



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, see <http://www.abs-tpa.com> and/or call 1-833-239-1273. For 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 [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-833-239-1273 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                                                                                            | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|---------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | <a href="#">Olin Health Center</a> : None. In- <a href="#">Network</a> : Individual <b>\$125</b> ; Family <b>\$250</b> . Out-of- <a href="#">Network</a> : Individual <b>\$250</b> ; Family <b>\$500</b> .                                         | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay.<br><br>If you have other family members on the <a href="#">plan</a> , each individual must meet their own <a href="#">deductible</a> before the <a href="#">plan</a> begins to pay.                                                                                                                                                                                                                                             |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. In- <a href="#">network</a> : Lab, <a href="#">preventive care emergency services</a> , some <a href="#">prescription drugs</a> , and <a href="#">Olin Health Center</a> visits are covered before you meet your <a href="#">deductible</a> . | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> . |
| Are there other <a href="#">deductibles</a> for specific services?              | No.                                                                                                                                                                                                                                                | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | <a href="#">Olin Health Center</a> and In- <a href="#">Network</a> (Combined): Individual <b>\$1,500</b> ; Family <b>\$3,000</b> . Out-of- <a href="#">Network</a> : Individual <b>\$2,300</b> ; Family <b>\$4,600</b> .                           | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services.<br><br>If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | Penalties for failure to obtain <a href="#">pre-authorization</a> for services, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, health care this <a href="#">plan</a> doesn't cover, pediatric vision                          | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

| Important Questions                                                          | Answers                                                                                                                              | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Will you pay less if you use a <a href="#">network provider</a> ?            | Yes. See <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-800-859-8452 for a list of in-network providers. | You pay the least if you use a <a href="#">provider</a> at <a href="#">Olin Health Center</a> for available services. You may pay more if you use a <a href="#">provider</a> in your <a href="#">Network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays (balance billing). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ? | No.                                                                                                                                  | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> . However, we will assign an <a href="#">Olin Health Center</a> physician as primary care. You may change your <a href="#">primary care physician</a> at your discretion.                                                                                                                                                                                                                                                                                                                                                                                                                                 |

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

| What You Will Pay                                                      |                                                        |                                                                 |                                       |                                              |                                                                                                                                                                                                                                                               |
|------------------------------------------------------------------------|--------------------------------------------------------|-----------------------------------------------------------------|---------------------------------------|----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Common Medical Event                                                   | Services You May Need                                  | MSU Student Health Services at Olin Health Center               | In-Network Coverage                   | Out-of-Network Coverage                      | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                        |
| If you visit a health care <a href="#">provider's</a> office or clinic | Primary care visit to treat an injury or illness       | \$15 <a href="#">copay</a> /visit<br>Deductible does not apply. | \$15 <a href="#">copay</a> /visit     | Deductible + 20% <a href="#">coinsurance</a> | Copay includes all related charges provided at health care provider's office.                                                                                                                                                                                 |
|                                                                        | <a href="#">Specialist</a> visit                       | \$15 <a href="#">copay</a> /visit<br>Deductible does not apply. | \$15 <a href="#">copay</a> /visit     | Deductible + 20% <a href="#">coinsurance</a> | See above.                                                                                                                                                                                                                                                    |
|                                                                        | <a href="#">Preventive care/screening/immunization</a> | No charge; deductible does not apply.                           | No charge; deductible does not apply. | Deductible + 20% <a href="#">coinsurance</a> | Well child visits covered. Maximum number of visits may apply.<br><br>You may have to pay for services that aren't considered <a href="#">preventive</a> . Ask your provider if the services you need are preventive. Then check what your plan will pay for. |

| Common Medical Event                                                                                                                                                                                                                                                                                                                                          | Services You May Need                                       | What You Will Pay                                                                                                      |                                                       |                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                                                               |                                                             | MSU Student Health Services at Olin Health Center                                                                      | In-Network Coverage                                   | Out-of-Network Coverage                      | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| If you have a test                                                                                                                                                                                                                                                                                                                                            | <a href="#">Diagnostic test</a> (x-ray, blood work)         | No charge                                                                                                              | Deductible + 5% <a href="#">coinsurance</a><br>Deduct | Deductible + 20% <a href="#">coinsurance</a> | Select services available at <a href="#">Olin Health Center</a> and are covered in full. May require <a href="#">preauthorization</a> . No charge and deductible does not apply for lab services                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                               | Imaging (CT/PET scans, MRIs)                                | Not available                                                                                                          | Deductible + 5% <a href="#">coinsurance</a>           | Deductible + 20% <a href="#">coinsurance</a> | May require <a href="#">preauthorization</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="https://www.aetna.com/individuals-families/find-a-medication/2024-aetna-advanced-control-plan.html">https://www.aetna.com/individuals-families/find-a-medication/2024-aetna-advanced-control-plan.html</a> | Preferred generic drugs                                     | \$10 <a href="#">copay</a> (30-day supply) / \$20 copay (90-day supply)<br>Deductible does not apply.                  |                                                       |                                              | You are required to use generic if available. If brand is chosen, you must pay 100% of the difference between generic and brand.<br>Limited to 30-day retail supply & 90-day retail supply.<br>In-network pharmacy and CVS Caremark are subject to In-network <a href="#">out-of-pocket limit</a> . Out of Network pharmacy is subject to Out of Network <a href="#">out-of-pocket limit</a> .<br>Certain specialty pharmacy drugs are considered non-essential health benefits and fall outside the <a href="#">out-of-pocket limits</a> . The cost of these drugs (though reimbursed by the manufacturer at no cost to you) will not be applied towards satisfying your <a href="#">out-of-pocket</a> maximums. |
|                                                                                                                                                                                                                                                                                                                                                               | Preferred brand drugs                                       | \$30 <a href="#">copay</a> (30-day supply) / \$60 <a href="#">copay</a> (90-day supply)<br>Deductible does not apply.  |                                                       |                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                               | Non-preferred brand drugs                                   | \$60 <a href="#">copay</a> (30-day supply) / \$120 <a href="#">copay</a> (90-day supply)<br>Deductible does not apply. |                                                       |                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                               | Preferred and non-preferred <a href="#">Specialty drugs</a> | \$75 <a href="#">copay</a><br>Deductible does not apply.                                                               |                                                       | Not Covered                                  | Limited to 30-day supply. Prior authorization required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| If you have outpatient surgery                                                                                                                                                                                                                                                                                                                                | Facility fee (e.g., ambulatory surgery center)              | Not available                                                                                                          | Deductible + 5% <a href="#">coinsurance</a>           | Deductible + 20% <a href="#">coinsurance</a> | Pre-certification required for Hospital Observations.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                               | Physician/surgeon fees                                      | Not available                                                                                                          | No charge                                             | Not covered                                  | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |

| What You Will Pay                                                         |                                                  |                                                          |                                                                                                                            |                                                                                                                                                                                                                    |                                                                                                                    |
|---------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|
| Common Medical Event                                                      | Services You May Need                            | MSU Student Health Services at Olin Health Center        | In-Network Coverage                                                                                                        | Out-of-Network Coverage                                                                                                                                                                                            | Limitations, Exceptions, & Other Important Information                                                             |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | Not available                                            | \$50 copay + 5% <a href="#">coinsurance</a><br>Deductible does not apply.                                                  | \$50 copay + 5% <a href="#">coinsurance</a><br>Deductible does not apply.                                                                                                                                          | Non-emergency services are covered but are subject to <a href="#">deductible</a> and <a href="#">coinsurance</a> . |
|                                                                           | <a href="#">Emergency medical transportation</a> | Not available                                            | 5% <a href="#">coinsurance</a><br>Deductible does not apply.                                                               | 5% <a href="#">coinsurance</a><br>Deductible does not apply.                                                                                                                                                       |                                                                                                                    |
|                                                                           | <a href="#">Urgent care</a>                      | Not available                                            | Deductible + 5% <a href="#">coinsurance</a>                                                                                | Deductible + 20% <a href="#">coinsurance</a>                                                                                                                                                                       | Copay includes all related charges provided at the urgent care facility.                                           |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | Not available                                            | Deductible + 5% <a href="#">coinsurance</a>                                                                                | Deductible + 20% <a href="#">coinsurance</a>                                                                                                                                                                       | Pre-certification required.                                                                                        |
|                                                                           | Physician/surgeon fees                           | Not available                                            | No Charge                                                                                                                  | Not Covered                                                                                                                                                                                                        | None                                                                                                               |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | \$15 <a href="#">copay</a><br>Deductible does not apply. | Office visits: \$15 <a href="#">copay</a><br>All other outpatient services:<br>Deductible + 5% <a href="#">coinsurance</a> | Mental health & behavioral health office visits: \$15 <a href="#">copay</a> after deductible<br>All other outpatient services to include substance abuse services:<br>Deductible + 20% <a href="#">coinsurance</a> | Some services may require prior authorization.                                                                     |
|                                                                           | Inpatient services                               | Not available                                            | Deductible + 5% <a href="#">coinsurance</a>                                                                                | Deductible + 20% <a href="#">coinsurance</a>                                                                                                                                                                       | Pre-certification required.                                                                                        |

| Common Medical Event                                           | Services You May Need                     | MSU Student Health Services at Olin Health Center          | What You Will Pay                                                                                                                                |                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|----------------------------------------------------------------|-------------------------------------------|------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                           |                                                            | In-Network Coverage                                                                                                                              | Out-of-Network Coverage                      | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                               |
| If you are pregnant                                            | Office visits                             | Not available                                              | Covered<br>Deductible does not apply.                                                                                                            | Deductible + 20% <a href="#">coinsurance</a> | <p><a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a>. Depending on the type of service, a <a href="#">copayment</a> may apply.</p> <p>Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Pre-certification is required for vaginal deliveries requiring more than a 48-hour stay and for cesarean section deliveries requiring more than a 96-hour stay, or no benefits are paid.</p> |
|                                                                | Childbirth/delivery professional services | Not available                                              | Deductible + 5% <a href="#">coinsurance</a>                                                                                                      | Deductible + 20% <a href="#">coinsurance</a> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                | Childbirth/delivery facility services     | Not available                                              | Deductible + 5% <a href="#">coinsurance</a>                                                                                                      | Deductible + 20% <a href="#">coinsurance</a> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>          | Not available                                              | Deductible + 5% <a href="#">coinsurance</a>                                                                                                      | Deductible + 20% <a href="#">coinsurance</a> | Pre-certification required.                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|                                                                | <a href="#">Rehabilitation services</a>   | \$15 copay<br>Deductible does not apply.                   | \$15 <a href="#">copay</a> + 5% <a href="#">coinsurance</a>                                                                                      | Deductible + 20% <a href="#">coinsurance</a> | <p>Only physical therapy services are available at <a href="#">Olin Health Center</a>. <a href="#">Olin Health Center</a> does not offer speech or occupational therapy.</p>                                                                                                                                                                                                                                                                                         |
|                                                                | <a href="#">Habilitation services</a>     | Physical Therapy: \$15 copay<br>Deductible does not apply. | Applied Behavior Analysis (ABA) - \$15 copay<br>Physical, Occupational, Speech Therapy (PT/OT/ST - \$15 copay + 5% <a href="#">coinsurance</a> ) | Deductible + 20% <a href="#">coinsurance</a> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                | <a href="#">Skilled nursing care</a>      | Not available                                              | Deductible + 5% <a href="#">coinsurance</a>                                                                                                      | Deductible + 20% <a href="#">coinsurance</a> | Services require prior authorization.                                                                                                                                                                                                                                                                                                                                                                                                                                |

| Common Medical Event                                           | Services You May Need                     | MSU Student Health Services at Olin Health Center                                                     | What You Will Pay                                           |                                                                                     |                                                                                                                                 |
|----------------------------------------------------------------|-------------------------------------------|-------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                           |                                                                                                       | In-Network Coverage                                         | Out-of-Network Coverage                                                             | Limitations, Exceptions, & Other Important Information                                                                          |
| If you need help recovering or have other special health needs | <a href="#">Durable medical equipment</a> | <a href="#">Olin Health Center</a> has certain DME items available. Member out-of-pocket costs apply. | Deductible + 5% <a href="#">coinsurance</a>                 | Not covered                                                                         | Certain exclusions apply.                                                                                                       |
|                                                                | <a href="#">Hospice services</a>          | Not available                                                                                         | Deductible + 5% <a href="#">coinsurance</a>                 | Deductible + 20% <a href="#">coinsurance</a>                                        | None.                                                                                                                           |
| If your child needs dental or eye care                         | Children's eye exam                       | Not available                                                                                         | Covered<br>Deductible does not apply.                       | Difference between the Aetna approved amount and the amount charged by the provider | Limited to covered dependent children of the student once in a calendar year through the end of the year in which they turn 19. |
|                                                                | Children's glasses                        | Not available                                                                                         | Covered<br>Deductible does not apply.                       | Difference between the Aetna approved amount and the amount charged by the provider | 1 routine eye exam/plan year to age 19.<br>1 pair of glasses or lenses/plan year to age 19.                                     |
|                                                                | Children's dental check-up                | Not available                                                                                         | Contact your benefit administrator for coverage information | 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                                          | • Hearing aids, unless due to covered injury or illness | • Private Duty Nursing     |
| • Cosmetic surgery                                     | • Long-term Care                                        | • Routine eye care (adult) |
| • Dental care (adult)                                  | • Non-emergency care when travelling outside the U.S.   | • Routine foot care        |
| • Gene-based, cellular, and other innovative therapies |                                                         | • Weight loss programs     |

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

- |                                              |                                                                        |                        |
|----------------------------------------------|------------------------------------------------------------------------|------------------------|
| • Bariatric surgery (medical necessity only) | • Gender affirming treatment                                           | • Weight loss programs |
| • Chiropractic care                          | • Infertility (For more information & exceptions, see policy document) |                        |

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at 1-833-239-1273. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). 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](http://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 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 the plan at 1-833-239-1273. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). You may be able to contact your state department of insurance for assistance. A list of states with Consumer Assistance Programs is available at: <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers> and <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/>

### 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? Yes

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 1-833-239-1273.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-239-1273.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-833-239-1273.

Navajo (Dine): Dine'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-833-239-1273.

*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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$125 |
| ■ <a href="#">Specialist copayment</a>                          | \$15  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 5%    |
| ■ Other <a href="#">coinsurance</a>                             | 5%    |

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*)

|                                        |                 |
|----------------------------------------|-----------------|
| <b>Total Example Cost</b>              | <b>\$12,700</b> |
| <b>In this example, Peg would pay:</b> |                 |
| <i>Cost Sharing</i>                    |                 |
| <a href="#">Deductibles</a>            | \$100           |
| <a href="#">Copayments</a>             | \$30            |
| <a href="#">Coinsurance</a>            | \$400           |
| <i>What isn't covered</i>              |                 |
| Limits or exclusions                   | \$60            |
| <b>The total Peg would pay is</b>      | <b>\$590</b>    |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                                                 |       |
|-----------------------------------------------------------------|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$125 |
| ■ <a href="#">Specialist copayment</a>                          | \$15  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 5%    |
| ■ Other <a href="#">coinsurance</a>                             | 5%    |

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*)

|                                        |                |
|----------------------------------------|----------------|
| <b>Total Example Cost</b>              | <b>\$5,600</b> |
| <b>In this example, Joe would pay:</b> |                |
| <i>Cost Sharing</i>                    |                |
| <a href="#">Deductibles</a>            | \$100          |
| <a href="#">Copayments</a>             | \$600          |
| <a href="#">Coinsurance</a>            | \$30           |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | \$20           |
| <b>The total Joe would pay is</b>      | <b>\$750</b>   |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|                                                                 |       |
|-----------------------------------------------------------------|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$125 |
| ■ <a href="#">Specialist copayment</a>                          | \$15  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 5%    |
| ■ Other <a href="#">coinsurance</a>                             | 5%    |

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

|                                        |                |
|----------------------------------------|----------------|
| <b>Total Example Cost</b>              | <b>\$2,800</b> |
| <b>In this example, Mia would pay:</b> |                |
| <i>Cost Sharing</i>                    |                |
| <a href="#">Deductibles</a>            | \$100          |
| <a href="#">Copayments</a>             | \$100          |
| <a href="#">Coinsurance</a>            | \$70           |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | \$0            |
| <b>The total Mia would pay is</b>      | <b>\$270</b>   |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.