**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?** | **$** 250<br>Coinsurance and copayments do not count toward the deductible. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care and Prescription Drugs are covered before you meet your deductible | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No | You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **What is the out-of-pocket limit for this plan?** | **$** 6,600 | The out-of-pocket limit is the most you could pay in a year for covered services |
| **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.firsthealth.com or call 1-800-226-5116 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% Coinsurance, $10 Copay/ visit | 40% Coinsurance, $10 Copay/ visit | One visit per day. |
| | Specialist visit | 20% Coinsurance, $10 Copay/ visit | 40% Coinsurance, $10 Copay/ visit | One visit per day. |
| | Preventive care/screening/ immunization | No Charge | 40% Coinsurance | 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 | $10 Copay/prescription | Not Covered | No copayment for contraceptives. Prescriptions must be filled at a participating pharmacy. |
| | Preferred brand drugs | $30 Copay/prescription | Not Covered | Prescriptions must be filled at a participating pharmacy. |
| | Non-preferred brand drugs | $50 Copay/prescription | Not Covered | Prescriptions must be filled at a participating pharmacy. |
| | Specialty drugs | $50 Copay/prescription | Not Covered | Prescriptions must be filled at a participating pharmacy. Pre-authorization is required. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% Coinsurance | 40% Coinsurance | ---none--- |
| | Physician/surgeon fees | 20% Coinsurance | 40% Coinsurance | 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 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 | 20% Coinsurance, $150 Copay/ visit | 20% Coinsurance, $150 Copay/ visit | ---none--- |
| | Emergency medical transportation | 20% Coinsurance | 20% Coinsurance | ---none--- |
| | Urgent care | 20% Coinsurance, $10 Copay/ visit | 40% Coinsurance, $10 Copay/ visit | ---none--- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% Coinsurance | 40% Coinsurance | ---none--- |
| | Physician/surgeon fees | 20% Coinsurance | 40% Coinsurance | 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 highest benefit value. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 20% Coinsurance, $10 Copay/ visit | 40% Coinsurance, $10 Copay/ visit | ---none--- |
| | Inpatient services | 20% Coinsurance | 40% Coinsurance | ---none--- |
| **If you are pregnant** | Office visits | 20% Coinsurance, $10 Copay/ visit | 40% Coinsurance, $10 Copay/ visit | One visit per day. |
| | Childbirth/delivery professional services | 20% Coinsurance | 40% Coinsurance | ---none--- |
| | Childbirth/delivery facility services | 20% Coinsurance | 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 | Up to 40 visits per Policy Year. |
| | Rehabilitation services | 20% Coinsurance<br>Outpatient: 20% Coinsurance, $10 Copay/ visit | 40% Coinsurance<br>Outpatient: 40% Coinsurance, $10 Copay/ visit | Outpatient: One visit per day |
| | Habilitation services | 20% Coinsurance, $10 Copay/ visit | 40% Coinsurance, $10 Copay/ visit | One visit per day. |
| | Skilled nursing care | 20% Coinsurance | 40% Coinsurance | Up to 60 visits per Policy Year. |

| 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) | |
| | Durable medical equipment | 20% Coinsurance | 40% Coinsurance | ---none--- |
| | Hospice services | 20% Coinsurance | 40% Coinsurance | ---none--- |
| **If your child needs dental or eye care** | Children's eye exam | No Charge | 40% Coinsurance | Preventive Only. One exam per Policy Year. |
| | Children's glasses | No Charge | 40% Coinsurance | One pair of prescribed frames and lenses per Policy Year. |
| | Children's dental checkup | No Charge | 40% Coinsurance | Preventive Only. Two checkups 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.)**

- Bariatric Surgery, except if Medically Necessary
- Cosmetic Surgery, unless resulting directly from 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
- Long-Term Care
- Routine Eye Care (Adult)
- 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.)**

- Acupuncture
- Chiropractic Care
- Dental Care (Adult), as a result of injury
- 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, when prescribed by the attending Physician while confined in a hospital.

**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: Office of Insurance Regulation, 200 East Gaines Street, Tallahassee, FL 32399 Business Telephone, 850-413-3140 Consumer Helpline, 1-877-693-5236 (In Florida) or http://www.floir.com. 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: Office of Insurance Regulation, 200 East Gaines Street, Tallahassee, FL 32399 Business Telephone, 850-413-3140 Consumer Helpline, 1-877-693-5236 (In Florida) or http://www.floir.com.

**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 *Coinsurance* | 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 | $60 |
| Coinsurance | $2400 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$2,770** |

### 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 *Coinsurance* | 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 | $700 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Joe would pay is** | **$1,310** |

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

| | |
|---|---|
| The plan's overall deductible | $250 |
| Specialist *Coinsurance* | 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 | $70 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$520** |

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