
 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.chpstudenthealth.com](http://www.chpstudenthealth.com) or calling toll free 1-877-657-5030. 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 [www.healthcare.gov/sbc-glossary](http://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 <a href="#">deductible</a> ?	<u>Preferred Provider</u> : \$150/ Individual <u>Non-Preferred Provider</u> : \$150/ Individual	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <a href="#">plan</a> begins to pay.
Are there services covered before you meet your <a href="#">deductible</a> ?	<b>Yes.</b> <u>Preventive care</u> services, and Prescription Drugs are covered before you meet your <u>deductible</u> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	<b>Yes.</b> Adult Dental Care: \$25 per Policy Year.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<u>Preferred Provider</u> : \$5,000 Individual/\$10,000 Family, <u>Non-Preferred Provider</u> : \$5,000 Individual/\$10,000 Family	The <u>out-of-pocket limit</u> 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 <u>own out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <a href="#">plan</a> doesn't cover. Your <u>Non-Preferred Provider</u> payments or other non-covered expenses do not count toward this limit.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.cofinity.net">www.cofinity.net</a> or call 1-877-657-5030 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your plan pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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)	Non-Preferred Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Limited to one visit per day. Includes care by Primary Physician, specialist, consultant, and any other licensed practitioner operating within the scope of his or her license
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	—————none—————
	<a href="#">Preventive care/screening/immunization</a>	No Charge	40% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	—————none—————
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	—————none—————
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="#">www.berxplan.com</a>	Generic drugs	\$25 <a href="#">copay</a> /prescription	Not Covered	No <a href="#">cost sharing</a> applies to ACA <a href="#">Preventive Care</a> medications filled at a participating network pharmacy. <a href="#">Deductible Waived</a> .
	Preferred brand drugs	\$50 <a href="#">copay</a> /prescription	Not Covered	
	Non-preferred brand drugs	\$50 <a href="#">copay</a> /prescription	Not Covered	
	<a href="#">Specialty drugs</a>	\$50 <a href="#">copay</a> /prescription	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	—————none—————
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Physician: one 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 the highest benefit value.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	—————none—————
	<a href="#">Emergency medical transportation</a>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Ground and/or air, water transportation.
	<a href="#">Urgent care</a>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Pre-Certification</u> required. Subject to Semi-Private room rate unless intensive care unit is required.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 1 visit per day when not related to surgery. <u>Pre-Certification</u> required for surgery. 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 the highest benefit value.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	—————none—————
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	—————none—————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you are pregnant	Office visits	20% coinsurance	40% <u>coinsurance</u>	<p><u>Cost sharing</u> does not apply to certain <u>preventive services</u>, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound)</p> <p>Hospital stays for mother and newly born child will be provided for up to 48 hours for normal vaginal delivery and 96 hours (not including the day of surgery) for a caesarean section delivery unless the caesarean section delivery is the result of <u>Complications of Pregnancy</u>. If the delivery is the result of <u>Complications of Pregnancy</u>, the Hospital stay will be covered the same as for any other Covered Sickness.</p>
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	—————none—————
	<a href="#">Rehabilitation services</a>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Including cardiac rehabilitation, pulmonary rehabilitation, Physical Therapy, occupational therapy, Chiropractic Care and speech therapy Cardiac rehabilitation and pulmonary rehabilitation Subject to Unlimited visits per Policy Year Physical Therapy, Occupational therapy and Chiropractic Care subject to combined limit of Unlimited visits per Policy Year Speech Therapy Unlimited visits per Policy Year
	<a href="#">Habilitation services</a>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Physical Therapy and Occupational therapy Unlimited visits per Policy Year Speech Therapy Unlimited visits per Policy Year
	<a href="#">Skilled nursing care</a>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Pre-authorization</u> required.
	<a href="#">Durable medical equipment</a>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	—————none—————
	<a href="#">Hospice services</a>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	—————none—————
<b>If your child needs dental or eye care</b>	Children's eye exam	0% <u>coinsurance</u>	0% <u>coinsurance</u>	To the end of the month in which the Insured Person turns age 19. Preventive only. 1 visit per Policy Year.
	Children's glasses	0% <u>coinsurance</u>	0% <u>coinsurance</u>	To the end of the month in which the Insured Person turns age 19. 1 pair of prescribed lenses and frames.
	Children's dental check-up	No Charge	0% <u>coinsurance</u>	To the end of the month in which the Insured Person turns age 19. Limited to 2 dental exams every 12 months. Preventive.

## 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
- Hearing Aids
- Long-term Care
- Cosmetic Surgery
- Infertility Treatment
- Routine Foot Care

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

- Bariatric Surgery
- Dental Care
- Non-emergency Care While Traveling Outside the United States
- Chiropractic Care
- Private Duty Nursing (inpatient)
- Routine Eye Care (Adult)
- Weight Loss Programs

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact Consolidated Health Plans at 1-877-657-5030. You may also contact your state insurance department at <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](http://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://www.michigan.gov/difs/0,5269,7-303-12902\\_12907---,00.html](http://www.michigan.gov/difs/0,5269,7-303-12902_12907---,00.html).

### 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](#).

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-657-5030.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-657-5030.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-657-5030.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-657-5030.

————— *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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$150
■ <a href="#">Specialist coinsurance</a>	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	0%

#### 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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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#### In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$200
Copayments	\$100
Coinsurance	\$2,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,860</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$150
■ <a href="#">Specialist coinsurance</a>	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	0%

#### 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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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#### In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$200
Copayments	\$1,400
Coinsurance	\$600
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$2,255</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$150
■ <a href="#">Specialist coinsurance</a>	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	0%

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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#### In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$200
Copayments	\$0
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$600</b>

\*Note: This [plan](#) has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.