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: $50/ Individual Non-Network: $50/ Individual 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 (Network) 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?	Network : $6,350/ Individual; $12,700/ Family; Non-Network: $6,350/ Individual; $12,700/ Family	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 https://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	$10 Copay/visit	30% Coinsurance	One visit per day.
	Specialist visit	$10 Copay/visit	30% Coinsurance	One visit per day.
	Preventive care/screening/ Immunization	No Charge	30% Coinsurance	Limited to those services required by the Affordable Care Act.
If you have a test	Diagnostic test (x-ray, blood work)	10% Coinsurance	30% Coinsurance	---none---
	Imaging (CT/PET scans, MRIs)	10% Coinsurance	30% 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	$10 Copay/prescription	Not covered	Prescriptions must be filled at a participating pharmacy.
	Preferred brand drugs	$20 Copay/prescription	Not covered	Prescriptions must be filled at a participating pharmacy.
	Non-preferred brand drugs	$20 Copay/prescription	Not covered	Prescriptions must be filled at a participating pharmacy.
	Specialty drugs	$20 Copay/prescription	Not covered	Prescriptions must be filled at a participating pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance	30% Coinsurance	---none---
	Physician/surgeon fees	10% Coinsurance	30% Coinsurance	Physician: 1 visit per day. If 2 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 immediate medical attention	Emergency room care	10% Coinsurance	10% Coinsurance	---none---
	Emergency medical transportation	10% Coinsurance	30% Coinsurance	---none---
	Urgent care	10% Coinsurance	30% Coinsurance	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance	30% Coinsurance	---none---

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		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	10% Coinsurance	30% Coinsurance	Physician: 1 visit per day. 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	$10 Copay/visit	30% Coinsurance	---none---
	Inpatient services	10% Coinsurance	30% Coinsurance	---none---
If you are pregnant	Office visits	$10 Copay/visit	30% Coinsurance	---none---
	Childbirth/delivery professional services	10% Coinsurance	30% Coinsurance	---none---
	Childbirth/delivery facility services	10% Coinsurance	30% Coinsurance	---none---
If you need help recovering or have other special health needs	Home health care	10% Coinsurance	30% Coinsurance	---none---
	Rehabilitation services	10% Coinsurance	30% Coinsurance	---none---
	Habilitation services	10% Coinsurance	30% Coinsurance	---none---
	Skilled nursing care	10% Coinsurance	30% Coinsurance	---none---
	Durable medical equipment	10% Coinsurance	30% Coinsurance	---none---
	Hospice services	10% Coinsurance	30% Coinsurance	---none---
If your child needs dental or eye care	Children's eye exam	No Charge	30% Coinsurance	Preventive Only. One exam per Policy Year.
	Children's glasses	No Charge	30% Coinsurance	One pair of prescribed lenses and frames per Policy Year.
	Children's dental check-up	No Charge	30% Coinsurance	Preventive Only. Two exams per Policy Year.

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 or reconstructive surgery
- Long-term care
- Routine foot care, except for the treatment of diabetes

	• Routine eye care (Adult)	• Weight loss programs

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, medically necessary only • Chiropractic care • Dental Care (Adult), due to injury only	• Hearing Aids, bone anchored hearing aids (osseointegrated auditory implants) • Infertility treatment	• 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)

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: Illinois Department of Insurance 320 W. Washington St, 4th Floor Springfield, IL 62767 (877) 527-9431, http://www.insurance.illinois.gov, email: DOI.Director@illinois.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 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: http://insurance.illinois.gov/Complaints/Complaints.asp.

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	$50
Specialist copayment	$10
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$50
Copayments	$60
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,370

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

The plan's overall deductible	$50
Specialist copayment	$10
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$50
Copayments	$700
Coinsurance	$180
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$990

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

The plan's overall deductible	$50
Specialist copayment	$10
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$50
Copayments	$30
Coinsurance	$140
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$260

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