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?	**PPO: $100** per person/**$200** per family. **Non-PPO**: **$200** per person/**$400** per family. Doesn't apply to preventive care.	You must pay all of the costs up to the **deductible** amount before this plan begins to pay for covered services you use Check your policy or plan document for when the **deductible** starts over, usually but not always, the plan's effective date. See the chart starting on page 2 for how much you pay for covered services after you meet this **deductible**.
Are there other deductibles for specific services?	Yes. **$50** deductible for High Cost Procedures, including but not limited to CAT scans, MRI and Laser Treatment	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these benefits.
Is there an out–of–pocket limit on my expenses?	Yes. **Non-PPO**: **$2,000** per person/**$4,000** per family.	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out–of–pocket limit?	Preferred providers, mental health expenses, prescription drug copays and hearing aid expenses.	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.
Is there an overall annual limit on what the plan pays?	Yes. **$500,000**.	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. For a list of preferred providers, see www.mycignaforhealth.com or call 1-800-633-7867.	If you use an in-network doctor or other health care **provide**r, this plan will pay some or all of the cost of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provide**r 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 **Preferred 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	Deductible then $30 copay	Deductible then 20% coinsurance	——————none——————
	Specialist visit	Deductible then $30 copay	Deductible then 20% coinsurance	——————none——————
	Other practitioner office visit	Deductible then $30 copay	Deductible then 20% coinsurance	Physical therapy limited to 60 days per policy year. Routine hearing exams covered in network only. Hearing aids and batteries limited to $1,000 per policy year.
	Preventive care/screening/immunization	No charge.	**Dependents under age 6**: 20% coinsurance All other preventive care: Not covered.	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	Deductible	Deductible then 20% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	$50 per condition deductible and policy year deductible	$50 per condition deductible, policy year deductible then 20% coinsurance	——————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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.expressscripts.com.	Generic drugs	$20 copay per 30 day supply	Not covered	Copay waived for generic contraceptives.
	Preferred brand drugs	$30 copay per 30 day supply	Not covered	——————none——————
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible	Deductible then 20% coinsurance	——————none——————
	Physician/surgeon fees	Deductible	Deductible then 20% coinsurance	When more than 1 surgery performed through same incision or immediate succession, additional surgery covered at 50%.
If you need immediate medical attention	Emergency room services	Deductible then $50 copay	In-network Deductible then $50 copay	Copay waived if admitted.
	Emergency medical transportation	Deductible	In-network Deductible	——————none——————
	Urgent care	Deductible	Deductible then 20% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible	Deductible then 20% coinsurance	——————none——————
	Physician/surgeon fee	Deductible	Deductible then 20% coinsurance	When more than 1 surgery performed through same incision or immediate succession, additional surgery covered at 50%.

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 mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Deductible then $30 copay	Deductible then 20% coinsurance	Non-biologically based illnesses limited to 24 visits per policy year, not including mental illness medication management office visits.
	Mental/Behavioral health inpatient services	Deductible	Deductible then 20% coinsurance	Non-biologically based illnesses limited to 60 days per policy year.
	Substance use disorder outpatient services	Deductible then $30 copay	Deductible then 20% coinsurance	——————none——————
	Substance use disorder inpatient services	Deductible	Deductible then 20% coinsurance	——————none——————
If you are pregnant	Prenatal and postnatal care	Deductible then $30 copay	Deductible then 20% coinsurance	——————none——————
	Delivery and all inpatient services	Deductible	Deductible then 20% coinsurance	——————none——————
If you need help recovering or have other special health needs	Home health care	Deductible	Deductible then 20% coinsurance	——————none——————
	Rehabilitation services	Deductible	Deductible then 20% coinsurance	——————none——————
	Habilitation services	Deductible	Deductible then 20% coinsurance	——————none——————
	Skilled nursing care	Deductible	Deductible then 20% coinsurance	——————none——————
	Durable medical equipment	Deductible	Deductible then 20% coinsurance	——————none——————
	Hospice service	Deductible	Deductible then 20% coinsurance	——————none——————
If your child needs dental or eye care	Eye exam	No charge	Not covered	Limited to preventive child vision screening only.
	Glasses	100%	100%	Not a covered expense
	Dental check-up	No charge	Not covered	Limited to child oral health risk assessment for young children.

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.)

- Dental care (Adult) (other than for repair of injury to sound natural teeth or for removal of impacted wisdom teeth).
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (adult)
- Routine foot care

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.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Private duty nursing
- Weight loss programs

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 Consolidated Health Plans at 1-800-633-7867. You may also contact your state insurance department at **http://www.mass.gov/ocabr/government/oca-agencies/doi-lp/** or 1-617-521-7794.

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 your state insurance department at **http://www.mass.gov/ocabr/government/oca-agencies/doi-lp/** or 1-617-521-7794.

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** $7,270
- **Patient pays** $270

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	$100
Copays	$20
Coinsurance	$
Limits or exclusions	$150
Total	**$270**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,120
- **Patient pays** $1,280

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	$100
Copays	$1100
Coinsurance	$
Limits or exclusions	$80
Total	**$1,280**

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.