AIG Benefit Solutions

Flagler College

(“the Policyholder”)

2015 – 2016
Student Health Insurance Plan

(“the Plan”)

Administrator Policy Number: CHH8050676
Underwriter Reference Number: CAS9149537

Insurance underwritten by: National Union Fire Insurance Company of Pittsburgh, Pa.,
with its principal place of business in New York, NY (“the Company”)

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-FL (Rev. 1-15). The Policy and Certificate on file at the College contains definitions, reductions, limitations, exclusions and termination provisions. Full details of the coverage are contained in the Policy and Certificate of Coverage. A Certificate of Coverage is available to the Covered Student upon request. If there is any conflict between the contents of this brochure and the Policy, the Policy shall govern. Travel Assistance services provided by Travel Guard Group, Inc. (“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.

Revised, 11/23/2015

AIG

FLAGLER COLLEGE

ELIGIBILITY

All students taking 6 or more credits at Flagler College will be automatically enrolled in and charged premium for coverage under the Flagler College Student Health Insurance Plan ("the Plan") unless coverage under the Plan is waived by showing 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/Flagler or they will automatically be billed for the insurance and the premium will be added to their student account. Waivers must be submitted by **September 11, 2015** for the Annual coverage term, or by **January 13, 2016** for the Spring/Summer coverage term (available to new students to the College in the Spring/Summer semester only).

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. If a student experiences ineligibility under another creditable coverage, he or she can email proof of ineligibility to qualifier@studentinsurance.com.

An eligible student must actively attend classes at the College for at least the first 30 days of the period for which he or she is enrolled. Except in the case of withdrawal due to Sickness or Injury, any student withdrawing from school during the first 30 days of the period for which he or she is enrolled will not be covered under the Plan and a full refund of premium will be made less any claims paid. Students who withdraw after such 30 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. The Company maintains the right to investigate student status and attendance records to verify that the Policy eligibility requirements have been met. If it is discovered that the Policy eligibility requirements have not been met, the Company's only obligation is to refund premium less any claims paid.

Eligible students may also enroll their eligible Dependents. An eligible Dependent is the Covered Student's Spouse residing with the Covered Student and the Covered Student's or Spouse's child until the date such child attains age 26, provided such child is not provided coverage under an employer-sponsored health plan through his or her own employment. A Dependent may become eligible for coverage under the Plan only when the student becomes eligible. A Covered Student my enroll his or her Dependents by

completing the enrollment process and paying the appropriate premium by **September 11, 2015** for the Annual coverage term, or by **January 13, 2016** for the Spring/Summer coverage term (available to Dependents of new students to the College in the Spring/Summer semester only). To enroll Dependent(s), Covered Students should contact the College Enrollment Department at Bollinger Specialty Group by calling 1-800-526-1379.

2015 – 2016 STUDENT HEALTH INSURANCE COST OF INSURANCE*

Term of Coverage	Annual 8/1/15 – 8/1/16	Spring/Summer** 1/01/16 – 8/1/16
Student Only	$1,775	$1,105
Each Dependent	$1,775	$1,105

*includes premium taxes and fees

**Spring/Summer semester-only coverage for students new to the school in the spring/summer semester.

EFFECTIVE AND TERMINATION DATES

The Policy becomes effective at 12:01 a.m. on August 1, 2015 and terminates at 12:01 a.m. on August 1, 2016. The coverage of an eligible student, including the student who initially waived coverage and subsequently enrolls within 31 days of ineligibility under another creditable coverage, 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; or (3) 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 Dependent may become eligible for coverage under this Policy only when the student becomes eligible.

Insurance for a Covered Student will end at 12:01 a.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:
    1. because of entering the armed forces of any country (premiums will be refunded on a pro-rata basis when written request is made); or
    2. when the withdrawal from school is during the first 30 days of the period for which the student is enrolled (a full refund of premium will be made (less any claims paid) when written request is made within 30 days of leaving school).

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, insurance for a Covered Student's Dependent will end when insurance for the Covered Student ends.

EXTENSION OF BENEFITS

In the event of a Total Disability: If the Covered Person is Totally Disabled on the date the Policy terminates as a result of Sickness or Injury, benefits will be payable for Eligible Expenses incurred until the earliest of: (1) the end of that Total Disability; (2) 12 months from the date the Policy terminates; or (3) the date the applicable Maximum Amount is reached.

Extension of benefits in the event of Total Disability is required regardless of whether the Policyholder or other entity secures replacement coverage from a new insurer or forgoes the provision of coverage.

In the event of Sickness or Injury: If the Covered Person is receiving treatment for a Sickness or Injury on the date the Policy terminates, benefits will be payable for Eligible Expenses incurred for that Sickness or Injury until the earliest of: (a) the date the Covered Person is no longer receiving treatment for that Sickness or Injury; (b) 12 months from the date the Policy terminates; or (c) the date the applicable Maximum Amount is reached.

In the event of pregnancy: If the Covered Person is pregnant on the date the Policy terminates, benefits will be payable for Eligible Expenses incurred until the earlier of: (a) the date the period of pregnancy ends; or (b) the date the applicable Maximum Amount is reached.

In the event of dental treatment: Dental benefits, if provided, shall extend to the end of a 90 day period after the Covered Person's coverage terminates under the Policy providing such coverage did not terminate as a result of the Covered Person or parent of the Covered Person voluntarily terminating coverage under the Policy.

In the event of Hospital Confinement: If a Covered Person is confined to a Hospital on the date the Policy terminates, benefits will be payable for the Eligible Expenses incurred during the continuation of that Hospital Confinement. Such benefits will be payable until the

earliest of: (1) the date the Hospital Confinement ends; (2) the end of the 30 day period following the date the Policy terminated; or (3) the date the applicable Maximum Amount is reached.

The Extension of Benefits will apply only to the extent the Covered Person will not be covered under the Policy or any other health insurance policy in the ensuing term of coverage.

DEFINITIONS

Whenever used in the Policy:

“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.

“Act” means the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

“Actual Charge” means the charge for the covered service by the provider who furnishes it.

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

"Complications of Pregnancy" means conditions which require Hospital stays before the pregnancy ends and whose diagnoses are distinct from but are caused or affected by pregnancy. These conditions are:
- acute nephritis or nephrosis; or
- pre-eclampsia; or
- eclampsia; puerperal infection; or
- RH Factor problems; or
- severe loss of blood requiring transfusion; or
- cardiac decompensation or missed abortion; or
- similar conditions as severe as these.

Not included are (a) false labor, occasional spotting or Doctor prescribed rest during the period of pregnancy; (b) morning sickness; (c) hyperemesis gravidarum; and (d) similar conditions not medically distinct from a difficult pregnancy. Complications of Pregnancy also include:
- non-elective cesarean section; and
- termination of an ectopic pregnancy; and
- spontaneous termination when a live birth is not possible. (This does not include voluntary or elective abortion.)

“Coinsurance” means the percentage of the Eligible Expense payable by the Covered Person under the Plan.

“Co-pay” means the initial dollar amount payable by the Covered Person for an Eligible Expense at the time service is rendered.

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

“Covered Person” means a Covered Student and his or her Dependent(s) insured under the Policy.

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

“Deductible/Deductible Amount” means the dollar amount of Eligible Expenses a Covered Person must pay during each Policy Year before benefits become payable.

“Dependent” means: (a) the Covered Student’s Spouse residing with the Covered Student; and (b) the Covered Student’s or Spouse’s child until the date such child attains age 26.

The term “child” includes:
(a) a Covered Student’s legally adopted child, foster child or other child in court-ordered custody who is placed in compliance with Chapter 63 of the Florida Statutes;
(b) a child who has been placed in the Covered Student’s home pending adoption procedures; or other child placed in compliance with Chapter 63 of the Florida Statutes from the moment of placement in the Covered Student’s residence; and
(c) a step-child if such child depends on the Covered Student or Spouse for full support.

“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.

"Durable Medical Equipment" consists of, but is not restricted to, the initial fitting and purchase of braces, trusses and crutches, renal dialysis equipment, hospital-type beds, traction equipment, wheelchairs and walkers. Durable Medical Equipment must be prescribed by the attending Doctor and be required for therapeutic use.

The following items are not considered to be Durable Medical Equipment: adjustments to vehicles, air conditioners, dehumidifiers and humidifiers, elevators and stair glides, exercise equipment, handrails, improvements made to a home or place of business, ramps, telephones, whirlpool baths, and other equipment which has both a non-therapeutic and therapeutic use.

"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; treatment for weight reduction; learning disabilities; treatment of infertility.

"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 except with respect to any expenses payable under the extension of benefits provision.

"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.

"Experimental/Investigational" means a drug, device or medical care or treatment that meets the following:

(a) the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
(b) the informed consent document used with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigational phase, if such a consent document is required by law;
(c) the drug, device, medical care or treatment or the patient's informed consent document used with the drug, device, medical care or treatment was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, if federal or state law requires such review and approval;
(d) reliable evidence shows that the drug, device or medical care or treatment is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, it efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

(e) reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical care or treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with standard means of treatment of diagnosis.

Reliable evidence means: published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility studying substantially the same drug, device, medical care or treatment; or the written informed consent used by the treating facility or other facility studying substantially the same drug, device or medical care or treatment. Eligible Expenses will be considered in accordance with the drug, device, medical care or treatment at the time the Expense is incurred.

“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; or (b) as a nursing or rest home; or (c) as a place for custodial or educational care. The term “Hospital” includes: (a) a substance abuse treatment facility during any period in which it provides effective treatment of substance abuse to the Covered Person; (b) an ambulatory surgical center or ambulatory medical center; (c) a mental health hospital if supervised and licensed by the Department of Mental Health; and (d) 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.

“Hospital Confinement/Hospital Confined” means a stay of at least 18 consecutive hours or for which a room and board charge is made.

“Immediate Family Member(s)” means a person who is related to the Covered Person in any of the following ways: Spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted or stepchild), or any individual who lives in the household of the Covered Person.

“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.

"One Sickness" means a Sickness and all recurrences and related conditions which are sustained by a Covered Person.

"Orthopedic Brace and Appliance” means a supportive device or appliance used to treat a Sickness or Injury.

"Personal Item" is one which is not needed for proper medical care and is used mainly for the purpose of meeting a personal need.

“Physiotherapy” means any form of the following administered by a Doctor for treatment of Sickness or Injury: physical or mechanical; diathermy; ultra-sonic therapy; heat treatment in any form; or manipulation or massage.

“Policy Year” means the period of time measured from the effective date to the termination date as shown in the schedule of benefits in the Policy on file with the Policyholder.

“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. Sickness also includes pregnancy and complications of pregnancy. All Sicknesses due to the same or a related cause are considered One Sickness.

“Sound Natural Teeth” means natural teeth, the major portion of the individual tooth which is present regardless of fillings and is not carious, abscessed, or defective. Sound Natural Teeth will not include capped teeth.

“Spouse” means the Covered Student’s legal Spouse

“Student Health Service” means any organization, facility or clinic owned, operated, maintained or supported by the Policyholder.

“Totally Disabled” and “Total Disability” means Injury or Sickness which wholly and continuously keeps the Covered Person, (a) with respect to a Covered Student: from attending classes at the location where he or she is enrolled; and (b) with respect to a Dependent, or a student if such classes are not in session, from doing those activities that are normal for a person in good health of the same age and sex.

FIRST HEALTH PROVIDER NETWORK

Covered Persons insured under the Plan may choose to be treated within or outside of the First Health Preferred Provider Organization (“PPO”). Reimbursement rates will vary according to the source of care as described under the Schedule of Benefits. Assignment of a PPO Provider does not guarantee eligibility or right to student health benefits. **It is the Covered Person’s responsibility to verify that a provider is a Participating Provider prior to services being rendered.** Please be aware that if a Covered Person is treated at a PPO Hospital, it does not mean that all providers at the Hospital are PPO providers. In addition, if a Covered Person is referred by a PPO provider to another provider or facility, it does not mean that the provider or the facility to which the Covered Person is referred is also a PPO provider. For treatment or care received outside the PPO geographic service area, benefits for Eligible Expenses will be payable at the Out of Network level. If treatment or care is received in a non-PPO facility because of an Emergency Medical Condition, benefits for Eligible Expense are payable at the In Network level. Benefits payable under the Plan for covered services rendered through the PPO network shall be based on the Allowable Charges of its providers. Benefits payable under the Plan for covered services rendered outside the PPO network shall be based on the Reasonable and Customary charges of the providers. To locate a PPO Provider, please call1-800-226-5116 or visit www.MyFirstHealth.com.

COORDINATION OF BENEFITS PROVISION

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.

MANDATED BENEFITS

The Plan will cover all applicable state mandates. Please see the Policy on file with the College for details.

FLAGLER COLLEGE SCHEDULE OF BENEFITS

	IN-NETWORK	OUT-OF-NETWORK
Aggregate Maximum Benefit per Policy Year per Covered Person	Unlimited	
Out-of-Pocket Limit In Network: $5,000 Per Covered Person per Policy Year / $12,700 Per Family Per Policy Year. Out-of-Pocket Limit Out of Network: $25,000 Per Covered Person per Policy Year / $63,500 Per Family Per Policy Year. This is a benefit that will apply in a Policy Year to a Covered Person who in that year reaches the Out-of-Pocket Limit shown above. The Out-of-Pocket Limit is reached when the amount of Eligible Expenses incurred by the Covered Person during the Policy Year for which the Covered Person is responsible due to Covered Percentages being less than 100%, reach the Out-of-Pocket Limit. The Out-of-Pocket Limit includes Coinsurance. The Out-of-Pocket Limit does not include charges in excess of Reasonable and Customary; charges in excess of any specified maximum or charges incurred for any services not covered under the Policy. When this benefit 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 in the remainder of that Policy Year up to any benefit maximum that may apply. If, in any Policy Year, the sum of Eligible Expense used toward the Out-of-Pocket Limit of a Covered Student and his or her covered Dependents equals the Family Out-of-Pocket shown in the Schedule of Benefits, the Out-of-Pocket Limit will be deemed to be met with respect to Eligible medical Expense incurred by such Covered Student and his covered Dependents for the rest of that Policy Year. When the Family Out-of-Pocket Limit is reached, the Covered Percentage will be increased to 100% of the Eligible Expenses incurred for the remainder of that year.		
Deductible Amount per Policy Year	Per Covered Person: $250 Per Family: $500	Per Covered Person: $500 Per Family $1,000
INPATIENT BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Daily Room and Board (average semi-private rate)	70% of Allowable Charge (“AC”)	50% of Reasonable & Customary (“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-pay per Hospital admission / 70% of AC	$150 Co-pay per Hospital admission / 50% of R&C
Physiotherapy, occupational therapy, cardiac/pulmonary therapy during Hospital Confinement	70% of AC	50% of R&C
Surgical Expense	70% of AC	50% of R&C
Assistant Surgeon (Inpatient Only)	70% of AC	50% of R&C
Anesthesia	70% of AC	50% of R&C
In-Hospital Doctor’s Fees Expense (other than a Doctor who performed surgery or administered anesthesia), limited to one visit per day and not related to Physiotherapy	$20 Co-pay per visit/70% of AC	$20 Co-pay per visit/50% of R&C
Mental and Nervous Disorders Expense	Same as any other Sickness	Same as any other Sickness
Alcoholism & Substance Abuse Expense	Same as any other Sickness	Same as any other Sickness
OUTPATIENT BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Surgical Expense	70% of AC	50% of R&C
Anesthesia	70% of AC	50% of R&C
Day Surgery Facility / Miscellaneous, when scheduled surgery is performed in a Hospital, outpatient facility or 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)	70% of AC	50% of R&C

Hospital Emergency Room and Non Scheduled Surgery For use of Hospital Emergency Room, including attending Doctor's charges, operating room, laboratory and x-ray examinations, supplies. The Co-pay amount will apply to each visit to the Hospital Emergency Room unless the Covered Person is admitted to the Hospital as an inpatient.	$250 Co-pay per visit/70% of AC	$250 Co-pay per visit/70% of R&C
Preventive Services includes Preventive Services such as screenings, exams, and immunizations as specified by the Patient Protection and Affordable Care Act. To view a list of covered Preventive Services, log onto www.healthcare.gov/preventive-care-benefits/	100% of AC (Deductible and Co-pay waived)	50% of R&C (Deductible and Co-pay apply)
Allergy Testing and Serum	$20 Co-pay per visit / 70% of AC	$20 Co-pay per visit/ 50% of R&C
Laboratory and X-ray Examinations (not otherwise covered under Preventive Services)	$20 Co-pay per visit / 70% of AC	$20 Co-pay per visit / 50% of R&C
CAT Scan/MRI and/or PET Scan	$20 Co-pay per visit / 70% of AC	$20 Co-pay per visit / 50% of R&C
Radiation Therapy and Chemotherapy	$20 Co-pay per visit / 70% of AC	$20 Co-pay per visit / 50% of R&C
Durable Medical Equipment and Orthopedic Appliance (no benefits will be payable for rental charges in excess of the purchase price)	70% of AC	50% of R&C
Orthopedic Braces and Appliances (benefits are payable only upon Doctor's written prescription)	70% of AC	50% of R&C
Diagnostic Services and medical procedures performed by the Doctor (other than Doctor's visits, Physiotherapy, x-rays and lab procedures) (not otherwise covered under Preventive Services)	$20 Co-pay per visit / 70% of AC	$20 Co-pay per visit / 50% of R&C
Respiratory Therapy	$20 Co-pay per visit / 70% of AC	$20 Co-pay per visit / 50% of R&C
Rehabilitative Services/Habilitative Services (Physiotherapy, limited to 35 visits per Injury or Sickness, Occupational Therapy, limited to 35 visits per Injury or Sickness, Chiropractic, limited to 35 visits per Injury or Sickness, Cardiac/Pulmonary, limited to 35 visits per Injury or Sickness)	$20 Co-pay per visit / 70% of AC	$20 Co-pay per visit / 50% of R&C
Dialysis and Filtration Procedures	$20 Co-pay per visit / 70% of AC	$20 Co-pay per visit / 50% of R&C
Intravenous Home Therapy	$20 Co-pay per visit / 70% of AC	$20 Co-pay per visit / 50% of R&C
Out of Hospital Doctors Fees Expense Doctor (other than Specialist) / Specialist Limited to one visit per day and does not apply when related to surgery. Includes injections when administered in the Doctor's office. Includes infusion therapy.	$10 Co-pay per visit / 100% of AC	$20 C0-pay per visit / 100% R&C
Consultant's Fees Expense (must be requested and ordered by the attending Doctor)	70% of AC	50% of R&C
Ambulance Expense	70% of R&C	
Dental Treatment (Injury Only to Sound Natural Teeth): $500 maximum per Injury	70% of AC	70% of R&C

Pediatric Dental Treatment Expense* (for Covered Persons under age 19 only) - Oral exam limited to 2 per Policy Year. Covered Percentage: • Diagnostic and Preventive Services • Basic Services • Major services • Orthodontic Services Co-pay Amount per visit *This coverage does not include orthodontic services for which treatment began prior to the effective date, nor will benefits be paid for gold foil restoration, gold fillings, inlays, crowns, bridges, and dentures. Please see the complete Policy on file with the College for full details.	 50% of R&C 50% of R&C 50% of R&C 50% of R&C $25	 50% of R&C 50% of R&C 50% of R&C 50% of R&C $25
Prescribed Medicines Expense – prescriptions must be filled at a Catamaran participating pharmacy. Benefits are based on a mandatory generic formulary. If the Covered Person or the Covered Person's Doctor chooses a brand-name drug, the Covered Person will pay the difference between the brand-name drug and the generic. The Co-pay will be waived for prescribed FDA-approved birth control. For a list of nationwide participating pharmacies, please visit www.mycatamaranrx.com.	Co-pay per prescription – limited to a 30 day supply: $15 - Generic $35 - Formulary Brand Name $80 - Non-Formulary Brand Drug	
Mental and Nervous Disorders Expense	Same as any other Sickness	Same as any other Sickness
Alcoholism and Substance Abuse Expense	Same as any other Sickness	Same as any other Sickness
Vision Care Expense – One routine exam per Policy Year and one set of lenses and frames per Policy Year Co-pay Amount Per visit: • Examination • Materials Covered Percentage (examination and materials) Maximum: Standard Plastic Lenses • Single vision • Bifocal • Trifocal • Lenticular • Progressive Frames Contact Lenses (In lieu of eyeglass lenses and frames) Fit, Follow-up & Materials: • Effective • Medically Necessary Please see the complete Policy on file with the College for full details.	 $25 $25 50% of R&C $150 $150 $150 $150 $150 $150 $150 $150	 $25 $25 50% of R&C $150 $150 $150 $150 $150 $150 $150 $150
Home Health Care Expense	70% of AC	50% of R&C
Hospice Care Expense	70% of AC	50%of R&C
Urgent Care Expense	$20 Co-pay per visit /70% of AC	$20 Co-pay per visit /50% of R&C
Maternity Care	70% of AC	50% of R&C
Skilled Nursing Facility	Same as any other Sickness	Same as any other Sickness

REPATRIATION OF REMAINS AND MEDICAL EVACUATION BENEFITS

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.

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. Please see page 12 for a description of the Travel Guard services and for procedures on how to contact Travel Guard.

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. Please see page 12 for a description of the Travel Guard services and for procedures on how to contact Travel Guard.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

MAXIMUM AMOUNT: $10,000

The Company will pay the benefit below for Injuries to a Covered Person:

(a) caused by an Accident which happens while covered by the Policy; and

(b) which directly, and from no other cause, result in any of the losses listed below within 180 days of the Accident that caused the Injury.

The amount of this benefit is shown in the table below.

For Loss of	Percentage of Maximum Amount
Life	100%
Both Hands or Both Feet	100%
Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and the Sight of One Eye	100%
One Foot and the Sight of One Eye	100%
Speech and Hearing in Both Ears	100%
One Hand or One Foot	50%
The Sight of One Eye	50%
Speech or Hearing in Both Ears	50%
Hearing in One Ear	25%
Thumb and Index Finger of Same Hand	25%

"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. "Loss" of hearing in an ear means total and irrecoverable loss of the entire ability to hear in that ear. "Loss" of speech means total and irrecoverable loss of the entire ability to speak. "Loss" of thumb and index finger means complete severance through or above the metacarpophalangeal joint of both digits.

"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.

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 Essential Health Benefits mandated by the Patient Protection and Affordable Care Act.
2. for services normally provided without charge by the Policyholder's health service, infirmary or Hospital, or by health care providers employed by the Policyholder or services covered by the Student Health Service fee.
3. for eyeglasses, contact lenses, or prescription for such, except as specifically provided in the Policy; radial keratotomy or laser

surgery. This exclusion does not apply to Essential Health Benefits mandated by the Patient Protection and Affordable Care Act.
4. for hearing examinations or hearing aids except as specifically provided in the Policy.
5. 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.
6. as a result of an Injury or Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law.
7. as a result of Injury sustained or Sickness contracted while in the service of the Armed Forces of any country. Upon the Covered Person entering the Armed Forces of any country, the Company will refund any unearned pro-rata premium. This does not include Reserve or National Guard Duty for training unless it exceeds 31 days.
8. for treatment provided in a government Hospital unless there is a legal obligation to pay such charges in the absence of insurance.
9. for cosmetic surgery except as required to correct an Injury. "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 newborn child which has resulted in a functional defect to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to do either of the following: (a) improve function; or (b) create a normal appearance, to the extent possible; or (c) as specifically provided for in the Policy. It also shall not include breast reconstructive surgery after a mastectomy.
10. as a result of committing or attempting to commit an assault or felony or participation in a felony.
11. for Elective Treatment or elective surgery, except as specifically provided in the Policy.
12. for any services rendered by a Covered Person's Immediate Family Member.
13. for any treatment, service or supply which is not Medically Necessary.
14. for surgery and/or treatment of: acne; breast implants or breast reduction unless Medically Necessary following a mastectomy; circumcision; deviated nasal septum, including submucuous resection and/or other surgical correction thereof; infertility(male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; learning disabilities; nonmalignant warts, moles and lesions; obesity and any condition resulting therefrom (including hernia of any kind, diabetes or heart disease); premarital examinations; and vasectomy.
15. for routine physical examinations, health examinations or preschool physical examinations. This exclusion does not apply to Preventive Services mandated by the Patient Protection and Affordable Care Act.
16. for sterilization except as specifically provided or sterilization reversal, including surgical procedure and devices or for birth control except prescription contraceptives drugs and devices.
17. 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.
18. for voluntary or elective abortions.
19. for Injury resulting from; the practicing for, participating in, or traveling as a team member to and from interscholastic, intercollegiate, or professional and semi-professional sports; skin diving; sky diving; or mountaineering (where ropes or guides are customarily used); or any other hazardous sport of hobby.
20. for rest cures or custodial care; care provided in: rest homes; health resorts; homes for the aged; halfway houses; college infirmaries or places mainly for domiciliary or custodial care; extended care in treatment or substance abuse facilities for domiciliary or custodial care.
21. for Injury resulting from fighting, except in self-defense.

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 Center

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.

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 nonmedical situation such as lost luggage, lost documents,

legal help, etc.

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 you should the need arise while you are traveling or away from home. The Travel Guard Medical Staff consists of full-time, onsite Registered Nurses and Emergency Physicians 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 physician has daily responsibility for a 24-hour period and is on-site during daytime hours.

What information will you need to provide Travel Guard when you call:

- Advise Travel Guard of 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 and 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 enroute emergencies that force them to interrupt their trips.

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

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
- In-patient Assistance
- Out-patient Assistance

Medical Transport:

- Medical Evacuation
- Repatriation of Remains

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 www.aig.com/travelguardassistance.com

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 9497226 and then click “Submit.”

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

(American Health Holding, Inc. is not affiliated with National Union Fire Insurance Company of Pittsburgh, Pa.)

For confidential health care advice and information, 24 hours a day, 365 days a year, call toll-free (866) 315-8756

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.

CLAIM PROCEDURE

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

1. Notify Bollinger, Inc. within 30 days after the date of the Injury or commencement of the Sickness, or as soon thereafter as is reasonably possible. Complete the Bollinger claim form in full and sign it.
   Mail a copy to Bollinger, Inc., PO Box 1329, Morristown, NJ 07962.
2. Claim forms are available online at www.BollingerColleges.com/Flagler or by calling 1-866-267-0092. 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, Inc. Online claim status is available at www.BollingerColleges.com/Flagler or by calling 1-866-267-0092.
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.

PLAN ADMINISTERED BY

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

PO Box 1329
Morristown, NJ 07962

1-800-526-1379

Visit our website at: www.BollingerColleges.com/Flagler

Broker

Thompson Baker Agency, Inc.
St. Augustine, FL
www.thompsonbaker.com

Preferred Provider Network:

First Health
www.MyFirstHealth.com

Student Health Insurance

AIG, Higher Education

Website: www.studentinsurance.com

Toll Free: 1-888-722-1668

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