
 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.studentplanscenter.com or by calling 1-800-756-3702. 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 <https://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 ?	Network: \$ 500/Individual Non-Network: \$1000/Individual Coinsurance and copayments do not count toward the deductible .	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 , Prescription Drugs, Outpatient Laboratory Services, and Outpatient Mental Health/Substance Use 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 ?	Network: \$7,900/Individual, \$13,700 Family; Non-Network: No Maximum	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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit ?	Premiums, balance-billed charges, 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/hcpdirectory/ or call 1-800-224-6224 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 .

 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	\$30 <u>Copay</u> / visit	50% <u>Coinsurance</u> , \$30 <u>Copay</u> / visit	One visit per day.
	Specialist visit	\$30 <u>Copay</u> / visit	50% <u>Coinsurance</u> , \$30 <u>Copay</u> / visit	One visit per day.
	Preventive care/screening/immunization	No Charge	50% <u>Coinsurance</u>	Limited to those services required by the Affordable Care Act.
If you have a test	Diagnostic test (x-ray, blood work)	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	---none---
	Imaging (CT/PET scans, MRIs)	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	---none---
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://saic.myahpcare.com/	Generic drugs	\$15 <u>Copay</u> / prescription	50% <u>Coinsurance</u>	---none---
	Preferred brand drugs	\$35 <u>Copay</u> / prescription	50% <u>Coinsurance</u>	---none---
	Non-preferred brand drugs	\$50 <u>Copay</u> / prescription	50% <u>Coinsurance</u>	---none---
	Specialty drugs	\$50 <u>Copay</u> / prescription	50% <u>Coinsurance</u>	---none---
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	---none---
	Physician/surgeon fees	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Physician: One visit per day. 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	Emergency room care	20% <u>Coinsurance</u> , \$300 <u>Copay</u> / visit	20% <u>Coinsurance</u> , \$300 <u>Copay</u> / visit	Copay waived if admitted
	Emergency medical transportation	20% <u>Coinsurance</u>	20% <u>Coinsurance</u>	---none---
	Urgent care	\$50 <u>Copay</u> / visit	50% <u>Coinsurance</u> , \$30 <u>Copay</u> / visit	One visit per day.

If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Precertification required
	Physician/surgeon fees	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Physician: One visit per day. 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. Precertification required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <u>Copay/</u> visit	20% <u>Coinsurance</u> , \$30 <u>Copay/</u> visit	---none---
	Inpatient services	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Precertification required
If you are pregnant	Office visits	\$30 <u>Copay/</u> visit	50% <u>Coinsurance</u> , \$30 <u>Copay/</u> visit	One visit per day.
	Childbirth/delivery professional services	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	---none---
	Childbirth/delivery facility services	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Up to 48 hours for normal vaginal delivery and 96 hours (not including the day of surgery) for a caesarean section delivery.
If you need help recovering or have other special health needs	Home health care	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Precertification required
	Rehabilitation services	20% <u>Coinsurance</u> , \$30 <u>Copay/</u> visit	50% <u>Coinsurance</u> , \$30 <u>Copay/</u> visit	Inpatient: Precertification required. Cardiac Rehabilitation services 36 per 6-month period.
	Habilitation services	20% <u>Coinsurance</u> , \$30 <u>Copay/</u> visit	50% <u>Coinsurance</u> , \$30 <u>Copay/</u> visit	Cardiac Rehabilitation services 36 per 6-month period.
	Skilled nursing care	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Precertification required
	Durable medical equipment	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	---none---
	Hospice services	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	---none---
If your child needs dental or eye care	Children's eye exam	No Charge	50% <u>Coinsurance</u>	Preventive Only. One exam per Policy Year.
	Children's glasses	No Charge	50% <u>Coinsurance</u>	One pair of prescribed frames and lenses per Policy Year.
	Children's dental check-up	No Charge	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](#).)

- Bariatric surgery
- Cosmetic surgery, unless directly related to a Covered Accidental Injury
- Long-term care
- Routine foot care, unless related to 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 a licensed Acupuncturist only
- Chiropractic care
- Dental Care (Adult), Accidental Injury only
- Hearing aids (limits apply)
- Infertility treatment (limits apply)
- Non-Emergency care when traveling outside the U.S., except there is no coverage (emergency or otherwise) for International Students in their Home Country
- Private-duty nursing
- Routine Eye Care (Adult) Limits Apply

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: Illinois Dept. of Insurance 122 S. Michigan Ave., 19th Floor Chicago, IL 60603 or (877) 527-9431 or <http://insurance.illinois.gov/default.html>. 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: Illinois Dept. of Insurance 122 S. Michigan Ave., 19th Floor Chicago, IL 60603 or (877) 527-9431 or <http://insurance.illinois.gov/default.html>

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](#).

————— *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	\$500
■ Specialist Copay	\$30
■ 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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$100
Coinsurance	\$2,400
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,060

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$500
■ Specialist Copay	\$30
■ 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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$1,000
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$1,860

Mia's Simple Fracture

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

■ The plan's overall deductible	\$500
■ Specialist Copay	\$30
■ 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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$200
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$900

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