National Guardian Life Insurance Company: Keiser University Student Health Insurance Plan

Coverage Period: 08/01/2016-07/31/2017

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

Coverage for: Student | 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.studentplanscenter.com or by calling 1-800-756-3702.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$250 Does not apply to Preventive Services and Prescription Drugs. Coinsurance and copayments do not count toward the deductible.	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 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.
Is there an out–of–pocket limit on my expenses?	Yes. $6,600	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, 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 specific coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. To locate a Network Provider call 800-226-5116 or go to www.firsthealth.com.	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 7. See your policy for additional information about **excluded services**.

Questions: Call 1-800-756-3702 or visit us at www.studentplanscenter.com.
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.studentplanscenter.com or call 1-800-756-3702 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 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	20% Coinsurance, $10 Copay	40% Coinsurance, $10 Copay	One visit per day.
	Specialist visit	20% Coinsurance, $10 Copay	40% Coinsurance, $10 Copay	One visit per day.
	Other practitioner office visit	20% Coinsurance, $10 Copay	40% Coinsurance, $10 Copay	One visit per day.
	Preventive care/ screening/immunization	0% Coinsurance, no deductible	40% Coinsurance	---none---
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance	40% Coinsurance	---none---
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	40% Coinsurance	---none---

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.studentplanscenter.com .	Generic drugs	$10 Copay	Not Covered	No copayment for generic contraceptives. Prescriptions must be filled at a participating pharmacy.
	Preferred brand drugs	$30 Copay	Not Covered	Prescriptions must be filled at a participating pharmacy.
	Non-preferred brand drugs	$50 Copay	Not Covered	Prescriptions must be filled at a participating pharmacy.
	Specialty drugs	$50 Copay	Not Covered	Prescriptions must be filled at a participating pharmacy. Pre-authorization required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	40% Coinsurance	---none---
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	Physician: One visit per day. If two or more surgical procedures are performed through the same incision or in immediate succession at the same operative session, We will pay a benefit equal to the benefit payable for the procedure with highest benefit value.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	20% Coinsurance, $150 Copay	20% Coinsurance, $150 Copay	---none---
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	---none---
	Urgent care	20% Coinsurance, $10 Copay	40% Coinsurance, $10 Copay	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	40% Coinsurance	---none---
	Physician/surgeon fee	20% Coinsurance	40% Coinsurance	Physician: One visit per day. If two or more surgical procedures are performed through the same incision or in immediate succession at the same operative session, We will pay a benefit equal to the benefit payable for the procedure with highest benefit value.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% Coinsurance, $10 Copay	40% Coinsurance, $10 Copay	---none---
	Mental/Behavioral health inpatient services	20% Coinsurance	40% Coinsurance	---none---
	Substance use disorder outpatient services	20% Coinsurance, $10 Copay	40% Coinsurance, $10 Copay	---none---
	Substance use disorder inpatient services	20% Coinsurance	40% Coinsurance	---none---
If you are pregnant	Prenatal and postnatal care	20% Coinsurance, $10 Copay	40% Coinsurance, $10 Copay	---none---
	Delivery and all inpatient services	20% Coinsurance	40% Coinsurance	Up to 48 hours for normal vaginal delivery and 96 hours (not including the day of surgery) for a caesarean section delivery.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	40% Coinsurance	Up to 40 visits per Policy Year
	Rehabilitation services	20% Coinsurance Outpatient: 20% Coinsurance, $10 Copay	40% Coinsurance Outpatient: 40% Coinsurance, $10 Copay	Outpatient: One visit per day.
	Habilitation services	20% Coinsurance, $10 Copay	40% Coinsurance, $10 Copay	One visit per day.
	Skilled nursing care	20% Coinsurance	40% Coinsurance	Up to 60 days per Policy Year.
	Durable medical equipment	20% Coinsurance	40% Coinsurance	---none---
	Hospice service	20% Coinsurance	40% Coinsurance	---none---
If your child needs dental or eye care	Eye exam	0% Coinsurance, no deductible	40% Coinsurance	Preventive Only. One visit per Policy Year.
	Glasses	0% Coinsurance, no deductible	40% Coinsurance	One pair of prescribed lenses and frames per Policy Year.
	Dental check-up	0% Coinsurance, no deductible	40% Coinsurance	Preventive Only. One exam every 6 months.

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.)**

- Bariatric Surgery, except if Medically Necessary
- Cosmetic Surgery, unless resulting directly from a Covered Injury that necessitates medical treatment within 24 hours of the Accident or results from Reconstructive Surgery
- Hearing Aids, except as a result of a covered accidental Injury
- 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
- Chiropractic Care
- Dental Care (Adult), as a result of injury
- Non-Emergency care when traveling outside the U.S., except there is no coverage (emergency or otherwise) for International Students in their Home Country
- Private-Duty Nursing, when prescribed by the attending Physician while confined in a hospital.

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 you rights to continue coverage, contact the insurer at 1-800-756-3702. You may also contact your state insurance department at Office of Insurance Regulation, 200 East Gaines Street, Tallahassee, FL 32399
Business Telephone, 850-413-3140 Consumer Helpline, 1-877-693-5236 (In Florida) http://www.floir.com/

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: 1-800-756-3702.

Office of Insurance Regulation, 200 East Gaines Street, Tallahassee, FL 32399, Business Telephone, 850-413-3140, Consumer Helpline, 1-877-693-5236 (In Florida), https://apps.fldfs.com/eService/Default.aspx

Additionally, a consumer assistance program can help you file your appeal. Insurance Commissioner, Florida Department of Insurance, 200 East Gaines Street, Tallahassee, FL 32399-0305; telephone: 850-413-3140; website: http://www.floir.com/, Email Address: Consumer.Services@myfloridacfo.com

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** $5,720
- **Patient pays** $1,820

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	$250
Copays	$20
Coinsurance	$1,400
Limits or exclusions	$150
Total	**$1,820**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,330
- **Patient pays** $1,070

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	$250
Copays	$500
Coinsurance	$240
Limits or exclusions	$80
Total	**$1,070**

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.

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