This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.chpstudent.com or by calling **1-800-633-7867**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$200 In-Network or $400 Out-of-Network; per person, per condition; does not apply to preventive care	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes; $4,500 per person	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Out-of-network, elective and non-covered medical expenses, premiums and balance-billed charges.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes, see www.chpstudent.com for list of participating providers	If you use an **in-network** doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your **in-network** doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network.** See the chart starting on page 2 for how this plan pays different kinds of **providers.**
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services.**

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In-Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit; then coinsurance 20%	$25 copay/visit; then coinsurance 40%	1 visit/ day; not paid same day as surgery
	Specialist visit	$25 copay/visit; then coinsurance 20%	$25 copay/visit; then coinsurance 40%	1 visit/day; not paid same day as surgery
	Other practitioner office visit	Coinsurance 20%	Coinsurance 40%	1 visit/day for Chiropractor
	Preventive care/screening/immunization	No charge	Coinsurance 40%	————none————
If you have a test	Diagnostic test (x-ray, blood work)	Coinsurance 20%	Coinsurance 40%	————none————
	Imaging (CT/PET scans, MRIs)	$500 copay/ procedure, then coinsurance 20%	$500 copay/ procedure, then coinsurance 40%	————none————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.chpstudent.com	Generic drugs	$25 copay/drug then coinsurance 20%	$25 copay/drug then coinsurance 20%	30 day supply per prescription
	Preferred brand drugs	$50 copay/drug then coinsurance 20%	$50 copay/drug then coinsurance 20%	30 day supply per prescription
	Non-preferred brand drugs	$50 copay/drug then coinsurance 20%	$50 copay/drug then coinsurance 20%	30 day supply per prescription
	Specialty drugs	$50 copay/drug then coinsurance 20%	$50 copay/drug then coinsurance 20%	————none————

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$500 copay/ surgical event, then coinsurance 20%	$500 copay/ surgical event, then coinsurance 40%	——————none——————
	Physician/surgeon fees	Coinsurance 20%	Coinsurance 40%	Assistant surgeon/anesthesia 25% surgeon's payment
If you need immediate medical attention	Emergency room services	$150 copay/visit; then coinsurance 20%	$150 copay/visit; then coinsurance 20%	——————none——————
	Emergency medical transportation	Coinsurance 20%	Coinsurance 20%	——————none——————
	Urgent care	$150 copay/visit; then coinsurance 20%	$150 copay/visit; then coinsurance 20%	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	Coinsurance 20%	Coinsurance 40%	——————none——————
	Physician/surgeon fee	Coinsurance 20%	Coinsurance 40%	Assistant surgeon/anesthesia 25% surgeon's payment; limited to 1 visit per day during confinement.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 copay/visit; then coinsurance 20%	$25 copay/visit; then coinsurance 40%	——————none——————
	Mental/Behavioral health inpatient services	Coinsurance 20%	Coinsurance 40%	——————none——————
	Substance use disorder outpatient services	$25 copay/visit; then coinsurance 20%	$25 copay/visit; then coinsurance 40%	——————none——————
	Substance use disorder inpatient services	Coinsurance 20%	Coinsurance 40%	——————none——————
If you are pregnant	Prenatal and postnatal care	Coinsurance 20%	Coinsurance 40%	——————none——————
	Delivery and all inpatient services	Coinsurance 20%	Coinsurance 40%	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	Coinsurance 20%	Coinsurance 40%	———————none———————
	Rehabilitation services	Coinsurance 20%	Coinsurance 40%	1 visit per day
	Habilitation services	Coinsurance 20%	Coinsurance 40%	1 visit per day
	Skilled nursing care	Coinsurance 20%	Coinsurance 40%	———————none———————
	Durable medical equipment	$50 copay/ prescription, then coinsurance 20%	$50 copay/ prescription, then coinsurance 40%	———————none———————
	Hospice service	Coinsurance 20%	Coinsurance 40%	Limited to Covered Persons with a life expectancy of 6 months or less
If your child needs dental or eye care	Eye exam	Covered 100% for $150, then Coinsurance 50%	Covered 100% for $150, then Coinsurance 50%	Combined with Glasses. Limited to one exam per year.
	Glasses	Covered 100% for $150, then Coinsurance 50%	Covered 100% for $150, then Coinsurance 50%	Combined with Glasses. Limited to one exam per year.
	Dental check-up	No Charge	No Charge	See your policy or plan document for additional information.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Dental care (Adult)
- Routine eye care (Adult)
- Bariatric surgery
- Infertility treatment
- Routine foot care
- Cosmetic surgery
- Long-term care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Hearing aids up to age 19, 1 every 3 years
- Non-emergency care when traveling outside the U.S.
- Private-duty nurse

Your Rights to Continue Coverage:

"Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-800-633-7867. You may also contact your state insurance department at Toll Free Consumer Line: In the Twin Cities metro area call (651) 539-1600 or statewide toll free at 800-657-3602.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: the plan administrator at www.chpstudent.com or 1-800-633-7867 or contact the Minnesota Department of Commerce Attn: Consumer Protection & Education Division, 85 7th Place East, Suite 500, St. Paul, MN 55101

Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): P ara obtener asistencia en Español, llame al 1-800-633-7867.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-633-7867
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-633-7867
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-633-78679

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,540
- **Patient pays** $2,000

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$200
Copays	$0
Coinsurance	$1,200
Limits or exclusions	$600
Total	**$2,000**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,900
- **Patient pays** $2,500

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$300
Copays	$1,200
Coinsurance	$700
Limits or exclusions	$300
Total	**$2,500**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✔ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✔ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.