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: $0/ Ind, $0/ Family Non-Network: $500/ Ind, $1,000 Family 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 In-Network Services 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.
What is the out-of-pocket limit for this plan?	Network: $5,000 Individual / $10,000 family Non-Network: $5,000 individual / $10,000 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 www.multiplan.com or call 1-888-342-7427 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	$25 Copay/ visit	30% Coinsurance	---none---
	Specialist visit	$25 Copay/ visit	30% Coinsurance	---none---
	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, lab)	Lab: Office:$25 Copay/ visit Op Hosp: 10% Coinsurance x-ray: Office:$25Copay, 10% Coinsurance, Op Hosp: 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	30% Coinsurance	Deductible waived In-Network
	Preferred brand drugs	$45 Copay/ prescription	30% Coinsurance	Deductible waived In-Network
	Non-preferred brand drugs	$75 Copay/ prescription	30% Coinsurance	Deductible waived In-Network
	Specialty drugs	$75 Copay/ prescription	30% Coinsurance	Deductible waived In-Network
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance	30% Coinsurance	---none---
	Physician/surgeon fees	10% Coinsurance	30% Coinsurance	---none---
If you need immediate medical attention	Emergency room care	10% Coinsurance (waived if admitted)	10% Coinsurance (waived if admitted)	---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	10% Coinsurance	10% Coinsurance	---none---
	Urgent care	$35 Copay/ visit	30% Coinsurance	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance	30% Coinsurance	---none---
	Physician/surgeon fees	10% Coinsurance	30% Coinsurance	If Covered multiple surgical procedures are performed through the same incision, We will pay for the procedure with the highest Allowed Amount and 50% of the amount We would otherwise pay under this Certificate for the secondary procedures
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 Copay/ visit	30% Coinsurance	---none---
	Inpatient services	10% Coinsurance	30% Coinsurance	---none---
If you are pregnant	Office visits	Prenatal: No Charge Postnatal: $25 Copayment	30% Coinsurance	---none---
	Childbirth/delivery professional services	10% Coinsurance	30% Coinsurance	---none---
	Childbirth/delivery facility services	10% Coinsurance	30% Coinsurance	Up to 48 hours for normal vaginal delivery and 96 hours for a caesarean section delivery.
If you need help recovering or have other special health needs	Home health care	10% Coinsurance	25% Coinsurance	40 visits per Plan Year
	Rehabilitation services	OP:10% Coinsurance IP: 10% Coinsurance		60 visits per condition per Plan Year combined therapies, Speech and Physical Therapy are only Covered following a hospital stay or surgery
	Habilitation services	OP:$25 Copay/ visit IP: 10% Coinsurance	30% Coinsurance	60 visits per condition, per Plan Year combined therapies
	Skilled nursing care	10% Coinsurance	30% Coinsurance	200 days per Plan Year
	Durable medical equipment	10% Coinsurance	30% Coinsurance	---none---
	Hospice services	10% Coinsurance	30% Coinsurance	210 days per Plan Year, 5 visits for family

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)	
				bereavement counseling
If your child needs dental or eye care	Children's eye exam	No Charge	50% Coinsurance	Preventive Only. One exam per Plan Year.
	Children's glasses	No Charge	50% Coinsurance	One pair of prescribed lenses and frames per Plan Year.
	Children's dental check-up	No Charge	50% Coinsurance	Preventive Only. One dental exam per 6 month period.

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
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care, except when a Member has a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in the legs or feet

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

- Chiropractic care
- Dental care (Adult), only when related to a Covered Accidental Injury or due to congenital disease or anomaly
- Hearing Aids, one per affected ear every 3 years
- 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
- Weight loss programs

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: New York State Department of Financial Services at One State Street New York, NY 10004 or http://dfs.ny.gov/insurance/dfs_insurance.htm or 1-800-342-3736. 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: New York State Department of Financial Services at One State Street New York, NY 10004 or http://www.dfs.ny.gov/insurance/extapp/extappqa.htm or 1-800-400-8882.

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 $0
- Specialist *Copay* $25
- 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	$0
Copayments	$500
Coinsurance	$1100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1660

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

- The plan's overall deductible $0
- Specialist *Copay* $25
- 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	$0
Copayments	$1300
Coinsurance	$200
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$1,560

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

- The plan's overall deductible $0
- Specialist *Copay* $25
- 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	$0
Copayments	$200
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$300

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