
 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, visit wpshealth.com or call 1-800-332-6421. 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 1-800-332-6421 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| <p>What is the overall deductible?</p> | <p>For preferred providers: \$7,900.00 / Covered Person or \$15,800.00 / Family For non-preferred providers: \$15,800.00 / Covered Person or \$31,600.00 / Family</p> | <p>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.</p> |
| <p>Are there services covered before you meet your deductible?</p> | <p>Yes. Preventive care services are covered before you meet your deductible.</p> | <p>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/.</p> |
| <p>Are there other deductibles for specific services?</p> | <p>No.</p> | <p>You don't have to meet deductibles for specific services.</p> |
| <p>What is the out-of-pocket limit for this plan?</p> | <p>For preferred providers: \$7,900.00 / Covered Person or \$15,800.00 / Family; For non-preferred providers: \$21,800.00 / Covered Person or \$43,600.00 / Family</p> | <p>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.</p> |
| <p>What is not included in the out-of-pocket limit?</p> | <p>Premiums, balance-billing charges, and health care this plan doesn't cover.</p> | <p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p> |
| <p>Will you pay less if you use a network provider?</p> | <p>Yes. See https://connect.wpsic.com/Gateway/commercialGateway/unauth/fadHome.do or call 1-800-332-6421 for a list of network providers.</p> | <p>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.</p> |

| | | |
|--|-----|--|
| 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 |
|--|--|--|---|--|
| | | Preferred Provider (You will pay the least) | Non-Preferred 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 | 0% coinsurance | 30% coinsurance | The deductible does not apply to your first three visits with a primary health care practitioner. |
| | Specialist visit | 0% coinsurance | 30% coinsurance | None |
| | Preventive care/screening/immunization | No charge | 30% coinsurance | You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive . Then check what your plan will pay for. You also have no charge for immunizations provided by a non-preferred provider . |
| If you have a test | Diagnostic test (x-ray, blood work) | 0% coinsurance | 30% coinsurance | Certain genetic tests and high-technology imaging may require prior authorization. Benefits may not be payable if you do not obtain prior authorization. |
| | Imaging (CT/PET scans, MRIs) | 0% coinsurance | 30% coinsurance | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://wpshealth.com/resources/files/32772-wps-ind-small-group-drug-formulary.pdf | Generic drugs | 0% coinsurance | 0% coinsurance | Covers up to a 30-day supply retail / 90-day supply home delivery. |
| | Preferred brand drugs | 0% coinsurance | 0% coinsurance | |
| | Non-preferred brand drugs | 0% coinsurance | 0% coinsurance | |
| | Specialty drugs | 0% coinsurance | 0% coinsurance | Specialty drugs are always limited to a 30-day supply. If brand dispensed when generic available, you are responsible for dollar amount difference between brand and generic. Specialty drugs and drugs provided by an entity other than a pharmacy require prior |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|---|--|---|
| | | Preferred Provider (You will pay the least) | Non-Preferred Provider (You will pay the most) | |
| | | | | authorization. Benefits may not be payable if you do not obtain prior authorization. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 0% coinsurance | 30% coinsurance | None |
| | Physician/surgeon fees | 0% coinsurance | 30% coinsurance | None |
| If you need immediate medical attention | Emergency room care | 0% coinsurance | 0% coinsurance | None |
| | Emergency medical transportation | 0% coinsurance | 0% coinsurance | |
| | Urgent care | 0% coinsurance | 0% coinsurance | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 0% coinsurance | 30% coinsurance | Non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not to obtain prior authorization. |
| | Physician/surgeon fees | 0% coinsurance | 30% coinsurance | Non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 0% coinsurance | 30% coinsurance | Non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization. |
| | Inpatient services | 0% coinsurance | 30% coinsurance | |
| If you are pregnant | Office visits | 0% coinsurance | 30% coinsurance | Cost sharing does not apply to certain 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). Non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization. |
| | Childbirth/delivery professional services | 0% coinsurance | 30% coinsurance | |
| | Childbirth/delivery facility services | 0% coinsurance | 30% coinsurance | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|--|---|---|
| | | Preferred Provider (You will pay the least) | Non-Preferred Provider (You will pay the most) | |
| If you need help recovering or have other special health needs | Home health care | 0% coinsurance | 30% coinsurance | Coverage is limited to 60 visits/year |
| | Rehabilitation services | 0% coinsurance | 30% coinsurance | Rehabilitation services: Coverage is limited to 20 visits/year for physical therapy; 20 visits/year for occupational therapy; and 20 visits/year for speech therapy. |
| | Habilitation services | 0% coinsurance | 30% coinsurance | Habilitation services: Coverage is limited to 20 visits/year for physical therapy; 20 visits/year for occupational therapy; and 20 visits/year for speech therapy. |
| | Skilled nursing care | 0% coinsurance | 30% coinsurance | Coverage is limited to 30 days per confinement in a skilled nursing facility. Non-emergent admissions require prior authorization. Benefits may not be payable if you do not obtain prior authorization. |
| | Durable medical equipment | 0% coinsurance | 30% coinsurance | Coverage is limited to a single purchase of a type of durable medical equipment every three years. Prior authorization required for: <ul style="list-style-type: none"> • All CPAP purchases and rentals • Purchases over \$1,000 • All other rentals as stated on our website Benefits may not be payable if you do not obtain prior authorization. |
| | Hospice services | 0% coinsurance | 30% coinsurance | Hospice services require prior authorization. Benefits may not be payable if you do not obtain prior authorization. |
| If your child needs dental or eye care | Children's eye exam | No charge | Not covered | Coverage limited to one exam/year. |
| | Children's glasses | 0% coinsurance | Not covered | Coverage limited to one pair of glasses/year. |
| | Children's dental check-up | Not covered | Not covered | No coverage for dental check-ups. |

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](#).)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine eye care (Adult)
- 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.)

- Chiropractic Care
- Hearing Aids

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 the Wisconsin Office of the Commissioner of Insurance at 1-800-236-8517; or the Department of Health and Human Services at 1-877-267-2323 x 61565 or www.cciio.cms.gov. 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: WPS at 1-800-332-6421. You may also contact your state insurance department at 1-800-236-8517.

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](#).

————— *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 | \$7,900.00 |
| ■ Specialist coinsurance | 0% |
| ■ Hospital (facility) coinsurance | 0% |
| ■ Other coinsurance | 0% |

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 | \$12,800.00 |
|---------------------------|--------------------|

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|-------------------|
| Deductibles | \$7,900.00 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$10.00 |
| The total Peg would pay is | \$7,910.00 |

Managing Joe's type 2 Diabetes

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

| | |
|---|------------|
| ■ The plan's overall deductible | \$7,900.00 |
| ■ Specialist coinsurance | 0% |
| ■ Hospital (facility) coinsurance | 0% |
| ■ Other coinsurance | 0% |

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 | \$7,400.00 |
|---------------------------|-------------------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|-------------------|
| Deductibles | \$7,100.00 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$7,100.00 |

Mia's Simple Fracture

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

| | |
|---|------------|
| ■ The plan's overall deductible | \$7,900.00 |
| ■ Specialist coinsurance | 0% |
| ■ Hospital (facility) coinsurance | 0% |
| ■ Other coinsurance | 0% |

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 | \$1,900.00 |
|---------------------------|-------------------|

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|-------------------|
| Deductibles | \$1,900.00 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,900.00 |