University Of Wisconsin Madison: Student Health Insurance Plan-International

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

Coverage Period: 08/15/2015 – 08/14/2016

Coverage for: Student & Family | **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.uhs.wisc.edu/ship or by calling 1-866-796-7899.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network: $0 Out-of-Network: $500 person/$1,000 family. Does not apply to services received at the UW-Madison University Health Services (UHS), in-network and prescription drugs.	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?	**No.**	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	**Yes.** In-Network: $2,000 person/$4,000 family. Out-of-Network: $4,000 person/$8,000 family.	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 limit**.
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 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.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting 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 1-866-796-7899 or visit us at www.uhs.wisc.edu/ship.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **cciio.cms.gov** or call 1-866-796-7899 to request a copy.

- **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 University Health Services (UHS)	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	No charge	10% coinsurance	40% coinsurance	---none---
	Specialist visit	Not covered	10% coinsurance	40% coinsurance	---none---
	Other practitioner office visit	No charge	10% coinsurance for chiropractic care	40% coinsurance for chiropractic care	---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
If you have a test	Diagnostic test (x-ray, blood work)	No charge	10% coinsurance	40% coinsurance	---none---
	Imaging (CT/PET scans, MRIs)	No charge	10% coinsurance	40% coinsurance	---none---

Common Medical Event	Services You May Need	Your Cost If You Use University Health Services (UHS)	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 **http://www.uhs.wisc.edu/ship/ or call 1-800-880-1188.**	Generic drugs	$5 copay/ prescription	$5 copay/ prescription	Not covered	No charge for prescribed FDA-approved contraceptives. Covers up to a 31-day supply (retail) per fill
	Preferred brand drugs	$15 copay/ prescription	$15 copay/ prescription	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	$25 copay/ prescription	$25 copay/ prescription	Not covered	Covers up to a 31-day supply (retail) per fill
	Specialty drugs	10% coinsurance	10% coinsurance	Not covered	Limited to $150 copay/prescription. Covers up to a 31-day supply (retail) per fill
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	10% coinsurance	40% coinsurance	---none---
	Physician/surgeon fees	Not covered	10% coinsurance	40% coinsurance	---none---
If you need immediate medical attention	Emergency room services	Not covered	10% coinsurance	40% coinsurance	0% coinsurance for life threatening medical emergency
	Emergency medical transportation	Not covered	10% coinsurance	40% 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	---none---
	Physician/surgeon fee	Not covered	10% coinsurance	40% coinsurance	---none---

Common Medical Event	Services You May Need	Your Cost If You Use University Health Services (UHS)	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	No charge	10% coinsurance	40% coinsurance	---none---
	Mental/Behavioral health inpatient services	Not covered	10% coinsurance	40% coinsurance	---none---
	Substance use disorder outpatient services	No charge	10% coinsurance	40% coinsurance	---none---
	Substance use disorder inpatient services	Not covered	10% coinsurance	40% coinsurance	---none---
If you are pregnant	Prenatal and postnatal care	Not covered	10% coinsurance	40% coinsurance	---none---
	Delivery and all inpatient services	Not covered	10% coinsurance	40% coinsurance	---none---
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.
	Rehabilitation 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
	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
	Skilled nursing care	Not covered	10% coinsurance	40% coinsurance	---none---
	Durable medical equipment	Not covered	10% coinsurance	40% coinsurance	---none---
	Hospice service	Not covered	20% coinsurance	40% coinsurance	---none---

Common Medical Event	Services You May Need	Your Cost If You Use University Health Services (UHS)	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	Not covered	No charge	Not Covered	Covers one exam/Plan Year.
	Glasses	Not covered	20% coinsurance & $25 copay/exam & $25 copay/materials	20% coinsurance & $25 copay/exam & $25 copay/materials	Covers up to $50 for lenses; $100 for frames or contacts/Plan Year
	Dental check-up	Not covered	50% coinsurance	50% coinsurance	---none---

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for 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 (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture when referred by the attending physician for rehabilitative services/habilitative services
- Chiropractic care
- 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
- Routine eye care (Adult)

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 University stops offering services in the State
- You move outside the coverage area

You must have been enrolled in this health insurance coverage for at least 120 days prior to the continuation effective coverage date. You must also be a resident in the State of Wisconsin. Continuation is available for a lifetime maximum period of one coverage period only (fall or spring/summer). It is not possible to enroll in continuation more than once.

For more information on your rights to continue coverage, contact AIG, Educational Markets at 866-796-7899.

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: AIG, Educational Markets, Appeal Letter, Two Aquarium Drive, Suite 200 Camden NJ 08103.

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.**

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** $6,630
- **Patient pays** $910

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	$0
Copays	$10
Coinsurance	$700
Limits or exclusions	$200
Total	**$910**

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

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

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	$0
Copays	$200
Coinsurance	$100
Limits or exclusions	$80
Total	**$380**

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.