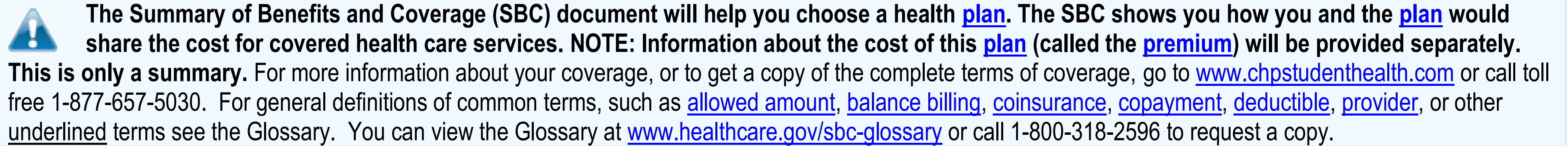

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.chpstudenthealth.com 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 or call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Preferred Provider: $350/Individual Non-Preferred Provider: $500/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.** Preventive care services, 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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	**Yes.** $100 for prescription drug coverage	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Preferred Provider: $6,350/Individual Non-Preferred Provider: $25,000/Individual	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges or health care this plan does not cover. The Insured Person's Non-Preferred Provider payments or other non-covered expenses do not count toward this limit.	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.

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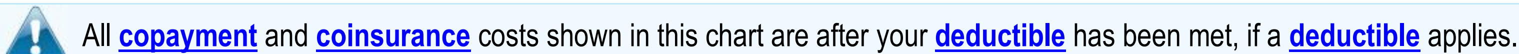
All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred 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, 25% coinsurance	$50 copay/visit, 50% coinsurance	Primary physician, specialist, and consultant. One visit per day.
	Specialist visit	$25 copay/visit, 25% coinsurance	$50 copay/visit, 50% coinsurance	One visit per day.
	Preventive care/screening/ immunization	No Charge	50% 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.
If you have a test	Diagnostic test (x-ray, blood work)	$25 copay/visit, 25% coinsurance	$50 copay/visit, 50% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	$25 copay/visit, 25% coinsurance	$50 copay/visit, 50% 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	$20 copay/prescription, 20% coinsurance	$20 copay/prescription, 20% coinsurance	No cost sharing 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 copay/prescription, 20% coinsurance	$50 copay/prescription, 20% coinsurance	
	Non-preferred brand drugs	$100 copay/prescription, 20% coinsurance	$100 copay/prescription, 20% coinsurance	
	Specialty drugs	$100 copay/prescription, 20% coinsurance	$100 copay/prescription, 20% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 copay/visit, 25% coinsurance	$300 copay/visit, 50% coinsurance	——————none——————
	Physician/surgeon fees	25% coinsurance	50% coinsurance	Physician: limit of 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.

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 need immediate medical attention	Emergency room care	$350 copay/visit, 25% coinsurance	$350 copay/visit, 25% coinsurance	———————none———————
	Emergency medical transportation	25% coinsurance	25% coinsurance	Ground, air or water transportation.
	Urgent care	$50 copay/visit, 25% coinsurance	$50 copay/visit, 50% coinsurance	———————none———————
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	50% coinsurance	Pre-Certification is required. Subject to Semi-Private room rate unless intensive care unit is required.
	Physician/surgeon fees	25% coinsurance	50% coinsurance	Pre-Certification is required. Physician: Limited to 1 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 mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/visit, 25% coinsurance	$50 copay/visit, 50% coinsurance	———————none———————
	Inpatient services	25% coinsurance	50% coinsurance	———————none———————
If you are pregnant	Office visits	$25 copay/visit, 25% coinsurance	$50 copay/visit, 50% 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. Cost sharing does not apply to certain preventive services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound)
	Childbirth/delivery professional services	25% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	25% coinsurance	50% coinsurance	

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 need help recovering or have other special health needs	Home health care	25% coinsurance	50% coinsurance	——————none——————
	Rehabilitation services	Inpatient: 25% coinsurance	Inpatient: 50% coinsurance	Inpatient Physical Therapy: Pre-Certification required
		Outpatient: $25 copay/visit, 25% coinsurance	Outpatient: $50 copay/visit, 50% coinsurance	Including cardiac rehabilitation, pulmonary rehabilitation, physical therapy, occupational therapy and speech therapy.
	Habilitation services	$25 copay/visit, 25% coinsurance	$50 copay/visit, 50% coinsurance	Covered to the extent that they are medically necessary.
	Skilled nursing care	25% coinsurance	50% coinsurance	Pre-Certification required.
	Durable medical equipment	25% coinsurance	50% coinsurance	Includes Prosthetic Devices
	Hospice services	25% coinsurance	50% coinsurance	——————none——————
If your child needs dental or eye care	Children's eye exam	0% coinsurance	0% coinsurance	To the end of the month in which the Insured Person turns age 19. Limited to 1 visit per Policy Year.
	Children's glasses	0% coinsurance	0% coinsurance	To the end of the month in which the Insured Person turns age 19. 1 pair of prescribed lenses and frames per Policy Year.
	Children's dental check-up	No Charge	0% coinsurance	To the end of the month in which the Insured Person turns age 19. Limited to 1 dental exam every 6 months. Preventive.

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 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 • Non-emergency Care While Traveling Outside the United States	• Private Duty Nursing (Inpatient) • Routine Eye Care (Adult) (age 19 and older)

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 1-877-657-5030. You may also contact your state insurance department at http://www.doi.sc.gov/701/Rights-as-a-Health-Insurance-Consumer. 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.doi.sc.gov/8/Consumers.

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** **$350**
- **Specialist Copayment** **$25**
- **Hospital (facility) Coinsurance** **25%**
- **Other Coinsurance** **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)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$400
Copayments	$100
Coinsurance	$3,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,760**

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

- **The plan's overall deductible** **$350**
- **Specialist Copayment** **$25**
- **Hospital (facility) Coinsurance** **25%**
- **Other Coinsurance** **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)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$400
Copayments	$1,300
Coinsurance	$700
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,455**

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

- **The plan's overall deductible** **$350**
- **Specialist Copayment** **$25**
- **Hospital (facility) Coinsurance** **25%**
- **Other Coinsurance** **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)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$400
Copayments	$100
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$900**

*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.