Goshen College: Student Health Insurance Plan (Policy #CLSP0051-13): Companion Life Insurance Company

Coverage Period: 8/15/2013 - 8/14/2014

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

Coverage for: Insured Student+Dependent | **Plan Type:** PPO

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.gallagherkoster.com/goshen** or by calling **1-877-320-4347**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$150 per plan year In-Network (doesn't apply to preventive care); $250 per plan year Out-of-Network	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 1st). 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 don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes, **$6,250** person	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?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	Yes, $500,000.	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes specific coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. For a list of preferred providers, see www.gallagherkoster.com/goshen or call 1-877-320-4347.	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?	Yes (deductible is waived if SHC referral provided)	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call **1-877-320-4347** or visit us at **www.gallagherkoster.com/goshen**

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.cciio.cms.gov** or call 1-877-320-4347 to request a copy.

Rev. 9-18-2013

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** 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 **participating providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance, $25 copayment per visit, no deductible	40% coinsurance	Limited to one visit per day.
	Specialist visit	0% coinsurance, $40 copayment per visit, no deductible	40% coinsurance	You must have the plan's permission before you see the **specialist**. Limited to one visit per day.
	Other practitioner office visit	0% coinsurance, $40 copayment per visit, no deductible	40% coinsurance	Limited to one visit per day.
	Preventive care/screening/immunization	No Charge	40% coinsurance, $400 maximum benefit per plan year	Coverage is subject to limits on the number of visits, specific dollar amounts paid by the issuer, and age requirements in accordance with the terms of the policy and state and federal guidelines.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	----------none----------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	----------none----------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at	Generic drugs	$15 copayment/ prescription (retail)	$15 copayment/ prescription (retail)	Limited to a 30-day supply per prescription. Prescriptions filled at non-Express Scripts pharmacies are not covered.
	Preferred brand drugs	$30 copayment/ prescription (retail)	$30 copayment/ prescription (retail)	
	Non-preferred brand drugs	$50 copayment/ prescription (retail)	$50 copayment/ prescription (retail)	
	Specialty drugs	Not Covered	Not Covered	Specialty drugs are not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	----------none----------
	Physician/surgeon fees	20% coinsurance	40% coinsurance	----------none----------
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance for Medical Emergency, otherwise 40% coinsurance	$150 copayment per visit (waived if admitted as an inpatient).
	Emergency medical transportation	20% coinsurance	20% coinsurance	----------none----------
	Urgent care	20% coinsurance	20% coinsurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Facility fee limited to semi-private room rate.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	0% coinsurance	40% coinsurance	$25 copayment per visit
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	Paid as any other Sickness
	Substance use disorder outpatient services	0% coinsurance	40% coinsurance	$25 copayment per visit
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	Paid as any other Sickness
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	----------none----------
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	----------none----------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	----------none----------
	Rehabilitation services	20% coinsurance	40% coinsurance	----------none----------
	Habilitation services	20% coinsurance	40% coinsurance	----------none----------
	Skilled nursing care	20% coinsurance	40% coinsurance	----------none----------
	Durable medical equipment	20% coinsurance	40% coinsurance	----------none----------
	Hospice service	20% coinsurance	40% coinsurance	----------none----------
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Not Covered
	Glasses	Not Covered	Not Covered	Not Covered
	Dental check-up	Not Covered	Not Covered	Not Covered

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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Eye exam, glasses, dental check-up (Child)
- Hearing aids
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Specialty drugs
- Weight loss programs

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.)

- Chiropractic care
- Private-duty nursing
- Intercollegiate Sports $1,000 lifetime maximum per Injury

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 1-877-320-4347. You may also contact your state insurance department at: Indiana Department of Insurance, Consumer Services Division, 311 West Washington Street, Suite 300, Indianapolis, IN 46204 (317) 232-2426 http://www.in.gov/idoi/.

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: Indiana Department of Insurance, Consumer Services Division, 311 West Washington Street, Suite 300, Indianapolis, IN 46204 (317) 232-2426 http://www.in.gov/idoi/.

Additionally, a consumer assistance program can help you file your appeal. Contact: Indiana Department of Insurance, Consumer Services Division, 311 West Washington Street, Suite 300, Indianapolis, IN 46204 (317) 232-2426 http://www.in.gov/idoi/.

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

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** $5,810
- **Patient pays** $1,730

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	$200
Copays	$30
Coinsurance	$1,500
Limits or exclusions	$0
Total	**$1,730**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,170
- **Patient pays** $1,230

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$200
Copays	$30
Coinsurance	$1,000
Limits or exclusions	$0
Total	**$1,230**

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**, **copayments**, and **coinsurance** 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 **copayments**, **deductibles**, and **coinsurance**. 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.