



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.choices.mus.edu or by calling 1-877-501-1722.

| Important Questions | Answers | Why this Matters: |
|---|---|--|
| What is the overall deductible? | \$500/person In-Network \$1,000/family In-Network | Deductible applies to all services unless otherwise indicated, or a copayment applies. |
| Are there other deductibles for specific services? | \$750/person Out-of-Network \$1,750/family Out-of-Network | There is a separate deductible for out of-network services. |
| Is there an out-of-pocket limit on my expenses? | \$3,500/person In-Network \$7,000/family In-Network \$6,000/person Out-of-Network \$12,000/family Out-of-Network | In-Network maximum out-of-pocket amount – includes deductible, coinsurance, and copayments Out-of-Network – a separate out-of-pocket amount, includes deductible, coinsurance, and copayments |
| What is not included in the out-of-pocket limit? | non-covered services, and balance billing | Even though you pay these expenses, they are not included in the out-of-pocket limit. |
| Is there an overall annual limit on what the plan pays? | No | There may be day limits or visit limits on some services, but no overall annual dollar limit. |
| Does this plan use a network of providers? | Yes | See www.abpmtpa.com/MUS or call 1-877-778-8600 to find a network provider. |
| Do I need a referral to see a specialist? | No | The deductible and coinsurance are higher if you choose an out-of-network specialist. |
| Are there services this plan doesn't cover? | Yes | See “Exclusions” in the Summary Plan Description (SPD) |



- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** payment of 25% would be \$250. 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/or **coinsurance amounts**.

| Common Medical Event | Services You May Need | Your cost if you use an | | Limitations & Exceptions | |
|--|---|---|---------------------------------|--|---|
| | | In-Network Provider | Out-of-Network Provider | | |
| If you visit a health care provider’s office or clinic | Primary care visit to treat an injury or illness | \$15 copayment | 35% | | |
| | Specialist visit | \$15 copayment | 35% | | |
| | Other practitioner visit- acupuncture/naturopathic, chiropractic, massage therapy | \$15 copayment | 35%- chiropractic only | Max 30 visits- except naturopathic, no visit limit You may be responsible for balance billing | |
| | Preventive care/screening/immunization | 0%, no deductible | 35% | | |
| If you have a test | Diagnostic test (x-ray, blood work) | 25% | 35% | | |
| | Imaging (CT/PET scans, MRIs) | 25% | 35% | May require prior authorization | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage in www.urx.mus.edu | | URx | Retail (30 days) | Mail-Order (90 days) | |
| | Generic Drugs- | TIER A | \$0 copay | \$0 copay | |
| | Preferred Brand Drugs- | TIER B | \$15 copay | \$30 copay | |
| | Non-preferred Brand Drugs- | TIER C | \$40 copay | \$80 copay | 50% of discounted price 100% of discounted price 50% coinsurance- retail pharmacy |
| | | TIER D | 50% coinsurance | 50% coinsurance | |
| Specialty drugs (see work book)- | TIER F TIER S | 100% coinsurance \$50 or \$200 copay | 100% coinsurance Not covered | | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery) center) | | 25% | 35% | |
| | Physician/surgeon fees | | 25% | 35% | |

Questions: Call 1-877-501-1722 or visit us at www.choices.mus.edu. If you aren’t clear about any of the terms used, you can view the Glossary at www.insuranceterms.gov

| Common Medical Event | Services You May Need | Your cost if you use an | | Limitations & Exceptions |
|--|---|-------------------------------------|-------------------------|---|
| | | In-Network Provider | Out-of-Network Provider | |
| If you need immediate medical attention | Emergency medical transportation | \$200 copayment | \$200 copayment | |
| | Emergency room services | \$125 copayment/visit | \$125 copayment/visit | All other charges- deductible & coinsurance apply |
| | Urgent care | \$50 copayment/visit | \$50 copayment/visit | All other charges- deductible & coinsurance apply |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 25% | 35% | |
| | Physician/surgeon fee | 25% | 35% | |
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | 1 st 4 at \$0, then \$15 | 35% | |
| | Mental/Behavioral health inpatient services | 25% | 35% | |
| | Substance use disorder outpatient services | 1 st 4 at \$0, then \$15 | 35% | |
| | Substance use disorder inpatient services | 25% | 35% | |
| If you are pregnant | Prenatal and postnatal care | 25% | 35% | |
| | Delivery and all inpatient services | 25% | 35% | |
| If you need help recovering or have other special health needs | Home health care | \$15 copayment/visit | 35% | Needs prior auth/max 30 visits/yr |
| | Rehabilitation services- inpatient/outpatient | 25% inpatient | 35% | Inpatient- 30 days/yr |
| | | \$15 copay outpatient | | Outpatient- 30 days/yr |
| | Skilled nursing care | 25% | 35% | 30 days/yr – needs prior authorization |
| | Durable medical equipment | 25% | 35% | |
| Hospice service | 25% | 25% | Maximum is 6 months | |
| If your child needs dental or eye care | Eye exam **covered by Health Plan | 0% - one/year | 35% - one/year | See Choices book for allowances |
| | Glasses **optional vision hardware- BCBS | | | |
| | Dental check-up ** Delta Dental | | | Fee schedule payment |

Questions: Call 1-877-501-1722 or visit us at www.choices.mus.edu. If you aren't clear about any of the terms used, you can view the Glossary at www.insuranceterms.gov

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](#).)

- work related accident or illness
- cosmetic procedures
- in-vitro fertilization

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.)

- organ transplant
- preventive services
- medically necessary travel with prior authorization- \$1,500 max/yr.

Your Rights to Continue Coverage:

You can keep this coverage as long as your premiums are paid, unless your employment terminates, or hours worked drop below 20. If you have no other coverage, you can choose to keep this coverage by electing COBRA. See your HR office for rules regarding election of COBRA benefits, and making premium payments.

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: Allegiance at 1-877-778-8600, or MUS EB at 1-877-501-1722.

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** \$5,140 + Rx drugs
- **Patient pays** \$2,200 + Rx copays

Sample care costs: \$7,540

| | |
|--|----------------|
| Hospital charges (mother) | \$2,700 |
| Routine obstetric care | \$2,100 |
| Hospital chgs (baby chgs are separate) | \$900 |
| Anesthesia | \$900 |
| Laboratory tests | \$500 |
| Prescriptions | \$200 |
| Radiology | \$200 |
| Vaccines, other preventive | \$40 |
| Total | \$7,540 |

Patient pays:

| | |
|----------------------|----------------|
| Deductibles | \$500 |
| Co-pays | \$ |
| Co-insurance | \$1,700 |
| Limits or exclusions | \$ |
| Total | \$2,200 |

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

- **Amount owed to providers:** \$4,100
- **Plan pays** \$1,745 + Rx drugs
- **Patient pays** \$855 + Rx copays

Sample care costs: \$4,100

| | |
|--------------------------------|----------------|
| Prescriptions | \$1,500 |
| Medical Equipment and Supplies | \$1,300 |
| Office Visits (8) | \$730 |
| Education | \$290 |
| Laboratory tests | \$140 |
| Vaccines, other preventive | \$140 |
| Total | \$4,100 |

Patient pays:

| | |
|----------------------------------|--------------|
| Deductibles | \$500 |
| Co-pays (OV copayments 8 x \$15) | \$120 |
| Co-insurance | \$235 |
| Limits or exclusions | \$ |
| Total | \$855 |

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.