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?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable	You don't have to meet deductibles before the plan pays for any services.
Are there other deductibles for specific services?	Not Applicable	You don't have to meet deductibles for any services.
What is the out-of-pocket limit for this plan?	Network: $5,550/Individual Non-Network: $6,850/Individual Prescription Drugs: Network: $1,300/Individual	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.myfirsthealth.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	10% Coinsurance	10% Coinsurance	One visit per day.
	Specialist visit	10% Coinsurance	10% Coinsurance	One visit per day.
	Preventive care/screening/ immunization	No Charge	10% Coinsurance	Limited to those services required by the Affordable Care Act.
If you have a test	Diagnostic test (x-ray, blood work)	10% Coinsurance	10% Coinsurance	---none---
	Imaging (CT/PET scans, MRIs)	10% Coinsurance	10% 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	10% Coinsurance	Prescriptions must be filled at a participating pharmacy.
	Preferred brand drugs	$20 Copay/ prescription	10% Coinsurance	Prescriptions must be filled at a participating pharmacy.
	Non-preferred brand drugs	$20 Copay/ prescription	10% Coinsurance	Prescriptions must be filled at a participating pharmacy.
	Specialty drugs	$20 Copay/ prescription	10% Coinsurance	Prescriptions must be filled at a participating pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance	10% Coinsurance	---none---
	Physician/surgeon fees	10% Coinsurance	10% 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 not pay a full allowance for each.
If you need immediate medical attention	Emergency room care	10% Coinsurance	10% Coinsurance	---none---
	Emergency medical transportation	10% Coinsurance	10% Coinsurance	---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)	
	Urgent care	10% Coinsurance	10% Coinsurance	One visit per day.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance	10% Coinsurance	---none---
	Physician/surgeon fees	10% Coinsurance	10% 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 not pay a full allowance for each.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% Coinsurance	10% Coinsurance	---none---
	Inpatient services	10% Coinsurance	10% Coinsurance	---none---
If you are pregnant	Office visits	10% Coinsurance	10% Coinsurance	---none---
	Childbirth/delivery professional services	10% Coinsurance	10% Coinsurance	---none---
	Childbirth/delivery facility services	10% Coinsurance	10% 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	10% Coinsurance	10% Coinsurance	---none---
	Rehabilitation services	10% Coinsurance	10% Coinsurance	One visit per day.
	Habilitation services	10% Coinsurance	10% Coinsurance	Covered to the extent Medically Necessary. One visit per day.
	Skilled nursing care	10% Coinsurance	10% Coinsurance	Custodial care or residential care is not covered.
	Durable medical equipment	10% Coinsurance	10% Coinsurance	---none---
	Hospice services	10% Coinsurance	10% Coinsurance	Home health aide limited to 100 hours per month.

If your child needs dental or eye care	Children's eye exam	No Charge	$10 Copay,10% Coinsurance	Preventive Only. One exam per Policy Year.
	Children's glasses	No Charge	$20 Copay, 10% Coinsurance	One pair of prescribed lenses and frames per Policy Year.
	Children's dental check-up	No Charge	10% Coinsurance	Preventive Only. Two exams every 12 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.)

- Cosmetic surgery, unless as a result of a Covered Injury that necessitates medical treatment within 24 hours of the Accident or results from Reconstructive Surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Routine foot care, except for the treatment of diabetes
- Weight Loss Program

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

- Acupuncture, by a licensed Acupuncturist only
- Bariatric surgery, only when considered Medically Necessary
- Chiropractic care
- 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
- Routine eye care (Adult) – Limits apply See Policy

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: State of Vermont, Department of Financial Regulation, 89 Main Street, Montpelier, VT 05620 or 1-800-964-1784 or www.dfr.vermont.gov. 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: State of Vermont, Department of Financial Regulation, 89 Main Street, Montpelier, VT 05620 or 1-800-964-1784 or http://www.dfr.vermont.gov/insurance/insurance-consumer/file-insurance-complaint.

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 *Coinsurance*	10%
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	$40
Coinsurance	$1,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,400**

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 *Coinsurance*	10%
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	$600
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$960**

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

The plan's overall deductible	$0
Specialist *Coinsurance*	10%
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	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$200**

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