LifeWise Assurance Company: UW GAIP + Vision/Dental

Coverage for: Individual or Family | **Plan Type:** PPO

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, call 1-800-971-1491 or visit us at https://students.lifewiseac.com/gaip/. 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 1-800-971-1491 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$75 Individual per quarter, up to $300 per plan year. Copays are not applied to the deductible. Doesn't apply to first $1,000 for academic student employee services at Husky Health Center.	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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Does not apply to Preventive care, copayments, prescription drugs and services listed below as "No charge".	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?	Yes. Dental $25 Individual/$75 Family. Adult Vision $10 exam, $25 glasses, $25 contacts	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.
What is the out-of-pocket limit for this plan?	In-network: $1,200 Individual/$2,400 Family Out-of-network: Not Applicable	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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, penalties for failure to obtain prior authorization for services, 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 https://students.lifewiseac.com/gaip/ or call 1-800-971-1491 for a list of in-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
		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	Deductible, then 10% coinsurance	Deductible, then 40% coinsurance	None
	Specialist visit	Deductible, then 10% coinsurance	Deductible, then 40% coinsurance	None
	Preventive care/screening/ immunization	No charge	Deductible, then 40% coinsurance	None
If you have a test	Diagnostic test (x-ray, blood work)	Deductible, then 10% coinsurance	Deductible, then 40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	Deductible, then 10% coinsurance	Deductible, then 40% coinsurance	Prior authorization required for some outpatient imaging tests.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available a https://student.lifewisea c.com/documents/0545 68_2026.pdf	Generic drugs	Rubenstein: $10 copay/prescription, deductible waived. Maintenance drugs $10 copay/prescription, deductible waived + shipping & handling. All Other: 20% coinsurance, deductible waived.	40% coinsurance, deductible waived	Covers up to a 35 day supply. Certain maintenance drugs provided at Rubenstein Pharmacy up to a 90 day supply.
	Preferred brand drugs	Rubenstein: $25 copay/prescription deductible waived. Maintenance drugs $40 copay/prescription, deductible waived + shipping & handling All Other: 20% coinsurance, deductible waived.	40% coinsurance, deductible waived	
	Non-preferred brand drugs	Rubenstein: $35 copay/prescription, deductible waived. Maintenance drugs $80 copay/prescription, deductible waived + shipping & handling. All Other: 40% coinsurance, deductible waived.	40% coinsurance, deductible waived	
	Specialty drugs	Covered as any other drug	Covered as any other drug	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		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)	Deductible, then 10% coinsurance	Deductible, then 40% coinsurance	Prior authorization is required for certain outpatient services.
	Physician/surgeon fees	Deductible, then 10% coinsurance	Deductible, then 40% coinsurance	None
If you need immediate medical attention	Emergency room care	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance	None
	Emergency medical transportation	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance	None
	Urgent care	Deductible, then 10% coinsurance	Hospital-based: Deductible, then 10% coinsurance Freestanding center: Deductible, then 40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then 10% coinsurance	Deductible, then 40% coinsurance	Prior authorization required for all planned inpatient stays.
	Physician/surgeon fees	Deductible, then 10% coinsurance	Deductible, then 40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance, deductible waived	20% coinsurance deductible waived	No fees at the Counseling Center for registered students. Chemical Dependency, deductible then covered in full for both in-network and out-of-network. Prior authorization is required for certain outpatient services.
	Inpatient services	10% coinsurance, deductible waived	40% coinsurance deductible waived	Chemical Dependency, deductible then covered in full for both in-network and out-of-network. Prior authorization is required for certain inpatient services.
If you are pregnant	Office visits	Deductible, then 10% coinsurance	Deductible, then 40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound).
	Childbirth/delivery professional services	Deductible, then 10% coinsurance	Deductible, then 40% coinsurance	
	Childbirth/delivery facility services	Deductible, then 10% coinsurance	Deductible, then 40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		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	Deductible, then 10% coinsurance	Deductible, then 40% coinsurance	Limited to 130 visits per plan year
	Rehabilitation services	Deductible, then 10% coinsurance	Deductible, then 40% coinsurance	Medical necessity reviewed after 12 outpatient visits per plan year, limited to 30 inpatient days per plan year.
	Habilitation services	Deductible, then 10% coinsurance	Deductible, then 40% coinsurance	Medical necessity reviewed after 12 outpatient visits per plan year, limited to 30 inpatient days per plan year.
	Skilled nursing care	$300 copay/visit, deductible, then 10% coinsurance	$300 copay/visit, deductible, then 40% coinsurance	Limited to 90 days per plan year.
	Durable medical equipment	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance	None
	Hospice services	Deductible, then 10% coinsurance	Deductible, then 40% coinsurance	None
If your child needs dental or eye care	Children's eye exam	10% coinsurance, deductible waived	25% coinsurance, deductible waived	Limited to one exam per plan year (under age 19).
	Children's glasses	No charge	No charge	Frames and lenses limited to 1 pair per plan year (under age 19)
	Children's dental check-up	No charge	No charge	Limited to two exams per plan year (under age 19).

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	• Infertility treatment	• Private-duty nursing
• Cosmetic surgery	• Long-term 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	• Foot care	• Non-emergency care when traveling outside the U.S.
• Chiropractic care or other spinal manipulations	• Hearing aids	• Routine eye care (Adult)
• Dental care (Adult, $1,500 limit)		

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: for ERISA plans, contact the Department of Labor's Employee Benefit's Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For governmental plans, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. For church plans and all other plans, call 1-800-562-6900 for the state insurance department, or the insurer at 1-800-971-1491. 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: your plan at 1-800-971-1491, or the state insurance department at 1-800-562-6900, or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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? 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 1-800-722-1471.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-722-1471.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-722-1471.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-722-1471.

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	**$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	$900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,260**

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	$500
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,020**

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	$10
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$510**

Notice of availability and nondiscrimination **800-971-1491 | TTY: 711**

Call for free language assistance services and appropriate auxiliary aids and services.
Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.
呼吁提供免费的语言援助服务和适当的辅助设备及服务。
呼籲提供免費的語言援助服務和適當的輔助設備及服務。
Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.
무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.
Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.
Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.
Звертайтесь за безкоштовною мовною підтримкою та відповідними додатковими послугами.
សូមហៅទូរសព្ទទៅសេវាជំនួយភាសាដោយឥតគិតថ្លៃ ព្រមទាំងសេវាកម្ម និងជំនួយចាំបាច់ដែលសមរម្យផ្សេងៗ។
無料言語支援サービスと適切な補助器具及びサービスをお求めください。
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Tajaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaajiloota barbaachisaa ta'an argachuuf bilbilaa.
મુફત ભાષા સહાયતા સેવાઓ અને ઉચિત સહાયક ચીજો અને સેવાઓ વાપરવા કોલ કરો।
Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.
ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.
Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.
Appelez pour obtenir des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés.
Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.
Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.
Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.
اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.
برای خدمات کمک زبانی رایگان و کمک‌ها و خدمات امدادی مقتضی، تماس بگیرید.

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