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, myCSUSAHealthPlan.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-833-346-1478 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $4,500/individual or $9,000/family per benefit period. Out-of-Network: $9,000 / individual or $18,000 / family per benefit period.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-Network preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: $7,000/individual or $14,000/family per benefit period. Out-of-Network: $14,000/individual or $28,000/family per benefit period.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Penalties for failure to obtain precertification for services, premiums, balance-billing charges, and health care services this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See myCSUSAHealthPlan.com or call 1-833-346-1478 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

(HHS - OMB control number: 0938-1146/Expiration date: 05/31/2026)

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	30% coinsurance	50% coinsurance	If you receive services in addition to office visit, then additional deductibles or coinsurance may apply. Virtual visits are available; please refer to your plan policy for more details.
	Specialist visit	30% coinsurance	50% coinsurance	If you receive services in addition to office visit, then additional deductibles or coinsurance may apply.
	Preventive care/screening/ immunization	No charge (deductible does not apply)	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	Precertification is required. If you don't get precertification, then benefits could be reduced by 50% of the total cost of the service.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com or call 1-855-340-8462.	Generic drugs	30% coinsurance	Retail: 30% coinsurance. Mail order: Not covered.	Deductible does apply. Retail: Up to a 30-day supply. Mail Order: Up to a 90-day supply. Deductible and coinsurance do not apply to preventive drugs required by the Affordable Care Act. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. If you use a non-participating pharmacy, you are responsible for any amount over the allowed amount. Specialty drugs are limited to a 30-day supply for Retail or Mail Order.
	Preferred brand drugs	30% coinsurance	Retail: 30% coinsurance. Mail order: Not covered.	
	Non-preferred brand drugs	30% coinsurance	Retail: 30% coinsurance. Mail order: Not covered.	
	Specialty drugs	30% coinsurance	Not covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	Precertification is required. If you don't get precertification, then benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	$200 copay then 30% coinsurance	Preferred provider benefit applies.	The full cost of services must be paid until the deductible is met. At that point, the copay and coinsurance will apply. The copay will be waived if admitted to the hospital.
	Emergency medical transportation	30% coinsurance	Preferred provider benefit applies.	Ground and air transportation covered.
	Urgent care	30% coinsurance	50% coinsurance	If you receive services in addition to urgent care, then additional deductibles or coinsurance may apply. You may have to pay for services that are not covered by the visit fee

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Precertification is required. If you don't get precertification, then benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance	50% coinsurance	Virtual visits are available; please refer to your plan policy for more details. Precertification is required for Partial Hospitalization, Intensive Outpatient and Inpatient Services. If you don't get precertification, then benefits could be reduced by 50% of the total cost of the service.
	Inpatient services	30% coinsurance	50% coinsurance	
If you are pregnant	Office visits	30% coinsurance	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copay, deductible or a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	40 visits/benefit period. Precertification is required. If you don't get precertification, then benefits could be reduced by 50% of the total cost of the service.
	Rehabilitation services	30% coinsurance	50% coinsurance	60 physical and occupational therapy visits combined/benefit period.
	Habilitation services	30% coinsurance	50% coinsurance	
	Skilled nursing care	30% coinsurance	50% coinsurance	60 days/benefit period. Precertification is required. If you don't get precertification, then benefits could be reduced by 50% of the total cost of the service.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
If you need help recovering or have other special health needs (continued)	Durable medical equipment	30% coinsurance	50% coinsurance	Precertification is required for all rentals and any purchase over $1,500. If you don't get precertification, then benefits could be reduced by 50% of the total cost of the service.
	Hospice services	30% coinsurance	50% coinsurance	Precertification is required. If you don't get precertification, then benefits could be reduced by 50% of the total cost of the service.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Routine vision screening required by the affordable care act is covered under preventive care.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

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
- Dental care (adult and children)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care
- Weight loss programs

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

- Bariatric surgery (with BMI greater than 35 covered In-Network only)
- Chiropractic care
- Cosmetic surgery (limited to qualifying accidents and breast cancer)
- Hearing aids (limit $2,500, 1 per ear per 36-month period)
- Infertility treatment (limited to $25,000 per lifetime)
- Most coverage provided outside the United States. See myCSUSAHealthPlan.com

* For more information about limitations and exceptions, see the plan or policy document at myCSUSAHealthPlan.com.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 1-833-346-1478.
Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-833-346-1478.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-346-1478.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-833-346-1478.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-346-1478.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-833-346-1478.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-833-346-1478.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-833-346-1478.

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

About these Coverage Examples:

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

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

The plan's overall deductible	**$4,500**
Specialist coinsurance	**30%**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$4,500
Copayments	$0
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,960**

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

The plan's overall deductible	**$4,500**
Specialist coinsurance	**30%**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$4,500
Copayments	$0
Coinsurance	$300
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$4,820**

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

The plan's overall deductible	**$4,500**
Specialist coinsurance	**30%**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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