Morris College Student Health Plan:
National Union Fire Insurance Company of Pittsburgh, Pa. Coverage Period: 08/10/2016 – 08/09/2017

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 http://studentinsurance.com/Apps/Schools/Default.aspx?ID=66 or by calling 1-877-657-5030.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$350 In Network/$500 Out of Network. Does not apply at the Student Health Center (SHC) or to preventive care In Network that is not available at the SHC.	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, $100 for prescription drugs. There are no other specific **deductibles.**	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, $6,350 In Network/$25,000 Out of Network	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.	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. For a list of **In Network Providers**, go to http://studentinsurance.com/Apps/Schools/Default.aspx?ID=66 or call 1-877-657-5030.	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 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 1-877-657-5030 or visit us at http://studentinsurance.com/Apps/Schools/Default.aspx?ID=66.
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.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/SBCUniformGlossary.pdf or call 1-877-657-5030 to request a copy.

- **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 In Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a SHC Provider	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	No charge	$25 copay/visit 25% coinsurance	$50 copay/visit 50% coinsurance	-None-
	Specialist visit	No charge	$25 copay/visit 25% coinsurance	$50 copay/visit 50% coinsurance	-None-
	Other practitioner office visit	No charge	$25 copay/visit 25% coinsurance	$50 copay/visit 50% coinsurance	-None
	Preventive care/screening/ immunization	No charge	$25 copay/visit 25% coinsurance	$50 copay/visit 50% coinsurance	No charge for a service rendered In Network that is not available at the SHC.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	$25 copay/visit 25% coinsurance	$50 copay/visit 50% coinsurance	-None
	Imaging (CT/PET scans, MRIs)	Not covered	$25 copay/visit 25% coinsurance	$50 copay/visit 50% coinsurance	-None-

Common Medical Event	Services You May Need	Your Cost If You Use a SHC Provider	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 http://studentinsurance.com/Apps/Schools/Default.aspx?ID=66.	Generic drugs	Not covered	$20 copay/prescription 20% coinsurance	Not covered	Limited to 30-day supply/prescription. Prescribed medicine benefits are based on a mandatory generic formulary. If you or your doctor chooses a brand drug, you will pay the difference between the brand drug and the generic, plus the brand copay.
	Preferred brand drugs	Not covered	$50 copay/prescription 20% coinsurance	Not covered	
	Non-preferred brand drugs	Not covered	$100 copay/prescription 20% coinsurance	Not covered	
	Specialty drugs	Not covered	$100 copay/prescription 20% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	$150 copay/visit 25% coinsurance	$300 copay/visit 50% coinsurance	-None-
	Physician/surgeon fees	25% coinsurance	25% coinsurance	50% coinsurance	-None-
If you need immediate medical attention	Emergency room services	Not covered	$350 copay/visit 25% coinsurance	$350 copay/visit 25% coinsurance	Copay does not apply if admitted to the hospital as an inpatient.
	Emergency medical transportation	Not covered	25% coinsurance	25% coinsurance	-None-
	Urgent care	Not covered	$50 copay/visit 25% coinsurance	$50 copay/visit 50% coinsurance	-None-
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	$250 copay/admission 25% coinsurance	$500 copay/admission 50% coinsurance	-None-
	Physician/surgeon fee	Not covered	25% coinsurance	50% coinsurance	Physician's visits limited to 1 visit/day

Common Medical Event	Services You May Need	Your Cost If You Use a SHC Provider	Your Cost If You Use an In Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Not covered	$25 copay/visit 25% coinsurance	$50 copay/visit 50% coinsurance	-None-
	Mental/Behavioral health inpatient services	Not covered	$250 copay/admission 25% coinsurance	$500 copay/visit 50% coinsurance	Physician's visits limited to 1 visit/day
	Substance use disorder outpatient services	Not covered	$25 copay/visit 25% coinsurance	$50 copay/visit 50% coinsurance	-None-
	Substance use disorder inpatient services	Not covered	$250 copay/admission 25% coinsurance	$500 copay/admission 50% coinsurance	Physician's visits limited to 1 visit/day
If you are pregnant	Prenatal and postnatal care	Not covered	$25 copay/visit 25% coinsurance	$50 copay/visit 50% coinsurance	-None-
	Delivery and all inpatient services	Not covered	$250 copay/admission 25% coinsurance	$500 copay/admission 50% coinsurance	Physician's visits limited to 1 visit/day
If you need help recovering or have other special health needs	Home health care	Not covered	25% coinsurance	50% coinsurance	Limited to 60 visits/plan year
	Rehabilitation services	Not covered	$25 copay/visit 25% coinsurance	$50 copay/visit 50% coinsurance	-None-
	Habilitation services	Not covered	$25 copay/visit 25% coinsurance	$50 copay/visit 50% coinsurance	-None-
	Skilled nursing care	Not covered	$250 copay/confinement 25% coinsurance	$500 copay/confinement 50% coinsurance	-None-
	Durable medical equipment	25% coinsurance	25% coinsurance	50% coinsurance	-None-
	Hospice service	Not covered	25% coinsurance	50% coinsurance	-None-
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Not covered	Dependents not covered.
	Glasses	Not covered	Not covered	Not covered	Dependents not covered.
	Dental check-up	Not covered	Not covered	Not covered	Dependents not covered.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Cosmetic surgery except reconstructive surgery when such surgery is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part; and breast reconstructive surgery after a mastectomy	• Dental care (Adult)	• Hearing aids
• Infertility treatment	• Long-term care	• Routine eye care (Adult)
• Routine foot care	• 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.)		
• Acupuncture (medically necessary)	• Bariatric surgery (medically necessary)	• Chiropractic care (medically necessary)
• Non-emergency care when traveling outside the U.S.	• Private-duty nursing (inpatient)	

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 by calling 1-877-657-5030. You may also contact your state insurance department at: South Carolina Department of Insurance, 1201 Main Street, Suite 1000, Columbia, SC 29201.

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: Consolidated Health Plans, 2077 Roosevelt Avenue, Springfield MA 01104. You may also contact your state insurance department at: South Carolina Department of Insurance, P.O. Box 100105, Columbia, South Carolina 29202-3105 or by calling 803-737-6160.

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.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-657-5030.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-657-5030.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-877-657-5030.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-657-5030.

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** $4,440
- **Patient pays** $3,100

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	$400
Copays	$800
Coinsurance	$1,700
Limits or exclusions	$200
Total	**$3,100**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,520
- **Patient pays** $2,880

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	$500
Copays	$1,200
Coinsurance	$1,100
Limits or exclusions	$80
Total	**$2,880**

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.