Wheaton College: Student Health Insurance Plan: (Policy #2014-S3-A27) Companion Life Insurance Company

Coverage Period: 8/1/2014 - 7/31/2015

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.gallagherstudent/WheatonIL or by calling 1-877-320-4347.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$300 per person, limit of 3 per plan year In-Network (Doesn't apply to preventive care or SHS); $300 per person, limit of 3 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?	Yes, $300 for Pediatric Dental services	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?	Yes, In-Network: **$5,950** per individual, $12,700 per family; Out-of-Network: **$8,000** per individual	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, deductibles, 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?	No	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. PHCS. For a list of preferred providers, see www.phcs.com or call 1-800-922-4362.	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.
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.gallagherstudent.com/WheatonIL.
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.

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- **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	$30 copayment/visit ($25 at SHS), 0% coinsurance	40% coinsurance after deductible	Limited to one visit per day.
	Specialist visit	$30 copayment/visit, 0% coinsurance	40% coinsurance after deductible	Limited to one visit per day.
	Other practitioner office visit	$30 copayment/visit, 0% coinsurance	40% coinsurance after deductible	Limited to one visit per day.
	Preventive care/screening/immunization	No Charge	40% coinsurance, subject to deductible and copayment	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 www.express-scripts.com.	Generic drugs	$15 copayment/ retail prescription; $5 copayment at SHS Pharmacy	Not Covered	Limited to a 30-day supply per prescription retail (for 90-day supply by mail order, copayments are $30/$50/$100). Prescriptions filled at non-Express Scripts pharmacies or outside the SHS are not covered.
	Preferred brand drugs	$25 copayment/ retail prescription	Not Covered	
	Non-preferred brand drugs	$50 copayment/ retail prescription	Not Covered	
	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	$100 copayment per visit (waived if admitted as an inpatient).
	Emergency medical transportation	20% coinsurance	20% coinsurance	----------none----------
	Urgent care	$50 copayment, then 20% coinsurance	40% coinsurance	Out-of-Network paid as In-Network if true Medical Emergency
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	$15 copayment per visit, then 0% coinsurance	40% coinsurance	----------none----------
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	Paid as any other Sickness
	Substance use disorder outpatient services	$15 copayment per visit, then 0% coinsurance	40% coinsurance	----------none----------
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	Paid as any other Sickness

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 are pregnant	Prenatal and postnatal care	$25 copayment first visit, then 0% coinsurance	40% coinsurance	----------none----------
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	----------none----------
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Limited to 100 visits per policy year
	Rehabilitation services	$20 copayment per visit, then 0% coinsurance	40% coinsurance	----------none----------
	Habilitation services	$20 copayment per visit, then 0% 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	$5,000 maximum per plan year
If your child needs dental or eye care	Eye exam	0% coinsurance, $20 copayment per exam, $40 copayment for materials and supplies		Pediatric services only
	Glasses	0% coinsurance, $20 copayment per exam, $40 copayment for materials and supplies		Pediatric services only
	Dental check-up	50% coinsurance, $300 specific deductible		Pediatric services only

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)
- Voluntary termination of pregnancy or elective abortion (including but not limited to abortifacient drugs and devices such as the placement of IUDs with and without hormone impregnation, the use of abortifacient drugs including Ella and Plan B, but not the removal of IUDs).
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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 ($20 copayment per visit, 20 visits per plan year)
- Hearing aids

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 877-320-4347. You may also contact your state insurance department at: State of Illinois Division of Insurance, 320 W. Washington, Springfield, Illinois 62767-0001, Tel: 312-814-2420.

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: State of Illinois Division of Insurance, 320 W. Washington, Springfield, Illinois 62767-0001, Tel: 312-814-2420.

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** $7,215
- **Patient pays** $325

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	$300
Copays	$25
Coinsurance	$0
Limits or exclusions	$0
Total	**$325**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,075
- **Patient pays** $1,325

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	$300
Copays	$25
Coinsurance	$1,000
Limits or exclusions	$0
Total	**$1,325**

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.