Monumental Life Insurance Company: Southern Vermont College Student Injury and Sickness Plan

Coverage Period: 08/15/2013 – 08/15/2014

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/svc or by calling 1-866-267-0092.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$100 in network \ $200 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?	No.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	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. See **www.MyFirstHealth.com** or call **1-800-226-5116** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.

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

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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**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amou**

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

e, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.

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

Common Medical Event	Services You May Need	Your cost if you use a 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	$25 co-pay/visit and 20% co-insurance	$25 co-pay/visit and 40% co-insurance	
	Other practitioner office visit	20% co-insurance	40% co-insurance	
	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	Generic drugs	$15 co-payment for generic		

about **prescription drug coverage** is available at www.caremark.com.	Brand name Specialty drugs	$35 co-payment for brand name or $45 co-payment for 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	$150 co-pay/visit and 20% co-insurance	$150 co-pay/visit and 20% co-insurance	Services that are normally provided without charge at the student health center are not covered. Co-pay waived, if Admitted. Medical Emergency covered at In Network co-insurance amounts
	Emergency medical transportation	20% co-insurance	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	$25 co-pay/visit and 20% co-insurance	$25 co-pay/visit and 40% co-insurance	none
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 co-pay/office visit and 20% co-insurance other outpatient services	$25 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	$25 co-pay/office visit and 20% co-insurance other outpatient services	$25 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 1-800-631-7788 or visit their website www.dfr.vermont.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 Vermont Department of Financial Regulation, Insurance Consumer Services at 1-800-964-1784 or visit their website at www.dfr.vermont.gov/insurance/insurance-consumer/file-insurance-complant.

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** $5,952
- **Patient pays** $1,948

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	$100
Co-pays	$450
Co-insurance	$1,398
Limits or exclusions	$0
Total	**$1,948**

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.