The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, https://wusmhealth.wustl.edu or call 314-362-2346. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $3,500 individual / $12,700 family; for out-of-network providers $3,500 individual / $12,700 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	premiums, balance-billing 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.
Will you pay less if you use a network provider?	Yes. See **https://wusmhealth.wustl.edu/students/.** Or call 314-362-2346 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge	Not Covered	Limited to Student Health and Forest Park Pediatrics providers.
	Specialist visit	$20.00/visit	20% co-insurance	No benefits will be paid for these services if a referral or pre-approval is not obtained from Student Health Service or Forest Park Pediatrics.
	Preventive care/screening/ immunization	No Charge	Not Covered	These services are free only when delivered by Student Health or Forest Park Pediatrics. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Please see www.healthcare.gov/preventive-care-benefits/ for complete details of the services provided for specific age and risk groups.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	20% co-insurance	Except as otherwise approved by Student Health Services or Forest Park Pediatrics, all adult testing must be obtained through the Student Health Services for coverage. Children are not eligible to utilize Student Health. Referral required from Primary Care Physician or Pediatric Primary Care Physician
	Imaging (CT/PET scans, MRIs)	No Charge	20% co-insurance	No benefits will be paid for these services if a referral or pre-approval is not obtained from Student Health Service or Forest Park Pediatrics.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://wusmhealth.wustl.edu	Generic drugs	20% co-insurance	20% co-insurance	Co-insurance waived for generic contraceptives and prescription wellness/preventive drugs. Prescriptions must be purchased at Student Health Service. Children are not eligible to utilize Student Health for medication instead approved to utilize the Center Advanced Medicine (CAM) pharmacy. No benefits will be paid for off campus retail pharmacy unless approved by Student Health Service or Forest Park Pediatrics.
	Preferred brand drugs	20% co-insurance	20% co-insurance	Only medication pre-approved by or coordinated through Student Health. Prescriptions must be purchased at Student Health Service. Children are not eligible to utilize Student Health for medication instead approved to utilize the CAM pharmacy. No benefits will be paid for off campus retail pharmacy unless approved by Student Health Service
	Non-preferred brand drugs	Not Covered	Not Covered	——————none——————
	Specialty drugs	20% co-insurance	Not Covered	Only medication pre-approved by or coordinated through Student Health. Prescriptions must be purchased at Student Health Service. Children are not eligible to utilize Student Health for medication instead approved to utilize the CAM pharmacy. No benefits will be paid for off campus retail pharmacy unless approved by Student Health Service
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	20% co-insurance	No benefits will be paid for these services if a referral or pre-approval is not obtained from Student Health Service or Forest Park Pediatrics.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	No Charge	20% co-insurance	No benefits will be paid for these services if a referral or pre-approval is not obtained from Student Health Service or Forest Park Pediatrics.
If you need immediate medical attention	Emergency room care	$50/visit 20% co-insurance	$50/visit 20% co-insurance	20% co-insurance after the first $200 Next business day notification required.
	Emergency medical transportation	20% co-insurance	20% co-insurance	Ambulance transportation from home, scene of accident or medical emergency to hospital; between hospitals; between hospital and skilled nursing facility.
	Urgent care	$50/visit 20% co-insurance	$50/visit 20% co-insurance	Next business day notification required.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500/visit	20% co-insurance	Semi-private room. No benefits will be paid for these services if a referral or pre-approval is not obtained from Student Health Service or Forest Park Pediatrics.
	Physician/surgeon fees	No Charge	20% co-insurance	No benefits will be paid for these services if a referral or pre-approval is not obtained from Student Health Service or Forest Park Pediatrics.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10.00/visit	50% co-insurance	A referral is required to see a Psychiatrist. In-network initial assessment no charge. Out-of-network referral required up to 6 visit limit.
	Inpatient services	$500/visit	50% co-insurance	Semi-private room. No benefits will be paid for these services if a referral or pre-approval is not obtained from Student Health Service.
If you are pregnant	Office visits	No Charge	20% co-insurance	No benefits will be paid for these services if a referral or pre-approval is not obtained from Student Health Service or Forest Park Pediatrics.
	Childbirth/delivery professional services	$500/first delivery $1000/additional delivery	20% co-insurance	——————none——————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	No Charge	20% co-insurance	——————none——————
If you need help recovering or have other special health needs	Home health care	20% co-insurance	Not Covered	No benefits will be paid for these services if a referral or pre-approval is not obtained from Student Health Service or Forest Park Pediatrics.
	Rehabilitation services	20% co-insurance	Not Covered	No benefits will be paid for these services if a referral or pre-approval is not obtained from Student Health Service or Forest Park Pediatrics. In-network physical therapy is covered 100%
	Habilitation services	20% co-insurance	Not Covered	No benefits will be paid for these services if a referral or pre-approval is not obtained from Student Health Service or Forest Park Pediatrics. In-network physical therapy is covered 100%
	Skilled nursing care	20% co-insurance	Not Covered	No benefits will be paid for these services if a referral or pre-approval is not obtained from Student Health Service or Forest Park Pediatrics.
	Durable medical equipment	20% co-insurance	Not Covered	No benefits will be paid for these services if a referral or pre-approval is not obtained from Student Health Service or Forest Park Pediatrics.
	Hospice services	20% co-insurance	Not Covered	No benefits will be paid for these services if a referral or pre-approval is not obtained from Student Health Service or Forest Park Pediatrics.
If your child needs dental or eye care	Children's eye exam	$20/visit	Not Covered	Limited to one exam per year.
	Children's glasses	50% co-insurance	Not Covered	Limited to one pair of glasses per year.
	Children's dental check-up	50% co-insurance	Not Covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery (except as noted in the policy)
- Cosmetic surgery (except as noted in the policy)
- Dental care (Adult) (other than for injury to sound natural teeth)
- Hearing aids (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Non-preferred brand drugs
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- Private-duty nursing
- Routine eye exam (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is your state insurance department at 573-751-4126 or Missouri Department of Insurance Truman State Office Building, Room 530, P. O. Box 690, Jefferson City, MO 65102. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact state insurance department at 573-751-4126.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Not Applicable

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 314-362-3523.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 314-362-3523.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 314-362-3523.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 314-362-3523.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) copayment	$500
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$500**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) copayment	$500
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (including disease education)
Diagnostic tests (blood work)
Prescription drugs
Durable medical equipment (glucose meter)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$1300
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1500**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) copayment	$500
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care (including medical supplies)
Diagnostic test (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$500**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 314-362-2346.

The plan would be responsible for the other costs of these EXAMPLE covered services.