Necessary care is required and there is no Preferred Provider available, benefits for an Out-of-Network provider will be payable at the same level as a Preferred Provider.

**Preferred Provider** means licensed health care providers, including, but not limited to, Providers, naturopaths, qualified athletic trainers, chiropractors, midwives, mental health and substance abuse treatment providers, Hospitals and other health care providers, who have contracted with the Insurer to provide specific medical care to Covered Persons in a service area at negotiated prices. A list of Preferred Providers for this policy is available by calling the toll free telephone number on Your identification card

**Preferred Allowance** means the amount a Preferred Provider will accept as payment in full for covered medical expense.

**Prescription Drugs** means 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 Provider; and 4) injectable insulin.

**Provider** means any 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.

**Sickness** means an illness, disease or condition of the Covered Person that causes a loss for which the 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 a Covered Person is confined in a Hospital for a medical condition on the date his insurance ends, expenses incurred during the continuation of that Hospital stay will be considered a Covered Expense, but only while such expenses are incurred during the 90 day period following the termination of insurance We will not continue to pay these Covered Expenses if:

1. the Covered Person’s medical condition no longer continues;
2. the Covered Person obtains other coverage; or
3. the Covered Expenses are incurred more than 3 months following termination of insurance.

If a Covered Person is totally disabled on the date of termination of the Policy, We will provide extension of benefits for 90 days following the termination of insurance.

**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.
### SCHEDULE OF MEDICAL EXPENSE BENEFITS

<table>
<thead>
<tr>
<th>Policy Year Maximum</th>
<th>Unlimited</th>
</tr>
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<tr>
<td>Deductible</td>
<td>$100 Per Covered Person per policy year</td>
</tr>
<tr>
<td>Co-insurance</td>
<td>As stated below</td>
</tr>
<tr>
<td>Medical Annual Out-of-Pocket Expense Limit – Includes Co-payments, Co-insurances and Deductibles</td>
<td>$5,050 Per Covered Person</td>
</tr>
<tr>
<td>Prescription Annual Out-of-Pocket Expense Limit</td>
<td>$1,300 Per Covered Person</td>
</tr>
<tr>
<td>Pre-Existing Conditions</td>
<td>Covered as any other Injury or Sickness</td>
</tr>
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#### Covered Inpatient Expenses:

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<tr>
<th>Covered Inpatient Expenses</th>
<th>Preferred Provider</th>
<th>Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Room &amp; Board – Limited to the semiprivate room rate</td>
<td>90% Preferred Allowance</td>
<td>90% U&amp;C</td>
</tr>
<tr>
<td>Hospital Miscellaneous</td>
<td>90% Preferred Allowance</td>
<td>90% U&amp;C</td>
</tr>
<tr>
<td>Intensive Care</td>
<td>90% Preferred Allowance</td>
<td>90% U&amp;C</td>
</tr>
<tr>
<td>Surgery</td>
<td>90% Preferred Allowance</td>
<td>90% U&amp;C</td>
</tr>
<tr>
<td>Anesthetist &amp; Assistant Surgeon Fees</td>
<td>90% Preferred Allowance</td>
<td>90% U&amp;C</td>
</tr>
<tr>
<td>Provider’s Visit (for injury or sickness)</td>
<td>90% Preferred Allowance</td>
<td>90% U&amp;C</td>
</tr>
<tr>
<td>Emergency Room Care – Medical Emergency only</td>
<td>90% Preferred Allowance</td>
<td>90% Preferred Allowance</td>
</tr>
<tr>
<td>Mental Health, Alcohol or Substance Abuse</td>
<td>90% Preferred Allowance</td>
<td>90% U&amp;C</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>90% Preferred Allowance</td>
<td>90% U&amp;C</td>
</tr>
</tbody>
</table>

#### Covered Outpatient Expenses:

<table>
<thead>
<tr>
<th>Covered Outpatient Expenses</th>
<th>Preferred Provider</th>
<th>Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider’s Visits – Does not apply when related to surgery or physiotherapy</td>
<td>90% Preferred Allowance</td>
<td>90% U&amp;C</td>
</tr>
<tr>
<td>Specialist Visits</td>
<td>90% Preferred Allowance</td>
<td>90% U&amp;C</td>
</tr>
<tr>
<td>Naturopathic Physicians</td>
<td>90% Preferred Allowance</td>
<td>90% U&amp;C</td>
</tr>
<tr>
<td>Licensed Athletic Trainers – limited to one visit per day</td>
<td>90% Preferred Allowance</td>
<td>90% U&amp;C</td>
</tr>
<tr>
<td>Day Surgery including day surgery miscellaneous expenses</td>
<td>90% Preferred Allowance</td>
<td>90% U&amp;C</td>
</tr>
<tr>
<td>Anesthetist &amp; Assistant Surgeon Fees</td>
<td>90% Preferred Allowance</td>
<td>90% U&amp;C</td>
</tr>
</tbody>
</table>
**Physiotherapy/Occupational Therapy** – limited to one visit per day.

<table>
<thead>
<tr>
<th>HEALTH SERVICES</th>
<th>Preferred Provider</th>
<th>Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chiropractor care</strong> – limited to one visit per day</td>
<td>90% Preferred Allowance</td>
<td>90% U&amp;C</td>
</tr>
<tr>
<td><strong>Diagnostic X-ray</strong></td>
<td>90% Preferred Allowance</td>
<td>90% U&amp;C</td>
</tr>
<tr>
<td><strong>Laboratory Procedures</strong></td>
<td>90% Preferred Allowance</td>
<td>90% U&amp;C</td>
</tr>
<tr>
<td><strong>Mental Health, Alcohol or Substance Abuse</strong></td>
<td>90% Preferred Allowance</td>
<td>90% U&amp;C</td>
</tr>
<tr>
<td><strong>Radiation Therapy and Chemotherapy</strong></td>
<td>90% Preferred Allowance</td>
<td>90% U&amp;C</td>
</tr>
<tr>
<td><strong>Hospice</strong> – by a licensed agency/provider for terminally ill patients with life expectancy of 6 months or less – limited to 100 hours per month</td>
<td>90% Preferred Allowance</td>
<td>90% U&amp;C</td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td>90% Preferred Allowance</td>
<td>90% U&amp;C</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Covered Expenses:</th>
<th>Preferred Provider</th>
<th>Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Durable Medical Equipment</strong></td>
<td>90% U&amp;C</td>
<td>90% U&amp;C</td>
</tr>
<tr>
<td><strong>Prosthetic Devices</strong></td>
<td>90% Preferred Allowance</td>
<td>90% U&amp;C</td>
</tr>
<tr>
<td><strong>Ambulance Service</strong></td>
<td>90% U&amp;C</td>
<td>90% U&amp;C</td>
</tr>
<tr>
<td><strong>Consulting Provider Fees</strong> – When requested and approved by the attending Provider.**</td>
<td>90% Preferred Allowance</td>
<td>90% U&amp;C</td>
</tr>
<tr>
<td><strong>Maternity (including midwifery services)</strong></td>
<td>90% Preferred Allowance</td>
<td>90% U&amp;C</td>
</tr>
<tr>
<td><strong>Complications of Pregnancy</strong></td>
<td>Payable as any other Sickness</td>
<td>Payable as any other Sickness</td>
</tr>
<tr>
<td><strong>Elective Abortion</strong> not to exceed a maximum of $750 per policy year.**</td>
<td>90% Preferred Allowance</td>
<td>90% U&amp;C</td>
</tr>
<tr>
<td><strong>Pediatric Dental Care (except for Preventive Care Items and Services)</strong></td>
<td>90% U&amp;C</td>
<td>90% U&amp;C</td>
</tr>
<tr>
<td><strong>Physical Exams, Adult Immunizations or Well Man Exam (except for Preventive Care Items and Services)</strong></td>
<td>90% Preferred Allowance</td>
<td>90% U&amp;C</td>
</tr>
<tr>
<td><strong>Preventive Care Items and Services, in accordance with section 2713 of the Public Health Service Act</strong></td>
<td>100%</td>
<td>90% U&amp;C</td>
</tr>
<tr>
<td>State Mandated Accident and Sickness Medical Expense Benefits:</td>
<td>Preferred Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>--------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Prostate Cancer Screening</td>
<td>90% Preferred Allowance</td>
<td>90% U&amp;C</td>
</tr>
<tr>
<td>Diabetes – Includes all Medically Necessary equipment, supplies, medications, labs and outpatient self-management training and educational services (except for Preventive Care Items and Services).</td>
<td>90% Preferred Allowance</td>
<td>90% U&amp;C</td>
</tr>
<tr>
<td>Clinical Trials Benefit</td>
<td>90% Preferred Allowance</td>
<td>90% U&amp;C</td>
</tr>
<tr>
<td>Dental Anesthesia and Facility – Facility charges and general anesthesia services performed in connection with dental services.</td>
<td>90% Preferred Allowance</td>
<td>90% U&amp;C</td>
</tr>
<tr>
<td>Early Childhood Development Disorders Benefit</td>
<td>90% Preferred Allowance</td>
<td>90% U&amp;C</td>
</tr>
<tr>
<td>Inherited Metabolic Diseases Benefit</td>
<td>90% Preferred Allowance</td>
<td>90% U&amp;C</td>
</tr>
<tr>
<td>Craniofacial Disorders Benefit</td>
<td>90% Preferred Allowance</td>
<td>90% U&amp;C</td>
</tr>
<tr>
<td>Prescription Drug Expense Benefit*</td>
<td>100% after a: $10 Co-pay for Generic Drug $20 Co-pay for Preferred Brand</td>
<td>90% U&amp;C</td>
</tr>
<tr>
<td>• Only a 30 day supply can be dispensed at any time</td>
<td></td>
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<tr>
<td>• One copayment per 30 day supply; copay does not apply to generic contraceptives</td>
<td></td>
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<tr>
<td>• Copayments apply to the out-of-pocket</td>
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<tr>
<td>*Exceptions may be made based on whether a drug is generic/preferred/non-preferred/specialty if a Provider certifies that a cheaper alternative is not effective.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Off-Label Prescription Drug Benefit</td>
<td>Same as Prescription Drug Expense</td>
<td>Same as Prescription Drug Expense</td>
</tr>
<tr>
<td>Telemadicine Services Benefit</td>
<td>90% Preferred Allowance</td>
<td>90% U&amp;C</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](http://www.gallagherstudent.com/Middlebury) and the Glossary of Terms available at [www.cciio.cms.gov](http://www.cciio.cms.gov) or you may request a copy by calling 1-800-430-0697.
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 Copayment for a 30-day supply of a brand name drug, prescriptions will be paid at 100% up to the policy year maximum.

Exclusions

Exclusions 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. Expenses in connection with vision services and prescriptions for adults, including eye examinations, eye refractions, eye glasses or contact lenses, or the fitting of eyeglasses or contact lenses, radial keratotomy or laser surgery for vision correction or the treatment of visual defects or problems except as specifically provided for in the Policy.
3. Expenses in connection with cosmetic treatment or cosmetic surgery, except as a result of:
   a. medically necessary reconstructive surgery with prior approval of physician;
   b. a covered Injury that occurred while the Covered Person was insured;
   c. a covered child's congenital defect or anomaly; or
   d. as specifically provided for in the Policy.
4. Drugs and medications for the treatment of impotence and/or sexual dysfunction.
5. 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.
6. War, or any act of war, whether declared or undeclared; service in the Armed Forces of any country. Loss which occurs during or as a result of committing or attempting to commit an assault, felony, or participation in a riot or insurrection, engaging in an illegal occupation.
7. Expenses incurred for Injury or Sickness for which benefits are paid or payable under any Worker's Compensation or Occupational Disease Law or Act, or similar legislation.
8. Treatment, services, supplies, in a Veteran's Administration or Hospital owned or operated by a national government or its agencies unless there is a legal obligation for the Covered Person to pay for the treatment.
9. Except as specifically provided for in the Policy, expenses incurred for dental care or treatment of the teeth, gums or structures directly supporting the teeth, including surgical extractions of teeth. This exclusion does not apply to the repair of injuries to sound natural teeth caused by a covered Injury, and as specifically provided in the Hospitalization and Anesthesia for Dental Procedures expense benefit.
10. Expenses incurred for acupuncture.
11. Except as otherwise provided under the Early Childhood Developmental Disorders Benefit, Autistic disease of childhood, hyperkinetic syndromes, milieu therapy.
12. Except as otherwise provided in this Policy, Elective Surgery or Elective Treatment.
13. Foot care including: flat foot conditions, supportive devices for the foot, subluxations, care of corns, bunions (except capsular or bone surgery), calluses, toenails, fallen arches, week feet, foot strain, and symptomatic complaints of the feet, except those related to diabetic care.
14. Hearing aids or other treatment for hearing defects or problems, except as otherwise provided in this Policy. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process.
15. Hirsutism, alopecia.

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.

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15. Hirsutism, alopecia.

Right of Reimbursement

If a Covered Person incurs expenses for Sickness or Injury that occurred due to the negligence of a third party: (a) We have the right to reimbursement for all benefits We have paid from any and all damages collected from the third party for those same expenses whether by action at law, settlement or compromise by the Covered Person, Covered Person’s parents, if the Covered Person is a minor, or Covered Person’s legal representative as a result of that Sickness or Injury, and (b) We are assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits paid for that Sickness or Injury.

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

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

3. Direct all questions regarding claim procedures, status of a submitted claim or payment of a claim, or benefit availability to the Claims Administrator, Health Smart Benefit Solution.

4. If you disagree with a claim payment decision, an Insured Person has the right to file an appeal. The process for filing an appeal can be found in the Appeals Procedure section of this brochure.

Any provisions of this Policy, which on its effective date, is in conflict with the statutes of the state in which the Policy is issued will be administered to conform to the requirements of the state statutes.

Appeals Procedure

To appeal a claim, send a letter stating the issues of the appeal to the Claims Administrator, Health Smart Benefit Solution, Appeal Department at 3320 West Market Street, Suite 100 Fairlawn, OH 44333. Include your name, phone number, address, school attended and email address, if available. Claims will be reviewed and responded to within 60 days by the Claims Administrator. A Covered Person who has exhausted all applicable internal review procedures has the right to an independent external review of a decision to deny, reduce or terminate health care coverage or to deny payment for a health care service.

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 1-866-8EYEMED 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.
ON CALL INTERNATIONAL

Global Assistance Program

The Global Assistance Program (GAP) is supplemental to the Student Insurance Plan. The GAP provides access to 24-hour worldwide assistance network, On Call International, for emergency assistance anywhere in the world. Simply call the assistance center at 1-855-226-7915 (toll free) or collect at 1-603-952-2045. The multilingual staff will answer your call and immediately provide reliable, professional and thorough assistance.

The Global Assistance Program is effective when you are outside your home country, or over 100 miles from home within the United States or when you are traveling.

The following emergency services are included:

1. Emergency medical Evacuation and Repatriation if you suffer an accident, injury or sickness resulting in a serious medical condition which in the opinion of the On Call physician requires transportation to be treated adequately. On Call will arrange and pay for air and/or surface transportation, medical care during transportation, communication and all usual and customary ancillary charges incurred in moving and transporting you to the nearest hospital where appropriate medical care is available.

After being treated at a medical facility, On Call will arrange and pay for the transport of the Participant with a qualified medical attendant to the Country of Domicile or Country of Residence for further medical treatment or recovery should it be deemed medically necessary by the On Call physician.

2. Return of Remains In the event of death, On Call shall make the arrangements and pay for casket or air tray, preparation and transportation of his/her remains to his/her place of residence or to the place of burial.

3. Return of Dependent Children If your Dependent(s) are present but left unattended as a result of your hospitalization or Medical Evacuation, On Call shall make and pay for travel arrangements to return them home, including a non-medical escort as needed. This service has a limit of $5,000.

4. Visit by Family/Friend If the Participant has or will be hospitalized for more than five (5) days while traveling, On Call shall make and pay for travel arrangements and suitable hotel accommodations for a person of your choice to join them. This service includes flights and up to $200 a day for hotel for a maximum of seven (7) days, up to a combined service limit of $5,000.

5. Additional Medical and Travel Assistance

If there are third party costs associated with the following services, On Call will notify you and you will be responsible for the costs:

- Pre-Trip Information
- Referral to the nearest, most appropriate medical facility, and/or provider
- Medical Monitoring by board certified emergency physicians in the United States
- Guarantee of Payment to provider and assistance in coordinating insurance benefits
- Prescription Replacement Assistance or Dispatch of Medicine if not available locally
- Emergency Message Forwarding to family, personal physician, school etc
- Emergency Travel Arrangements for disrupted travel
- Legal Consultation and Referral

- Lost Luggage Assistance
- Lost/Stolen Travel Documents Assistance

24 Hour Nurse Helpline

Students may utilize the Nurse Advice Line anytime they need confidential medical advice. A registered Nurse counselor will provide a clinical assessment 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 Students). Nurses shall not diagnose Member’s ailments.

Contact On Call International to access any of the GAP services described above.

Toll Free from U.S. and Canada: 1-855-226-7915
Collect Worldwide: 1-603-952-2045
mail@oncallinternational.com

This is only an outline of services and terms, conditions and exclusions apply.

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
Website: 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 #SH552A4 subject to change

This Plan is Underwritten by:

Companion Life Insurance Company
Policy Number: 2016KIA09

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.

Privacy Practices

For a copy of the Company’s Privacy Notice, go to www.commercialtravelers.com/privacy.html

Or

Request one from:

Commercial Travelers Mutual Insurance Company
c/o Privacy officer
70 Genesee Street
Utica, NY 13502

(Please indicate the school you at tend with you write ten request.)

Representation of this plan must be approved by the company.