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?	$250/ 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.** Preventive Care Services, Sports Accident Expenses 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 deductible for specific services.
What is the out-of-pocket limit for this plan?	$6,850/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.	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?	Not Applicable.	This plan does not use a provider network. You can receive covered services from any provider.
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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**Accident:** (Hospital Outpatient Dept./Clinic): $35 copay (waived if admitted), 0% coinsurance up to $25,000, then 20% coinsurance (Doctor's Office): $20 copay, 0% coinsurance to $25,000 then 20% coinsurance **Sickness:** (Hospital Outpatient Dept./Clinic): $35 copay (waived if admitted), 0% coinsurance to $2,000 then 20% coinsurance (Doctor's Office): $20 copay, 0% coinsurance to $2,000 then 20% U&R	$35 copay waived if admitted
	Specialist visit	**Accident:** (Hospital Outpatient Dept./Clinic): $35 copay (waived if admitted), 0% coinsurance up to $25,000, then 20% coinsurance (Doctor's Office): $20 copay, 0% coinsurance to $25,000 then 20% coinsurance **Sickness:** (Hospital Outpatient Dept./Clinic): $35 copay (waived if admitted), 0% coinsurance to $2,000 then 20% coinsurance (Doctor's Office): $20 copay, 0% coinsurance to $2,000 then 20% U&R	$35 copay waived if admitted Chiropractor: 12 visits per Policy Year.
	Preventive care/screening/ immunization	No Charge	Limited to those services required by the Affordable Care Act.
If you have a test	Diagnostic test (x-ray, blood work)	**Accident:** 0% coinsurance to $25,000, then 20% coinsurance **Sickness:** 0% coinsurance to $2,000, then 20% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	**Accident:** 0% coinsurance to $25,000, then 20% coinsurance **Sickness:** 0% coinsurance to $2,000, then 20% coinsurance	——————none——————

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.cigna.com	Generic drugs	$10 copay/prescription	——————none——————
	Preferred brand drugs	$25 copay/prescription	——————none——————
	Non-preferred brand drugs	$50 copay/prescription	——————none——————
	Specialty drugs	$50 copay/prescription	——————none——————
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**Accident:** 0% coinsurance to $25,000, then 20% coinsurance **Sickness:** 0% coinsurance to $2,000, then 20% coinsurance	——————none——————
	Physician/surgeon fees	**Accident:** 0% coinsurance to $25,000, then 20% coinsurance **Sickness:** 0% coinsurance to $2,000, then 20% coinsurance	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. Does not include coverage for removal of wisdom teeth, imbedded in bone or not.
If you need immediate medical attention	Emergency room care	**Accident**: $50 copay, 0% coinsurance to $25,000 then 20% coinsurance **Sickness**: $50 copay, 0% coinsurance to $2,000 then 20% coinsurance	Copay waived if admitted.
	Emergency medical transportation	**Accident:** 0% coinsurance to $25,000, then 20% coinsurance **Sickness:** 0% coinsurance to $2,000, then 20% coinsurance	——————none——————
	Urgent care	**Accident:** (Hospital Outpatient Dept./Clinic): $35 copay (waived if admitted), 0% coinsurance up to $25,000, then 20% coinsurance (Doctor's Office): $20 copay, 0% coinsurance to $25,000 then 20% coinsurance **Sickness:** (Hospital Outpatient Dept./Clinic): $35 copay (waived if admitted), 0% coinsurance to $2,000 then 20% coinsurance (Doctor's Office): $20 copay, 0% coinsurance to $2,000 then 20% U&R	$35 copay waived if admitted.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	**Accident:** 0% coinsurance to $25,000, then 20% coinsurance **Sickness:** 0% Coinsurance to $2,000, then 20% coinsurance	——————none——————
	Physician/surgeon fees	**Accident:** 0% coinsurance to $25,000, then 20% coinsurance **Sickness:** 0% coinsurance to $2,000, then 20% coinsurance	Physician visits limited to 1 per day. If two or more surgical procedures performed through the same incision or in immediate succession at the same session, benefits will equal benefit payable for the procedure with the highest benefit value.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Accident**: N/A **Sickness**: (Outpatient Dept./Clinic): $35 copay, 0% coinsurance to $2,000 then 20% coinsurance (Doctor's Office): $20 copay, 0% coinsurance to $2,000 then 20% coinsurance	$35 copay waived if admitted
	Inpatient services	**Accident:** N/A **Sickness**: 0% coinsurance to $2,000 then 20% coinsurance	——————none——————
If you are pregnant	Office visits	**Accident**: N/A **Sickness**: (Outpatient Dept./Clinic): $35 copay, 0% coinsurance to $2,000 then 20% coinsurance (Doctor's Office): $20 copay, 0% coinsurance to $2,000 then 20% coinsurance	$35 copay waived if admitted
	Childbirth/delivery professional services	**Accident:** N/A **Sickness:** 0% coinsurance to $2,000 then 20%	——————none——————
	Childbirth/delivery facility services	**Accident:** N/A **Sickness:** 0% coinsurance to $2,000 then 20%	——————none——————

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	**Accident:** 0% coinsurance to $25,000, then 20% coinsurance **Sickness:** 0% coinsurance to $2,000, then 20% Coinsurance	——————none——————
	Rehabilitation services	**Accident:** 0% coinsurance to $25,000, then 20% coinsurance **Sickness:** 0% coinsurance to $2,000, then 20% coinsurance	——————none——————
	Habilitation services	**Accident:** 0% coinsurance to $25,000, then 20% coinsurance **Sickness:** 0% coinsurance to $2,000, then 20% coinsurance	——————none——————
	Skilled nursing care	**Accident:** 0% coinsurance to $25,000, then 20% coinsurance **Sickness:** 0% coinsurance to $2,000, then 20% coinsurance	100 days per Policy Year.
	Durable medical equipment	**Accident:** 0% coinsurance to $25,000, then 20% coinsurance **Sickness:** 0% coinsurance to $2,000, then 20% coinsurance	——————none——————
	Hospice services	**Accident:** 0% coinsurance to $25,000, then 20% coinsurance **Sickness:** 0% coinsurance to $2,000, then 20% coinsurance	——————none——————
If your child needs dental or eye care	Children's eye exam	No Charge	Preventive only. One vision exam per Policy Year
	Children's glasses	Not Covered	N/A
	Children's dental check-up	No Charge	Preventive only. One 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.)

- Cosmetic Surgery
- Dental Care (Adult), except treatment for impacted wisdom teeth or dental abscesses
- Long-term Care
- Private Duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care, except in the treatment of diabetes

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

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Hearing Aids, Insured Persons 21 and under
- Infertility Treatment
- Non-emergency Care While Traveling Outside the United States
- Weight Loss Programs - See Weight Loss Program Benefit

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://www.mass.gov/ocabr/government/oca-agencies/doi-lp/. 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: MA Division of Insurance http://www.mass.gov/ocabr/government/oca-agencies/doi-lp/

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	$250
Specialist *Copayment*	$35
Hospital (facility) *Coinsurance*	0%
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	**$12,740**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$410**

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 *Copayment*	$35
Hospital (facility) *Coinsurance*	0%
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	**$7,410**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,210**

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

The plan's overall deductible	$250
Specialist *Copayment*	$35
Hospital (facility) *Coinsurance*	0%
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	$250
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$450**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.chpstudenthealth.com or toll free 1-877-657-5030.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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