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.studentplanscenter.com or by calling 1-800-756-3702.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$500. Waived for services received at the SHC. Does not apply to Preventive Services and Prescription Drugs. Coinsurance and copayments do not count toward the deductible.	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?	Yes, Home Health Care: $50 Deductible per Policy Year. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. $6,250	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, 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 specific coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. For a list of preferred providers, call PHCS toll free at 1-800-922-4362 or see www.phcs.com	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 this plan doesn't cover are listed on page 7. See your policy 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 in-network **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% Coinsurance, $40 Copay per visit	50% Coinsurance, $40 Copay per visit	One visit per day.
	Specialist visit	20% Coinsurance, $40 Copay per visit	50% Coinsurance, $40 Copay per visit	One visit per day.
	Other practitioner office visit	20% Coinsurance, $40 Copay per visit	50% Coinsurance, $40 Copay per visit	One visit per day.
	Preventive care/ screening/immunization	0% Coinsurance, no deductible	50% Coinsurance	---none---
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance, $25 Copay per visit	50% Coinsurance, $25 Copay per visit	---none---
	Imaging (CT/PET scans, MRIs)	20% Coinsurance, $25 Copay per visit	50% Coinsurance, $25 Copay per visit	---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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.studentplanscenter.com	Generic drugs	$25 Copay	Not Covered	No copayment for generic contraceptives. Prescriptions must be filled at a participating pharmacy.
	Preferred brand drugs	$45 Copay	Not Covered	Prescriptions must be filled at a participating pharmacy.
	Non-preferred brand drugs	$60 Copay	Not Covered	Prescriptions must be filled at a participating pharmacy.
	Specialty drugs	$60 Copay	Not Covered	---none---
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	50% Coinsurance	---none---
	Physician/surgeon fees	20% Coinsurance Physician: $40 Copay per visit	50% Coinsurance Physician: $40 Copay per visit	Physician: One visit per day. If multiple surgical procedures are performed during the same operative session but through different incisions, We will pay as shown in the Schedule of Benefits for the most expensive procedure and 50% of covered expenses for the additional surgeries.

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 immediate medical attention	Emergency room services	20% Coinsurance $500 Copay per visit (waived if admitted)	20% Coinsurance $500 Copay per visit (waived if admitted)	---none---
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	---none---
	Urgent care	20% Coinsurance, $40 Copay per visit	50% Coinsurance, $40 Copay per visit	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance, $250 Copay per confinement	50% Coinsurance, $250 Copay per confinement	---none---
	Physician/surgeon fee	20% Coinsurance	50% Coinsurance	Physician: One visit per day. If multiple surgical procedures are performed during the same operative session but through different incisions, We will pay as shown in the Schedule of Benefits for the most expensive procedure and 50% of covered expenses for the additional surgeries.

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 mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% Coinsurance, $40 Copay per visit	50% Coinsurance, $40 Copay per visit	---none---
	Mental/Behavioral health inpatient services	20% Coinsurance, $250 Copay per confinement	50% Coinsurance, $250 Copay per confinement	---none---
	Substance use disorder outpatient services	20% Coinsurance, $40 Copay per visit	50% Coinsurance, $40 Copay per visit	---none---
	Substance use disorder inpatient services	20% Coinsurance, $250 Copay per confinement	50% Coinsurance, $250 Copay per confinement	---none---
If you are pregnant	Prenatal and postnatal care	20% Coinsurance	50% Coinsurance	---none---
	Delivery and all inpatient services	20% Coinsurance, $250 Copay per confinement	50% Coinsurance, $250 Copay per confinement	A minimum of 48 hours of inpatient care following a vaginal delivery; or a minimum of 96 hours of inpatient care following delivery by cesarean section.

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, $50 Deductible per Policy Year	50% Coinsurance, $50 Deductible per Policy Year	40 visits per Policy Year.
	Rehabilitation services	20% Coinsurance	50% Coinsurance	Treatment must be received within 30 days of release by a doctor. 30 visit maximum.
	Habilitation services	20% Coinsurance	50% Coinsurance	---none---
	Skilled nursing care	20% Coinsurance	50% Coinsurance	---none---
	Durable medical equipment	20% Coinsurance	50% Coinsurance	---none---
	Hospice service	20% Coinsurance	50% Coinsurance	---none---
If your child needs dental or eye care	Eye exam	0% Coinsurance, no deductible	50% Coinsurance	Preventive Only. One exam per Policy Year.
	Glasses	0% Coinsurance, no deductible	50% Coinsurance	One pair of prescribed lenses and frames per Policy Year.
	Dental check-up	0% Coinsurance, no deductible	50% Coinsurance	Preventive Only. Benefit will be paid one time every 6 months and one time every 12 months if done in a school setting.

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.)**

- Cosmetic Surgery, except as a result of a covered Injury that occurred while the Covered Person was insured or a covered child's congenital defect or anomaly
- Hearing Aids, except for bone anchored hearing aids (osseointegrated auditory implants)
- Long-Term Care
- Routine Eye Care (Adult)
- Routine Foot Care, except if related to diabetic 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
- Bariatric Surgery, if related to treatment for diabetes or medically necessary Bariatric surgery
- Chiropractic Care
- Dental Care (Adult), injury to sound natural teeth only
- 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

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, contact the insurer at 1-800-756-3702. You may also contact your state insurance department at: 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

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: 1-800-756-3702.
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
Additionally, a consumer assistance program can help you file your appeal. Contact: 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

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.**

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** $5,325
- **Patient pays** $2,215

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	$500
Copays	$415
Coinsurance	$1,300
Limits or exclusions	$0
Total	**$2,215**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,608
- **Patient pays** $1,792

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	$500
Copays	$680
Coinsurance	$312
Limits or exclusions	$300
Total	**$1,792**

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.