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, go to www.chpstudenthealth.com or call 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 or call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Preferred Provider: $150/individual Non-Preferred Provider: $300/individual	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.** Network Preventive care, and Student Health Center expenses 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?	Preferred Provider: $6,600/individual Non-Preferred Provider: No Maximum/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-billing charges, and health care this plan doesn't cover. Your Non-Preferred Provider payments or other non-covered expenses do not count toward this limit.	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.cigna.com or call 1-877-657-5030 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
		Preferred Provider (You will pay the least)	Non-Preferred 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, 20% coinsurance	$25 copay/visit, 40% coinsurance	Limited to one visit per day.
	Specialist visit	$25 copay/visit 20% coinsurance	$25 copay/visit 40% coinsurance	When requested by the attending physician
	Preventive care/screening/ immunization	No Charge	40% coinsurance	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)	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.chpstudenthealth.com	Generic drugs	$10 copay/prescription, 20% coinsurance		No cost sharing applies to ACA Preventive Care medications filled at a participating network pharmacy or Student Health Center. Non-Preferred Provider benefits are provided on a reimbursement basis. Claim forms must be received within 90 days.
	Preferred brand drugs	$25 copay/prescription, 20% coinsurance		
	Non-preferred brand drugs	$35 copay/prescription, 20% coinsurance		
	Specialty drugs	$35 copay/prescription, 20% coinsurance		
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: Limited to 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
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$100 copay/visit, 20% coinsurance	$100 copay/visit, 20% coinsurance	Copay waived if admitted.
	Emergency medical transportation	20% coinsurance	40% coinsurance	Ground and/or air, water transportation.
	Urgent care	$75 copay/visit, 20% coinsurance	$75 copay/visit, 40% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Subject to Semi-Private room rate unless intensive care unit is required. Pre-Certification required
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Physician: Limited to 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	$25 copay/visit, 20% coinsurance	$25 copay/visit, 40% coinsurance	——————none——————
	Inpatient services	20% coinsurance	40% coinsurance	——————none——————
If you are pregnant	Office visits	$25 copay/visit, 20% coinsurance	$25 copay/visit, 40% coinsurance	Cost sharing does not apply to certain preventive services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) 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 Complications of Pregnancy. If the delivery is the result of Complications of Pregnancy, the Hospital stay will be covered the same as for any other Covered Sickness.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	

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 help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	——————none——————
	Rehabilitation services	20% coinsurance	40% coinsurance	Including cardiac rehabilitation, pulmonary rehabilitation, physical therapy and occupational therapy. Physical therapy, occupational therapy and speech therapy subject to unlimited visits per Policy Year.
	Habilitation services	20% coinsurance	40% coinsurance	Only if Medically Necessary.
	Skilled nursing care	20% coinsurance	40% coinsurance	Pre-Certification required.
	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	0% coinsurance	40% coinsurance	To the end of the month in which the Insured Person turns age 19. Limited to 1 visit per Policy Year.
	Children's glasses	0% coinsurance	40% coinsurance	To the end of the month in which the Insured Person turns age 19. Limited to 1 pair of prescribed lenses and frames per Policy Year.
	Children's dental check-up	No Charge	40% coinsurance	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
- Bariatric Surgery
- Cosmetic Surgery
- 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.)

- Chiropractic Care
- Dental Care (Accidental Injury only)
- Hearing Aids
- Infertility Treatment
- Non-emergency Care While Traveling Outside the United States
- Private Duty Nursing

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: http://insurance.illinois.gov/consumer/consumerMain.html 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: http://insurance.illinois.gov/Complaints/UnderstandComplaintProcess.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, kwiijigo 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 plan's overall deductible	$150
Specialist *Copay*	$25
Hospital (facility) *Coinsurance*	20%
Other *Coinsurance*	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)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$200
Copayments	$100
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,860**

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

The plan's overall deductible	$150
Specialist *Copay*	$25
Hospital (facility) *Coinsurance*	20%
Other *Coinsurance*	%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)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$900
Coinsurance	$400
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,555**

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

The plan's overall deductible	$150
Specialist *Copay*	$25
Hospital (facility) *Coinsurance*	20%
Other *Coinsurance*	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)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$200
Copayments	$100
Coinsurance	$300
What isn't covered	
Limits or exclusions	$
The total Mia would pay is	**$600**

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