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, https://www.utoledo.edu/depts/hr/benefits/student/undergraduate-plans.html . 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 www.healthcare.gov/sbc-glossary/or call 1-866-752-8881 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0-Student Health Center (SHC) or University of Toledo Medical Center (UTMC) or University of Toledo Physicians (UTP); $1,500 per person - network providers; $3,000 per person – out-of-network providers.	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, for services rendered at the SHC and preventive care/screenings/immunizations provided by network providers.	This plan covers some items and services even if you haven't 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?	$7,900 for individual, $15,800 for family-SHC/UTP/UTMC and network providers combined; $7,900 for individual, $15,800 for family – out-of-network providers.	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 preauthorization 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 myprovidersearch.com or call 1-888-752-8881 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.

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	No charge SHC; 30% coinsurance UTP/ UTMC; $10 copay per visit + 40% coinsurance network provider	$15 copay per visit + 50% coinsurance of Usual, Customary and Reasonable (UCR)	None
	Specialist visit	No charge SHC; 30% coinsurance UTP/ UTMC; $20 copay per visit + 40% coinsurance network provider	$30 copay per visit + 50% coinsurance of UCR	None
	Preventive care/screening/ immunization	No charge for all facilities	50% of UCR	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)	No charge SHC, 30% coinsurance UTP/UTMC; 40% coinsurance network provider	50% of UCR	None
	Imaging (CT/PET scans, MRIs)	No charge SHC, 30% coinsurance UTP/UTMC; 40% coinsurance network provider	50% of UCR	Failure to obtain preauthorization for non-emergency imaging will result in a 100% penalty

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at: https://www.utoledo.edu/depts/hr/benefits/student/undergraduate-plans.html	Generic drugs	30 Day University of Toledo Outpatient Pharmacy (UTOP): $5 copay per prescription; 30 Day network provider: $10 copay + 40% coinsurance per prescription; 90 Day (Maintenance) UTOP: $12.50 copay per prescription	30 Day: $15 copay + 50% coinsurance per prescription	90 Day supply covered at UTOP only Travel only: Pre-certification is required to obtain a 90-day supply from network provider when traveling 35 miles from campus. Failure to receive preauthorization will result in a 100% penalty.
	Preferred brand drugs	30 Day UTOP: $15 copay per prescription; 30 Day network provider: $20 copay + 40% coinsurance per prescription; 90 Day (Maintenance) UTOP: $37.50 copay per prescription	30 Day: $30 copay + 50% coinsurance per prescription	
	Non-preferred brand drugs	30 Day UTOP: $30 copay per prescription; 30 Day network provider: $40 copay + 40% coinsurance per prescription; 90 Day (Maintenance) UTOP: $75 copay per prescription	30 Day: $60 copay + 50% coinsurance per prescription	
	Specialty drugs	30 Day UTOP only: $75 copay per prescription	Not covered	All Specialty drugs must be filled at UTOP
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance for SHC/UTP/UTMC; 40% coinsurance network provider	50% of UCR	Failure to obtain preauthorization will result in a 100% penalty
	Physician/surgeon fees	30% coinsurance SHC/UTP/UTMC; $20 copay per visit + 40% coinsurance network provider	$30 copay per visit + 50% of UCR	None
If you need immediate medical attention	Emergency room care	$250 copay per visit SHC/UTP/UTMC; $350 copay per visit network provider	$350 copay per visit then 100% above UCR	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)	
	Emergency medical Transportation	30% coinsurance	30% coinsurance	Covered only when medically necessary
	Urgent care	100% SHC; 30% UTP/UTMC; $30 copay per visit + 40% coinsurance network provider	$45 copay per visit + 50% coinsurance of UCR	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance (services available from UTP/UTMC only); 40% coinsurance network provider	50% of UCR	Failure to obtain preauthorization will result in a 100% penalty
	Physician/surgeon fees	30% coinsurance (services available from UTP/UTMC only); 40% coinsurance network provider	50% of UCR	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge SHC, 30% coinsurance UTP/UTMC; 40% coinsurance network provider	50% of UCR	None
	Inpatient services	30% coinsurance (services available at UTP/UTMC only); 40% coinsurance network provider	50% of UCR	Failure to obtain preauthorization will result in a 100% penalty
If you are pregnant	Office visits	30% coinsurance (No charge for Preventive Service) SHC/UTP/UTMC; 40% coinsurance network provider	50% of UCR	None
	Childbirth/delivery professional services	30% coinsurance (services only available at UTP/UTMC); 40% coinsurance network provider	50% of UCR	None
	Childbirth/delivery facility services	30% coinsurance 40% coinsurance network provider (services not currently available at UTP/UTMC)	50% of UCR	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)	
If you need help recovering or have other special health needs	Home health care	30% coinsurance (services available at UTP/UTMC only); 40% coinsurance network provider	50% of UCR	Failure to obtain preauthorization will result in a 100% penalty
	Rehabilitation services	30% coinsurance (services available at UTP/UTMC only); 40% coinsurance network provider	50% of UCR	After 25 visits (combined for SHC and UTMC/UTP and Network), patient responsibility is 50%. Failure to obtain preauthorization will result in a 100% penalty
	Habilitation services	30% coinsurance (services available at UTP/UTMC only); 40% coinsurance network provider	50% of UCR	After 25 visits (combined for SHC and UTMC/UTP and Network), patient responsibility is 50%. Failure to obtain preauthorization will result in a 100% penalty
	Skilled nursing care	30% coinsurance (services available at UTP/UTMC only); 40% coinsurance network provider	50% of UCR	Limited to 90 days per Plan Year. Failure to obtain preauthorization will result in a 100% penalty
	Durable medical equipment	30% coinsurance (services available at UTP/UTMC only); 40% coinsurance network provider	50% of UCR	Failure to obtain preauthorization for equipment over $500 will result in a 100% penalty
	Hospice services	30% coinsurance (services available at UTP/UTMC only); 40% coinsurance network provider	50% of UCR	Failure to obtain preauthorization will result in a 100% penalty
If your child needs dental or eye care	Children's eye exam	No charge	No charge	1 exam per year. Limited to $30 for out-of-network provider
	Children's glasses	No charge	No charge	1 total pair per year. Limited to $150 for frames for network provider. Limited to $25 for single lenses, $35 for bifocals, $45 for trifocals and lenticular lenses, and $30 for frames for out-of-network provider
	Children's dental check-up	No charge	40% coinsurance	1 exam 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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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.)

- Chiropractic care
- Infertility treatment
- Private-duty nursing (only covered for outpatient, when medically necessary and not custodial in nature)
- Routine eye care (Adult)

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: Ohio Department of Insurance at 1-800-686-1526. 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: PayerFusion Holdings, LLC at 1-866-752-8881.

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 1-866-752-8881.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-752-8881.
[Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-866-752-8881.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-752-8881.

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	$1,500
Specialist copayment	$20
Hospital (facility) coinsurance	40%
Other coinsurance	40%

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$80
Coinsurance	$5,200
What isn't covered	
Limits or exclusions	$40
The total Peg would pay is	**$6,820**

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

The plan's overall deductible	$1,500
Specialist copayment	$20
Hospital (facility) coinsurance	40%
Other coinsurance	40%

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$30
Coinsurance	$600
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,130**

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

The plan's overall deductible	$1,500
Specialist copayment	$20
Hospital (facility) coinsurance	40%
Other coinsurance	40%

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	$0
Copayments	$400
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$800**

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