STUDENT
INJURY AND SICKNESS INSURANCE

URSINUS COLLEGE

Collegeville, Pennsylvania 19426

2013-2014

"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 Insurance Services, 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."

Underwritten By
MONUMENTAL LIFE INSURANCE COMPANY
Cedar Rapids, Iowa

POLICY NUMBER: A609J

TABLE OF CONTENTS

INTRODUCTION

This brochure is a brief description of the Injury and Sickness Insurance Plan for students attending Ursinus College. The exact provisions governing the insurance are contained in the Master Policy issued to the College. The Master Policy shall control in the event of any conflict between the Policy and this brochure.

POLICY TERM

The insurance coverage under Ursinus College Student Injury and Sickness Insurance Plan for the Annual Policy is effective at 12:01 a.m. on August 7, 2013. The Annual Policy terminates at 12:00 a.m. on August 7, 2014 or the end of the period through which the premiums are paid.

COST OF INSURANCE

	ANNUAL 8/7/13 8/7/14	SPRING 1/1/14 - 8/7/14
Student Only	$1,700.00	$1,054.00
Spouse	$4,154.00	$2,522.00
Each Dependent Child	$1,822.00	$1,117.00

ELIGIBILITY

■ **Compulsory**

All Ursinus College full-time students are required to have some form of medical insurance. Full-time students who do not provide annual proof of insurance by June 30, 2013, will be billed for this plan. An eligible student's coverage becomes effective on August 7, 2013 for Fall Semester or January 1, 2014 for Spring Semester and terminates at 12:01 a.m. on August 7, 2014.

Waiver

Students who have coverage under a family policy may waive enrollment in the Ursinus College Student Injury and Sickness Insurance Plan by completing the online waiver process at www.ursinus.edu/wellness. Students who lose family coverage during the school year should contact the Wellness Center. All full-time students must complete an online enrollment and/or waiver annually.

Waiver Deadline Dates

The online enrollment and/or waiver must be completed:

for Fall Semester.....June 30, 2013

for Spring Semester.....January 27, 2014

■ **Voluntary Enrollment**

Voluntary enrollment is available to all registered Ursinus College students. Enroll online at www.ursinus.edu/wellness.

An eligible student's coverage becomes effective on August 7, 2013 at 12:01 am or the day after the postmark date of the premium payment, whichever is later, and terminates at 12:00 a.m. on August 7, 2014 or at the end of the period through which the premiums are paid.

Enrollment Deadline Dates

Voluntary online enrollment must be completed:

for Fall Semester.....September 29, 2013

for Spring Semester.....January 27, 2014

ENROLLMENT PERIOD

Students and their eligible dependents wishing to purchase coverage must enroll during the open enrollment period at the beginning of the Fall Semester. The Spring Semester open enrollment period is available only for new students (and their dependents) first entering the College for the Spring Semester.

Late enrollment after September 29, 2013 is considered only if a change has occurred in your insured status regarding coverage that was in force during the open enrollment period. Late enrollment must be completed within 30 days of the termination of other coverage. Contact Bollinger, Inc. for rates and forms.

TERMINATION OF INSURANCE

Benefits are payable under this Plan only for those expenses incurred while this Plan is in effect as to the Insured Person. No benefits are payable for expenses incurred after the date the insurance terminates for the Insured Person, except as may be provided under Extension of Benefits.

EXTENSION OF BENEFITS

If an Insured Person is confined to a hospital on the day his or her insurance terminates, charges incurred during the continuance of that hospital confinement shall be payable in accordance with this Plan, but only while they are incurred during the 31-day period following such termination of insurance.

PREMIUM REFUND POLICY

Except for medical withdrawal due to an Injury or Sickness, any student withdrawing from the school during the first 31 days of the period for which coverage is purchased shall not be covered under this Plan and a full refund of the premium will be made. Students withdrawing after 31 days will remain covered under this Plan for the full period for which the premium has been paid and no refund will be made available. Premiums received by the Company are fully earned upon receipt.

Coverage for an Insured Person entering the Armed Forces of any country will terminate as of the date of such entry. Those Insured Students withdrawing from the school to enter military service will be entitled to a pro-rata refund of premium upon written request within 90 days.

OTHER COVERAGE OPTIONS

Insured Students (and their insured dependents) not eligible to re-enroll in the Student Injury and Sickness Insurance Plan after your coverage under the Plan expires due to graduation or discontinuation of studies at the College may elect to purchase other coverage. This election must be made prior to the expiration of your coverage. Contact Bollinger, Inc. for enrollment information.

Students in need of specialized coverage (i.e. International Travel or Short Term Medical) should contact Bollinger, Inc. for possible options.

DEPENDENTS

An Insured Student enrolled in this Plan may also enroll their Dependent(s). Dependent means: (1) an Insured's spouse; and (2) an Insured's unmarried child who is primarily dependent on you for support and maintenance and: a) is age 29 and younger; b) is not married; c) has no Dependents; d) is a residence of Pennsylvania or is enrolled as a full time student; and e) is not provided coverage under any other plan.

The term "children" includes an Insured Student's biological children; step-children; adopted children from the date of placement in the Insured Student's home and who depend on the Insured Student for their full support.

A child's coverage will not end because the child has reached the age limit shown above, if he or she: (a) is not able to earn his or her own living as a result of mental illness, developmental disability or mental retardation; and (b) became so handicapped before reaching the age limit; and (c) is chiefly dependent on the Insured Student for support and maintenance. Within 61 days after the child reaches the age limit, the Insured Student must send us proof of the child's dependency or handicap. We may ask for more proof of the child's dependency and handicap, but We will not ask for proof more frequently than annually after the two year period following the child's attainment of the limiting age.

Any Dependent on active duty in any military, naval, or air force of any country is not eligible for coverage under this Policy.

You are under no obligation to enroll your Dependents in this Plan. However, if enrolling Dependents, you must enroll them for the same coverage as the Insured Student. The last date to enroll Dependents is September 29, 2013 for the Fall Semester and January 27, 2014 for the Spring Semester. To enroll Dependents, follow the instructions on the dependent enrollment form, available by contacting Bollinger, Inc.

Coverage for newborn children will consist of coverage for Sickness or Injury, including necessary care or treatment of congenital defects, birth abnormalities, or premature birth, and routine nursery care. Such coverage will start from the moment of birth, if the Insured Student is already insured for dependent child(ren) coverage when the child is born. If the Insured Student does not have dependent coverage when the child is born, We cover the newborn child, for dependent benefits for the first 31 days from and after the moment of birth, or any minor child placed with an Insured Student for adoption for dependent benefits from and after the moment the child is placed in the physical custody of the Insured Student for adoption. To continue the child's dependent benefits past the first 31 days, the Insured Student must complete the dependent enrollment form and pay the necessary premium within 31 days of the child's birth. Contact Bollinger, Inc. for rates.

DEFINITIONS

ACTUAL CHARGE means the fee charged by the Physician or Hospital for a covered service.

ALLOWABLE CHARGE means the contracted amount that the Preferred Provider Organization agree to accept as payment in full. Eligible charges incurred at non-Preferred Provider Organization providers an allowable charge is based on the Usual and Customary Charge.

AGGREGATE MAXIMUM BENEFIT means benefits for any one Injury or Sickness per Policy Year which are payable throughout a period of continuous coverage. Benefits will terminate at the end of a period of continuous coverage, subject to an Aggregate Maximum Benefit as shown on the Schedule of Benefits.

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.

CONFINED OR CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital and is charged room and board by the facility. He must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. The term "Inpatient" is the same as Confined under this Policy.

Confinement does not include treatment received in the Outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

CONTINUOUS COVERAGE means that period of time during which the Insured Person is continuously covered under one of the Ursinus College Student Injury and Sickness Plans, with no lapse in coverage between this policy and the prior policies.

COSMETIC and RECONSTRUCTIVE PROCEDURES and SERVICES means (1) procedures and related services that are performed to reshape structures of the body in order to alter a person's appearance; and (2) procedures and related services that are performed on structures of the body to improve/restore bodily functions or appearance resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes.

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.

COVERED PERSON means the Insured or a Dependent for whom an application has been received and the required premium has been paid.

COVERED SERVICES mean services by or under the direct supervision of a Physician or licensed psychologist, when performed in a Physician's or licensed psychologist's office, hospital, in a community mental health facility or in an alcoholism treatment facility.

DEDUCTIBLE means the dollar amount of Covered Medical Expenses that must be paid as an out-of-pocket expense by each Covered Person per 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.

DEPENDENT means the Insured's spouse, unless they are legally separated, the Insured's children, including adopted and foster children, under the age of 26; and children whose support is required by a court decree.

Children include natural children, stepchildren, legally adopted children and children placed with the Insured for the purpose of adoption. Newborn children are covered immediately from birth and adopted children are covered from

the moment of placement as certified by the public or private agency making the placement. .They must be primarily dependent on the Insured for support and maintenance and must live in a parent-child relationship with the Insured.

A spouse or child who is covered under this Policy as an Insured will not be eligible as a Dependent. If a husband and wife are both insured as Students, a child will be the Dependent of only one.

ELECTIVE SURGERY AND ELECTIVE TREATMENT means any surgery or treatment that is not Medically Necessary, including any service, treatment, or supply that is deemed by us to be research or experimental; 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.

INJURY means bodily injury caused by an accident. The accident must occur while the Covered Person's insurance is in force under this Policy. 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 those persons who are registered as participants with the Policyholder and for who the proper premium payment has been made.

MEDICAL EMERGENCY means the occurrence of a sudden, serious and unexpected Sickness or Injury. In the absence of immediate medical attention, a reasonable person could believe this condition would result in death, permanent placement of the Covered Person's health in jeopardy, serious impairment of bodily functions or serious and permanent dysfunction of any body organ or part. Expenses incurred for a medical emergency will be paid only for Sickness or Injury which fulfills the above conditions. These expenses will not be paid for minor injuries or minor sicknesses.

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.

SICKNESS means an illness or trauma related disorder due to Injury which causes a loss while this Policy is in force and 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 and Complications of Pregnancy.

USUAL AND CUSTOMARY CHARGE means the charge which in the Company's experience is most often incurred for any given procedure. In no event shall the Company's payment for surgical procedures exceed the Usual and Customary Charges which in the Company's experience are normally made by the majority of Physicians in that area.

OUTPATIENT PRESCRIPTION DRUG EXPENSE BENEFIT

CAREMARK

After a copayment of $10 for generic or $25 for a brand name drug per prescription, the cost of prescription drugs is payable in full.

Prescriptions must be filled at a Caremark Participating Pharmacy. Insured Persons will be given an insurance ID card to show to the Pharmacy as proof of coverage.

Before you receive your insurance ID card, if you need to have a prescription filled, go to any participating pharmacy, pay for the medication in full and save the receipt. Your insurance ID card will include instructions on how to file for reimbursement for prescriptions filled before you received your card. Reimbursement will be at the Caremark contracted discount rate and will be less than the rate charged by the pharmacy.

After you receive your insurance ID card, no claim forms need be completed. After you receive the card you may call the toll-free customer service number listed on your card for assistance with pharmacy locations at 1-866-284-9266. This number is effective for enrolled members only. You will need the group number and member number printed on the card.

Not all medications are payable. Expenses incurred for psychotropic and acne drugs are excluded under this Plan. Home Delivery Pharmacy Service is available for medication taken to treat ongoing health conditions.

PREFERRED PROVIDER NETWORK

FIRST HEALTH

The Ursinus College Student Injury and Sickness Insurance Plan utilizes the FirstHealth Network for the Insurance Plan. While you may utilize any provider you choose, you will decrease your out-of-pocket expenses if you receive care locally and nationally through First Health Network which provides access to hospitals and health care providers through its Network. However, you are not required to go to a Preferred Provider as use of this network is strictly optional.

There are advantages to using a Network Provider, and consequently out-of-pocket expenses will be less based on a Preferred Allowance, which means that Network Providers have agreed to accept a predetermined fee as payment for their services. The Insured Person should be aware that Network Provider Hospitals may be staffed with Out-of-Network Providers. Receiving services or care from an Out-of-Network Provider at a Network Hospital does not guarantee that all charges will be paid at the Network Provider level of benefits. It is important that the Insured Person verify that his or her Doctors are Network Providers. The best way to identify Preferred Providers is when calling for an appointment or at the time of service, or by contacting the First Health Network at their toll free number at 1-800-226-5116 or visit their website at www.MyFirstHealth.com.

PLAN SUMMARY

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

For Accidental Death or Dismemberment occurring within 365 days from the date of accidental bodily Injury, the Company will pay, in addition to the medical expense benefits provided herein, one of the following (the largest applicable amount):

Accidental Death	$2,500.00
Both Hands, Feet or Eyes	$2,500.00
One Hand and One Foot	$ 2,500.00
One Hand and Sight of One Eye	$ 2,500.00
One Hand and Sight of One Eye	$2,500.00
One Hand or Foot or Sight of One Eye	$1,250.00

MANDATED BENEFITS

ALCOHOLISM AND DRUG ABUSE TREATMENT BENEFIT

Benefits will be payable when a Covered Person incurs expenses for alcohol or other drug abuse and dependency treatments. Benefits limitations are as follows:

(a) Inpatient detoxification must either be provided in a Hospital or in an inpatient non-hospital facility which has a written affiliation agreement with a Hospital for emergency, medical and psychiatric or psychological support services, meets the minimum standards for client-to-staff ratios and staff qualifications which are established by the Department of Health and is licensed as an alcoholism and/or drug addiction treatment program. Inpatient detoxification services covered include (1) lodging and dietary services; (2) Physician, psychologist, nurse, certified addictions counselor and trained staff services; (3) diagnostic x-ray; (4) psychiatric, psychological and medical laboratory testing; and (5) drugs, medicines, equipment use and supplies. Treatment under this section (a) is limited for each covered student to four admissions for detoxification and reimbursement per admission is limited to seven (7) days of treatment or an equivalent amount.

(b) Non-hospital resident care must be provided in a facility which meets minimum standards for client-to-staff ratios and staff qualifications established by the Office of Drug and Alcohol programs and is appropriately licensed by the Department of Health as an alcoholism or drug addiction treatment program. A licensed Physician or licensed psychologist must certify the covered student is suffering from alcohol or other drug abuse or dependency and refer the student for the appropriate treatment. Non-hospital resident care services covered include (1) lodging and dietary services; (2) Physician, psychologist, nurse, certified addictions counselor and trained staff services; (3) rehabilitation therapy and counseling; (4) family counseling and intervention; (5) psychiatric, psychological and medical laboratory testing; and (6) drugs, medicines, equipment use and supplies. Treatment under this section (b) is limited to thirty (30) days per year for residential care. Additional days may be available as provided in the next section (c). Treatment is limited to a lifetime maximum for each covered student of ninety (90) days.

(c) Outpatient care must be provided in a facility appropriately licensed by the Department of Health as an alcoholism or drug addiction treatment program. A licensed Physician or licensed psychologist must certify the covered student is suffering from alcohol or other drug abuse or dependency and refer the student for the appropriate treatment. Outpatient care services covered include (1) Physician, psychologist, nurse, certified addictions counselor and trained staff services; (2) rehabilitation therapy and counseling; (3) family counseling and intervention; (4) psychiatric, psychological and medical laboratory tests; (5) drugs, medicines, equipment use and supplies. Treatment is limited to thirty (30) outpatient, full-session visits or equivalent partial visits per year. Treatment is limited to a maximum lifetime benefit of one hundred and twenty (120) outpatient, full-session visits or equivalent partial visits.

Treatment under section (c) will be payable for thirty (30) separate sessions of outpatient or partial hospitalization services per year, which may be exchanged on a two-to-one basis to secure up to fifteen (15) additional non-hospital, residential alcohol treatment days.

AUTISM SPECTRUM DISORDERS COVERAGE

(a) Benefits are provided to Covered Persons under twenty-one (21) years of age for the diagnostic assessment and treatment of autism spectrum disorders.

(b) Coverage provided under this section shall be subject to a maximum benefit of $36,000 per year but shall not be subject to any limits on the number of visits to an autism service provider for treatment of autism spectrum disorders. Payments made by us on behalf of a Covered Person for treatment of a health condition unrelated to or distinguishable from the individual's autism spectrum disorder shall not be applied toward any maximum benefit established under this subsection.

(c) Benefits are subject to the annual deductibles, co-payments or Coinsurance requirements imposed for similar coverage under this Policy.

(d) For purposes of this section, the results of a diagnostic assessment of autism spectrum disorder shall be valid for a period of not less than twelve (12) months, unless a licensed Physician or licensed psychologist determines an earlier assessment is necessary.

(e) Upon denial or partial denial by the Company of a claim for diagnostic assessment of autism spectrum disorders or a claim for treatment of autism spectrum disorders, a Covered Person or an authorized representative

shall be entitled to an expedited internal review process pursuant to the procedures set forth in Article XXI, followed by an expedited independent external review process established and administered by the Insurance Department.

(f) The Company or Covered Person or an authorized representative may appeal to a court of competent jurisdiction an order of an expedited independent external review disapproving a denial or partial denial. Pending a ruling of such court, the Company shall pay for those services, if any, that have been authorized or ordered until such ruling.

(g) For purposes of this section, the term "autism service provider" shall include any behavior specialist in this Commonwealth providing treatment of autism spectrum disorders pursuant to a treatment plan until one (1) year from the time that regulations are promulgated or until three (3) years from the effective date of this section, whichever is later.

CHEMOTHERAPY BENEFIT

Benefits will be payable as shown on the Schedule, when a Covered Person incurs expenses for cancer chemotherapy and/or cancer hormone treatments, whether performed in a Physician's office, in an Outpatient department of a Hospital, in a Hospital as a Hospital inpatient or in any other medically appropriate treatment setting.

COLORECTAL CANCER SCREENING BENEFIT

Benefits are payable for colorectal cancer screening for Covered Persons in accordance with American Cancer Society guidelines for colorectal cancer screening published as of January 1, 2008, and consistent with approved medical standards and practices.

(1) Coverage for nonsymptomatic Covered Persons who are fifty (50) years of age or older shall include, but not be limited to:

(i) An annual fecal occult blood test.

(ii) A sigmoidoscopy, a screening barium enema or a test consistent with approved medical standards and practices to detect colon cancer, at least once every five (5) years.

(iii) A colonoscopy at least once every ten (10) years.

(2) Coverage for symptomatic Covered Persons shall include a colonoscopy, sigmoidoscopy or any combination of colorectal cancer screening tests at a frequency determined by a treating physician.

(3) Coverage for nonsymptomatic Covered Persons who are at high or increased risk for colorectal cancer who are under fifty (50) years of age shall include a colonoscopy or any combination of colorectal cancer screening tests in accordance with the American Cancer Society guidelines on screening for colorectal cancer published as of January 1, 2008.

Benefits are subject to the annual deductibles, co-payments or coinsurance requirements imposed for similar coverages under this Policy.

For the purpose of this section:

(1) " Colonoscopy " means an examination of the rectum and the entire colon using a lighted instrument called a colonoscope.

(2) " Colorectal cancer screening " means any of the following procedures that are furnished to an individual for the purpose of early detection of colorectal cancer:

(i) Screening fecal-occult blood or fecal immunochemical test.

(ii) Screening flexible sigmoidoscopy.

(iii) Screening colonoscopy.

(iv) Screening barium enema.

(v) Screening test consistent with approved medical standards and practices to detect colon cancer.

(3) " Nonsymptomatic person at high or increased risk " means an individual who poses a higher than average risk for colorectal cancer according to the American Cancer Society guidelines on screening for colorectal cancer as of January 1, 2008.

(4) " Symptomatic person " means an individual who experiences a change in bowel habits, rectal bleeding or persistent stomach cramps, weight loss or abdominal pain.

DIABETES SUPPLIES, EQUIPMENT AND SELF-MANAGEMENT TRAINING BENEFIT
Benefits are payable for Medically Necessary equipment, supplies, pharmacologic agents and Outpatient self-management training and education, including medical nutrition therapy for covered students with insulin-dependent diabetes, insulin using diabetes, gestational diabetes and non-insulin using diabetes as prescribed by a Physician. Benefits are payable at the same level as any other Sickness.

Equipment and supplies include the following: blood glucose monitors, monitor supplies, insulin, injection aids, syringes, insulin infusion devices, pharmacological agents for controlling blood sugar and orthodics.

Diabetes Outpatient self-management training and education provided under the supervision of a licensed health care professional with expertise in diabetes to ensure that persons with diabetes are educated as to the proper self-management and treatment of their diabetes, including information on proper diets.

Coverage for self-management education and education relating to diet and prescribed by a licensed physician shall include:

(1) visits medically necessary upon the diagnosis of diabetes;
(2) visits under circumstances whereby a physician identifies or diagnoses a significant change in the patient's symptoms or conditions that necessitates changes in a patient's self-management; and
(3) where a new medication or therapeutic process relating to the person's treatment and/or management of diabetes has been identified as medically necessary by a licensed physician.

Benefits are subject to the annual deductibles, co-payments or coinsurance requirements imposed for similar coverages under this Policy.

EMERGENCY SERVICES BENEFIT
Reimbursement will be made for Medically Necessary services that are provided to a Covered Person in a hospital emergency facility due to a Medical Emergency.

Medical Emergency means a medical condition with acute symptoms of severity or severe pain for which:
(1) care is sought as soon as possible after the medical condition becomes evident to the patient or the patient's parent or guardian; and
(2) the absence of immediate medical attention could result in:
  a) placing health in serious jeopardy;
  b) serious impairment to bodily functions;
  c) serious dysfunction of any body part; or
  d) other serious medical consequences.

MAMMOGRAPHY BENEFIT
Benefits will be payable when a Covered Person incurs expenses for mammographic examinations. Coverage will include all costs associated with a mammogram every year for women 40 years of age or older and with any mammogram based on a Physician's recommendation for women under 40 years of age. Prior to payment for a screening mammogram, we will verify that the screening mammography service provider is properly licensed by the department. Benefits will be payable at the same benefit level as any other outpatient visit or diagnostic test for Sickness.

MASTECTOMY RECONSTRUCTION BENEFIT; MASTECTOMY LENGTH OF STAY
Benefits will be payable as shown on the Schedule, when a Covered Person incurs expenses for inpatient care following a mastectomy for the length of stay that the treating Physician determines is necessary to meet generally accepted criteria for safe discharge. A benefit is payable for a home health care visit that the treating Physician determines is necessary within forty-eight (48) hours after discharge when the discharge occurs within forty-eight hours following admission for the mastectomy. Coverage under this section shall, however, remain subject to any co-payment, coinsurance or deductible amounts set forth in the Policy.
Benefits are also payable as shown on the Schedule, for prosthetic devices and reconstructive surgery incident to any mastectomy. Coverage for prosthetic devices and reconstructive surgery shall be subject to the deductible and coinsurance conditions applied to the mastectomy and all other terms and conditions applicable to other benefits.

Coverage for prosthetic devices inserted during reconstructive surgery and the reconstructive surgery itself will be limited to surgical procedures performed within six years of the date of the mastectomy.

SERIOUS MENTAL ILLNESS BENEFIT

Benefits will be payable as shown on the Schedule, when a Covered Person incurs expenses for treatment Serious Mental Illness. Benefits for serious mental illnesses will be limited as follows:

(1) up to thirty (30) inpatient and sixty (60) Outpatient days annually;

(2) a person covered under this Policy will be able to convert coverage of inpatient days to Outpatient days on a one-for-two basis;

(3) there shall be no difference in either the annual or lifetime dollar limits in coverage for serious mental illnesses and any other illnesses;

Serious Mental Illness means any of the following mental illnesses as defined by the American Psychiatric Association in the most recent edition of the Diagnostic and Statistical Manual: schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder and delusional disorder.

METABOLIC DISEASE FORMULA BENEFIT

Benefits are payable for formulas that are equivalent to a prescription drug, medically necessary for the therapeutic treatment of rare hereditary genetic metabolic disorders and administered under the direction of a physician. Benefits will be payable at the same benefit level as any Outpatient Prescription benefit, if included in the plan, otherwise as any Outpatient procedure for Sickness.

WOMEN'S PREVENTIVE HEALTH SERVICES BENEFIT

Benefits will be payable when a Covered Person incurs expenses for: (1) an annual gynecological examination, including a pelvic examination and clinical breast examination; and (2) routine pap smears in accordance with the recommendations of the American College of Obstetricians and Gynecologists. Benefits will be payable at the same benefit level as any other outpatient visit or diagnostic test for Sickness.

EMERGENCY SERVICES BENEFIT

Reimbursement will be made for Medically Necessary services that are provided to a Covered Person in a hospital emergency facility due to a Medical Emergency.

Medical Emergency means a medical condition with acute symptoms of severity or severe pain for which:

(1) care is sought as soon as possible after the medical condition becomes evident to the patient or the patient's parent or guardian; and

(2) the absence of immediate medical attention could result in:

a) placing health in serious jeopardy;

b) serious impairment to bodily functions;

c) serious dysfunction of any body part; or

d) other serious medical consequences.

MANDATED CONDITIONAL BENEFITS

ANESTHESIA BENEFIT

Benefits are payable when a service is performed by a certified registered nurse anesthetist, certified registered nurse practitioner, certified enterostomal therapy nurse, certified community health nurse, certified psychiatric mental health nurse or certified clinical nurse specialist, certified by the State Board of Nursing or a national nursing organization recognized by the State Board of Nursing and lawfully permitted to perform that service under the Professional Nursing Law. When payment is made for health care services performed by a registered professional nurse, neither duplicate payments or reimbursements will be made to both a nurse provider and another provider nor to the same provider for the same services provided in a single encounter. Benefits are subject to the annual deductibles, co-payments or coinsurance requirements imposed for similar coverage under this Policy.

CERTIFIED NURSE MIDWIFE BENEFIT
Benefits are payable for services rendered by a duly licensed certified nurse midwife practicing within those areas for which the certified nurse midwife is licensed in the state where he or she is practicing. Whenever such service is performed by a licensed certified nurse midwife, he or she shall be granted such rights of participation, plan admission and registration as granted to a Physician or osteopath performing such service. When payment is made for health care services performed by a licensed certified nurse midwife, no payment or reimbursement will be payable to a Physician or osteopath for the service performed by the licensed certified nurse midwife. Benefits are subject to the annual deductibles, co-payments or coinsurance requirements imposed for similar coverage under this Policy.

CHILDHOOD IMMUNIZATION BENEFIT
Benefits are payable for Child Immunizations and for Medically Necessary booster doses of all immunizing agents used in Child Immunizations. These covered benefits are payable at 100% of the actual amount. The covered benefits are not subject to any Policy Deductibles.
Child Immunizations means the immunizing agent, reimbursement for which shall not exceed 150% of the average wholesale price, which, as determined by the Department of Health, conform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control, the United States Department of Health and Human Services.

MATERNITY LENGTH OF STAY BENEFIT; NEWBORN LENGTH OF STAY
Benefits are payable for a minimum of 48 hours of inpatient care following a normal vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section for a female covered under this Policy and her newly born child in a licensed health care facility. Benefits will be paid at the same level as any other inpatient Sickness.

If the Physician, obstetrician, pediatrician or certified nurse midwife in conference with the mother decides to shorten the length of the stay to less than that provided for under this benefit, coverage for a home health care follow-up visit, provided the first visit occurs within 48 hours of discharge, will be provided. Benefits will be paid at the same level as any other Sickness.

MEDICAL EVACUATION, REPATRIATION AND TRAVEL ASSISTANCE

MEDICAL EVACUATION BENEFIT

When an Insured incurs expense for his Medical Evacuation to his natural country, the Company will pay for the actual expenses incurred for such evacuation, not to exceed $10,000. The evacuation must be recommended and approved by the attending physician.

REPATRIATION BENEFIT

In the event of the death of an Insured, the Company will pay for those incurred expenses up to a Maximum of $7,500 for the preparation and transportation of the body to the Insured's place of residence in his/her home country. This benefit does not include the transportation expense of anyone accompanying the body.

TRAVEL ASSISTANCE PROGRAM
(Administered by On Call International)

Nurse Help Line: On Call shall provide Students enrolled in this Plan with clinical assessment, education and general health information. This service shall be performed by a registered Nurse counselor to assist in identifying the appropriate level and source(s) of care for Students (based on symptoms reported and/or health care questions asked by or on behalf of Students). Nurses shall not diagnose Student's ailments.

Travel Assistance: Each Insured Student and his/her enrolled Dependents are also eligible for travel assistance services when traveling 100 miles or more away from their home and campus address. Travel Services are only available for medical claims that are covered under the College's Student Accident and Sickness Insurance Plan. 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.

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

Note: The 24-Hour Nurse Help Line and the Travel Assistance program are not insurance. Neither is connected with or provided by Monumental Life Insurance Company.

EXCLUSIONS

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. Surgical, medical or other services received in a facility primarily designed to care for students, faculty or employees of a college or other institution of learning for which there is no charge. With the exception of some services performed at College Health Center;

3. Services and supplies not Medically Necessary for the diagnosis recommended by the attending physician;

4. 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;

5. 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 within 24 hours of the accident. Correction of deviated nasal septum shall be considered as Cosmetic surgery for the purpose of this Policy;

6. Elective Surgery or Elective Treatment;

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 resulting from the playing, practice, participating, or conditioning in any intercollegiate 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;

9. Riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as fare-paying passenger in an aircraft operated by a commercial scheduled airline. This exclusion does not apply to insured students while taking flight instructions for University credit;

10. Declared or undeclared war, while participating in a riot, civil disorder, civil commotion or acts of terrorism;

11. Committing or attempting to commit an assault or felony; or fighting, except in self defense;

12. Injury or Sickness for which benefits are payable under any Worker's Compensation or Occupational Disease Law;

13. 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;

14. Treatment provided in a government hospital unless there is a legal obligation to pay such charges in the absence of other insurance;

15. Psychiatric treatment after it has been determined according to medically accepted standards, the condition will not respond to treatment;

16. Treatment for infertility (male or female), including any services or supplies rendered for the purpose or with the intent or inducing conception;

17. Expenses incurred after the termination date except as provided under the Extension of Benefits;

18. Personal and convenience items and completion of forms;

CLAIM PROCEDURE

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

1. Internet physicians and hospitals may submit itemized bills directly to Bollinger, Inc. electronically using BOLL1 or mailing them to the address below.

2. 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. Written proof of loss must be given within 90 days after the date of the loss, or as soon thereafter as possible. Mail a copy to Bollinger, Inc, P.O. Box 727, Short Hills, NJ 07078-0727.

3. Claim forms are available online at www.BollingerColleges.com/ursinus or by calling 866-267-0092. If the providers have given you bills, attach them to the claim form.

4. Direct all questions regarding benefits available under this Plan, claim procedures, status of a submitted claim or payment of a claim to Bollinger, Inc.. Online claim status is available at www.BollingerCollege.com/ursinus or by calling 866-267-0092.

5. 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.

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.

EFFECT ON BENEFITS This provision will be used to determine a Covered Person's benefits for any Policy Year when the sum of the following is more than the Allowable Expenses:

(1) the benefits that would be paid under this Policy in the absence of this provision; and

(2) the benefits that would be paid under all other Plans in the absence of similar provisions whether or not a claim is made. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service given will be considered as a benefit paid.

The benefits of another Plan that co-ordinates its benefits with this Policy will be ignored in order to determine the benefits under this Policy if:

(1) another Plan provides that its benefits be paid after the benefits of this Policy; and
(2) this Policy provides that its benefits be paid before such other Plan.

ORDER OF BENEFIT DETERMINATION The Plan that pays first figures its benefits exactly as though duplicate coverage does not exist. The second Plan will pay for Allowable Expenses not covered by the first Plan if this amount is not more than the benefits payable when there is no duplicate coverage.

When two or more Plans contain non-duplication clauses, the order in which the Plans will pay benefits will be as follows:

(1) a Plan that covers the person as other than a Dependent will pay before a Plan that covers the person as a Dependent;
(2) a Plan that covers the person as a Dependent of a person whose birthday falls earlier in a year will pay before a Plan that covers the person as a Dependent of a person whose birthday falls later in that same year, except that:
    a) a Plan that covers a child as a Dependent of the parent with custody will pay before a Plan that covers the child as a Dependent of the parent without custody. This occurs when the parents are separated or divorced and the parent with custody has not remarried;
    b) a Plan that covers a child as a Dependent of the parent with custody will pay before a Plan that covers the child as a Dependent of the stepparent. A Plan that covers the child as a Dependent of the stepparent will pay before the benefits of a Plan which covers the child as a Dependent of the parent without custody. This occurs when the parents are divorced and the parent with custody has remarried;
    c) however, a Plan that covers a child as a Dependent of the parent who is financially liable will pay before any other Plan that covers the child as a Dependent child. This occurs when there is a court decree which would otherwise establish financial liability for the medical, dental or other health care expenses of the child; and
(3) the first Plan to pay when the order of payment cannot be determined by these rules will be the Plan that has covered the person for the longer period of time.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION In order to determine whether this provision applies the Company may.

(1) release or obtain any necessary information from any other organization or person with a legitimate interest;
(2) require any person claiming benefits to furnish such necessary information; and
(3) receive information reasonably related to a claim for benefits under this Plan.

FACILITY OF PAYMENT The Company has the right to make payments to any organizations when payments have been made under any other Plans and should have been made under this Policy.

Payment will be in any amount determined by the Company to be warranted. The amounts paid will be considered benefits paid and the Company will be liable only to the extent of payment made.

RIGHT OF RECOVERY The Company may recover any payments it makes in excess of the amount needed to satisfy the intent of this provision from among one or more of the following:

(1) any person that receives payments; or
(2) any other insurance companies or other organizations.

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 the link below:
www.bollingercolleges.com/ursinus

IMPORTANT NUMBERS

GENERAL INSURANCE QUESTIONS/CLAIMS AND COVERAGE QUESTIONS

Bollinger Insurance Solutions

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

Student Health Customer Service 866-267-0092
Website.....www.BollingerColleges.com/ursinus

• **STUDENT WELLNESS CENTER**
Phone 610-409-3100

• **PARTICIPATING PHARMACY ..... Page 7**

For pharmacy locations after you receive your ID card (Number is effective for enrolled members only).
Phone 866-284-9266
Website..... .www.Caremark.com

• **PREFERRED PROVIDER NETWORK..... Page 7**

First Health Network

Phone 800-226-5116
Website..... www.MyFirstHealth.com

• **TRAVEL ASSISTANCE .....Page 13**

ON CALL INTERNATIONAL *It could happen to you!*

Medical Evacuation, Lost Passports, Luggage On Call International
Toll Free U.S. and Canada.....866-525-1955
Dial Direct/Call Collect Worldwide 603-328-1955
Website.....www.oncallinternational.com

Offered and Administered by:

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

Preferred Provider Network:

Policy No.A609J
Policy Form SH3000GPM.PA (Rev. 04/10) 26107644

Monumental Life Insurance Company: Ursinus College Student Injury and Sickness Plan

Coverage Period: 08/07/2013 – 08/07/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual | **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.BollingerColleges.com/Ursinus** or by calling 1-866-267-0092.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$150 in network \ $250 out of network** per Policy Year. Does not apply to In-Network preventative and wellness services.	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 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. **$5,000 per Individual / $10,000 per Family per** Policy Year.	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?	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.
Are there services this plan doesn't cover?	Yes.	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**.

Questions: Call 1-866-267-0092 or visit us at www.BollingerColleges.com/ursinus
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-866-267-0092 to request a copy.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

2617644A

Monumental Life Insurance Company: Ursinus College Student Injury and Sickness Plan

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **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 In-Network Provider	Your cost if you use a 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	$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	20% co-insurance	40% co-insurance	
	Other practitioner office visit	20% co-insurance for chiropractor and acupuncture	40% co-insurance for chiropractor and acupuncture	
	Preventive care/screening/immunization	No charge	40% co-insurance	none
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance	40% co-insurance	none
	Imaging (CT/PET scans, MRIs)	20% co-insurance	40% co-insurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com.	Generic drugs	$15 co-payment for generic		
	Brand name /Specialty drugs	$25 co-payment for brand name or specialty drugs, per prescription		

If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	40% co-insurance	none
	Physician/surgeon fees	20% co-insurance	40% co-insurance	none
If you need immediate medical attention	Emergency room services	$100 co-pay/visit and 20% co-insurance	$100 co-pay/visit and 20% co-insurance	Services that are normally provided without charge at the student health center are not covered. Copay waived, if Admitted. Medical Emergency covered at In Network co-insurance amounts
	Emergency medical transportation	20% co-insurance	20% co-insurance	Medical Emergency covered at In Network co-insurance amounts
	Urgent care	20% co-insurance	40% 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	none
	Physician/surgeon fee	20% co-insurance	40% co-insurance	none
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 co-pay/office visit and 20% co-insurance other outpatient services	$20 co-pay/office visit and 40% co-insurance other outpatient services	none
	Mental/Behavioral health inpatient services	20% co-insurance	40% co-insurance	none
	Substance use disorder outpatient services	$20 co-pay/office visit and 20% co-insurance other outpatient services	$20 co-pay/office visit and 40% co-insurance other outpatient services	none
	Substance use disorder inpatient services	20% co-insurance	40% co-insurance	none
If you are pregnant	Prenatal and postnatal care	20% co-insurance	40% co-insurance	none
	Delivery and all inpatient services	20% co-insurance	40% co-insurance	none
If you need help recovering or have other special health needs	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

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
- Bariatric surgery
- Dental care (Adult)
- Elective Abortion
- Elective Surgery or treatment
- Eyeglasses
- 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
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Weight loss programs

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 1-877-881-6388 or e-mailing them at ra-in-comsumer@pa.gov.

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 Pennsylvania Insurance Department at www.insurance.pa.gov or call their toll-free hotline at 1-877-881-6388.

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.

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** $5,472
- **Patient pays** $1,638

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	$150
Co-pays	$0
Co-insurance	$1,478
Limits or exclusions	$0
Total	**$1,638**

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	$700**
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

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.