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 plan brochure, call 1-877-657-5044 or visit www.chpstudenthealth.com. 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.chpstudenthealth.com. or call 1-800-633-7867 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$150 per person/$450 per family ($75 for students with referral from Student Health & Wellness Center (SH & WC), Counseling Center, or the Georgetown University Student Health Center).	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care 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 www.chpstudenthealth.com
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?	For network providers $3,000 individual/$9,000 family; for out-of-network providers $7,750 individual/$15,500 per family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
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 1-877-657-5044 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?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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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	$20 copayment 10% coinsurance	36% coinsurance	None
	Specialist visit	10% coinsurance	36% coinsurance	None
	Preventive care/screening/ immunization	No charge: deductible does not apply	16% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	36% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	36% coinsurance	
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 copayment/ prescription (retail) SH & WC $8 copayment	$15 copayment/prescription	Copayment waived for generic contraceptives and wellness/preventive prescription drugs. You must pay out-of-pocket for prescriptions at an out-of-network pharmacy and then submit the receipt for reimbursement.
	Preferred brand drugs	$25 copayment/ prescription (retail) SH & WC $8 copayment	$25 copayment/prescription	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	36% coinsurance	None
	Physician/surgeon fees	10% coinsurance	36% coinsurance	None
If you need immediate medical attention	Emergency room care	$50 copayment 0% coinsurance	$50 copayment 0% coinsurance	No referral required. When a student presents to the Emergency Room the Deductible is automatically reduced to $75 for the ER charges only (facility, doctor and ancillary charges). However, follow-up care should be coordinated through the Health Services. If a referral is not received for the follow-up care, then the student will have to meet the balance of the $150 Deductible.
	Emergency medical transportation	No Charge	No Charge	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	$50 copayment/visit 0% coinsurance Deductible waived	$50 copayment/visit 0% coinsurance Deductible waived	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	36% coinsurance	Precertification required or $200 per admission charge applies.
	Physician/surgeon fees	10% coinsurance	36% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	36% coinsurance	None
	Inpatient services	0% coinsurance	36% coinsurance	Precertification required or $200 per admission charge applies.
If you are pregnant	Office visits	10% coinsurance	36% coinsurance	Cost sharing does not apply to certain preventive services. Precertification required for stays longer than 48 hours for vaginal delivery or 96 hours for cesarean delivery, or $200 charge applies
	Childbirth/delivery professional services	10% coinsurance	36% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	36% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	10% coinsurance	None
	Rehabilitation services	10% coinsurance	36% coinsurance	None
	Habilitation services	10% coinsurance	36% coinsurance	
	Skilled nursing care	10% coinsurance	36% coinsurance	Precertification required or $200 per admission charge applies.
	Durable medical equipment	10% coinsurance	10% coinsurance	None
	Hospice services	10% coinsurance	36% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	16% coinsurance	Coverage limited to one exam/year.
	Children's glasses	No charge	16% coinsurance	Coverage limited to one pair of glasses/year.
	Children's dental check-up	No charge		None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your or plan brochure for more information and a list of any other excluded services.)

- Cosmetic surgery, except in connect with gender reassignment surgery, or to correct accidental injury or illness or congenital defect.
- Dental Care (Adult)
- Long-term care
- Private duty nursing
- 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.)

- Acupuncture (in lieu of Anesthesia)
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact Consolidated Health Plans at 1-877-657-5044. 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: Consolidated Health Plans at 1-877-657-5044. Additionally, a consumer assistance program can help you file your appeal. Contact the Health Education and Advocacy Unit, Consumer Protection Division, 200 St. Paul Place, 16th Floor, Baltimore, MD 21202, 1-877-261-8807.

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 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 1-877-657-5044.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-657-5044.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-877-657-5044.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-657-5044.

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 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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$150
Copayments	$100
Coinsurance	$1300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,610**

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 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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$150
Copayments	$800
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,310**

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

The plan's overall deductible	$150
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*	$150
Copayments	$0
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$250**

*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.