
 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](http://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](http://www.healthcare.gov/sbc-glossary) or call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	Preferred Provider: \$1,100/individual Non-Preferred Provider: \$2,200/individual <i>(waived when referred by the Student Health Center)</i>	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay.
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	<b>Yes.</b> <a href="#">Preventive care</a> and SHC referred services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	<b>No.</b>	You don't have to meet <a href="#">deductible</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	For <a href="#">Preferred providers</a> : \$6,600/individual; \$13,200/family; for <a href="#">Non-Preferred providers</a> : \$6,600/individual	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their <a href="#">own out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, health care this <a href="#">plan</a> doesn't cover, and <a href="#">Non-Preferred Provider</a> payments.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.cigna.com">www.cigna.com</a> or call 1-877-657-5030 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	<b>No.</b>	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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 <a href="#">provider's office</a> or clinic	Primary care visit to treat an injury or illness	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Includes care by primary Physician, <a href="#">specialist</a> , consultant and any other license practitioner operating within the scope of his or her license. Limit of one visit per day. <a href="#">Deductible</a> waived if Student Health Center Referred.
	<a href="#">Specialist</a> visit	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Limit of one visit per day.
	<a href="#">Preventive care/screening/immunization</a>	No Charge	40% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	When prescribed by a physician. <a href="#">Deductible</a> waived if Student Health Center Referred.
	Imaging (CT/PET scans, MRIs)	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	When prescribed by a physician. <a href="#">Deductible</a> waived if Student Health Center Referred.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.cigna.com">www.cigna.com</a>	Generic drugs	\$20 <a href="#">copay/prescription</a> , 30% <a href="#">coinsurance</a> <a href="#">Deductible</a> waived.	\$20 <a href="#">copay/prescription</a> , 40% <a href="#">coinsurance</a>	No <a href="#">Cost-Sharing</a> applies to ACA Preventive Care medications filled at a participating network pharmacy.  Non-Preferred Provider benefits are provided on a reimbursement basis. Claim forms must be received within 90 days.
	Preferred brand drugs	\$50 <a href="#">copay/prescription</a> , 30% <a href="#">coinsurance</a> <a href="#">Deductible</a> waived	\$50 <a href="#">copay/prescription</a> , 40% <a href="#">coinsurance</a>	
	Non-preferred brand drugs	\$70 <a href="#">copay/prescription</a> , 30% <a href="#">coinsurance</a> <a href="#">Deductible</a> waived	\$70 <a href="#">copay/prescription</a> , 40% <a href="#">coinsurance</a>	
	<a href="#">Specialty drugs</a> (Generic, Preferred Brand, and Non-Preferred Brand)	\$20 <a href="#">copay/prescription</a> , 30% <a href="#">coinsurance</a> <a href="#">Deductible</a> waived.	\$20 <a href="#">copay/prescription</a> , 40% <a href="#">coinsurance</a>	
		\$50 <a href="#">copay/prescription</a> , 30% <a href="#">coinsurance</a> <a href="#">Deductible</a> waived	\$50 <a href="#">copay/prescription</a> , 40% <a href="#">coinsurance</a>	
	\$70 <a href="#">copay/prescription</a> , 30% <a href="#">coinsurance</a> <a href="#">Deductible</a> waived	70 <a href="#">copay/prescription</a> , 40% <a href="#">coinsurance</a>		

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Deductible</u> waived if Student Health Center Referred.
	Physician/surgeon fees	30% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Deductible</u> waived if Student Health Center Referred. 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 immediate medical attention	<a href="#">Emergency room care</a>	\$150 <u>copay</u> /visit, 30% <u>coinsurance</u>	\$150 <u>copay</u> /visit, 30% <u>coinsurance</u>	<u>Deductible</u> waived if Student Health Center Referred.
	<a href="#">Emergency medical transportation</a>	30% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Deductible</u> waived if Student Health Center Referred. Including ground and/or air transportation.
	<a href="#">Urgent care</a>	\$50 <u>copay</u> /visit, 30% <u>coinsurance</u>	\$50 <u>copay</u> /visit, 40% <u>coinsurance</u>	<u>Deductible</u> waived if Student Health Center Referred.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Deductible</u> waived if Student Health Center Referred. Subject to Semi-Private room rate unless intensive care unit is required. <u>Pre-Certification</u> required.
	Physician/surgeon fees	30% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Deductible</u> waived if Student Health Center Referred. 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. <u>Pre-Certification</u> required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% <u>coinsurance</u> /visit	40% <u>coinsurance</u> /visit	Limited to one visit per day.
	Inpatient services	30% <u>coinsurance</u> /visit	40% <u>coinsurance</u> /visit	-----none-----

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Preferred Provider (You will pay the least)	
If you are pregnant	Office visits	30% <u>coinsurance</u> /visit	40% <u>coinsurance</u> /visit	<u>Cost-Sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in SBC (i.e. ultrasound). 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 <u>complications of pregnancy</u> .
	Childbirth/delivery professional services	30% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	30% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	30% <u>coinsurance</u>	40% <u>coinsurance</u>	—————none—————
	<a href="#">Rehabilitation services</a>	30% <u>coinsurance</u>	40% <u>coinsurance</u>	Including cardiac rehabilitation and pulmonary rehabilitation When prescribed by the attending physician. Limited to one visit per day. Inpatient Physical Therapy: <u>Pre-Certification</u> required
	<a href="#">Habilitation services</a>	30% <u>coinsurance</u>	40% <u>coinsurance</u>	Covered to the extent that they are <u>medically necessary</u> . When prescribed by the attending physician. Limited to one visit per day.
	<a href="#">Skilled nursing care</a>	30% <u>coinsurance</u>	40% <u>coinsurance</u>	Limit of up to 60 days per Policy Year. <u>Pre-Certification</u> required.
	<a href="#">Durable medical equipment</a>	30% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Deductible</u> waived if Student Health Center Referred
	<a href="#">Hospice services</a>	30% <u>coinsurance</u>	40% <u>coinsurance</u>	—————none—————
If your child needs dental or eye care	Children's eye exam	30% <u>coinsurance</u>	40% <u>coinsurance</u>	Limit of one visit per Policy Year. To the end of the month in which the Insured Person turns age 19.
	Children's glasses	30% <u>coinsurance</u>	40% <u>coinsurance</u>	Limit of one pair of prescribed lenses and contact lenses per Policy Year. To the end of the month in which the Insured Person turns age 19.
	Children's dental check-up	No Charge	0% <u>coinsurance</u>	Limit of 2 exam every 12 months. To the end of the month in which the Insured Person turns age 19. Preventive only.

## 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
- Hearing Aids
- Infertility Treatment
- 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)
- Non-emergency Care While Traveling Outside the United States
- Private Duty Nursing (Inpatient)

**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: <https://disb.dc.gov/>. 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](http://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: <https://disb.dc.gov/service/file-complaint-or-report-fraud>

### 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, kwijigo 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,100
■ <a href="#">Specialist Coinsurance</a>	30%
■ Hospital (facility) <a href="#">Coinsurance</a>	30%
■ Other <a href="#">Coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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#### In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,100
Copayments	\$100
Coinsurance	\$3,800
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$5,060</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,100
■ <a href="#">Specialist Coinsurance</a>	30%
■ Hospital (facility) <a href="#">Coinsurance</a>	30%
■ Other <a href="#">Coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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#### In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,100
Copayments	\$1,300
Coinsurance	\$900
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$3,355</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,100
■ <a href="#">Specialist Coinsurance</a>	30%
■ Hospital (facility) <a href="#">Coinsurance</a>	30%
■ Other <a href="#">Coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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#### In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,100
Copayments	\$0
Coinsurance	\$600
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,700</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.