
 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.chpstudenthealth.com](http://www.chpstudenthealth.com) or calling 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:
What is the overall <a href="#">deductible</a> ?	<u>Preferred Provider</u> : \$100/Individual <u>Non-Preferred Provider</u> : \$100/Individual	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> is covered before you meet your <a href="#">deductible</a> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <u>plan</u> ?	For <a href="#">Preferred Providers</a> : \$2,500/individual, \$5,000/family; for <a href="#">Non-Preferred Providers</a> : \$3,500/individual	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their <u>own out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover, and <u>Non-Preferred Provider</u> payments.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.phcs.com">www.phcs.com</a> or call 1-877-657-5030 for a list of <a href="#">Preferred Providers</a> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$20 <a href="#">copay</a> /visit, 10% <a href="#">coinsurance</a>	\$20 <a href="#">copay</a> /visit, 30% <a href="#">coinsurance</a>	One visit per day.
	<a href="#">Specialist</a> visit	\$20 <a href="#">copay</a> /visit, 10% <a href="#">coinsurance</a>	\$20 <a href="#">copay</a> /visit, 30% <a href="#">coinsurance</a>	When requested by the attending physician.
	<a href="#">Preventive care/screening/immunization</a>	No Charge	30% <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 for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	When prescribed by a physician.
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	When prescribed by a physician.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.berxplan.com">www.berxplan.com</a>	Generic drugs	\$10 <a href="#">copay</a> /prescription	\$10 <a href="#">copay</a> /prescription, 30% <a href="#">coinsurance</a>	No <a href="#">Cost-sharing</a> applies to ACA Preventive Care medications filled at a participating network pharmacy. <a href="#">Non-Preferred Provider</a> benefits are provided on a reimbursement basis. Claim forms must be received within 90 days. You will not be required to pay more for a <a href="#">prescription drug</a> than the lesser of the applicable <a href="#">copayment</a> , the allowable claim amount You would pay if purchasing without health benefits or discounts.
	Preferred brand drugs	\$25 <a href="#">copay</a> /prescription	\$25 <a href="#">copay</a> /prescription, 30% <a href="#">coinsurance</a>	
	Non-preferred brand drugs	\$50 <a href="#">copay</a> /prescription	\$50 <a href="#">copay</a> /prescription, 30% <a href="#">coinsurance</a>	
	<a href="#">Specialty drugs</a>	\$50 <a href="#">copay</a> /prescription	\$50 <a href="#">copay</a> /prescription, 30% <a href="#">coinsurance</a>	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	—————none—————
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	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	<a href="#">Emergency room care</a>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	—————none—————
	<a href="#">Emergency medical transportation</a>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Including ground and/or air, water transportation.
	<a href="#">Urgent care</a>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Pre-authorization</u> required. Subject to semi-private room rate unless intensive care unit is required.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Physician: limited to 1 visit per day of confinement. <u>Pre-authorization</u> required. 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	\$20 <u>copay</u> /visit, 10% <u>coinsurance</u>	\$20 <u>copay</u> /visit, 30% <u>coinsurance</u>	one visit per day.
	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	—————none—————
If you are pregnant	Office visits	\$20 <u>copay</u> /visit, 10% <u>coinsurance</u>	\$20 <u>copay</u> /visit, 30% <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 unless the caesarean section delivery is the result of <u>Complications of Pregnancy</u> . <u>Cost-sharing</u> does not apply for preventive services. 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).
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	

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)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	—————none—————
	<a href="#">Rehabilitation services</a>	Inpatient: 10% <u>coinsurance</u>	Inpatient: 30% <u>coinsurance</u>	Inpatient Physical Therapy: <u>Pre-authorization</u> required.
		Outpatient: \$20 <u>copay</u> /visit, 10% <u>coinsurance</u>	Outpatient: \$20 <u>copay</u> /visit, 30% <u>coinsurance</u>	Including cardiac rehabilitation, pulmonary rehabilitation, physical therapy, occupational therapy and speech therapy. Up to 35 visits per Policy Year. When prescribed by the attending physician. Limited to one visit per day.
	<a href="#">Habilitation services</a>	\$20 <u>copay</u> /visit, 10% <u>coinsurance</u>	\$20 <u>copay</u> /visit, 30% <u>coinsurance</u>	Covered to the extent that they are <u>medically necessary</u> . When prescribed by the attending physician. Limited to one day per Policy Year.
	<a href="#">Skilled nursing care</a>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Pre-authorization</u> required.
	<a href="#">Durable medical equipment</a>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	—————none—————
	<a href="#">Hospice services</a>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	—————none—————
<b>If your child needs dental or eye care</b>	Children's eye exam	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 1 exam per Policy Year. To the end of the month in which the Insured Person turns age 19.
	Children's glasses	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 1 pair of prescribed lenses and frames per Policy Year. To the end of the month in which the Insured Person turns age 19.
	Children's dental check-up	No Charge		Preventive only. Limited to 2 dental exam every 12 months. To the end of the month in which the Insured Person turns age 19.

## 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
- 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.)

- Acupuncture
- Chiropractic care
- Dental care—(accidental injury only, \$100 per tooth per Policy Year)
- Hearing aids (limited benefit)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (Inpatient)
- Routine eye care (adult) – (one eye examination per Policy Year)

**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: <http://www.tdi.texas.gov/consumer/index.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](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: Consolidated Health Plans at 1-800-633-7867. You may also contact your state insurance department at <http://www.tdi.texas.gov/consumer/index.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](#).

### 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 [plan's](#) overall [deductible](#) \$100
- [Specialist Copay](#) \$20
- 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*)

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

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$100
Coinsurance	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,460</b>

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

- The [plan's](#) overall [deductible](#) \$100
- [Specialist Copay](#) \$20
- 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*)

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

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$800
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$1,155</b>

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

- The [plan's](#) overall [deductible](#) \$100
- [Specialist Copay](#) \$20
- 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*)

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

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$100
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$400</b>