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.chpstudenthealth.com or calling toll free (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?	In-Network: $400/individual Non-Network: $400/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 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?	In-Network/Non-Network: $5,550/individual combined Prescription Drugs: Network $1,350/Individual	The out-of-pocket limit is the most you could pay in a year for covered services. Three family members must meet the individual deductible before the family will not be required to pay any further cost sharing under the deductible.
What is not included in the out-of-pocket limit?	Copayments for certain services, 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?	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.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146
Released on April 6, 2016

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 and 20% coinsurance	$25 copay/visit and 40% coinsurance	1 visit per day
	Specialist visit	$25 copay/visit and 20% coinsurance	$25 copay/visit and 40% coinsurance	1 visit per day
	Preventive care/screening/ immunization	No Charge	20% 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.cigna.com	Generic drugs	$15 copay	No Benefit	No copayment for contraceptives. All prescriptions must be filled at a participating pharmacy
	Preferred brand drugs	$30 copay	No Benefit	All prescriptions must be filled at a participating pharmacy
	Non-preferred brand drugs	$50 copay	No Benefit	All prescriptions must be filled at a participating pharmacy
	Specialty drugs	$50 copay	No Benefit	All prescriptions must be filled at a participating pharmacy
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	——————none——————
	Physician/surgeon fees	20% coinsurance	40% coinsurance	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 one. Physician – 1 visit per day
If you need immediate medical attention	Emergency room care	$100 copay 20% coinsurance	$100 copay 20% coinsurance	——————none——————
	Emergency medical transportation	20% coinsurance	40% coinsurance	——————none——————
	Urgent care	$25 copay/visit and 20% coinsurance	$25 copay/visit and 40% coinsurance	1 visit per day

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 have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Pre-Certification Required
	Physician/surgeon fees	20% coinsurance	40% coinsurance	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 one. This benefit is not payable in addition to Physician's visits. Physician – 1 visit per day Pre-Certification Required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance and $25 copay	40% coinsurance and $25 copay	——————none——————
	Inpatient services	20% coinsurance	40% coinsurance	——————none——————
If you are pregnant	Office visits	$25 copay/office visit and 20% coinsurance	$25 copay/office visit and 40% coinsurance	1 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 unless the caesarean section delivery is the result of Complications of Pregnancy.
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	1 visit per day
	Habilitation services	20% coinsurance	40% coinsurance	1 visit per day when medically necessary
	Skilled nursing care	20% coinsurance	40% coinsurance	Medically necessary services only Pre-Certification Required
	Durable medical equipment	20% coinsurance	40% 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)	
	Hospice services	20% coinsurance	40% coinsurance	Home health aide limited to 100 hours per month Homemaker services limited to 100 hours per month
If your child needs dental or eye care	Children's eye exam	No Charge	$25 copay 40% coinsurance	Preventive only. 1 visit per Policy Year.
	Children's glasses	No Charge	$50 for lenses and frames	1 pair of prescribed lenses and frames.
	Children's dental check-up	No Charge	20% coinsurance	Preventive only. 2 dental exam 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 directly resulting from a covered Accidental Injury
- Dental Care (adult), due to injury only
- Hearing Aids
- Infertility Treatment
- Long-term Care
- Routine Foot Care, except for the treatment of diabetes
- Weight Loss Programs

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

- Acupuncture, by licensed Acupuncturist only
- Bariatric Surgery
- Chiropractic Care, limited to 12 visits per Policy Year, Prior approval required after 12th visit
- Non-emergency Care While Traveling Outside the United States, except there is no coverage, emergency or otherwise, for International Students in their Home Country.
- Private Duty Nursing
- Routine Eye Care (Adult), 1 exam per Policy Year

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.dfr.vermont.gov/insurance/insurance-consumer/ask-question. 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://www.dfr.vermont.gov/insurance/insurance-consumer/file-insurance-complaint or 1-800-964-1784 or 802-828-3302.

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	$400
Specialist *Copay*	$ 25
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	$400
Copayments	$100
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,960**

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

The plan's overall deductible	$400
Specialist *Copay*	$ 25
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	$400
Copayments	$900
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,660**

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

The plan's overall deductible	$400
Specialist *Copay*	$ 25
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	$400
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$800**

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