National Guardian Life Ins. Co.: Gold Plan- University of Connecticut Graduate and Undergraduate Students

Coverage Period: 8/15/16-8/14/17

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual and Dependents | **Plan Type:** PPO

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?	**In-Network:** $300 per person/$900 per family **Out-of-Network:** $600 per person/$1,800 per family Doesn't apply to Emergency Services, Office Visits, in-network preventive/wellness and immunization services, in-network Physical Therapy, in-network prescription drugs or when treatment received at UConn/SHS.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes, $25 under Home Health Care Benefit	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.
Is there an out–of–pocket limit on my expenses?	Yes. **In-Network:** $6,850 per person/$13,700 per family. **Out-of-Network:** No limit	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.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services such as office visits.
Does this plan use a network of providers?	Yes. For a list of preferred providers, see www.cigna.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 staring 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**.

Questions: Call 1-800-633-7867 or visit us at www.chpstudent.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-633-7867 to request a copy.

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- **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 **In-Network 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	$20 copay	40%	Limited to 1 visit per day when not related to surgery. Co-pay and deductible waived at UConn/SHS.
	Specialist visit	**Office Visit:** $20 copay **Consultant visit when requested by a Physician:** Deductible then No Charge	40%	Limited to 1 visit per day when not related to surgery. Co-pay and deductible waived at UConn/SHS
	Other practitioner office visit	**Office Visit**: $20 copay **Consultant visit when requested by a Physician:** Deductible then No Charge	40%	Limited to 1 visit per day when not related to surgery. Co-pay and deductible waived at UConn/SHS
	Preventive care/screening/ immunization	No charge	Deductible then 40%	Limited to those services required by the Affordable Care Act.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible then 20%	Deductible then 40%	Deductible waived for In-Network outpatient laboratory expenses only.
	Imaging (CT/PET scans, MRIs)	Deductible, then 20%	Deductible then 40%	——————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.cigna.com.	Generic drugs	$5 copay	Deductible then 40%	Copay waived for generic contraceptives.
	Preferred brand drugs	$40 copay	Deductible then 40%	
	Non-preferred drugs	$60 copay	Deductible then 40%	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible then 20%	Deductible then 40%	——————none——————
	Physician/surgeon fees	Deductible then 20%	Deductible then 40%	——————none——————
If you need immediate medical attention	Emergency room services	$150 copay	The lesser of: 1.) The In-Network amount 2.) 20% of U&R; or 3.) Any amount above the Medicare reimbursement level.	
	Emergency medical transportation	Deductible then: 1.) no charge; or 2.) the amount above the rate established by the CT Dept. of Public Health.	The lesser of: 1.) The In-Network amount 2.) 20% of U&R; or 3.) Any amount above the Medicare reimbursement level.	——————none——————
	Urgent care	$20 copay	Deductible then 40%	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible then 20%	Deductible then 40%	——————none——————
	Physician/surgeon fee	Deductible then 20%	Deductible then 40%	Physician's visits limited to 1 per day when not related to surgery. If 2 or more surgical procedures are performed through the same incision of immediate succession at the same operative session, benefit will be equal to highest benefit value.

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	$20 copay	40%	Copay waived at UConn/SHS.
	Mental/Behavioral health inpatient services	Deductible then 20%	Deductible then 40%	——————none——————
	Substance use disorder outpatient services	$20 copay	40%	Copay waived at UConn/SHS.
	Substance use disorder inpatient services	Deductible then 20%	Deductible then 40%	——————none——————
If you are pregnant	Prenatal and postnatal care	$20 copay	40%	——————none——————
	Delivery and all inpatient services	Deductible then 20%	Deductible then 40%	——————none——————
If you need help recovering or have other special health needs	Home health care	$25 deductible then 25%	Deductible then 40%	Limited to 100 visits per policy year.
	Rehabilitation services	Inpatient: Deductible then 20% Outpatient: $20 copay	Deductible then 40%	——————none——————.
	Habilitation services	$20 copay	Deductible then 40%	——————none——————
	Skilled nursing care	Deductible then 20%	Deductible then 40%	Limited to 90 days per policy year.
	Durable medical equipment	Deductible then 20%	Deductible then 40%	——————none——————.
	Hospice service	Deductible then 20%	Deductible then 40%	——————none——————
If your child needs dental or eye care	Eye exam	No Charge	Deductible then 40%	Preventive Only. One visit and one pair of prescription lenses and frames per Policy Year.
	Glasses	100%	100%	Covered under Pediatric Vision Care benefit.
	Dental check-up	No charge	Deductible then 40%	Preventive only. One exam every six (6) months.

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture • Bariatric surgery • Cosmetic surgery	• Dental care (adult) (other than injury to sound natural teeth or impacted wisdom teeth) • Long-term care	• Routine eye care (adult) • Routine foot care • Weight loss programs

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.)		
• Chiropractic care	• Hearing aids (limited benefit) • Infertility treatment	• Non-Emergency care when traveling outside of the U.S. • Private-duty nursing

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.ct.gov/cid/site/default.asp or call (800) 203-3447.

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: http://www.ct.gov/cid/site/default.asp or call (800) 203-3447.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-633-7867.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-633-7867.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-633-7867.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-633-7867.

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** $5,690
- **Patient pays** $1,850

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	$300
Copays	$10
Coinsurance	$1,390
Limits or exclusions	$150
Total	**$1,850**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,380
- **Patient pays** $1,020

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	$300
Copays	$400
Coinsurance	$240
Limits or exclusions	$80
Total	**$1,020**

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.