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 or by calling 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 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?	Preferred Provider & Non-Preferred Provider: $0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	N/A	This plan covers items and services. But a copayment or coinsurance may apply. 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?	For Preferred Providers: $3,000/individual, $6,000/family; for Non-Preferred Providers $10,000/individual	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 has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover and Non-Preferred Provider balance-billing payments.	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.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146
Released on April 6, 2016

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, 0% coinsurance	$25 copay/visit, 20% coinsurance	1 visit per day.
	Specialist visit	0% coinsurance	20% coinsurance	When requested by the attending physician.
		Chiropractor: $25 copay/visit, 0% coinsurance	Chiropractor: $25 copay/visit, 20% coinsurance	Short term therapy only.
	Preventive care/screening/ immunization	0% coinsurance	20% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	20% coinsurance	When prescribed by a physician.
	Imaging (CT/PET scans, MRIs)	0% coinsurance	20% coinsurance	When prescribed by a physician.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.cigna.com	Generic drugs	$15 copay/prescription, 0% coinsurance	Not Covered	No Cost-Sharing applies to ACA Preventive Care medications filled at a participating network pharmacy or Student Health Center.
	Preferred brand drugs	$30 copay/prescription, 0% coinsurance	Not Covered	
	Non-preferred brand drugs	$50 copay/prescription, 0% coinsurance	Not Covered	
	Specialty drugs	$50 copay/prescription, 0% coinsurance	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	20% coinsurance	----------none----------
	Physician/surgeon fees	0% coinsurance	20% coinsurance	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	$100 copay/visit, 0% coinsurance	$100 copay/visit 0% coinsurance	Copay waived if admitted
	Emergency medical transportation	0% coinsurance	20% coinsurance	Including ground and/or air, water transportation.
	Urgent care	$50 copay/visit, 0% coinsurance	$50 copay/visit, 20% coinsurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	20% coinsurance	Subject to Semi-Private room rate unless intensive care unit is required. Pre-Certification required.
	Physician/surgeon fees	0% coinsurance	20% coinsurance	Physician: 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. Pre-Certification required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/visit, 0% coinsurance	$25 copay/visit, 20% coinsurance	One visit per day.
	Inpatient services	0% coinsurance	20% coinsurance	----------none----------
If you are pregnant	Office visits	$25 copay/visit, 0% coinsurance	$25 copay/visit, 20% coinsurance	Cost-Sharing does not apply for preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in SBC (i.e. ultrasound). 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.
	Childbirth/delivery professional services	0% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	20% 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	0% coinsurance	20% coinsurance	----------none----------
	Rehabilitation services	0% coinsurance	20% coinsurance	Including Cardiac Rehabilitation, Pulmonary Rehabilitation, Physical Therapy, Occupational Therapy and Speech Therapy. Cardiac Therapy limited to 36 visits per Policy Year. Physical therapy and Occupational Therapy subject to 40 visits for each therapy per Policy Year. Speech Therapy limited to 30 visits per Policy Year Inpatient Physical Therapy: Pre-Certification required. When prescribed by the attending physician. Limited to one visit per day.
	Habilitation services	0% coinsurance	20% coinsurance	Physical Therapy and Occupational therapy subject to 40 visits for each therapy per Policy Year Speech Therapy limited to 30 visits per Policy Year. When prescribed by the attending physician Limited to one visit per day.
	Skilled nursing care	0% coinsurance	20% coinsurance	Pre-Certification required.
	Durable medical equipment	0% coinsurance	20% coinsurance	----------none----------
	Hospice services	0% coinsurance	20% coinsurance	----------none----------
If your child needs dental or eye care	Children's eye exam	0% coinsurance	20% coinsurance	Limited to 1 visit per Policy Year To the end of the month in which the Insured Person turns age 19.
	Children's glasses	0% coinsurance	20% coinsurance	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	0% coinsurance	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.)

- Acupuncture
- 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.)

- Chiropractic care (short-term therapy only)
- Dental care (Accidental Injury only, up to $900 per tooth and $3,000 per Policy Year)
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (inpatient)
- Routine eye care (Adult)(1 exam 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: https://oci.wi.gov/Pages/ConsumersHome.aspx. 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: https://ociaccess.oci.wi.gov/complaints/public/.

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	$0
Specialist *Coinsurance*	0%
Hospital (facility) *Coinsurance*	0%
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	$0
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$560**

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

The plan's overall deductible	$0
Specialist *Coinsurance*	0%
Hospital (facility) *Coinsurance*	0%
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	$0
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,155**

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

The plan's overall deductible	$0
Specialist *Coinsurance*	0%
Hospital (facility) *Coinsurance*	0%
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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$0**

The plan would be responsible for the other costs of these EXAMPLE covered services.