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?	Tier 1: $0/Individual / $0/Family; Tier 2: $300/Individual / $600/Family; Tier 3: $600/Individual / $1,200/Family; Tier 4: $1,200/Individual / $2,400/Family. All Tiers combined maximum: $1,200/Individual / $2,400/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(UHS), Preventive care not available at UHS (except Tier 4), services received at select Imaging Providers, 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?	**Tier 1**: $0/Individual / $0/Family; **Tier 2**: $1,500/Individual / $3,000/Family; **Tier 3**: $3,000/Individual / $6,000/Family; **Tier 4**: $6,000/Individual / $12,000/Family. All Tiers combined maximum: $6,000/Individual / $12,000 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.	You pay the least if you use a provider in Tier 1. You pay more if you use a provider in Tiers 2 and 3. 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
		Tier 1 UHS/Preferred Providers (You will pay the least)	Tier 2 Premier Network Ruby Providers	Tier 3 Network Providers	Tier 4 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	20% coinsurance	40% coinsurance	None
	Specialist visit	No Charge	10% coinsurance	20% coinsurance	40% coinsurance	Includes all medically necessary services rendered by a chiropractor. Also includes medically necessary therapeutic manipulations and related services rendered by a D.O. Short-term therapy only. For chiropractic care and spinal manipulation, Pre-Certification required after 12th visit
	Preventive care/screening/ immunization	Student/Spouse: No Charge Children: Not covered	Student/Spouse: Not covered Children: No charge	Student/Spouse: Not covered Children: No charge	Student/Spouse: Not covered Children: 40% coinsurance	Student/Spouse: No charge for services rendered at Tier 2 or 3 Network Providers 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.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1 UHS/Preferred Providers (You will pay the least)	Tier 2 Premier Network Ruby Providers	Tier 3 Network Providers	Tier 4 Out-of-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	10% coinsurance	20% 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	Services provided by a select Imaging Provider*: No charge; otherwise, 20% coinsurance	40% coinsurance	Pre-Certification required. When prescribed by an attending physician. *To locate a participating select Imaging Provider, contact The Alliance or by using the provider links at www.uhs.wisc.edu/ship
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/	Level 1 (Generic drugs)	$15 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
	Level 2 (Preferred brand drugs)	$35 copay/prescription Deductible does not apply.			Not Covered	
	Level 3 (Non-preferred brand drugs)	$60 copay/prescription Deductible does not apply.			Not Covered	
	Specialty drugs	20% coinsurance Deductible does not apply.			Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Covered	10% coinsurance	20% coinsurance	40% coinsurance	Pre-Certification Required.
	Physician/surgeon fees	Not Covered	10% coinsurance	20% coinsurance	40% coinsurance	Pre-Certification Required.

* 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
		Tier 1 UHS/Preferred Providers (You will pay the least)	Tier 2 Premier Network Ruby Providers	Tier 3 Network Providers	Tier 4 Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	Not Covered	Medical Emergency: $100 copay/visit; 0% coinsurance Non-Medical Emergency: $100 copay/visit; 10% coinsurance	Medical Emergency: $100 copay/visit; 0% coinsurance Non-Medical Emergency: $100 copay/visit; 20% coinsurance	Medical Emergency: $100 copay/visit, 0% coinsurance Non-Medical Emergency: $100 copay/visit; 40% coinsurance	Medical Emergency care subject to Tier 3 deductible amount. Copayment waived if admitted.
	Emergency medical transportation	Not Covered	Not Covered	20% coinsurance	20% coinsurance	Emergency medical transportation subject to Tier 3 deductible amount.
	Urgent care	No Charge	10% coinsurance	20% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Covered	10% coinsurance	20% coinsurance	40% coinsurance	Pre-Certification required.
	Physician/surgeon fees	Not Covered	10% coinsurance	20% coinsurance	40% coinsurance	Pre-Certification required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	10% coinsurance	20% coinsurance	40% coinsurance	Pre-Certification required for surgery.
	Inpatient services	Not covered	10% coinsurance	20% coinsurance	40% coinsurance	Pre-Certification required for all inpatient admissions including for the treatment of substance use disorder, residential treatment facility.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1 UHS/Preferred Providers (You will pay the least)	Tier 2 Premier Network Ruby Providers	Tier 3 Network Providers	Tier 4 Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	Not covered	10% coinsurance	20% 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	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	Not covered	10% coinsurance	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	Not covered	10% coinsurance	20% coinsurance	40% coinsurance	Pre-Certification required. Limited to 60 visits/Plan Year. No coverage for custodial care.
	Rehabilitation services	No charge for physical therapy/all other rehabilitation services not covered	Inpatient: 10% coinsurance Outpatient: 10% coinsurance	Inpatient: 20% coinsurance Outpatient: 20% coinsurance	Inpatient: 40% coinsurance Outpatient: 40% coinsurance	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 12th visit.
	Habilitation services	No charge for physical therapy/all other habilitation services not covered	10% coinsurance	20% coinsurance	40% coinsurance	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 12th visit.
	Skilled nursing care	Not covered	10% coinsurance	20% coinsurance	40% coinsurance	Pre-Certification required. Covered to the extent of Medical Necessity.
	Durable medical equipment	Not covered	10% coinsurance	20% coinsurance	40% coinsurance	Pre-Certification is required for over $500.
	Hospice services	Not covered	10% coinsurance	20% coinsurance	40% coinsurance	None

* 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
		Tier 1 UHS/Preferred Providers (You will pay the least)	Tier 2 Premier Network Ruby Providers	Tier 3 Network Providers	Tier 4 Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not Covered	$25 copay/exam, 10% coinsurance	$25 copay/exam, 20% coinsurance	$25 copay/exam, 20% coinsurance	Covers one exam/Plan Year.
	Children's glasses	Not Covered	$25 copay/materials, 10% coinsurance	$25 copay/materials, 20% coinsurance	$25 copay/materials, 20% coinsurance	Covers up to $50 for lenses; $100 for frames or contacts/Plan Year
	Children's dental check-up	Not Covered	50% coinsurance	50% coinsurance	50% coinsurance	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)

* For more information about limitations and exceptions, see the plan or policy document at https://www.uhs.wisc.edu/ship/.

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.*

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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	**$300**
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**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,560**

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

The plan's overall deductible	**$300**
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**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$300
Copayments	$600
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,120**

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

The plan's overall deductible	**$300**
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**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$300
Copayments	$100
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$600**

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

NOTICE OF NON-DISCRIMINATION AND ACCESSIBIILITY 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: اذا تحدثت **(Arabic) ةيبرعلا**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. اتصل بـ 657-5030 (877).

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。

ىسارف امش نابز رگا :هجوت **(Farsi)** دباش می امش ارتیاخ در نایگار طور هب ینابز دادما تامدخ ،تاسا.
(877) 657-5030 تماس بگیرید.

कृपा ध्या द: यद आप **हंद** **(Hindi)** भाषी ह तो आपके लए भाषा सहायता सेवाएंन: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.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohjį' (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) ચુ ના: જો તમે જરાતી બોલતા હો, તો િન:લ્કુ ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છ. 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

Українська (Ukrainian) УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером (877) 657-5030

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ(877) 657-5030

ਪੰਜਾਬੀ (Punjabi) ਧਆਿਨ ਿਦਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ਭਾਸ਼ਾ ਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ (877) 657-5030

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ,
ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ (877) 657-5030