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 **https://wusmhealth.wustl.edu/students/** or by calling 314-362-2346.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
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 $6,350 for the Individual, per policy year and $12,700 for the Family, per policy year.**	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?	Copayments, 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 $2,000,000**	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 office visits.
Does this plan use a network of providers?	**Yes.** For a list of **preferred** Providers, **https://wusmhealth.wustl.edu/students/.** or by calling 314-362-2346.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all 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?	**Yes** .	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.**
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 314-362-2346 or visit us at http://wusmhealth.wustl.edu/students/.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://wusmhealth.wustl.edu/students/.or call 314-362-2346 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	No Charge	Not Covered	Limited to Student Health and Forest Park Pediatrics providers.
	Specialist visit	$20.00/visit	20% co-insurance	Unless Approved 20% co-insurance Usual and Customary Charges
	Other practitioner office visit	20% co-insurance for chiropractor	20% co-insurance for chiropractor	Cost share applies to chiropractic services and is limited to 15 visits per year.
	Preventive care/screening/immunization	No Charge	Not Covered	Unless ACIP required immunization 80% co-insurance
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	20% co-insurance	Except as otherwise approved by Student Health Services, all testing must be obtained through the Student Health Services for coverage.
	Imaging (CT/PET scans, MRIs)	No Charge	20% co-insurance	Except as otherwise approved by Student Health Services, all testing must be obtained through the Student Health Services for coverage.

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 https://wusmhealth.wustl.edu/students/ or 314-362-2346.	Generic drugs	20 % co-insurance	50% co-insurance	Co-insurance waived for generic contraceptives and prescription wellness/preventive drugs. Prescriptions must be purchased at University Health Service.
	Preferred brand drugs	20% co-insurance	50% co-insurance	Only medication pre-approved by or coordinated through Student Health.
	Non-preferred brand drugs	Not Covered	Not Covered	————————none————————
	Specialty drugs	20% co-insurance	50% co-insurance	Only medication pre-approved by or coordinated through Student Health.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	30% co-insurance	Only when pre-approved by Student Health Service
	Physician/surgeon fees	No Charge	30% co-insurance	Only when pre-approved by Student Health Service
If you need immediate medical attention	Emergency room services	$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-	Next business day notification required.
	Urgent care	$50/visit	$50/visit 20% co-insurance	Next business day notification required.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250/visit	20% co-insurance-	Semi-private room
	Physician/surgeon fee	No Charge	20% co-insurance-	————————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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10.00/visit	20% co-insurance	Psychiatrist's services outside the scope of Student Health Services, except as approved by Student Health Services
	Mental/Behavioral health inpatient services	$250/visit	20% co-insurance-	Semi-private room
	Substance use disorder outpatient services	$10.00/visit	20% co-insurance	————————none————————
	Substance use disorder inpatient services	$250/visit	20% co-insurance-	Semi-private room
If you are pregnant	Prenatal and postnatal care	No Charge	20% co-insurance	With Student Health approval only.
	Delivery and all inpatient services	$250/first delivery $1000/ additional delivery	20% co-insurance-	————————none————————
If you need help recovering or have other special health needs	Home health care	20% co-insurance	Not Covered	Visiting nurse service except for those approved by or coordinated through Student Health Services
	Rehabilitation services	20% co-insurance	Not Covered	Visit limitation may apply
	Habilitation services	20% co-insurance	Not Covered	Limits are combined with Rehabilitation Services. Visit limitation may apply
	Skilled nursing care	20% co-insurance	Not Covered	Visiting nurse service except for those approved by or coordinated through Student Health Services.
	Durable medical equipment	20% co-insurance	Not Covered	————————none————————
	Hospice service	20% co-insurance	Not Covered	————————none————————
If your child needs dental or eye care	Eye exam	$20/visit	Not Covered	Limited to one exam per years.
	Glasses	50% co-insurance	Not Covered	Limited to one pair of glasses per year.
	Dental check-up	50% co-insurance	Not Covered	Limitations, including dollar limits, may apply.

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.)		
• 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 (except as noted in the policy) • Long-term care • Non-preferred brand drugs	• Non-emergency care when traveling outside the U.S. • 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.)		
• Chiropractic care	• Routine eye care (Adult)	• Private-duty nursing

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 314-362-2346. You may also contact 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,

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: 314-362-2346.

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 314-362-2346

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 314-362-2346

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 314-362-2346

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 314-362-2346

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** $7,240
- **Patient pays** $ 300

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	$
Copays	$300
Coinsurance	$
Limits or exclusions	$
Total	**$300**

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your cost may be higher. For more information, please contact: 314-362-2346.

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,300
- **Patient pays** $1,100

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	$
Copays	$200
Coinsurance	$600
Limits or exclusions	$300
Total	**$1100**

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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