# Carleton College: Student Injury and Sickness Insurance Plan (Policy #CLSP0047-13):

## Companion Life Insurance Company

**Coverage Period:** 8/15/2013 - 8/15/2014  
**Coverage for:** Insured Student+Dependent | **Plan Type:** PPO

---

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

---

⚠️ **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.cirstudenthealth.com/carleton or by calling 1-800-322-9901.

---

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>$100 per plan year</td>
<td>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.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No</td>
<td>You don’t have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.</td>
</tr>
<tr>
<td><strong>Is there an out-of-pocket limit on my expenses?</strong></td>
<td>No</td>
<td>There’s no limit on how much you could pay during a coverage period for your share of the cost of covered services.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>This plan has no out-of-pocket limit.</td>
<td>Not applicable because there’s no out-of-pocket limit on your expenses.</td>
</tr>
<tr>
<td><strong>Is there an overall annual limit on what the plan pays?</strong></td>
<td>Yes, $500,000.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Does this plan use a network of providers?</strong></td>
<td>Yes. For a list of preferred providers, see <a href="http://www.cirstudenthealth.com/carleton">www.cirstudenthealth.com/carleton</a> or call 1-800-322-9901.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Do I need a referral to see a specialist?</strong></td>
<td>Yes</td>
<td>This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan’s permission before you see the specialist.</td>
</tr>
<tr>
<td><strong>Are there services this plan doesn’t cover?</strong></td>
<td>Yes</td>
<td>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.</td>
</tr>
</tbody>
</table>

---

**Questions:** Call 1-800-322-9901 or visit us at www.cirstudenthealth.com/carleton.  
If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-322-9901 to request a copy.
Companion Life Insurance Company Coverage Period: 8/15/2013 - 8/15/2014

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

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

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan’s **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven’t met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **participating providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Your Cost If You Use an In-network Provider</th>
<th>Your Cost If You Use an Out-of-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Limited to one visit per day.</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>You must have the plan's permission before you see the <strong>specialist</strong>. Limited to one visit per day.</td>
</tr>
<tr>
<td>Other practitioner office visit</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Limited to one visit per day.</td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>50% coinsurance, Deductible waived</td>
<td>Coverage is subject to limits on the number of visits, specific dollar amounts paid by the issuer, and age requirements in accordance with the terms of the policy and state and federal guidelines.</td>
</tr>
</tbody>
</table>

### If you have a test

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Your Cost If You Use an In-network Provider</th>
<th>Your Cost If You Use an Out-of-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>none</td>
</tr>
</tbody>
</table>
Table: Summary of Benefits and Coverage

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use an In-network Provider</th>
<th>Your Cost If You Use an Out-of-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>$15 copayment/ prescription (retail)</td>
<td>Not Covered</td>
<td>Limited to a 30-day supply per prescription. Prescriptions filled at non-Express Scripts pharmacies are not covered.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$30 copayment/ prescription (retail)</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$45 copayment/ prescription (retail)</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Specialty drugs are not covered.</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>$150 copayment per visit (waived if admitted as an inpatient).</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Facility fee limited to semi-private room rate.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td></td>
</tr>
</tbody>
</table>

Questions: Call 1-800-322-9901 or visit us at www.cirstudenthealth.com/carleton.
If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-322-9901 to request a copy.

Rev. 05-02-2013
### Summary of Benefits and Coverage: What this Plan Covers & What it Costs

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

**Plan Type:** PPO

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use an In-network Provider</th>
<th>Your Cost If You Use an Out-of-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>--------------none-----------</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td></td>
<td></td>
<td>--------------none-----------</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td></td>
<td></td>
<td>--------------none-----------</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td></td>
<td></td>
<td>--------------none-----------</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>--------------none-----------</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>--------------none-----------</td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>--------------none-----------</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Eye exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

**Questions:** Call 1-800-322-9901 or visit us at [www.cirstudenthealth.com/carleton](http://www.cirstudenthealth.com/carleton).

If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-800-322-9901 to request a copy.
Carleton College: Student Injury and Sickness Insurance Plan (Policy #CLSP0047-13):

Companion Life Insurance Company

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

Summary of Benefits and Coverage:

What this Plan Covers & What it Costs

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

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.)

<table>
<thead>
<tr>
<th>Services Your Plan Does NOT Cover</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
</tr>
<tr>
<td>Bariatric surgery</td>
</tr>
<tr>
<td>Cosmetic surgery</td>
</tr>
<tr>
<td>Dental care (Adult)</td>
</tr>
<tr>
<td>Hearing aids</td>
</tr>
<tr>
<td>Infertility treatment</td>
</tr>
<tr>
<td>Long-term care</td>
</tr>
<tr>
<td>Non-emergency care when traveling outside the U.S.</td>
</tr>
<tr>
<td>Routine eye care (Adult)</td>
</tr>
<tr>
<td>Routine foot care</td>
</tr>
<tr>
<td>Weight loss programs</td>
</tr>
</tbody>
</table>

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.)

<table>
<thead>
<tr>
<th>Other Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic care</td>
</tr>
<tr>
<td>Private-duty nursing</td>
</tr>
</tbody>
</table>

Questions: Call 1-800-322-9901 or visit us at www.cirstudenthealth.com/carleton.

If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-322-9901 to request a copy.

Rev. 05-02-2013
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 888-293-9229. You may also contact your state insurance department at: Minnesota Department of Commerce Insurance Division, 85 7th Place East, Suite 500, St. Paul, MN 55101. Phone: 651-296-4026, Email general.commerce@state.mn.us

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: Minnesota Department of Commerce Insurance Division, 85 7th Place East, Suite 500, St. Paul, MN 55101. Phone: 651-296-4026, Email general.commerce@state.mn.us

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:** $5,940
- **Patient pays:** $1,600

**Sample care costs:**

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital charges (mother)</td>
<td>$2,700</td>
</tr>
<tr>
<td>Routine obstetric care</td>
<td>$2,100</td>
</tr>
<tr>
<td>Hospital charges (baby)</td>
<td>$900</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>$900</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$500</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$200</td>
</tr>
<tr>
<td>Radiology</td>
<td>$200</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$7,540</strong></td>
</tr>
</tbody>
</table>

**Patient pays:**

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$100</td>
</tr>
<tr>
<td>Copays</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,500</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$1,600</strong></td>
</tr>
</tbody>
</table>

---

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,200
- **Patient pays:** $1,200

**Sample care costs:**

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$2,900</td>
</tr>
<tr>
<td>Medical Equipment and Supplies</td>
<td>$1,300</td>
</tr>
<tr>
<td>Office Visits and Procedures</td>
<td>$700</td>
</tr>
<tr>
<td>Education</td>
<td>$300</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$100</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$5,400</strong></td>
</tr>
</tbody>
</table>

**Patient pays:**

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$100</td>
</tr>
<tr>
<td>Copays</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,100</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$1,200</strong></td>
</tr>
</tbody>
</table>

---

*Questions: Call 1-800-322-9901 or visit us at www.cirstudenthealth.com/carleton. If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-322-9901 to request a copy.*
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.