

## LifeWise Assurance Company : UW ISHIP Gold + 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 [student.lifewiseac.com/uw/ship](http://student.lifewiseac.com/uw/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 1-800-971-1491 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$100 Individual / \$200 Family per quarter, up to \$400 Individual / \$800 Family per plan year. Copays are not applied to the <u>deductible</u> . Doesn't apply to services at the campus clinic.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. Does not apply to <u>Preventive care</u> , <u>copayments</u> , <u>prescription drugs</u> and services listed below as "No charge"	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	Yes. Adult Dental \$25 Individual/\$75 Family	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	In-network: \$3,400 Individual / \$6,800 Family Out-of-network: \$6,400 Individual / \$12,800 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , the overall family <u>out-of-pocket limit</u> must be met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premium</u> , <u>balance-billed</u> charges, penalties for failure to obtain <u>prior authorization</u> for services, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://student.lifewiseac.com/uw/ship">student.lifewiseac.com/uw/ship</a> or call 1-800-971-1491 for a list of <u>in-network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	<u>Deductible</u> , then 25% <u>coinsurance</u>	<u>Deductible</u> , then 40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	<u>Deductible</u> , then 25% <u>coinsurance</u>	<u>Deductible</u> , then 40% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	No charge for out-of-network immunizations
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	25% <u>coinsurance</u> , <u>deductible</u> waived	<u>Deductible</u> , then 40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	<u>Deductible</u> , then 25% <u>coinsurance</u>	<u>Deductible</u> , then 40% <u>coinsurance</u>	<u>Prior authorization</u> is required for certain outpatient imaging tests.
If you need drugs to treat your illness or condition  More information about <u>prescription drug coverage</u> is available at <a href="https://student.lifewisea.com/uw/ship/pharmacy/drug-search.aspx">https://student.lifewisea.com/uw/ship/pharmacy/drug-search.aspx</a>	Preferred generic drugs	\$20 <u>copay</u> /prescription, <u>deductible</u> waived	50% <u>coinsurance</u> , <u>deductible</u> waived	Covers up to a 30 day supply. <u>Prior authorization</u> is required for certain drugs. Maximum <u>copay/coinsurance</u> of up to \$150/prescription for all out-of-network prescriptions as well as for in-network <u>Specialty drugs</u> .
	Preferred brand drugs	\$30 <u>copay</u> /prescription, <u>deductible</u> waived	50% <u>coinsurance</u> , <u>deductible</u> waived	
	Non-preferred drugs	\$45 <u>copay</u> /prescription, <u>deductible</u> waived	50% <u>coinsurance</u> , <u>deductible</u> waived	
	<u>Specialty drugs</u>	50% <u>coinsurance</u> , <u>deductible</u> waived	50% <u>coinsurance</u> , <u>deductible</u> waived	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	<u>Deductible</u> , then 25% <u>coinsurance</u>	<u>Deductible</u> , then 40% <u>coinsurance</u>	<u>Prior authorization</u> is required for certain outpatient services.
	Physician/surgeon fees	<u>Deductible</u> , then 25% <u>coinsurance</u>	<u>Deductible</u> , then 40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copay</u> /visit, <u>deductible</u> then 25% <u>coinsurance</u>	\$100 <u>copay</u> /visit, <u>deductible</u> then 25% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	<u>Deductible</u> , then 25% <u>coinsurance</u>	<u>Deductible</u> , then 25% <u>coinsurance</u>	None
	<u>Urgent care</u>	<u>Deductible</u> , then 25% <u>coinsurance</u>	Hospital-based: \$100 <u>copay</u> /visit, <u>deductible</u> then 25% <u>coinsurance</u> Freestanding center: <u>Deductible</u> , then 40% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	<u>Deductible</u> , then 25% coinsurance	<u>Deductible</u> , then 40% coinsurance	<u>Prior authorization</u> is required for certain inpatient services.
	Physician/surgeon fees	<u>Deductible</u> , then 25% coinsurance	<u>Deductible</u> , then 40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	No charge	None
	Inpatient services	<u>Deductible</u> , then 25% coinsurance	<u>Deductible</u> , then 40% coinsurance	<u>Prior authorization</u> is required for certain inpatient services.
If you are pregnant	Office visits	<u>Deductible</u> , then 25% coinsurance	<u>Deductible</u> , then 40% coinsurance	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound).
	Childbirth/delivery professional services	<u>Deductible</u> , then 25% coinsurance	<u>Deductible</u> , then 40% coinsurance	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound).
	Childbirth/delivery facility services	<u>Deductible</u> , then 25% coinsurance	<u>Deductible</u> , then 40% coinsurance	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound).
If you need help recovering or have other special health needs	<u>Home health care</u>	<u>Deductible</u> , then 25% coinsurance	<u>Deductible</u> , then 40% coinsurance	Limited to 130 visits per <u>plan</u> year
	<u>Rehabilitation services</u>	<u>Deductible</u> , then 25% coinsurance	<u>Deductible</u> , then 40% coinsurance	Limited to 25 outpatient visits per <u>plan</u> year, limited to 30 inpatient days per <u>plan</u> year. Includes physical therapy, speech therapy, and occupational therapy. <u>Prior authorization</u> is required for certain inpatient services.
	<u>Habilitation services</u>	<u>Deductible</u> , then 25% coinsurance	<u>Deductible</u> , then 40% coinsurance	Limited to 25 outpatient visits per <u>plan</u> year, limited to 30 inpatient days per <u>plan</u> year. Includes physical therapy, speech therapy, and occupational therapy. <u>Prior authorization</u> is required for certain inpatient services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	<u>Skilled nursing care</u>	<u>Deductible</u> , then 25% coinsurance	<u>Deductible</u> , then 40% coinsurance	Limited to 60 days per <u>plan</u> year. <u>Prior authorization</u> is required for certain inpatient services.
	<u>Durable medical equipment</u>	<u>Deductible</u> , then 25% coinsurance	<u>Deductible</u> , then 40% coinsurance	<u>Prior authorization</u> is required for purchase of some durable medical equipment.
	<u>Hospice services</u>	<u>Deductible</u> , then 25% coinsurance	<u>Deductible</u> , then 40% coinsurance	Limited to 14 inpatient days
If your child needs dental or eye care	Children's eye exam	<u>Deductible</u> , then 25% coinsurance	<u>Deductible</u> , then 40% coinsurance	Limited to one exam per <u>plan</u> year (under age 19).
	Children's glasses	No charge	No charge	Frames and lenses limited to 1 pair per <u>plan</u> year (under age 19).
	Children's dental check-up	<u>Deductible</u> , then 10% coinsurance	<u>Deductible</u> , then 30% coinsurance	Limited to two exams per <u>plan</u> year (under age 19).

## Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"><li>• Bariatric surgery</li><li>• Cosmetic surgery</li></ul>	<ul style="list-style-type: none"><li>• Hearing aids</li><li>• Infertility treatment</li><li>• Long-term care</li></ul>	<ul style="list-style-type: none"><li>• Private-duty nursing</li><li>• Weight loss programs</li></ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"><li>• Acupuncture</li><li>• Chiropractic care or other spinal manipulations</li></ul>	<ul style="list-style-type: none"><li>• Dental care (Adult, under \$1,500 limit)</li><li>• Foot care</li><li>• Non-emergency care when traveling outside the U.S.</li></ul>	<ul style="list-style-type: none"><li>• Routine eye care (Adult)</li><li>• Voluntary Termination of Pregnancy</li></ul>

**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: 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](http://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.

**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 1-800-971-1491.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-971-1491.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-971-1491.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-971-1491.

-----*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 <u>plan's</u> overall <u>deductible</u>	\$400
■ <u>Specialist</u> <u>coinsurance</u>	25%
■ Hospital (facility) <u>coinsurance</u>	25%
■ Other <u>coinsurance</u>	25%

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$400
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$3,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,460</b>

### Managing Joe's type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$400
■ <u>Specialist</u> <u>coinsurance</u>	25%
■ Hospital (facility) <u>coinsurance</u>	25%
■ Other <u>coinsurance</u>	25%

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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles*</u>	\$400
<u>Copayments</u>	\$1,000
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,620</b>

### Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$100
■ <u>Specialist</u> <u>coinsurance</u>	25%
■ Hospital (facility) <u>coinsurance</u>	25%
■ Other <u>coinsurance</u>	25%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles*</u>	\$100
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$600
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,000</b>

## Discrimination is Against the Law

Premera Blue Cross (Premera) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera 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 — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email [AppealsDepartmentInquiries@Premera.com](mailto:AppealsDepartmentInquiries@Premera.com). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the 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 Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

## Language Assistance

**ATENCIÓN:** si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-722-1471 (TTY: 711).

**注意:** 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-722-1471 (TTY: 711)。

**CHU Ý:** Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-722-1471 (TTY: 711).

**주의:** 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-722-1471 (TTY: 711) 번으로 전화해 주십시오.

**ВНИМАНИЕ:** Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-722-1471 (телетайп: 711).

**PAUNAWA:** Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.

Tumawag sa 800-722-1471 (TTY: 711).

**УВАГА!** Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 800-722-1471 (телетайп: 711).

**ប្រយ័ត្ន:** បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃ

គឺអាចមានសំរាប់អ្នក។ ចូរទូរស័ព្ទ 800-722-1471 (TTY: 711)។

**注意事項:** 日本語を話される場合、無料の言語支援をご利用いただけます。800-722-1471 (TTY:711) まで、お電話にてご連絡ください。

**ማስታወሻ:** የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም አርዳታ ድርጅቶች፣ በነጻ ሊያገለግሉት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ

800-722-1471 (መስማት ለተሳናቸው: 711)።

**XIYEEFFANNAA:** Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-722-1471 (TTY: 711).

**ملحوظة:** إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-722-1471 (رقم هاتف الصم والبكم: 711).

**ਧਿਆਨ ਦਿਓ:** ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤਾਮਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-722-1471

(TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

**ACHTUNG:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.

Rufnummer: 800-722-1471 (TTY: 711).

**ໂປດຊາບ:** ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ,

ແມ່ນມີຮ່ຳໃຫ້ທ່ານ. ໂທ 800-722-1471 (TTY: 711).

**ATANSYON:** Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-722-1471 (TTY: 711).

**ATTENTION:** Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-722-1471 (ATS : 711).

**UWAGA:** Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-722-1471 (TTY: 711).

**ATENÇÃO:** Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-722-1471 (TTY: 711).

**ATTENZIONE:** In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero

800-722-1471 (TTY: 711).

**توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-722-1471 (TTY: 711) تماس بگیرید.