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.christiestudenthealth.com/[insertschoolname] or by calling 1-888-445-1458.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Yes. $200 per Member, per Policy Year for In-Network Services, $400 per Member, per Policy Year for Out-of-Network Services. Does not apply to In-Network Preventive Services, In-Network Pediatric Vision Services	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes, for In-Network. $2,000 per Member services/$8,000 per Family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, 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?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **In-Network providers**, visit www.christiestudenthealth.com/oberlincollege or call **1-844-603-6191**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services his plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **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 **participating providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 Copay per visit	40% Coinsurance	None
	Specialist visit	$20 Copay per visit	40% Coinsurance	None
	Other practitioner office visit	$20 Copay per visit	40% Coinsurance	None
	Preventive care/screening/immunization	No Charge	40% Coinsurance	Includes preventive health services specified in the health care reform law or benefits provided as mandated by state law.
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance	40% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	40% Coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.christiestudenthealth.com/oberlincollege	Generic drugs	$10 Copay per prescription	40% Coinsurance per prescription	Covers up to a 30 day supply (retail). Mail order In-network is subject to 2.5 copays per 90 day supply, Out-of-network is 20% Coinsurance.
	Preferred brand drugs	$25 Copay per prescription		
	Non-preferred brand drugs			
	Specialty drugs		Not Covered	Specialty drugs covered at Participating Pharmacies only.

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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	40% Coinsurance	None
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	None
If you need immediate medical attention	Emergency room services	$100 copay/visit plus 20% Coinsurance	$100 copay/visit plus 20% Coinsurance	None
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	Ground and air transportation covered
	Urgent care	$50 copay/visit plus 20% Coinsurance	$50 copay/visit plus 40% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	40% Coinsurance	None
	Physician/surgeon fee	20% Coinsurance	40% Coinsurance	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 Copay per visit	40% Coinsurance	None
	Mental/Behavioral health inpatient services	20% Coinsurance	40% Coinsurance	None
	Substance use disorder outpatient services	$20 Copay per visit	40% Coinsurance	None
	Substance use disorder inpatient services	20% Coinsurance	40% Coinsurance	None
If you are pregnant	Prenatal and postnatal care	**Routine Outpatient** – No Charge **Non-Routine Outpatient** – 20% Coinsurance	40% Coinsurance	None
	Delivery and all inpatient services	20% Coinsurance	40% Coinsurance	None

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	40% Coinsurance	Coverage for private duty nursing in home setting is limited to 110 visits per Policy Year.
	Rehabilitation services	20% Coinsurance	40% Coinsurance	Coverage includes Physical, Occupational & Speech Therapies. Coverage is limited to 20 visits per Policy Year for each Therapy type.
	Habilitation services	20% Coinsurance	40% Coinsurance	Coverage includes Physical, Occupational & Speech Therapies. Coverage is limited to 20 visits per Policy Year for each Therapy type.
	Skilled nursing care	20% Coinsurance	40% Coinsurance	None
	Durable medical equipment	20% Coinsurance	40% Coinsurance	None
	Hospice service	20% Coinsurance	40% Coinsurance	None
If your child needs dental or eye care	Eye exam	No Charge	40% Coinsurance	Coverage is limited to one exam per Policy Year.
	Glasses	No Charge	40% Coinsurance	Coverage is limited to one pair of glasses (lenses and frames) per Policy Year.
	Dental check-up	No Charge	30% Coinsurance	Coverage is limited to one exam per 6 months.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Glasses (Adult)
- Infertility treatment
- Long term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Chiropractic care
- Dental care (Child)
- Glasses (Child)
- Private Duty Nursing
- Routine Eye Care (Child)

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, you can contact the insurer at 1-844-603-6191. You may also contact your state insurance department at (614) 644-2658 or visit www.insurance.ohio.gov/.

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 state insurance department at (614) 644-2658 or visit www.insurance.ohio.gov/ or contact U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, your State Department of Insurance can help you file your **appeal**. Visit www.insurance.ohio.gov/ for more information.

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 1-844-603-6191.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-603-6191.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-844-603-6191.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-603-6191.

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** $6,290
- **Patient pays** $1,250

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	$200
Copays	$10
Coinsurance	$1040
Limits or exclusions	$0
Total	**$1,250**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,830
- **Patient pays** $570

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	$200
Copays	$30
Coinsurance	$340
Limits or exclusions	$0
Total	**$570**

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.