



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 <https://www.uhs.wisc.edu/ship/> 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?	In- Network Provider : \$150/ individual, \$300/ family; Out-of-Network Provider : \$500/ individual, \$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, Preventive care , Quality Path , and outpatient prescription 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 deductibles for specific services.
What is the out-of-pocket limit for this plan?	For In- Network Provider \$3,000/ individual; \$6,000/ family; For Out-of-Network Provider \$6,000/ individual; \$12,000/ family; Combined In- Network and Out-of-Network Provider : \$3,000/individual; \$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. See http://www.uhs.wisc.edu/ship/ or call 1-800-223-4139 for a list of The Alliance network providers ; or 1-800-226-5116 for a list of First Health 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 .

 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)	In-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	No Charge	10% coinsurance Chiropractic Care: 10% coinsurance	40% coinsurance Chiropractic Care: 40% coinsurance	None
	Preventive care/screening/immunization	Student/Spouse: No Charge Children: Not covered	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 services rendered In- Network or 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	Pre-Certification required but not for Laboratory Procedures. When prescribed by an attending physician.
	Imaging (CT/PET scans, MRIs)	Not Covered	10% coinsurance	40% coinsurance	Pre-Certification required. When prescribed by an attending physician.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.uhs.wisc.edu/ship/	Tier 1 (Generic drugs)	\$10 copay /prescription Deductible does not apply.	\$10 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. 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. Specialty Drugs Limited to \$150 copay /prescription.

* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://www.uhs.wisc.edu/ship/>

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)	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Tier 2 (Preferred brand drugs)	\$25 copay /prescription <u>Deductible</u> does not apply.	\$25 copay /prescription <u>Deductible</u> does not apply.	Not Covered	No charge for prescribed FDA-approved contraceptives. Covers up to a 31-day supply (retail) per fill. Unless a brand name contraceptive is prescribed as <u>medically necessary</u> , a <u>copay</u> will apply if a member receives a brand name contraceptive when a generic equivalent is available.
	Tier 3 (Non-preferred brand drugs)	\$40 copay /prescription <u>Deductible</u> does not apply.	\$40 copay /prescription <u>Deductible</u> does not apply.	Not Covered	No charge for prescribed FDA-approved contraceptives. Covers up to a 31-day supply (retail) per fill. Unless a brand name contraceptive is prescribed as <u>medically necessary</u> , a <u>copay</u> will apply if a member receives a brand name contraceptive when a generic equivalent is available.
	Specialty drugs	10% coinsurance <u>Deductible</u> does not apply.	10% coinsurance <u>Deductible</u> does not apply.	Not Covered	No charge for prescribed FDA-approved contraceptives. Covers up to a 31-day supply (retail) per fill. Unless a brand name contraceptive is prescribed as <u>medically necessary</u> , a <u>copay</u> will apply if a member receives a brand name contraceptive when a generic equivalent is available. Specialty Drugs Limited to \$150 <u>copay</u> /prescription.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Covered	10% coinsurance	40% coinsurance	<u>Pre-Certification</u> Required.
	Physician/surgeon fees	Not Covered	10% coinsurance	40% coinsurance	<u>Pre-Certification</u> Required.
If you need immediate medical attention	Emergency room care	Not Covered	Medical Emergency: \$100 copay /visit; 0% coinsurance	Medical Emergency: Paid the same as In-Network Provider	<u>Copayment</u> waived if admitted.

* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://www.uhs.wisc.edu/ship/>

Common Medical Event	Services You May Need	Your Cost If You Use University Health Services (UHS)	What You Will Pay		Limitations, Exceptions, & Other Important Information
			In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
			Non-Medical Emergency: \$100 copay/visit; 10% coinsurance	Non-Medical Emergency: \$100 copay/visit; 40% coinsurance	
	Emergency medical transportation	Not Covered	10% coinsurance	10% coinsurance	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	Pre-Certification required.
	Physician/surgeon fees	Not Covered	10% coinsurance	40% coinsurance	Pre-Certification required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Outpatient Services, other than office visits: No Charge Office visits: No Charge	Outpatient Services, other than office visits: 10% coinsurance Office visits: 10% coinsurance	Outpatient Services, other than office visits: 40% coinsurance Office visits: 40% coinsurance	Pre-Certification required except for Office Visits.
	Inpatient services	Not covered	10% coinsurance	40% coinsurance	Pre-Certification 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.
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	

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Common Medical Event	Services You May Need	Your Cost If You Use University Health Services (UHS)	What You Will Pay		Limitations, Exceptions, & Other Important Information
			In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	Not covered	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-Certification required. Limited to 60 visits/ <u>Plan</u> Year. No coverage for custodial care.
	Rehabilitation services	No charge for physical therapy/all other <u>rehabilitation services</u> not covered	Inpatient: 10% <u>coinsurance</u> Outpatient: 10% <u>coinsurance</u>	Inpatient 40% <u>coinsurance</u> Outpatient: 40% <u>coinsurance</u>	Limited to 40 physical therapy visits; 40 occupational therapy visits; 20 speech therapy visits; 20 cognitive rehabilitation visits/condition. Pre-Certification required for Physical and Occupational therapy after the 12 th visit.
	Habilitation services	No charge for physical therapy/all other <u>habilitation services</u> not covered	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 40 physical therapy visits; 40 occupational therapy visits; 20 speech therapy visits; 20 cognitive rehabilitation visits/condition. Pre-Certification required for Physical and Occupational therapy after the 12 th visit.
	Skilled nursing care	Not covered	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-Certification required. Covered to the extent of Medical Necessity.
	Durable medical equipment	Not covered	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-Certification is required for over \$500.
	Hospice services	Not covered	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	If your child needs dental or eye care	Children's eye exam	Not Covered	\$25 <u>copay</u> /exam, 20% <u>coinsurance</u>	\$25 <u>copay</u> /exam, 20% <u>coinsurance</u>
Children's glasses		Not Covered	\$25 <u>copay</u> /materials, 20% <u>coinsurance</u>	\$25 <u>copay</u> /materials, 20% <u>coinsurance</u>	Covers up to \$50 for lenses; \$100 for frames or contacts/ <u>Plan</u> Year

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Common Medical Event	Services You May Need	Your Cost If You Use University Health Services (UHS)	What You Will Pay		Limitations, Exceptions, & Other Important Information
			In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Children's dental check-up	Not Covered	50% <u>coinsurance</u>	50% <u>coinsurance</u>	Covers one oral evaluation every 6 months

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 ([Pre-Certification](#) 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 :[Pre-Certification](#) 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: <https://oci.wi.gov/Pages/Homepage.aspx> or contact Wellfleet Group, LLC toll free 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 on how 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.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Not Applicable.

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](#).

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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](#) \$150
- [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	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$150
Copayments	\$10
Coinsurance	\$1,300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,520

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$150
- [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	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$150
Copayments	\$300
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$770

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$150
- [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	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$150
Copayments	\$100
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$550

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

NOTICE OF NON-DISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

The Company complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Company does not exclude people or treat them worse because of their race, color, national origin, age, disability, or sex.

The Company provides free aids and services to people with disabilities to communicate effectively with us, such as:

1. Qualified sign language interpreters
2. Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose first language is not English when needed to communicate effectively with us, such as:

1. Interpreters
2. information translated into other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that Wellfleet Insurance Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator,
PO Box 15369, Springfield, MA 01115-5369
(413) 733-4540
civilcoordinator@wellfleetinsurance.com

You can file a grievance in person, by mail, fax, or email. If you need help filing a grievance our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building
Washington, DC 20201
800-8681019; 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

The Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

LANGUAGE ASSISTANCE PROGRAM

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call (877) 657-5030.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al (877) 657-5030.

請注意：如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請致電：(877) 657-5030。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi (877) 657-5030.

알림: 한국어(**Korean**)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다.
(877) 657-5030번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa (877) 657-5030.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по номеру (877) 657-5030.

تنبيه: إذا كنت تحدثت **بالتعريب (Arabic)**، نإفتامدخد فدعاسملا قيوغلا قينا جملا قاحتملك. عاجرلا لاصتلاً ب (877) 657-5030.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan (877) 657-5030.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le (877) 657-5030.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer (877) 657-5030.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para (877) 657-5030.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero (877) 657-5030.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie (877) 657-5030 an.

注意事項：日本語(**Japanese**)を話される場合、無料の言語支援サービスをご利用いただけます。(877) 657-5030にお電話ください。

ی سارف امشد نابز رگا: ہمتوجہ (Farsi) دباشد می امشد ارتیاخدر نایگار طور ہدی نابز دادما تآمدخ، تاسد.
تماس بگیرید. (877) 657-5030

कृपा ध्या दा: याद आप हंद। (Hindi) भाषी ह तो आपके लए भाषा सहायता सेवाएं: शुल् उपलब् ह। कृपा पर काल कर। (877) 657-5030

CEEB TOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau (877) 657-5030.

ប្រយ័ត្ន: ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ: (Khmer) សេវាកម្មភាសាជំនួយឥតគិតថ្លៃមានសម្រាប់អ្នក។ សូមទូរស័ព្ទមកលេខ (877) 657-5030 ។

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti (877) 657-5030.

DÍI BAA'ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yánilti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohjí' (877) 657-5030 hodíilnih.

OGOW: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac (877) 657-5030

ગુજરાતી (Gujarati) યુ ના: જો તમે જરાતી બોલતા હો, તો િન:લુ ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છે. ફોન કરો (877) 657-5030

λληνικά (Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε (877) 657-5030

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