**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, www.studentplanscenter.com or by calling 1-800-756-3702. 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 1-800-318-2596 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | Network: **$250**/Insured Person<br>Out-of-Network: **$500**/Insured Person<br>Coinsurance and copayments do not count toward the deductible. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care and Prescription Drugs are 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?** | Network providers $6,600 Individual / $13,200 Family<br>Out-of-network providers $13,200 | 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, the overall family out-of-pocket limit must be met. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billed charges, health care 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 www.lakelandcare.com or call 269-927-5207<br>See www.phcs.com or call 1-800-922-4362 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. |

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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 |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network 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 | $20 Copay/visit ($15 at UMS), 20% Coinsurance | $20 Copay/visit ($15 at UMS), 40% Coinsurance | One visit per day. |
| | Specialist visit | $20 Copay/visit ($15 at UMS), 20% Coinsurance | $20 Copay/visit ($15 at UMS), 40% Coinsurance | One visit per day. |
| | Preventive care/screening/ immunization | No Charge | No Charge | Limited to those services required by the Affordable Care Act. |
| **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.studentplanscenter.com | Generic drugs | 50% Coinsurance | Not Covered | No coinsurance for contraceptives. Prescriptions must be filled at a participating pharmacy. |
| | Preferred brand drugs | 50% Coinsurance | Not Covered | Prescriptions must be filled at a participating pharmacy. |
| | Non-preferred brand drugs | 50% Coinsurance | Not Covered | Prescriptions must be filled at a participating pharmacy. |
| | Specialty drugs | 50% Coinsurance | Not Covered | Prescriptions must be filled at a participating pharmacy. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $150 Copay/visit, 20% Coinsurance | $150 Copay/visit, 40% Coinsurance | ---none--- |
| | Physician/surgeon fees | 20% Coinsurance | 40% Coinsurance | Physician: One visit per day.<br>If two or more surgical procedures are performed through the same incision or in immediate succession at the same operative session, We will pay a benefit equal to the benefit payable for the procedure with highest benefit value. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you need immediate medical attention** | Emergency room care | $250 Copay/visit, 20% Coinsurance | $250 Copay/visit, 20% Coinsurance | ---none--- |
| | Emergency medical transportation | 20% Coinsurance | 40% Coinsurance | ---none--- |
| | Urgent care | $50 Copay/visit, 20% Coinsurance | $50 Copay/visit, 40% Coinsurance | ---none--- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $150 Copay/visit, 20% Coinsurance | $150 Copay/visit, 40% Coinsurance | ---none--- |
| | Physician/surgeon fees | 20% Coinsurance | 40% Coinsurance | Physician: One visit per day of confinement. If two or more surgical procedures are performed through the same incision or in immediate succession at the same operative session, We will pay a benefit equal to the benefit payable for the procedure with highest benefit value. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $20 Copay/visit ($15 at UMS), 20% Coinsurance | $20 Copay/visit ($15 at UMS), 40% Coinsurance | One visit per day. |
| | Inpatient services | $150 Copay/visit, 20% Coinsurance | $150 Copay/visit, 40% Coinsurance | ---none--- |
| **If you are pregnant** | Office visits | $20 Copay/visit ($15 at UMS), 20% Coinsurance | $20 Copay/visit ($15 at UMS), 40% Coinsurance | One visit per day. |
| | Childbirth/delivery professional services | 20% Coinsurance | 40% Coinsurance | ---none--- |
| | Childbirth/delivery facility services | $150 Copay/visit, 20% Coinsurance | $150 Copay/visit, 40% Coinsurance | Up to 48 hours for normal vaginal delivery and 96 hours (not including the day of surgery) for a caesarean section delivery. |
| **If you need help recovering or have other special health needs** | Home health care | 20% Coinsurance | 40% Coinsurance | 60 visits per Policy Year. |
| | Rehabilitation services | $15 Copay/visit, 20% Coinsurance | $15 Copay/visit, 40% Coinsurance | Outpatient only. Combined benefit maximum of: 30 visits per Policy Year for PT, OT and Chiropractic; 30 visits per Policy Year for ST; 30 visits per Policy Year for Cardiac and Pulmonary Rehabilitation. |
| | Habilitation services | $15 Copay/visit, 20% Coinsurance | $15 Copay/visit, 40% Coinsurance | ---none--- |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Skilled nursing care | 20% Coinsurance | 40% Coinsurance | 45 days per Policy Year. |
| | Durable medical equipment | 20% Coinsurance | 40% Coinsurance | ---none--- |
| | Hospice services | 20% Coinsurance | 40% Coinsurance | 45 days per Policy Year. |
| **If your child needs dental or eye care** | Children's eye exam | No Charge | No Charge | Preventive Only. One exam per Policy Year. |
| | Children's glasses | No Charge | No Charge | One pair of prescribed lenses and frames per Policy Year. |
| | Children's dental check-up | No Charge | No Charge | Preventive Only. One checkup every 6 months. |

## 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.)**

- Cosmetic surgery, except as a result of a covered Injury that necessitates medical treatment within 24 hours of the Accident or results from Reconstructive Surgery
- Hearing aids, except as a result of a covered accidental Injury
- Infertility treatment, unless such infertility is a result of a Covered Injury or Covered Sickness
- Long-term care
- Routine foot care

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

- Acupuncture, by a licensed Acupuncturist only
- Bariatric surgery, subject to limits shown in benefit description
- Chiropractic care
- Dental care (Adult), for accidental injury only
- Non-Emergency care when traveling outside the U.S., except there is no coverage (emergency or otherwise) for International Students in their Home Country
- Private-duty nursing (inpatient)
- Routine eye care (Adult), preventive, up to one visit per Policy Year including frames & lenses
- Weight Loss Programs – must be Physician supervised. Prior approval is required.

**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: DIFS, PO Box 30220, Lansing MI 48909-7720, 517-284-8800 or 877-999-6442 (Toll-Free), http://www.michigan.gov/difs. 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 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: DIFS, PO Box 30220, Lansing MI 48909-7720, 517-284-8800 or 877-999-6442 (Toll-Free), http://www.michigan.gov/difs/0,5269,7-303-12902_35510-263249--,00.html.

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**Does this plan provide Minimum Essential Coverage?** **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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.

*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 | $250 |
| Specialist copayment | $20 |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**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** | **$12,740** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $250 |
| Copayments | $40 |
| Coinsurance | $2,400 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$2,750** |

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

| | |
|---|---|
| The plan's overall deductible | $250 |
| Specialist copayment | $20 |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**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** | **$7,410** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $250 |
| Copayments | $200 |
| Coinsurance | $1,200 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Joe would pay is** | **$1,710** |

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

| | |
|---|---|
| The plan's overall deductible | $250 |
| Specialist copayment | $20 |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**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** | **$1,900** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $250 |
| Copayments | $100 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$550** |



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