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.uhs.wisc.edu/ship. 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 1-877-657-5031 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network provider: $0/individual or $0/family Out-of-network provider: $500/ individual or $1,000/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Services received at UW-Madison University Health Services, in the plan's network, out-of-network Emergency room care, and prescriptions drugs 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 deductible for specific services.
What is the out-of-pocket limit for this plan?	Network provider: $2,000 Individual / $4,000 family Out-of-network provider: $4,000 individual/ $8,000 family Combined Network Provider and Out-of-Network maximum: $3,000/individual or $6,000/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, and health care this plan doesn't cover.	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. For a list of in-network providers go to http://www.uhs.wisc.edu/ship/ or call 1-800-223-4139 for providers in The Alliance network or 1-800-226-5116 for providers in the First Health network.	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.

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
		Your Cost If You Use University Health Services (UHS)	Network Provider (You will pay the least)	Out-of-Network 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	No charge	10% coinsurance	40% coinsurance	None
	Specialist visit	0% coinsurance	10% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunization	No charge	Student/Spouse: Not covered/ Children: No charge	Student/Spouse: Not covered/ Children: 40% coinsurance	Student/Spouse: No charge for services rendered In-network that are not available at UHS/Children: No charge for immunizations In- or Out-of-Network. 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)	No charge	10% coinsurance	40% coinsurance	Precertification required for imaging.
	Imaging (CT/PET scans, MRIs)	Not covered	10% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **http://www.uhs.wisc.edu/ship/** or call 1-866-818-6911.	Generic drugs (Tier 1)	$5 copay/prescription Deductible does not apply.	$5 copay/prescription Deductible does not apply.	Not covered	No charge for prescribed FDA-approved contraceptives. Covers up to a 31-day supply (retail) per fill.
	Preferred brand drugs (Tier 2)	$15 copay/Prescription Deductible does not apply.	$15 copay/prescription Deductible does not apply.	Not covered	Unless a brand name contraceptive is prescribed as medically necessary, a copay will apply if a member receives a brand name contraceptive when a generic equivalent is available. Covers up to a 31-day supply (retail) per fill.
	Non-preferred brand drugs (Tier 3)	$25 copay/Prescription Deductible does not apply.	$25 copay/prescription Deductible does not apply.	Not covered	Covers up to a 31-day supply (retail) per fill.
	Specialty drugs (Tier 4)	10% coinsurance Deductible does not apply.	10% coinsurance Deductible does not apply.	Not covered	Limited to $150 copay/prescription. Covers up to a 31-day supply (retail) per fill.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Your Cost If You Use University Health Services (UHS)	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	10% coinsurance	40% coinsurance	Precertification required.
	Physician/surgeon fees	Not covered	10% coinsurance	40% coinsurance	Precertification required.
If you need immediate medical attention	Emergency room care	Not covered	$100 copay, 0% coinsurance	$100 copay, 0% coinsurance Deductible does not apply.	Copay waived if admitted.
	Emergency medical transportation	Not covered	10% coinsurance	10% coinsurance Deductible does not apply.	None
	Urgent care	No charge	10% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	10% coinsurance	40% coinsurance	Precertification required.
	Physician/surgeon fees	Not covered	10% coinsurance	40% coinsurance	Precertification required.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Your Cost If You Use University Health Services (UHS)	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	10% coinsurance	40% coinsurance	Precertification required for all inpatient admissions including for the treatment of substance use disorder, residential treatment facility and, all partial hospitalization in a hospital, residential treatment facility or facility established for the treatment of substance abuse.
	Inpatient services	Not covered	10% coinsurance	40% coinsurance	
If you are pregnant	Office visits	Not covered	10% coinsurance	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 the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	Not covered	10% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	Not covered	10% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	Not covered	10% coinsurance	40% coinsurance	Limited to 60 visits/Plan Year. No coverage for custodial care. Precertification required.
	Rehabilitation services	No charge for physical therapy/all other rehabilitation services not covered	10% coinsurance	40% coinsurance	Limited to 40 physical therapy visits; 40 occupational therapy visits; 20 speech therapy visits; 20 cognitive rehabilitation visits/condition. Precertification required for Physical and Occupational therapy after the 12th visit.
	Habilitation services	No charge for physical therapy/all other habilitation services not covered	10% coinsurance	40% coinsurance	Limited to 40 physical therapy visits; 40 occupational therapy visits; 20 speech therapy visits; 20 cognitive rehabilitation visits/condition. Precertification required for Physical and Occupational therapy after the 12th visit.
	Skilled nursing care	Not covered	10% coinsurance	40% coinsurance	Precertification required.
	Durable medical equipment	Not covered	10% coinsurance	40% coinsurance	Precertification required for equipment over $500..
	Hospice services	Not covered	10% coinsurance	40% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Your Cost If You Use University Health Services (UHS)	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	20% coinsurance and $25 copay/exam	20% coinsurance and $25 copay/exam after deductible	Covers one exam/Plan Year.
	Children's glasses	Not covered	20% coinsurance ; $25 copay/materials	20% coinsurance ; $25 copay/materials	Covers up to $50 for lenses; $100 for frames or contacts/Plan Year
	Children's dental check-up	Not covered	50% coinsurance	50% coinsurance	None

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 (except reconstructive surgery when such surgery is incidental to or follows surgery resulting from trauma, infection or other disease of the involved part or reconstructive surgery because of a congenital disease or anomaly of a covered dependent child which has resulted in a functional defect, or breast reconstructive surgery after a mastectomy)
- Dental care (Adult)
- 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 (when referred by the attending physician for rehabilitative services/habilitative services)
- Chiropractic care (Precertification required after 12th visit.)
- Hearing aids (If age 18 and older, benefits are limited to a single purchase (including repair/replacement) every three years. If under 18, benefits will not exceed the cost of one hearing aid per ear per child more than once every three years.)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (Inpatient: Precertification required.)
- Routine eye care (Adult)

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: Your state insurance department at https://oci.wi.gov/Pages/Homepage.aspx. For more information on your rights to continue coverage, contact the plan

at 1-877-657-5031. 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: Wellfleet Group, LLC, Appeals Department, 2077 Roosevelt Ave., Springfield, MA 01104 or call toll free 1-877-657-5031.

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 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 1-877-657-5031.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-657-5031.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-657-5031.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-657-5031.

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** **10%**
- **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)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$20
Coinsurance	$1,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,380**

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** **10%**
- **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)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$760**

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

- **The plan's overall deductible** **$0**
- **Specialist coinsurance** **10%**
- **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)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$200**

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