



2013–2014

STUDENT INJURY & SICKNESS INSURANCE PLAN

Your student health insurance coverage, offered by Monumental Life Insurance Company, may not meet the minimum standards required by the health care reform law for the restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are \$1.25 million for policy years before September 23, 2012; and \$2 million for policy years beginning on or after September 23, 2012 but before January 1, 2014. Restrictions for annual dollar limits for student health insurance coverage are \$500,000 for policy years beginning on or after September 23, 2012, but before January 1, 2014. If you have any questions or concerns about this notice, contact Bollinger Inc., Short Hills, NJ, 1-866-267-0092. Be advised that you may be eligible for coverage under a group health plan of a parent's employer or under a parent's individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent's employer plan or the parent's individual health insurance issuer for more information.

✓ This Policy contains a deductible provision

Underwritten By:
MONUMENTAL LIFE INSURANCE COMPANY
Cedar Rapids, Iowa
a Transamerica company
Visit us on the Web: www.BollingerColleges.com/FIT

To purchase dental insurance, please visit www.FITdentalplan.com

Underwritten by:
Stonebridge Life Insurance Company

Visit us on the Web:
www.BollingerColleges.com/FIT

Student Health Care Services Introduction

Your provider

FLORIDA TECH HOLZER HEALTH CENTER—
OMNI HEALTHCARE

West corner of Country Club Rd. and University Blvd.
Melbourne, FL 32901 • Phone (321) 674-8078

Fall and Spring Semester:

Monday through Thursday 8 a.m. – 8 p.m.,
Friday 8 a.m to 5 p.m.

Summer Semester:

Monday through Friday 9 a.m. to 3 p.m.

Appointments

Walk in only, no appointments are required

Routine Medical Care

Holzer Health Center can provide routine and preventative services including women's wellness to students registered at the university. Routine and preventative services are considered services not related to a specific Injury or Sickness. Students are strongly encouraged to coordinate these services with the Health Center. Payment for such treatment is expected at the time of service.

Provider for Dependents

Enrolled Dependents (spouse residing with the Insured student, and children up to age 26 that are not self-supporting and reside with the Insured student) should seek medical advice from First Health Provider for Dependents. There will be a \$25 Co-Pay collected at the time of service. Appointments are required.

Emergencies and After Hours

If you have a medical emergency, please call 911 or go to the closest emergency room.

If it is not an emergency, but after hours, call the Acute Care Clinic at (321) 723-9411 for availability or go to an Urgent Care Center in the First Health Network.

If you are ill and not sure if your illness can wait until the next business day, call (321) 723-9411 for an on call physician.

Acute Care Clinic (321)723-9411

Please call ahead for availability.

Hours: Monday through Friday, 8 a.m.—6 p.m.

This location is intended to provide care for conditions that require immediate care and the Student Health Center is closed.

Services obtained will be subject to terms and conditions of your insurance.

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STUDENT BLANKET HEALTH INSURANCE

Introduction

Florida Institute of Technology requires all full-time degree-seeking domestic and all international students to have medical insurance to cover the costs of treatment for Injury and Sickness. Florida Tech offers a medical insurance policy, underwritten by Monumental Life Insurance Company.

The plan utilizes the First Health Network of providers. (HHC). OMNI Healthcare Inc. staffs the Holzer Health Center, which is for students participating in the school-endorsed health insurance program.

NOTE: OMNI Healthcare Inc. is a multispecialty group based in Melbourne, Florida. OMNI Healthcare Inc. is an independent contractor and is solely responsible for the diagnostic services, treatment and care it provides. Monumental Life Insurance Company and Florida Institute of Technology cannot be held responsible for these services. Always confirm whether or not your provider participates in First Health Network.

FIRST HEALTH NETWORK PLAN

The plan has been established to provide you with most of the medical services you and your covered Dependents will need while you are attending school. Primary medical care can also be provided to you at the Holzer Health Center. If additional medical treatment is necessary, you may be referred to one of the specialists who participate in the First Health Network. You are strongly encouraged to visit the Holzer Health Care Center first for medical care to obtain In Network benefits. Note: Dependents of covered students should seek medical advice from a provider in the First Health Network. A \$25 Co-pay will be collected at the time of service. You may contact First Health directly at (888) 685-7774 or visit www.myfirsthealth.com.

In-Network Physician Co-pay, Coinsurance and Deductible

Each time you obtain medical service for a Sickness or Injury (other than at the Holzer Health Center) from a First Health Physician, whether a PCP or Specialist, you pay a \$25 Co-pay for the office visit and 20% coinsurance for medical services other than the office visit. You are required to pay the \$25 Co-pay at the time of services. The provider will bill the 20% coinsurance to you. The policy's annual \$75 Deductible will apply to medical services, other than the Physician's visit. There will be no cost-sharing for in-network preventative services. See the Schedule of Benefits for details on reimbursement and specific services. All other policy provisions and limitations remain the same.

Out-of-Network Services

Any advice, treatment or care obtained from a provider who is not part of the First Health Network will be subject to the \$250 Out-of-Network Deductible and 40% coinsurance. Also, You may have to pay for these services at the time of the visit and submit a claim form with paid bills for reimbursement. Please note: First Health has providers around the country. You can always call (888) 685-7774 or visit www.myfirsthealth.com to locate a provider in your area, if you are 50 miles away from Melbourne or are a Dependent of a covered student.

Note: Emergency services will always be reimbursed according to the in-network schedule.



ELIGIBILITY

Full-time employees of the university, including adjunct faculty, and part-time employees including their Dependent children and spouses, are not eligible to enroll in the student medical plan. University Alliance enrolled students are not eligible to participate in the Florida Institute of Technology Student Health Insurance program.

Domestic Students

Student health insurance is MANDATORY for all full-time degree-seeking undergraduate (12 credits or more) students and degree-seeking graduate students (9 credits or more). All other degree-seeking students taking a minimum of 6 credit hours are eligible. Online students or students attending classes through the Extended Studies Division of University College do not meet the eligibility requirements.

International Students

All international students are automatically charged on their student account for Florida Tech's student health insurance, unless they are officially sponsored by their home government or agency that guarantees health insurance fees as part of the student's contract with Florida Tech. Exceptions may be granted only if you have an insurance plan meeting very strict requirements. For consideration, you may request a waiver of participation from the Office of Business and Retail Operations prior to the deadline. No submissions will be considered after this date. The Office of Business and Retail Operations is located at Florida Tech Commons.

Dependents

Full-time degree-seeking domestic and all international students participating in this program may insure their Dependents for an additional charge. Eligible Dependents are the spouse who lives with the Insured and any children and stepchildren up to the calendar year of his/her 26th birthday.

TERM OF COVERAGE

This policy becomes effective on August 10, 2013, at 12:00 a.m. and expires on August 9, 2014 at 11:59 p.m. Your enrollment/waiver will extend for your uninterrupted enrollment at Florida Tech. Students withdrawing from Florida Tech within the first 21 days of any term will have the applicable semester's health insurance charge refunded at 100 percent, unless a claim has been submitted. Students withdrawing after the first 21 days will remain covered under the policy for the full period for which the premium has been paid.

- All eligible students and their Dependents enrolled in this plan will be insured for a covered Injury or Sickness 24 hours a day anywhere in the world for the period for which the premium has been paid. Protection is in effect during all vacation periods.
- Coverage will terminate at the end of the period for which the premium has been paid. Any termination will be without prejudice to any claim beginning before termination.

ANNUAL COST

Basic Accident and Sickness Coverage

Student Under Age 35	\$1,269
Student Age 35 or Older	\$2,020
Each Dependent	\$1,646

Student rates include an administrative fee.

The cost for Injury and Sickness coverage is automatically added to the student's account unless the completed waiver form with proof of coverage is submitted to the Campus Services Office by the second week of the student's first semester. Your enrollment/waiver will extend for the length of your stay at Florida Tech, unless you officially withdraw or do not enroll in Florida Tech.

Refund Provision

In the event an Insured person leaves school to enter active military service, coverage will cease and a pro-rata refund of premium will be made upon request. Other than as stated here, no refunds are available.

DEFINITIONS

COINSURANCE means the out-of-pocket expenses to be paid by the Insured as a percentage of the Covered Medical Expenses.

COMPLICATIONS OF PREGNANCY means conditions whose diagnoses are distinct from pregnancy, but are adversely affected by pregnancy or are caused by pregnancy, such as: (1) acute nephritis; (2) nephrosis; (3) cardiac decompensation; (4) missed abortion; (5) non-elective cesarean section; (6) ectopic pregnancy which is terminated; (7) spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible; (8) pernicious vomiting; (9) pre-eclampsia; (10) similar medical and surgical conditions of comparable severity.

It does not include: (1) false labor; (2) occasional spotting; (3) Physician prescribed rest; (4) morning sickness; and (5) similar conditions associated with the management of a difficult pregnancy not constituting a medically distinct complication of pregnancy.

COVERED MEDICAL EXPENSES are Usual, Customary, and Medically Necessary charges that are:

1. not in excess of the Maximum amount payable for services as specified in the Schedule;
2. in excess of any deductible amount; and
3. incurred while the Covered Person's coverage under this Policy is in force.

DEDUCTIBLE means the dollar amount of Covered Medical Expenses that must be paid as an out-of-pocket expense by each Covered Person each Policy Year before benefits are payable under this Policy. The Deductible Amount is shown on the Schedule. Under certain conditions, the Deductible Amount may be lowered or waived by the Company.

ELECTIVE SURGERY means any surgery or treatment that is not Medically Necessary or is not recognized as generally accepted medical practice in the United States. Elective Surgery and Elective Treatment do not include any procedures deemed a Medical Necessity. Elective Surgery does not mean a Cosmetic Procedure required to correct an Injury for which benefits are otherwise payable under this Policy.

Elective Surgery and Elective Treatment includes, but is not limited to, surgery and/or treatment for acne, acupuncture; breast implants; breast reduction; circumcision; corns, calluses and bunions; cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under the Policy, and except for cosmetic surgery required to correct a covered Injury or infection or other diseases of the involved part and reconstructive surgery because of congenital disease or anomaly of a covered newborn child for which benefits are otherwise payable under the Policy; deviated nasal septum, including submucous resection and/or other surgical correction; fertility tests; hair growth or removal; impotence; organic or otherwise; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing contraception; learning disabilities except for prescription drugs prescribed by a physician to treat such disabilities; nonmalignant warts, moles and lesions; obesity and any condition resulting therefrom (including hernia or any kind) with the exception of screening, counseling or behavioral interventions for the treatment of obesity and except for the treatment of an underlying covered Sickness; premarital examinations; sexual reassignment surgery; skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; temporomandibular joint dysfunction (TMJ); tubal ligation; vasectomy; and weight loss or reduction.

*Fertility related services—they are not mandated by Federal law; however, many states have fertility mandates

HOSPITAL means an institution which meets all of the following requirements:

1. it must be operated according to law;
2. it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made.
3. it must provide diagnostic and surgical facilities supervised by Physicians;
4. Registered Nurses must be on 24 hour call or duty;
5. the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

Hospital includes a rehabilitation facility, if such rehabilitation is specifically for treatment of physical disability. A Hospital is not a rest, convalescent, extended care or skilled nursing facility. It is not a place

which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. It is not a facility where, in the absence of insurance, there is no legal obligation to pay.

INJURY means bodily injury caused by an accident. The accident must occur while the Covered Person's insurance is in effect under this Policy. A Covered Person must begin receiving services, supplies or treatment within 30 days from the time of accident in order for it to be considered a covered Injury. All injuries sustained by one person in any one accident, including all related conditions and recurrent symptoms of these Injuries, are considered a single covered Injury. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

INSURED means an eligible student as outlined in this Policy and in the Master Application for whom an application has been received and has paid the required premium. The words he, his, and him refer to the Insured, regardless of gender.

MEDICALLY NECESSARY means care which a Physician has determined to be certifiably essential for the diagnosis or treatment of a Sickness or Injury. This determination must be based on objective results produced by an examination of the Covered Person's demonstrable symptoms. The Physician's treatment plan may be reviewed by an impartial third party whose determination will be binding on us and the Insured.

OUTPATIENT means expenses incurred for Medically Necessary services received other than as Confined.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. He must be practicing within the scope of his license for the service or treatment given. He may not be the Insured or a member of his Immediate Family.

PRESCRIPTION DRUGS means any Medically Necessary drugs that, under the applicable state or federal law, may be dispensed only upon written prescription of a Physician; and injectable insulin.

SICKNESS means an illness, or disease which first manifests while this Policy is in effect which results in Covered Medical Expenses. All related conditions and recurrent symptoms of the same or a similar condition will be considered the same Sickness. It also includes Pregnancy.

TOTALLY DISABLED means as the result of an Injury or Sickness, the Covered Person's inability to perform the material and substantial duties of any occupation for which he is reasonably fitted by education, training, or experience.

USUAL AND CUSTOMARY CHARGE means those charges for necessary treatment and services that are reasonable for the treatment of cases of comparable severity and nature. This will be derived from the mean charge based on the experience in a related area of the service and the FAIR Health schedule of fees valued at the 90th percentile.



PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-existing Conditions. They are defined as an Injury sustained or a Sickness for which the Covered Person was medically treated or advised by a Physician within the twelve months immediately prior to his Effective Date of Coverage under this Policy. This Pre-Existing Conditions Limitation provision does not apply to:

1. Covered person's and their Dependents under 19 years of age.
2. Genetic information in the absence of a diagnosis of the condition related to such information;
3. a Covered Person who, as of the last day of the 30-day period beginning with the date of birth, was covered under prior creditable coverage;
4. a Covered Person who has prior coverage without a lapse of 62 days or more;
5. a child who is adopted or placed for adoption before attaining 18 years of age; and as of the last day of the 30-day period beginning on the date of adoption or placement for adoption, is covered under creditable coverage;
6. Pregnancy.

Covered Medical Expenses resulting from a Pre-existing Condition will not be covered unless: (1) six consecutive months have elapsed during which no medical treatment or advice is given by a Physician for such condition; or (2) the Covered Person has been insured under this Policy or the University's prior policies for the immediate prior year; or (3) the Covered Person has been receiving benefits under the University's prior policies and has been continuously insured since the date of accident, Injury, or Sickness, whichever occurs first. Routine follow-up care to determine whether a breast cancer has recurred in a person who has been previously determined to be free of breast cancer does not constitute medical advice, diagnosis, care, or treatment for purposes of determining Pre-existing Conditions unless evidence of breast cancer is found during or as a result of the follow-up care.

OTHER COVERED SERVICES

Dental Treatment for Impacted Wisdom Teeth: If the insured's sickness requires treatment for impacted wisdom teeth, we will pay 80% of the Usual and Customary Charge for an In-Network provider or 60% of the Usual and Customary Charge for an Out of Network provider.

Elective Abortion: We will pay the expense for the voluntary termination of Your pregnancy. We will pay 80% of the Usual and Customary Charge for an In-Network provider up to \$300 or 60% of the Usual and Customary Charge up to \$300 for an Out of Network provider.

COORDINATION OF BENEFITS

EXPLANATION When a person is covered by more than one Plan, the benefits that are paid will be shared between the Plans. This is done so that the total benefits paid will not be more than 100 percent of the Allowable Expenses for any Covered Person.

In a Policy Year this Policy will pay:

1. its regular benefits in full; or
2. a reduced amount of benefits if a Covered Person is covered under more than one Plan. If a reduced amount of benefits is paid using this provision, each benefit that would be payable in the absence of this provision:
 - a) will be reduced to the same proportion; and
 - b) the reduced amount will be charged against any benefit limit of this Policy that applies.

EXTENSION OF BENEFITS AFTER TERMINATION

The coverage provided under this Policy ceases on the termination date. However, if a Covered Person is Totally Disabled on the termination date from a covered Injury or Sickness, Covered Medical Expenses for such Injury or Sickness will continue to be paid until the Covered Person is no longer Totally Disabled, but not to exceed 90 days from the expiration date of coverage, or the Maximum Policy benefit, whichever occurs first. Covered Medical Expenses for maternity care for a pregnancy which commenced while the Policy was in effect, shall be continued for the period of that pregnancy and will not be based upon total disability.

The total payments made in respect of the Covered Person for each condition both before and after the termination date will never exceed the Maximum Benefit.

MANDATED BENEFITS

The Plan will pay benefits for the following Mandated Benefits and any other mandate in accordance with Florida insurance laws: Mammography Benefit; Prosthetic Device and Reconstructive Breast Surgery Benefit; Post-Surgical Mastectomy Care Benefit; Osteoporosis Prevention and Treatment; Maternity, Mid-Wife Care, Post Delivery Care; Diabetes Supplies, Equipment and Self-Management Training Benefit; Dental General Anesthesia Benefit and Hospital Dental Procedure Benefit ; Bone Marrow transplant; Enteral formulas coverage; Cleft lip and cleft palate of children coverage; Mental and Nervous Disorders; Substance Abuse Impaired Person Benefit; Children Health Supervision Services.

CAREMARK PRESCRIPTION DRUG PLAN

This Plan includes a prescription drug benefit for prescription drug services throughout the United States. A listing of contracted pharmacies and service is available from Caremark Customer Service at 1-800-391-6443 or online at www.caremark.com. This pharmacy benefit is provided to cover prescriptions associated with a covered Sickness or Injury occurring during the Policy Year. After enrolling, your Caremark ID card will be sent to you within 6 weeks. If you do not present the card, you will need to pay for the prescription and then submit a reimbursement form for prescriptions filled at a network pharmacy along with the paid receipt in order to be reimbursed. To obtain reimbursement forms or for information about mail-order prescriptions or network pharmacies, please call Caremark Customer Care toll free at 1-800-391-6443. Note: Caremark is not connected with Monumental Life Insurance Company.

COVERAGE OF DEPENDENTS

A child born to an Insured person while the policy is in force will be covered by this policy from birth. Coverage for such newborn child will consist of coverage for Injury or Sickness, including necessary care or treatment of congenital defects, birth abnormalities or premature birth and transportation costs of the newborn to and from the nearest available facility appropriately staffed and equipped to treat the newborn's condition, when such transportation is certified by the attending Physician as necessary to protect the health and safety of the newborn child. The coverage of such transportation will not exceed a maximum of \$1,000. All liability with respect to such child shall terminate at the end of 31 days, unless on or before such 31st day when additional premium is paid.

ACCIDENTAL DEATH AND DISMEMBERMENT

Accidental Death and Dismemberment Insurance covers You for a Loss as shown below. The Loss must result from an accident, directly and independently of all other causes. The Accident must take place while you are an Insured under this policy. Also, the Loss must take place within 52 weeks after the accident.

The following table shows the amounts We will pay:

For loss of:	Amount:
Life.....	\$5,000
Both hands or both feet or sight of both eyes.....	\$5,000
One hand and one foot.....	\$5,000
One hand and sight of one eye.....	\$5,000
One foot and sight of one eye.....	\$5,000
One hand or one foot or sight of one eye.....	\$2,500

The most We will pay for all Losses as the result of one Accident is \$5,000. Loss to hands and feet means severance at or above the wrist or ankle joints. Loss of sight means total and irrecoverable loss of sight.

MEDICAL EVACUATION BENEFIT

Upon receipt of due proof that a Covered Person incurred expenses for Physician ordered Emergency Medical Evacuation, including medically appropriate transportation and Medically Necessary Care, en route to the nearest suitable Hospital or to the Covered Person's home country, when the Covered Person is critically ill or Injured and has been Hospital Confined for at least 5 days, and appropriate local care is not available, we will pay the Usual and Customary Charge incurred not to exceed \$10,000, subject to the prior approval of the Claims Administrator for this Policy and the attending Physician. Prior approval can be obtained by calling Bollinger, Inc. at 800-526-1379.

REPATRIATION OF REMAINS BENEFIT

If the Insured person suffers a covered loss of life We will pay, subject to the limitations stated below, for Covered Expenses reasonably incurred to return the Insured person's body to their home country, but not exceeding a Maximum Per Insured person benefit amount of \$7,500, and this is also the Aggregate Maximum for all travel benefits including the Medical Evacuation Benefit.

EXCLUSIONS

The policy does not cover Loss nor provide benefits for:

1. Expenses incurred as the result of dental treatment, except as specifically provided for Covered Persons under age 19 and for treatment resulting from Injury to natural teeth;
2. Eyeglasses, radial keratotomy, contact lenses, hearing aids or prescriptions or examinations except for Covered Persons under age 19 or as required for repair caused by a covered Injury;
3. Cosmetic surgery, except for the correction of birth defects, correction of deformities resulting from cancer surgery, or surgery that is required as a result of an Injury which necessitates medical treatment. Correction of deviated nasal septum shall be considered as Cosmetic surgery for the purpose of this Policy;
4. Injury resulting from skin diving or sky diving, mountaineering (where ropes or guides are customarily used), or any other hazardous sport or hobby;
5. Declared or undeclared war, participating in riot, civil disorder, civil commotion, or acts of terrorism;
6. Treatment for acne; breast implants, except for prosthetic devices incident to a mastectomy; breast reduction; circumcision; deviated nasal septum, including submucous resection and/or other surgical correction thereof; infertility (male or female), including any services or supplies rendered for the purpose or with the intent or inducing conception; learning disabilities except for prescriptions taken as prescribed by a physician for the treatment of such learning disabilities; lesions; warts; obesity and any condition resulting therefrom (including hernia of any kind (except for counseling, screening or behavioral interventions for obesity); tubal ligation; and vasectomy;
7. Suicide or attempted suicide while sane or insane, including drug overdose; or intentional self-inflicted Injury (except in Colorado and Missouri, while sane);
8. Injury sustained or Sickness contracted while in the service of the armed forces of any country. When an Insured enters the armed forces, we will refund any unearned pro-rata premium with respect to such person;
9. Injury or Sickness for which benefits are paid under any Worker's Compensation or Occupational Disease Law;
10. Treatment provided in a government Hospital unless there is a legal obligation to pay such charges in the absence of other insurance;
11. Injury sustained or Sickness contracted as a result of the use of alcohol or the misuse of drugs, medicines, or narcotics or hallucinogen, unless taken in the dosage and for the purpose prescribed by the Covered Person's Physician;
12. Injury resulting from the playing, practice, participating, or conditioning in any intercollegiate sport, in excess of \$1,000, contest or competition sponsored by the College, any professional or semi-professional sport, or Injury sustained while traveling to or from such sport, contest or competition as a participant.
13. Elective Surgery or Elective Treatment.

STUDENT ASSISTANCE SERVICES

(Administered by On Call International)

The following services are available for use by the students insured under this plan. For additional information, please refer to the plan web site:

www.BollingerColleges.com/svc.

Nurse Helpline: Clinical assessment, education and general health information performed by a registered Nurse counselor to assist in identifying the appropriate level and source(s) of care for Students. Nurses shall not diagnose a Student's ailments.

Travel Assistance Services: Services provided include: Emergency Medical Transportation (Evacuation/Repatriation); Medical Monitoring; Medical, Dental, & Pharmacy Referrals; Deposit, Advance, & Payment Guarantees; Dispatch of Medicine, Physician, or Nurse; Return of Deceased Remains; Return of Minor Children Assistance; Pre-Trip Information; 24/7 Emergency Travel Arrangements; Translation Assistance; Emergency Travel Funds Assistance; Worldwide Legal Assistance; Lost/Stolen Travel Documents Assistance; Emergency Message Forwarding; and Lost Luggage Assistance.

Bedside Visit: In the event that a covered student will be hospitalized 7 days or longer, On Call International will provide a benefit of up to \$2,500 for a parent or family member to join the hospitalized student. The benefit can go towards transportation and accommodations. In all cases On Call International must make and pay for the travel and accommodations arrangements. There is no reimbursement for transportation or accommodations if made by the family or school.

Emergency Return Home: If a parent or sibling of a covered student dies or is hospitalized for a life threatening illness while the student is away at school (100 miles or more), On Call International will provide a benefit of up to \$2,500 for the student to return home. In all cases On Call International must make and pay for the travel arrangements. There is no reimbursement for transportation if made by the student, family or school.

Identity Theft Recovery Assistance: On Call International has an Identity Theft Recovery Unit who will listen, document, support, and guide participants who experience identity theft.

U.S. & Canada Toll Free: 866-525-1955 **International Collect:** 603-328-1955

Note: The On Call related services listed above are not insurance and are not connected with or provided by Monumental Life Insurance Company.

CLAIM PROCEDURES

1. Complete a claim form, which is available on-line at our website, www.BollingerColleges.com/FIT. Please read and follow the instructions provided on the back of the claim form carefully.
2. The claim form must be completed and signed. Written Proof of Loss (itemized bills) must be furnished with the claim within 90 days from the date of loss. Mail the claim to the address on the form.
3. Preauthorization and pre-certification of the benefits to providers of medical service are not required nor provided by us.
4. No claim will be processed until a Bollinger, Inc. claim form is received.

For Information contact the Plan Administrator:



P.O. Box 727

Short Hills, NJ 07078-0727

866-267-0092 (Claims/Coverage)

800-526-1379 (Other Questions)

www.BollingerColleges.com/fit

PLAN ADMINISTRATOR



P.O. Box 727
Short Hills, NJ 07078-0727
866-267-0092 (Claims/Coverage)
800-526-1379 (Other Questions)
www.BollingerColleges.com/svc

PREFERRED PROVIDER NETWORK



www.MyFirstHealth.com

PLEASE KEEP THIS BROCHURE AS A GENERAL SUMMARY OF THE INSURANCE BENEFITS. The Master Policy on file at the school contains all of the provisions, limitations, exclusions and qualifications of your insurance benefits, some of which may not be included on this brochure. If any discrepancy exists between the brochure and the Policy, the Master Policy will govern and control the payment of benefits.

This brochure provides a description of your insurance program. You may obtain a complete certificate of insurance, including your appeal rights and grievances procedures, by accessing www.BollingerColleges.com/FIT

FLORIDA INSTITUTE OF TECHNOLOGY
Student Medical Benefit Plan - I.D. Card

This is to certify that as of August 10, 2013, insurance coverage is provided in accordance with all terms and provisions of Policy No. CFL221J issued to the above named college for the student named below.

Name _____ Student ID # _____

Street Address _____

Town _____ State _____ Zip Code _____

This coverage expires August 10, 2014

UNDERWRITTEN BY:
MONUMENTAL LIFE
INSURANCE COMPANY
Cedar Rapids, Iowa

ADMINISTERED BY:
Bollinger
Insurance Solutions

PREFERRED PROVIDER NETWORK:



PO Box 727
Short Hills, NJ 07078
1-866-267-0092

Monumental Life Insurance Company: Florida Institute of Technology Student Injury and Sickness Plan

Coverage Period: 08/10/2013 – 08/09/2014
 Coverage for: Individual | Plan Type: PPO

Summary of Benefits and Coverage: What this Plan Covers & What it Costs



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.BollingerColleges.com/FIT, or by calling 1-866-267-0092.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$75 in network \ \$250 out of network per Policy Year. Does not apply to In-Network preventative and wellness services or treatment provided at the Student Health Center.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1 st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	No.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	No.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	This plan has no out-of-pocket limit.	Not applicable because there is no out-of-pocket limit on your expenses.
Is there an overall annual limit on what the plan pays?	No.	Coverage is limited to \$500,000 aggregate maximum per Policy Year. The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.MyFirstHealth.com or call 1-800-226-5116 for a list of participating providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.

Questions: Call 1-866-267-0092 or visit us at www.BollingerColleges.com/FIT

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You can view the Glossary

Monumental Life Insurance Company: Florida Institute of Technology Student Injury and Sickness Plan

Coverage Period: 08/10/2013 – 08/09/2014

Coverage for: Individual | Plan Type: PPO

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Are there services this plan doesn't cover?	Yes.
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Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services.

! Co-payments are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Co-insurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount, e, if the plan's allowed amount for an overnight hospital stay is \$1,000, your co-insurance payment of 20% would be \$200. This may change if you haven't met your deductible.

- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the allowed amount is \$1,000, you may have to pay the \$500 difference. (This is called balance billing.)
- This plan may encourage you to use in-network providers by charging you lower deductibles, co-payments and co-insurance amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out of Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 co-pay/visit and 20% co-insurance	\$25 co-pay/visit and 40% co-insurance	Services that are normally provided without charge at the student health center are not covered.
	Specialist visit	\$25 co-pay/visit and 20% co-insurance	\$25 co-pay/visit and 40% co-insurance	
If you have a test	Other practitioner office visit	No charge	40% co-insurance	none
	Preventive care/screening/immunization	No charge	40% co-insurance	
	Diagnostic test (x-ray, blood work)	20% co-insurance	40% co-insurance	
If you need drugs to treat your illness or condition More information	Imaging (CT/PET scans, MRIs)	20% co-insurance	40% co-insurance	none
	Generic drugs	\$15 co-payment for generic		

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Monumental Life Insurance Company: Florida Institute of Technology Student Injury and Sickness Plan

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about prescription drug coverage is available at www.caremark.com.	Brand name Specialty drugs	\$25 co-payment for brand name or \$50 co-payment for specialty drugs, per prescription	
	If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center) Physician/surgeon fees	20% co-insurance 20% co-insurance 40% co-insurance 40% co-insurance
If you need immediate medical attention	Emergency room services	\$250 co-pay/visit and 20% co-insurance	Services that are normally provided without charge at the student health center are not covered. Co-pay waived, if Admitted. Medical Emergency covered at In Network. co-insurance amounts
	Emergency medical transportation	20% co-insurance	Medical Emergency covered at In Network co-insurance amounts
	Urgent care	20% co-insurance	Services that are normally provided without charge at the student health center are not covered.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	40% co-insurance
	Physician/surgeon fee	\$25 co-pay/visit and 20% co-insurance	\$25 co-pay/visit and 20% co-insurance
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% co-insurance other outpatient services	40% co-insurance other outpatient services
	Mental/Behavioral health inpatient services	20% co-insurance	40% co-insurance
	Substance use disorder outpatient services	20% co-insurance other outpatient services	40% co-insurance other outpatient services
If you are pregnant	Substance use disorder inpatient services	20% co-insurance	40% co-insurance
	Prenatal and postnatal care	20% co-insurance	40% co-insurance

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Coverage for: Individual | Plan Type: PPO

	20% co-insurance	40% co-insurance	none
Delivery and all inpatient services	20% co-insurance	40% co-insurance	none
Home health care	20% co-insurance	40% co-insurance	Coverage is limited to one visit per day
Rehabilitation services	20% co-insurance	40% co-insurance	Coverage is limited to one visit per day
Habilitation services	20% co-insurance	40% co-insurance	Coverage is limited to one visit per day
Skilled nursing care	20% co-insurance	40% co-insurance	Coverage is limited to one visit per day
Durable medical equipment	20% co-insurance	40% co-insurance	none
Hospice service	Not Covered	Not Covered	none

If you need help recovering or have other special health needs

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Elective Surgery or treatment
- Bariatric surgery
- Eyeglasses
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private duty nursing
- Routine eye care (Adult)
- Routine foot care
- Treatment for Acne

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (if prescribed for rehabilitation purposes)
- Chiropractic care
- Elective Abortion
- Hearing aids
- Weight loss programs
- Non-emergency care when traveling outside the U.S.
- Dental Treatment for Impacted Wisdom Teeth

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Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your premium. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-866-267-0092. You may also contact your state insurance department at 1-877-693-5236.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: The Florida Department of Financial Services at 1-877-693-5236 or on the web at <https://apps.flds.com/E-SERVICE/Default.aspx>

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

————— *To see examples of how this plan might cover costs for a sample medical situation, see the next page.* —————

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Coverage Examples

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$5,612
- Patient pays \$1,928

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$75
Co-pays	\$450
Co-insurance	\$1,403
Limits or exclusions	\$0
Total	\$1,928

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,580
- Patient pays \$820

Sample care costs:

Prescriptions	\$2,900*
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$760**
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$0
Co-pays	\$560
Co-insurance	\$260
Limits or exclusions	\$0
Total	\$820

* Assume \$100 per Generic Rx in this scenario

** Assume 5 visits in this scenario

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your

providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in **out-of-pocket costs**, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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