Student Health Insurance Plan

designed for

Burlington College 2015-2016

— Please keep this outline of coverage for future reference —

Policy Number: 2015K1A05

Underwritten by Companion Life Insurance Company
As Policy Form Number: BSHP-POL et al

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Introduction

The Burlington College Student Health Insurance Plan has been developed especially for Burlington 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. Burlington College is pleased to offer the Plan as described in this brochure.

This brochure is a brief description of the insurance coverage under the Burlington 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 Commercial Travelers. 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 and Graduate Students will be automatically enrolled and included on the student's tuition bill, unless evidence of comparable coverage is provided and a waiver of coverage form is submitted on or before the waiver of coverage deadline. Dependents of Insured Students may also enroll.

Online Waiver Process

Students who are currently enrolled in a Health Insurance Plan of comparable coverage that will be in effect until August 14, 2016 can elect to waive the Burlington 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/Burlington.
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 Burlington 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.

Burlington 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 15, 2015. 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 08/15/2015 at 12:01 AM and expires on 08/14/2016 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

	Annual Coverage 08/15/2015 - 08/14/2016	Spring Semester 01/01/2016 - 08/14/2016
Student	$1,810*	$1,174*
Spouse	$3,290	$2,107
Each Child	$2,550	$1,637

*The above rates include administrative fee.

Refund of Premium

Except for medical withdrawal due to a covered Injury or Sickness, in the event the insured student withdraws from school within the first 31 days of the semester. We will refund any premiums paid for the student and any covered Dependents. A pro-rata refund of premium will be made only in the event:

1. The covered Person enters full-time active duty in any Armed Forces; and
2. We receive proof of such active duty service.

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.

Network Providers

The Burlington College Student Health Insurance Plan provides access to hospitals and health care providers throughout the country through the PHCS 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 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 PHCS Network is to call PHCS toll free at 1-800-922-4362 or visit their website at www.phcs.com.

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.

"Covered Sickness" means Sickness, disease or trauma related disorder due to injury which:
1. Causes a loss while the policy is in force; and
2. Which results in Covered Medical Expenses.

Covered Sickness includes Mental Health Disorder and Substance Use Disorders.

"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 to 26 years of age.

A "child", includes an Insured's: 1) Natural child; 2) Stepchild; 3) Adopted child; and 4) Foster child for whom the member has legal custody or legal guardianship.

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.

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

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

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

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

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

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

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

"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.

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

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

"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.

"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.

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 will be covered under this plan, but only for a covered Injury or Sickness for which covered expenses were incurred before the termination date.

We will not continue to pay these Covered Expenses if:

1. the Covered Person's medical condition no longer continues;
2. the Covered person reaches the Maximum per covered Accident or Covered Sickness; or
3. the Covered Person obtains other coverage;
4. the Covered Expenses are incurred more than 3 months following 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 BENEFITS	
Policy Year Maximum	Unlimited
Deductible – In-Network	$250 per Covered Person per Policy Year
Deductible – Out-of-Network	$500 per Covered Person per Policy Year
Co-insurance In-Network	80% of Preferred Allowance, unless indicated otherwise
Co-insurance Out-of-Network	60% of Usual & Customary Charges ("U&C"), unless indicated otherwise
In Network: Out-of-Pocket Expense Limit – Includes Co-payments, Co-insurances and Deductibles	$5,000 per individual, $12,700 per family, per Policy Year
Out-of-Network: Out-of-Pocket Expense Limit – Includes Co-payments, Co-insurances and Deductibles	$10,000 per individual per Policy Year
Pre-Existing Conditions	Covered as any other Injury or Sickness

Covered Inpatient Expenses:	**In-Network Provider**	**Out-of-Network Provider**
Hospital Room & Board – Limited to the semiprivate room rate	80% Preferred Allowance	60% U&C
Hospital Miscellaneous	80% Preferred Allowance	60% U&C
Intensive Care	80% Preferred Allowance	60% U&C
Surgery	80% Preferred Allowance	60% U&C
Anesthetist & Assistant Surgeon Fees	80% Preferred Allowance	60% U&C
Doctor/Specialist Office Visit	80% Preferred Allowance	60% U&C
Emergency Room - Out-of-Network paid to same extent as In-Network for true Medical Emergency only	80% Preferred Allowance $250 copay per visit, waived if admitted	60% U&C $250 copay per visit, waived if admitted
Urgent Care	80% Preferred Allowance	60% U&C
Mental Health & Substance Abuse	Same as any other Covered Sickness	
Physiotherapy/Occupational Therapy - payable on the same basis as any other Injury or Sickness	80% Preferred Allowance	60% U&C
Registered Nurse's Services	80% Preferred Allowance	60% U&C
Pre-Admission Testing	80% Preferred Allowance	60% U&C
Routine Newborn Care	80% Preferred Allowance	60% U&C
Skilled Nursing Facility	80% Preferred Allowance	60% U&C
Covered Outpatient Expenses:	**In-Network Provider**	**Out-of-Network Provider**
Doctor's Visits – Includes consultants and specialists. Does not apply when related to surgery or physiotherapy.	80% Preferred Allowance Doctor: $25 copay per visit Specialist: $50 copay per visit	60% U&C Doctor: $25 copay per visit Specialist: $50 copay per visit
Day Surgery including day surgery miscellaneous expenses	80% Preferred Allowance	60% U&C
Ambulatory Surgical Expense	80% Preferred Allowance	60% U&C
Anesthetist & Assistant Surgeon Fees	80% Preferred Allowance	60% U&C
Outpatient Miscellaneous Expenses	80% Preferred Allowance	60% U&C
Outpatient Rehabilitation Therapy including Physical Therapy, Occupational Therapy, Speech Therapy, Pulmonary Therapy and Cardiac Rehabilitation, Dialysis and Infusion Therapy	80% Preferred Allowance $25 copay per visit	60% U&C $25 copay per visit
Diagnostic X-ray and Laboratory Procedures	80% Preferred Allowance	60% U&C
Mental Health & Substance Abuse	Same as any other Covered Sickness	
Radiation Therapy and Chemotherapy	80% Preferred Allowance	60% U&C
Hospice	80% Preferred Allowance	60% U&C
Other Covered Expenses:	**In-Network Provider**	**Out-of-Network Provider**
Durable Medical Equipment	80% Preferred Allowance	60% U&C
Ambulance Service	80% Preferred Allowance	80% U&C
Mastectomy and Breast Reconstruction	80% Preferred Allowance	60% U&C
Maternity/Complications of Pregnancy - payable on the same basis as any other Sickness	80% Preferred Allowance	60% U&C
Dental Treatment , $1,000 maximum (Injury to Sound, Natural Teeth only)	80% Preferred Allowance	60% U&C
Intercollegiate Sports Expenses Benefit limited to $1,000 per Injury	100% Preferred Allowance	100% U&C

Pediatric Dental Services Benefit Covers: • Preventive Services - including exams and cleanings (two per year), fluoride treatments and sealants to age 16; • Basic Services - including fillings, x-rays, oral surgery and simple extractions; • Major Services - including endodontics, periodontics, crowns, bridges and dentures; Orthodontia.	100% of U&C for preventive services 50% U&C for all other covered	
Pediatric Vision Services Benefit	100% U&C for preventive services After $20 copay per exam; $40 copay for materials and supplies	
Preventive Services – such as screenings, exams, and immunizations as specified by the Patient Protection and Affordable Care Act (PPACA). For more information visit: http://healthcare.gov	100% Preferred Allowance, no cost sharing (Policy Year Deductible does not apply)	60% U&C
Outpatient Pharmacy Benefits (30 day supply) Prescriptions must be filled at a participating Catamaran Pharmacy	Copay: Generic-$15; Brand Name-$35; Multi-Source-$70; $0 Generic Contraceptive.	
Emergency Medical Evacuation	Unlimited benefit maximum, paid at 100% of actual charges under a separate agreement by On Call International	
Repatriation of Remains	Unlimited benefit maximum, paid at 100% of actual charges under a separate agreement by On Call International	
State Mandated Accident and Sickness Medical Expense Benefits:	**In-Network Provider**	**Out-of-Network Provider**
Cancer Screening Tests	Same as any other covered condition	
Clinical Trials for Cancer Treatment	Same as any other covered condition	
Low protein Modified Food Products	100% of U&C To the extent that special food products exceed the cost of a normal diet	
Diabetes	Same as any other covered condition	
Treatment to Bones or Joints in the Face, Neck or Head	Same as any other covered condition	
Contraceptive Coverage	Same as any other covered condition	
Home Health Care Benefit	Same as any other covered condition	
Off-Label Drug Use Benefit	Same as any other covered condition	
Emergency Services prior to Stabilization – (Pre-admission testing)	Same as any other covered condition	
Prescription Drugs Purchased in Canada	Same as any other covered condition	
Prosthetic Device	Same as any other covered condition	
Tobacco Cessation	Same as any other covered condition	
General Anesthesia or Certain Dental Procedures	Same as any other covered condition	
Anti-Cancer Medications	Same as any other covered condition	
Autism Disorder	Same as any other covered condition	

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/Burlington and the Glossary of Terms available at www.cciio.cms.gov or you may request a copy by calling 1-888-272-4945.

Outpatient Prescribed Medicine Expense

After a copayment of $15 for generic or $35 for a preferred brand name drug and $70 for brand drugs, per prescription the cost of eligible prescription drugs is payable in full. Birth Control is included with $0 copay for generic contraceptives. Prescriptions must be filled at a Catamaran Participating Pharmacy. Insured Persons will be given an insurance ID card which includes prescription drug information and should be shown to the Pharmacy as proof of coverage. A directory of participating pharmacies is available by calling Catamaran at 800-248-1062.

After you receive your insurance ID card, no claims forms need to be completed. After you receive the card you may call the toll-free customer service number listed on your card for assistance with pharmacy locations (800-248-1062). This number is effective for enrolled members only. You can access Catamaran online at www.mycatamaranrx.com.

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. Skeletal irregularities of one or both jaws including Temporomandibular Joint Dysfunction (TMJ), orthognathia and mandibular retrognathis, nasal or sinus surgery, except as specifically provided.
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 Service benefit, radial keratotomy or laser surgery for vision correction or the treatment of visual defects or problems;
4. 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.
5. Injuries arising out of (in excess of $1,000):
   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.
6. 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;
7. 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.
8. Expense incurred in connection with voluntary sterilization, or sterilization reversal, vasectomy or vasectomy reversal and sexual reassignment;
9. 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;
10. 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:
11. 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:
12. 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 except as provided under the Pediatric Dental Services benefit or the Hospitalization and Anesthesia for Dental Procedures expense benefit;
13. Expenses incurred for acupuncture;
14. Elective Surgery or Elective Treatment as defined by the Policy;
15. 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;
16. Hearing examinations or hearing aids; or other treatment for hearing defects or problems. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;
17. Immunizations, except as specifically provided in the Policy; preventive medicines or vaccines, except when required for treatment of a covered Injury or as specifically provided in the Policy;
18. Hirsutism, alopecia;
19. Weight management, weight reduction, treatment for obesity, surgery for the removal of excess skin or fat, or nutrition programs, except as related to treatment for diabetes;
20. Routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of any Injury or Sickness, except as specifically provided by the Policy.

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 reimburment 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 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.

Coordination of Benefits

This provision applies to persons covered by the Policy and one or more other medical or dental plans. This Plan is excess to any other plan of medical or dental insurance the Covered Person may have.

No benefit is payable for any Covered Expense incurred, which is paid or payable by any other valid and collectible insurance. Covered Expenses does not include any amount not covered by the primary carrier due to penalties for failure to comply with policy provisions or requirements

This provision will not apply to the first $100.00 of incurred Covered Expense.

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, Commercial Travelers Mutual Insurance Company, 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 Commercial Travelers Mutual Insurance Company.
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 statues of the state in which the Policy is issued will be administered to conform with 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, Commercial Travelers, Appeal Department at 70 Genesee Street, Utica, NY 13502. 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/Burlington 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 1-888-272-4945.
- 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/Burlington.

ON CALL INTERNATIONAL Global Assistance Program

The Global Assistance Program (GAP) is supplemental to the Student Insurance Plan. The GAP provides access to a s 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 you 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*:

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 pau 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.

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.

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.

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.

*On call International must pay and arrange for all services include above, reimbursement for self-paid expenses will not be considered; it is not insurance but is added as a service in your Students Health Insurance Policy.

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 aliments.

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
1-888-272-4945
Email: Burlingtonstudent@gallagherstudent.com
Website: www.gallagherstudent.com/Burlington

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:

Commercial Travelers

College Claims Department
70 Genesee Street
Utica, NY 13502
1-800-756-3702
Email: claims@commercialtravelers.com
Electronic Claims Payer ID #: 88091
To review claims online, go to www.commercialtravelers.com

This Plan is Underwritten by:

Companion Life Insurance Company
Policy Number: 2015K1A05

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 attend with you written request.)

Representation of this plan must be approved by the company.