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: $500/Individual, $1,000/family Non-Preferred Provider: $1,000/Individual, $2,000/family	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.** Network Preventive care, network physician visits and urgent care 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?	For Preferred Providers: $5,000/Individual; $10,000/Family; for Non-Preferred Providers: $8,000/Individual; $16,000/Family	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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, and Non-Preferred Provider 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 Preferred 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, 20% coinsurance	$25 copay/visit, 40% coinsurance	Includes care by Urgent Care, primary physician, specialist, consultant, and any other license practitioner operating within the scope of his or her license.
	Specialist visit	$35 copay/visit, 20% coinsurance	40% coinsurance	When requested by the attending physician.
	Preventive care/screening/ immunization	No Charge	40% 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)	20% coinsurance	40% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% 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	$15 copay/prescription	$15 copay/prescription 40% coinsurance	No Cost-Sharing applies to ACA Preventive care medications filled at a participating network pharmacy. No Cost-Sharing applies for Orally Administered Cancer Chemotherapy when obtained from a network provider, Mail Order or Specialty Pharmacy (if applicable). Supply Limits- We will pay for no more than a 30-day supply of Prescription Drug purchased at a retail pharmacy. You are responsible for one (1) Cost-Sharing amount for up to a 30-day supply.
	Preferred brand drugs	$30 copay/prescription	$30 copay/prescription 40% coinsurance	
	Non-preferred brand drugs	$45 copay/prescription	$90 copay/prescription 40% coinsurance	
	Specialty drugs	$45 copay/prescription	$90 copay/prescription 40% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	——————none——————
	Physician/surgeon fees	20% coinsurance	40% 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	$125 copay/visit, 20% coinsurance	$125 copay/visit, 20% coinsurance	Copay waived if admitted. Includes urgent care expenses.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Including ground, water, fixed wing and rotary wing air transportation.
	Urgent care	$35 copay/visit, 20% coinsurance	40% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Subject to Semi-Private room rate unless intensive care unit is required. Pre-Certification required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Physician: Limit of one visit per day by any one doctor when not related to surgery. 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, 20% coinsurance	$25 copay/visit, 40% coinsurance	——————none——————
	Inpatient services	20% coinsurance	40% coinsurance	——————none——————
If you are pregnant	Office visits	$25 copay/visit, 20% coinsurance	$25 copay/visit, 40% 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). A minimum of 48 hours of Inpatient care in hospital after vaginal delivery. A minimum of 96 hours of Inpatient are in hospital after a caesarean delivery.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% 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	20% coinsurance	40% coinsurance	Up to 100 visits per Policy Year- limit does not apply to infusion therapy as provided under this benefit.
	Rehabilitation services	20% coinsurance	40% coinsurance	Cardiac rehabilitation limited to 36 visits per Policy Year. Pulmonary rehabilitation limited to 20 visits per Policy Year, except if rendered as part of Physical therapy, the physical therapy visit will apply. Physical therapy, Occupational therapy, speech therapy and Inhalation Therapy limited to 20 visits per Policy Year. When prescribed by the attending physician. Inpatient Physical Therapy: Pre-Certification required. Limited to 60 visits per Policy Year.
	Habilitation services	20% coinsurance	40% coinsurance	Covered to the extent that they are medically necessary-including services for children (up to age 21) with a medical diagnosis of Autism Spectrum Disorder. Clinical Therapeutic Intervention, including but not limited to Applied Behavior Analysis, limited to 20 hours per week. Physical Therapy, Occupational Therapy and Speech and Language therapy limited to 20 visits per Policy Year. When prescribed by the attending physician.
	Skilled nursing care	20% coinsurance	40% coinsurance	Up to 90 visits per policy year. Pre-Certification required.
	Durable medical equipment	20% coinsurance	40% coinsurance	——————none——————
	Hospice services	20% coinsurance	40% coinsurance	——————none——————

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 your child needs dental or eye care	Children's eye exam	0% coinsurance		Including low vision services. Limited to 1 visit per Policy Year. Limited to Insured Person's to the end of the month in which the person turns 19.
	Children's glasses	0% coinsurance		Including low vision services. Limited to 1 pair of prescribed lenses and frames per Policy Year. Limited to Insured Person's to the end of the month in which the person turns 19.
	Children's dental check-up	No Charge	0% coinsurance	Preventive and Diagnostic. Limited to 1 visit every 6 months. Coverage is limited to covered persons through the end of the month in which the person turns 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
- Hearing Aids
- Infertility Treatment
- Long-term Care
- Non-emergency Care While Traveling Outside the United States
- Routine Eye Care (Adult)
- 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 (accidental injury)
- Private Duty Nursing (Pre-Certification required.

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/Homepage.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://oci.wi.gov/Pages/Consumers/GrievancesComplaints.aspx

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	$500
Specialist *Copayment*	$35
Hospital (facility) *Coinsurance*	20%
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	$500
Copayments	$600
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,460**

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 *Copayment*	$35
Hospital (facility) *Coinsurance*	20%
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	$500
Copayments	$1,500
Coinsurance	$300
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,355**

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

The plan's overall deductible	$500
Specialist *Copayment*	$35
Hospital (facility) *Coinsurance*	20%
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	$500
Copayments	$100
Coinsurance	$300
What isn't covered	
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.