MILLSAPS COLLEGE

Jackson, Mississippi

("the Policyholder")

2014-2015 Student Health Insurance Plan

NON-RENEWABLE TERM INSURANCE

The policy is a non-renewable one-year term policy. Similar Coverage may be available for the following academic year. It is the insured's responsibility to maintain continuity of coverage by inquiring about such coverage if he or she has not received the information for the new policy year.

Insurance Underwritten by National Union Fire Insurance Company of Pittsburgh, Pa., with its principal place of business in New York, NY
("the Company")

Administrator Policy # CHH8050735
Underwriter Reference # CAS9497238

NOTE

Please keep this brochure as a general summary of the insurance. This is only a brief description of the coverage available under policy series S30749NUFIC-PPO-MS. The Policy on file at the College contains all of the definitions, reductions, limitations, exclusions and termination provisions. Full details of coverage are contained in the Policy. If any discrepancy exists between this brochure and the Policy, the Policy will govern. Travel Assistance services provided by Travel Guard. Insurance and services provided by member companies of American International Group, Inc. For additional information, please visit our website at www.AIG.com.

www.BollingerColleges.com/Millsaps

(Revised 10-15-14)

ELIGIBILITY

All full-time students registered at Millsaps College for 12 or more credits will be automatically enrolled in and charged premium for coverage under the Millsaps College Student Health Insurance Plan ("the Plan") unless coverage is waived by providing proof of comparable health insurance coverage by the waiver deadline. To waive out of the Plan, students must complete the online waiver form at www.BollingerColleges.com/Millsaps or they will be automatically billed for the insurance and the premium will be added to their student account. Waivers must be submitted by **October 2, 2014.** An eligible student must actively attend classes at the Policyholder's school for the first 45 days of the period for which he or she is enrolled. Students who withdraw after such 45 days will remain covered under the Plan and no refund will be made. Home study, correspondence, Internet and television (TV) courses do not fulfill the Eligibility requirements that the student actively attended classes. Eligibility requirements must be met each time premium is paid to continue coverage. The Company maintains the right to investigate student status and attendance records to verify that the Plan eligibility requirements have been met. If it is discovered that the Plan eligibility requirements have not been met, the Company's only obligation is to refund premium less any claims paid.

A student who initially waived coverage under the Plan but subsequently experiences ineligibility under another creditable coverage may elect to enroll for coverage under the Plan within 31 days of the date of ineligibility under another creditable coverage. Proof of ineligibility under the other creditable coverage is required at time of enrollment. Contact Bollinger Specialty Group at 855-338-8015 for rates and enrollment information.

Eligible students may also enroll their eligible dependents. An eligible dependent is the Covered Student's spouse residing with the Covered Student or the Covered Student's or spouse's child until the date such child attains age 26. A dependent may become eligible for coverage under the Plan only when the student becomes eligible or within 31 days of marriage, birth or adoption.

To enroll a dependent, please print and complete the dependent enrollment form found on the website www.BollingerColleges.com/Millsaps. Make your check or money order payable to Bollinger Inc. and mail it along with the form to Bollinger Specialty Group, PO Box 398, Short Hills, NJ 07078. All dependent enrollment forms must be received by October 31, 2014.

EFFECTIVE AND TERMINATION DATES

The Policy on file with the Policyholder becomes effective at 12:01 a.m. on August 20, 2014 and terminates at 11:59 p.m. on August 19, 2015.

The coverage of an eligible student who enrolls for coverage under the Plan shall take effect on the latest of the following dates: (1) the Policy Effective Date; (2) the day after the date for which the first premium for the Covered Student's coverage is received by the Company; (3) the date the Policyholder's term of coverage begins; or (4) the date the student becomes a member of an eligible class of persons as described in the Description of Class section of the Schedule of Benefits in the Policy on file with the Policyholder.

A covered dependent's coverage shall take effect on the later the following dates: (1) the date the coverage for the Covered Student becomes effective; or (2) the date the dependent is enrolled for coverage, provided premium is paid when due.

Insurance for a Covered Student will end at 11:59 p.m. on the first of these to occur:
(a) the date the Policy terminates;
(b) the last day for which any required premium has been paid; or
(c) the date on which the Covered Student withdraws from the school because of:
(1) entering the armed forces of any country (premiums will be refunded on a pro-rata basis (less any claims paid) when written request is made within 30 days of leaving school); or
(2) withdrawal from school during the first 45 days of the period for which enrollment was made.

If withdrawal from the Policyholder's school is for other than (1) or (2) above, no premium refund will be made. Students will be covered for the Policy term for which they are enrolled and for which premium has been paid.

Except as specifically provided in the Policy, insurance for a Covered Student's dependent will end when insurance for the Covered Student ends.

COST OF INSURANCE*

Term of Coverage	Annual 8/20/14-8/19/15	Spring/Summer ** 1/16/15-8/19/15	Summer Only*** 5/31/15-8/19/15
Student	$1,394	$ 805	$ 401
Spouse	$3,379	$1,956	$ 957
Each child	$2,057	$1,190	$ 587

*includes taxes and administrative fees
**Spring/Summer-only coverage is available only to students new to the College in the Spring/Summer semester.
***Summer-only coverage is available only to students new to the College in the Summer semester.

DEFINITIONS

"Accident" means an occurrence which (a) is unforeseen; (b) is not due to or contributed to by Sickness or disease of any kind; and (c) causes Injury.

"Allowable Charges" ("AC") means the charges agreed to by the Preferred Provider Organization for specified covered medical treatment, services and supplies.

"Covered Percentage" means the percentage of the Eligible Expense that is payable as a benefit under the Policy.

"Covered Person" means a Covered Student while coverage under the Policy is in effect and those dependents with respect to whom a Covered Student is insured.

"Covered Student" means a student of the Policyholder who is insured under the Policy.

"Doctor" as used herein means: (a) legally qualified physician licensed by the state in which he or she practices; and (b) a practitioner of the healing arts performing services within the scope of his or her license as specified by the laws of the state of such practitioner; and (c) certified nurse midwives and licensed midwives while acting within the scope of that certification. The term "Doctor" does not include a Covered Person's immediate family member.

"Elective Treatment" means medical treatment, which is not necessitated by a pathological change in the function or structure in any part of the body, occurring after the Covered Person's effective date of coverage. Elective treatment includes, but is not limited to: vasectomy; breast reduction unless as a result of mastectomy; sexual reassignment surgery; submucous resection and/or other surgical correction for deviated nasal septum; other than necessary treatment of covered acute purulent sinusitis; treatment for weight reduction; learning disabilities; immunizations; botox injections; treatment of infertility and routine physical examinations.

"Eligible Expense" as used herein means a charge for any treatment, service or supply which is performed or given under the direction of a Doctor for the Medically Necessary treatment of a Sickness or Injury: (a) not in excess of the Reasonable and Customary charges; or (b) not in excess of the charges that would have been made in the absence of this coverage; (c) with respect to the Preferred Provider, is the Allowable Charge; (d) is the negotiated rate, if any; and (e) incurred while the Policy is in force as to the Covered Person.

"Emergency Medical Condition" means a Sickness or Injury for which medical treatment is sought at the nearest available facility. The condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that without immediate medical care could reasonably be expected to result in any of the following:
(a) the Covered Person's life could be in serious jeopardy;
(b) bodily functions would be seriously impaired; or
(c) a body organ or part would be seriously damaged; or
(d) serious disfigurement; or
(e) serious jeopardy to the health of the fetus.

"Emergency Services" means, with respect to an Emergency Medical Condition:
(a) 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
(b) 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)).

Emergency does not include the recurring symptoms of a chronic illness or condition unless the onset of such symptoms could reasonably be expected to result in the complications listed above.

"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.

"Hospital" means a facility which meets all of these tests:
(a) it provides in-patient services for the care and treatment of injured and sick people; and
(b) it provides room and board services and nursing services 24 hours a day; and
(c) it has established facilities for diagnosis and major surgery; and
(d) it is supervised by a Doctor; and
(e) it is run as a Hospital under the laws of the jurisdiction in which it is located; and
(f) it is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Hospital does not include a place run mainly: (a) as a convalescent home; (b) as a nursing or rest home; (c) as a place for custodial or educational care; or (d) as an institution mainly rendering treatment or services for: mental or nervous disorders; or substance abuse. The term "Hospital" includes: (a) an ambulatory surgical center or ambulatory medical center; and (b) a birthing facility certified and licensed as such under the laws where located. It shall also include rehabilitative facilities if such is specifically for treatment of physical disability.

Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

"Injury" means bodily injury due to an Accident which: (a) results solely, directly and independently of disease, bodily infirmity or any other causes; (b) occurs after the Covered Person's effective date of coverage; and (c) occurs while coverage is in force. All injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered one Injury.

"Medical Necessity/Medically Necessary" means that a drug, device, procedure, service or supply is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury based on generally accepted current medical practice in the United States at the time it is provided.

A service or supply will not be considered as Medically Necessary if:
(a) it is provided only as a convenience to the Covered Person or provider; or
(b) it is not the appropriate treatment for the Covered Person's diagnosis or symptoms; or
(c) it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment; or
(d) it is experimental/investigational or for research purposes; or
(e) could have been omitted without adversely affecting the patient's condition or the quality of medical care; or
(f) involves treatment of or the use of a medical device, drug or substance not formally approved by the U.S. Food and Drug Administration (FDA); or
(g) involves a service, supply or drug not considered reasonable and necessary by the Center for Medicare and Medicaid Services Issues Manual; or
(h) it can be safely provided to the patient on a more cost-effective basis such as outpatient, by a different medical professional or pursuant to a more conservative form of treatment.

The fact that any particular Doctor may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

"Preventive Services" mandated by the Patient Protection and Affordable Care Act and, In addition to any other preventive benefits described in the Policy or Certificate, means the following services and without the imposition of any cost-sharing requirements, such as deductibles, copayment amounts or coinsurance amounts to any Covered Person receiving any of the following:

1. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, except that the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention of breast cancer shall be considered the most current other than those issued in or around November 2009;
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;
3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health resources and Services Administration; and
4. With respect to women, such additional preventive care and screenings, not described in paragraph 1 above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

The Company shall update new recommendations to the preventive benefits listed above at the schedule established by the Secretary of Health and Human Services.

"Reasonable and Customary" ("R&C") means the charge, fee or expense which is the smallest of: (a) the actual charge; (b) the charge usually made for a covered service by the provider who furnishes it; (c) the negotiated rate, if any; and (d) the prevailing charge made for a covered service in the geographic area by those of similar professional standing.

"Geographic area" means the three digit zip code in which the services, procedure, devices, drugs, treatment or supplies are provided or a greater area, if necessary, to obtain a representative cross-section of charge for a like treatment, service, procedure, device, drug or supply.

"Sickness" means disease or illness including related conditions and recurrent symptoms of the Sickness which begins after the effective date of a Covered Person's coverage. Sickness also includes pregnancy and complications of pregnancy. All Sicknesses due to the same or a related cause are considered one Sickness.

SCHEDULE OF BENEFITS

	IN NETWORK	OUT OF NETWORK
Aggregate Maximum Amount per Policy Year	Unlimited	
Out-of-Pocket Limit The Out-of-Pocket Limit will apply in a Policy Year to a Covered Person who in that year reaches the Out-of-Pocket Limit. The Out-of-Pocket Limit is reached when the amount of Eligible Expenses incurred by the Covered Person during the Policy Year for which no benefits are payable due to covered percentages less than 100%. The Out-of-Pocket Limit does not include charges in excess of Reasonable and Customary; expenses incurred for prescription drugs; charges in excess of any specified maximum or charges incurred for any services not covered under the Policy. When the Out-of-Pocket Limit becomes applicable to a Covered Person during a Policy Year, covered percentages are increased to 100% for all Eligible Expenses incurred by the Covered Person for the remainder of that Policy Year up to any benefit maximum that may apply.	$5,000 per Covered Person per Policy Year / $12,700 per Family per Policy Year	$10,000 per Covered Person per Policy Year / $25,000 per Family per Policy Year
Deductible Amount per Covered Person per Policy Year	$250	$500
INPATIENT BENEFITS	**IN NETWORK**	**OUT OF NETWORK**
Daily Room & Board Expense, semi-private room rate.	80% of AC	60% of R&C
Miscellaneous Hospital Expense, includes expenses incurred for anesthesia and operating room; laboratory tests and x-rays, (including professional fees); oxygen tent; drugs, medicines (excluding take-home drugs), dressings; and other Medically Necessary and prescribed Hospital expenses. $150 co-payment per Hospital admission	80% of AC	60% of R&C
Physiotherapy, during Hospital confinement.	80% of AC	60% of R&C
Surgical Expense	80% of AC	60% of R&C
Anesthetist	80% of AC	60% of R&C
Doctor's Visits (Doctor other than a Doctor who performed surgery or administered anesthesia)	80% of AC	60% of R&C
Alcoholism Expense	Same as any other Sickness	Same as any other Sickness
Mental and Nervous Conditions Expense	80% of AC	60% of R&C
OUTPATIENT BENEFITS	**IN NETWORK**	**OUT OF NETWORK**
Day Surgery Facility / Miscellaneous, when scheduled surgery is performed in a Hospital/outpatient facility/ambulatory surgical center, including use of operating room, x-ray examinations and laboratory tests (including professional fees); anesthesia; infusion therapy; drugs or medicines and supplies; therapeutic services (excluding physiotherapy or take home drugs and medicines)	80% of AC after a $150 co-payment	60% of R&C after a $150 co-payment

Surgical Expense	80% of AC	60% of R&C
Anesthetist	80% of AC	60% of R&C
Doctor's Visits (A Doctor other than a Doctor who performed surgery or administered anesthesia.)	80% of AC after a $15 co-payment	60% of R&C after a $15 co-payment
Hospital Emergency Room/Non-Scheduled Surgery: co-payment is waived if admitted	80% of AC after a $250 co-payment	80% of R&C after a $250 co-payment
Urgent Care	80% of AC after a $15 co-payment	60% of R&C after a $15 co-payment
Rehabilitative Care (physical therapy, occupational therapy, chiropractic services, cardiac/pulmonary)	80% of AC after a $15 co-payment	60% of R&C after a $15 co-payment
Laboratory and X-ray Examinations	80% of AC after a $15 co-payment	60% of R&C after a $15 co-payment
CAT Scan/MRI/PET Scan	80% of AC after a $15 co-payment	60% of R&C after a $15 co-payment
Radiation Therapy and Chemotherapy	80% of AC after a $15 co-payment	60% of R&C after a $15 co-payment
Diagnostic Services, and medical procedures performed by the Doctor (other than Doctor's visits, physiotherapy, x-rays and lab procedures).	80% of AC after a $15 co-payment	60% of R&C after a $15 co-payment
Prescribed Medicines Expense – prescriptions should be filled at a Catamaran participating pharmacy. For a list of nationwide participating pharmacies, please visit www.mycatamaranrx.com. This benefit applies to all prescribed FDA-approved birth control methods. The co-pay will be waived for prescribed FDA-	Co-pay per prescription – limited to a 30 day supply: $10 Generic $35 Formulary Brand Name $50 Non-Formulary Brand Name and Specialty	
Alcoholism Expense	Same as any other Sickness	Same as any other Sickness
Mental and Nervous Conditions Expense	80% of AC	60% of R&C
OTHER SERVICES	**IN NETWORK**	**OUT OF NETWORK**
Pediatric Dental Treatment Expense (for Covered Persons under age 19 only): **Covered Percentage:** For Orthodontic Services For Oral Examination (Preventive) For X-Ray and Pathology For Prophylaxis and Fluoride Applications (Preventive) For Amalgam Restorations – Primary Teeth For Amalgam Restorations – Permanent Teeth For Synthetic Restorations For Oral Surgery (Includes local anesthesia and routine post-operative care) Extractions For Endodontics (excluding final restoration) For Major Restorative (crowns, bridges, partial and full dentures) Co-payment Amount per visit	 50% of AC 70% of AC 70% of AC 70% of AC 50% of AC 50% of AC 50% of AC 60% of AC 60% of AC 60% of AC $25	 50% of R&C 70% of R&C 70% of R&C 70% or R&C 50% of R&C 50% of R&C 50% of R&C 60% of R&C 60% of R&C 60% of R&C $25

Dental Treatment Expense (Injury Only)	80% of AC	80% of R&C
Pediatric Vision Care Expense (for Covered Persons under age 19 only): **Co-payment amount per visit:** • Examination • Materials • Covered percentage Standard Plastic Lenses: • Single Vision • Bifocal • Trifocal • Lenticular • Progressive • Frames **Contact Lenses (in lieu of eyeglass lenses and frames) Fit, Follow-up and Materials** -Effective -Medically Necessary **Limited to one pair of lenses and one set of frames per Plan year.**	 $25 $100 60% of AC $150 $150 $150 $150 $150 $150 $150 $150	 $25 $100 60% of R&C $150 $150 $150 $150 $150 $150 $150 $150
Vision Care Expense (For Covered Persons age 19 and Over): **Co-payment amount per visit:** • Materials • Covered percentage Standard Plastic Lenses: • Single Vision • Bifocal • Trifocal • Lenticular • Progressive • Frames **Contact Lenses (in lieu of eyeglass lenses and frames) Fit, Follow-up and Materials** -Effective -Medically Necessary **Limited to one pair of lenses and one set of frames per Plan year.**	 $100 60% of AC $150 $150 $150 $150 $150 $150 $150 $150	 $100 60% of R&C $150 $150 $150 $150 $150 $150 $150 $150

Preventive Benefits, as specified by the Patient Protection and Affordable Care Act. (To view a list of covered preventive services, log onto www.healthcare.gov/prevention/index.html).	100% of AC (not subject to the deductible or co-payments)	60% of R&C (deductibles and co-payments apply)
Hospice Care Expense	80% of AC	60% of R&C
Home Health Care Expense	80% of AC	60% of R&C
Durable Medical Equipment	80% of AC	60% of R&C
Ambulance Expense	80% of R&C	

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

he Company will pay the benefit below for Injuries to a Covered Person: (a) caused by an Accident which happens while covered by the Plan; and (b) which directly, and from no other cause, result in any of the losses listed below within 90 days of the Accident that caused the Injury.

For Loss of	Maximum Amount
Life	$10,000
Both Hands or Both Feet	$10,000
Sight of Both Eyes	$10,000
One Hand and One Foot	$10,000
One Hand and the Sight of One Eye	$10,000
One Foot and the Sight of One Eye	$10,000
One Hand or One Foot	$ 5,000
The Sight of One Eye	$ 5,000

“Loss” of a hand or foot means complete severance through or above the wrist or ankle joint. “Loss” of sight of an eye means the total, irrevocable loss of the entire sight in that eye. “Severance” means the complete separation and dismemberment of the part from the body.

If a Covered Person suffers more than one loss as a result of the same Accident, the Company will pay only for the loss with the largest benefit.

PPO PROVIDERS

A Preferred Provider Organization (PPO) is an organization in which a group of Hospitals and Doctors have agreed to provide medical care services to Covered Persons. The PPO for the Plan is selected by the Company. The PPO provides these services according to negotiated fee schedules that are considered full payment for services rendered, subject to policy provisions. A Covered Person has the option to use a PPO provider or a non-PPO provider. The PPO for Millsaps College is First Health. To obtain a list of participating providers and hospitals, visit www.studentinsurance.com/MS/Millsaps/ and click on “Find your Doctor/Hospital”.

PREFERRED PROVIDER ORGANIZATION: FIRST HEALTH
TOLL FREE TELEPHONE NUMBER: 800-226-5116
FIRST HEALTH WEBSITE: WWW.FIRSTHEALTH.COM

If a Covered Person seeks treatment from a nonparticipating provider, benefits will be reduced to the percentage shown in the Schedule of Benefits. Please be aware that if a Covered Person is treated at a PPO Hospital, it does not guarantee that all providers at the Hospital are participating providers. In addition, if a Covered Person is referred by a participating provider to another facility or provider, it does not mean that the provider to which the Covered Person is referred is also a participating provider. It is the Covered Person’s responsibility to verify that the provider is part of the PPO.

STATE MANDATED BENEFITS

The Plan covers all applicable state mandated benefits. Please see the Policy on file with the College for details.

COORDINATION OF BENEFITS

The Plan will coordinate benefits with other health carriers when duplicate coverage exists. Total payment from this coverage and other health coverages under which the Covered Person is enrolled shall not exceed 100% of the cost of the covered services.

EXCLUSIONS AND LIMITATIONS

The Policy does not cover nor provide benefits for loss or expenses incurred:

1. as a result of dental treatment, except as provided elsewhere in the Policy. This exclusion does not apply to Preventive Benefits mandated by the Patient Protection and Affordable Care Act.
2. for eye examinations, eyeglasses, contact lenses, or prescription for such except as specifically provided in the Policy; radial keratotomy or laser surgery; hearing aids. This exclusion does not apply to Preventive Benefits mandated by the Patient Protection and Affordable Care Act.
3. as a result of an Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a commercial scheduled airline. This exclusion does not apply to a Covered Student while taking flight instructions for Policyholder credit.
4. for Injury or Sickness resulting from war or act of war, declared or undeclared.
5. as a result of an Injury or Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law.
6. for treatment provided in a government Hospital unless there is a legal obligation to pay such charges in the absence of insurance.
7. for cosmetic surgery except as required to correct an Injury for which benefits are otherwise payable under the Policy or as specifically provided for in the Policy. "Cosmetic surgery" shall not include reconstructive surgery when such surgery is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part and reconstructive surgery because of a congenital disease or anomaly of a covered dependent child which has resulted in a functional defect. It also shall not include breast reconstructive surgery after a mastectomy.
8. as a result of committing or attempting to commit an assault or felony or participation in a felony, riot, insurrection or civil commotion.
9. for Elective Treatment or elective surgery; except as specifically provided in the Policy.
10. after the date insurance terminates for a Covered Person.
11. for any services rendered by a Covered Person's immediate family member.
12. for any treatment, service or supply which is not Medically Necessary.
13. as a result of suicide or any attempt at suicide, including drug overdose or intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury.
14. for surgery and/or treatment of: acne; deviated nasal septum, including submucuous resection and/or other surgical correction thereof; fertility tests; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; hair growth or removal; nonmalignant warts, moles and lesions; obesity and any condition resulting therefrom (including hernia of any kind, diabetes or heart disease); and weight reduction. This exclusion does not apply to Preventive Benefits mandated by the Patient Protection and Affordable Care Act.
15. for sterilization or sterilization reversal, including surgical procedures and devices; or for birth control except as specifically provided in the Policy.
16. as a result of a motor vehicle accident if the Covered Person is not properly licensed to operate the motor vehicle within the jurisdiction in which the Accident takes place. This exclusion will not apply to passengers if they are Covered Persons under the Policy.
17. for voluntary or elective abortions.
18. for Injury resulting from: the practicing for, participating in, or traveling as a team member to and from intercollegiate, club, professional and semi-professional sports activity, including travel to and from the activity and practice.

19. for rest cures or custodial care.
20. for Injury resulting from fighting, except in self-defense.
21. within the Covered Person's home country of domicile with respect to an international Covered Person.
22. for treatment, service or supply for which a charge would not have been made in the absence of insurance.

STUDENT HEALTH CENTER REFERRAL REQUIREMENT

A referral from the Student Health Center is required before benefits are payable. This provision does not apply: (a) if the Student Health Center is closed, however, the student must return to the Student Health Center for necessary follow-up care; (b) if the covered service is rendered at another facility during school breaks or vacation times; (c) if medical care is received when student is more than 100 miles from campus; (d) if medical care is obtained by a student who is not eligible to use the Student Health Center; (e) for maternity; (f) for mental disorders; or (g) for an Emergency Medical Condition; however, the student must return to the Student Health Center for necessary follow-up care. No authorization or referral requirement shall apply to obstetrical or gynecological care provided by in-network providers. Benefits for Emergency Medical Condition will be payable at the PPO level whether treatment is received from a PPO provider or Non-PPO provider.

This referral requirement does not apply to the Covered Student's dependent(s). Per the Patient Protection and Affordable Care Act, if designation of a primary care physician is required, the Covered Person must be allowed to designate a physician who specializes in pediatrics as the child's primary care physician if the provider is in the network.

CLAIM PROCEDURE

In the event of an Injury or Sickness, the Insured Person should:

1. Notify Bollinger Specialty Group within 30 days after the date of the Injury or commencement of the Sickness, or as soon thereafter as reasonably possible, by mailing a completed and signed Bollinger claim form to Bollinger Specialty Group, PO Box 727, Short Hills, NJ 07078-0727.
2. Claim forms are available online at www.BollingerColleges.com/Millsaps or by calling 1-855-338-8015. If the providers have given you bills, please keep a copy and attach them to the claim form.
3. Direct all questions regarding benefits available under the Plan, claim procedures, status of a submitted claim or payment of a claim to Bollinger Specialty Group. Online claim status is available at www.BollingerColleges.com/Millsaps or by calling 1-855-338-8015.
4. Itemized medical bills must be attached to the claim form at the time of submission. Subsequent medical bills received after the initial claim form has been submitted should be mailed promptly to Bollinger.

TRAVEL GUARD
DESCRIPTION OF TRAVEL ASSIST AND STUDENT ASSIST SERVICES

Procedures on How to Access Travel Guard and Student Assist Services 24-Hour Assistance Call Services

When to Contact Travel Guard:

- Before you incur expenses.
- If you are 100+ miles from home and require medical assistance or have a medical emergency.
- If you are 100+ miles from home and need assistance with a non-medical situation such as lost luggage, lost documents, legal help, etc.

How to Contact Travel Guard:

- Inside the US and Canada, dial 1-877-249-5362 toll-free.

- Outside the US and Canada:
    - Request an international operator.
    - Request the operator to place a collect call to the USA at 1-715-295-9625.
- Our fax number is 1-262-364-2203.

Travel Guard is available 24-hours-a-day/7-days-a-week/365-days-a-year. Our multi-lingual/multi-cultural Travel Assistance Coordinators (TACs) are trained professionals ready to help participants should the need arise while traveling. The Travel Guard Medical Staff consists of full-time, on-site Registered Nurses and Emergency Doctors who work as a team to provide the best outcome for our clients. This team is directed by a dedicated Medical Director (MD) and Manager of Medical Services (RN). Nursing staff is on-site 24-hours; a Doctor has daily responsibility for a 24-hour period and is on-site during daytime hours.

What information will you need to provide when you call:

- Advise Travel Guard your insurance company name.
- Provide your Policy Number or School Name.
- Advise Travel Guard regarding the nature of your call and/or emergency. Be sure to provide your contact information at your current location in the event Travel Guard needs to call you back.

Description of Services

General Information: Services listed below include advice and information regarding travel documentation, immunization requirements, political/environmental warnings, and information on global weather conditions. Travel Guard can also provide information on available
currency exchange rates, local Bank/Government holidays, and by implementing our databases with the information, provide ATM and Customer Service locations to clients. Travel Guard also provides emergency message storage & relay and translation services.

- Visa & Immunization
- Weather & Exchange Rates
- Environmental & Political Warnings

Technical: Services listed below include assistance to members in the event of lost or stolen luggage, personal effects, documents and tickets. Travel Guard can arrange cash transfers & vehicle return in the event of illness or accident, provide legal referrals, and help with arrangements for members who encounter en route emergencies that force them to interrupt their trips.

- Legal Referral
- Lost/Stolen Luggage Information
- Claims-related Assistance & Personal Effects Assistance
- Lost Document Assistance & Cash Transfer Assistance
- Embassy/Consulate Information
- Telephone Interpretation
- Enroute Travel Assistance

Medical: These services are the most complicated of those offered and can last up to several weeks. They involve Travel Guard's Medical Staff in addition to other network providers and often include post-case payment/billing coordination on the traveler's behalf. These services include physician/dental/hospital referral, medical case monitoring, shipment of medical records and prescription medications, medical evacuation, repatriation of remains and insurance
claims coordination.

Medical Assistance:

- Medical Referral
- Out-patient Assistance
- In-patient Assistance

Medical Transport:

- Medical Evacuation
- Repatriation of Remains

REPATRIATION AND MEDICAL EVACUATION BENEFITS

(Benefits for Repatriation of Remains and Medical Evacuation are provided by National Union Fire Insurance Company of Pittsburgh, Pa.)

REPATRIATION OF REMAINS: $10,000 Maximum Amount

If a Covered Person suffers loss of life due to Injury or emergency Sickness while outside his or her home country, the Company will pay, subject to the limitations set out herein, for Eligible Expenses reasonably incurred to return his or her body to his or her current place of primary residence, but not exceeding the Maximum Amount per Covered Person.

Eligible Expenses include, but are not limited to: (1) embalming or cremation: (2) the most economical coffins or receptacles adequate for transportation of the remains; and (3) transportation of the remains by the most direct and economical conveyance and route possible.

MEDICAL EVACUATION: $10,000 Maximum Amount

The Company will pay, subject to the limitations set out herein, for eligible Medical Evacuation expenses reasonably incurred if the Covered Person suffers an Injury or emergency Sickness that warrants his or her Medical Evacuation while outside his or her home country but not exceeding the Maximum Amount per Covered Person for all Medical Evacuations due to all Injuries from the same accident or all emergency Sicknesses from the same or related causes. The Doctor ordering the Medical Evacuation must certify: (a) that the severity of the Covered Person's Injury or emergency Sickness warrants his or her Medical Evacuation; and (b) the Covered Person has been Hospital confined for at least five (5) consecutive days prior to Medical Evacuation. All Transportation arrangements made for the Medical Evacuation must be by the most direct and economical conveyance and route possible.

Travel Guard must make all arrangements and must authorize all expenses in advance for these benefits to be payable. If it was not reasonably possible to contact Travel Guard in advance, the Company reserves the right to determine the benefits payable, including any reductions.

Repatriation of Remains and Medical Evacuation benefits are subject to all policy provisions.

STUDENT ASSIST SERVICES

Concierge Services: You receive the comfort, care, and attention of Travel Guard's Personal Assistance Coordinators available 24/7 to respond to virtually any request — large or small.

Personal Security Assistance: You can feel safe and secure with Travel Guard's Personal Security Assistance at home or while traveling. To activate personal security services, please log onto http://aig.com/travelguardassistance.

To register:

(1) Click on "Sign In" in the upper right-hand corner.
(2) Click on "Register Here".
(3) Complete required fields: first name, last name, email address, policy number 9497181 and then click "Submit."

AMERICAN HEALTH HOLDING, INC.
24-HOUR STUDENT EMERGENCY CARE HOTLINE

For confidential health care advice and information, 24 hours a day, 365 days a year, call toll-free (866) 315-8756 (American Health Holding, Inc. is not affiliated with National Union Fire Insurance Company of Pittsburgh, Pa.)

Comprehensive Resources and Advice from Registered Nurses

- Direct access to an extensive Health Information Library, covering issues ranging from women's health to pediatrics. Detailed directories with topic codes and instructions for access to health-related topics.

- Choose to talk directly with a nurse. Discuss a current illness or health issue, or receive counseling on chronic conditions. Nurses can also educate callers about treatments, lifestyle choices and self-care strategies.

- Integrated phone access to specially trained personnel, trained to provide referral services for a number of health related concerns including mental health and/or substance abuse

SUBMIT ALL CLAIMS TO:

Bollinger Specialty Group

BOLLINGER, INC., A SUBSIDIARY OF
ARTHUR J. GALLAGHER & CO.

P.O. Box 727
Short Hills, NJ 07078-0727
855-338-8015

Local Broker

Collegiate Risk Management
110 Athens Street
Tarpon Springs, FL 34689
Phone: 1-800-922-3420 Fax: 727-939-8323
www.Collegiaterisk.com

Preferred Provider Network:

First Health Network

www.myfirsthealth.com
1-800-226-5116