

 **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](http://wpshealth.com) or call 1-800-332-6451. 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 1-800-332-6451 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	For preferred <a href="#">providers</a> : \$3,500.00 / Covered Person or \$7,000.00 / Family; For non-preferred <a href="#">providers</a> : \$7,000.00 / Covered Person or \$14,000.00 / Family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> services, office visits and prescription drugs purchased, other than <a href="#">specialty drugs</a> , from a pharmacy are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	Yes. \$500.00 / Covered Person for <a href="#">specialty drugs</a> . There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	For preferred <a href="#">providers</a> : \$7,900.00 / Covered Person or \$15,800.00 / Family; For non-preferred <a href="#">providers</a> : \$15,000.00 / Covered Person or \$30,000.00 / Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="https://connect.wpsic.com/Gateway/commercialGateway/unauth/fadHome.do">https://connect.wpsic.com/Gateway/commercialGateway/unauth/fadHome.do</a> or call 1-800-332-6451 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$45.00 <a href="#">copayment</a> / office visit and 10% <a href="#">coinsurance</a> for other outpatient services; <a href="#">deductible</a> does not apply to the office visit charge	40% <a href="#">coinsurance</a>	\$0 <a href="#">copayment</a> / telehealth visit charge with our approved telehealth provider  \$10.00 <a href="#">copayment</a> / office visit charge for a preferred convenient care clinic visit  \$45.00 <a href="#">copayment</a> / visit for preferred chiropractor
	<a href="#">Specialist</a> visit	\$90.00 <a href="#">copayment</a> / office visit and 10% <a href="#">coinsurance</a> for other outpatient services; <a href="#">deductible</a> does not apply to the office visit charge	40% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	40% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for. You also have no charge for immunizations provided by a non-preferred <a href="#">provider</a> .
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	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)	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you need drugs to treat your illness or condition	Generic drugs	\$25.00 <a href="#">copayment</a> / prescription (retail) & \$62.50 <a href="#">copayment</a> / prescription (home delivery)	\$25.00 <a href="#">copayment</a> / prescription (retail) & \$62.50 <a href="#">copayment</a> / prescription (home delivery)	Preferred generic drugs are no charge.  The <a href="#">deductible</a> does not apply to generic and brand name drugs which are not <a href="#">specialty drugs</a> .

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)	
More information about <a href="https://wpshealth.com/resources/files/32772-wps-ind-small-group-drug-formulary.pdf">prescription drug coverage</a> is available at <a href="https://wpshealth.com/resources/files/32772-wps-ind-small-group-drug-formulary.pdf">https://wpshealth.com/resources/files/32772-wps-ind-small-group-drug-formulary.pdf</a>	Preferred brand drugs	\$60.00 <a href="#">copayment</a> / prescription (retail) & \$150.00 <a href="#">copayment</a> / prescription (home delivery)	\$60.00 <a href="#">copayment</a> / prescription (retail) & \$150.00 <a href="#">copayment</a> / prescription (home delivery)	Covers up to a 30-day supply retail/90-day supply home delivery.  If brand dispensed when generic available, you are responsible for the dollar amount difference between brand and generic. Drugs provided by an entity other than a pharmacy require prior authorization. Benefits may not be payable if you do not obtain prior authorization.  <a href="#">Specialty drugs</a> are subject to a separate <a href="#">deductible</a> amount and are always limited to a 30-day supply. <a href="#">Specialty drugs</a> require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
	Non-preferred brand drugs	\$100.00 <a href="#">copayment</a> / prescription (retail) & \$250.00 <a href="#">copayment</a> / prescription (home delivery)	\$100.00 <a href="#">copayment</a> / prescription (retail) & \$250.00 <a href="#">copayment</a> / prescription (home delivery)	
	<a href="#">Specialty drugs</a>	40% <a href="#">coinsurance</a> / prescription (retail & home delivery)	40% <a href="#">coinsurance</a> / prescription (retail & home delivery)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$500.00 <a href="#">copayment</a> / emergency room charge and 10% <a href="#">coinsurance</a> for other emergency room services; <a href="#">deductible</a> does not apply to the emergency room charge	\$500.00 <a href="#">copayment</a> / emergency room charge and 0% <a href="#">coinsurance</a> for other emergency room services; <a href="#">deductible</a> does not apply to the emergency room charge	Urgent care professional charges may be subject to the \$90.00 <a href="#">specialist</a> office visit <a href="#">copayment</a> depending on the specialty of the physician providing treatment.
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	
	<a href="#">Urgent care</a>	\$45.00 <a href="#">copayment</a> / urgent office visit and 10% <a href="#">coinsurance</a> for other urgent care services; <a href="#">deductible</a> does not apply	\$45.00 <a href="#">copayment</a> / urgent office visit and 10% <a href="#">coinsurance</a> for other urgent care services; <a href="#">deductible</a> does	

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)	
		to the urgent office visit charge	not apply to the urgent office visit charge	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$45.00 <a href="#">copayment</a> / therapy office visit and 10% <a href="#">coinsurance</a> for other outpatient services; <a href="#">deductible</a> does not apply to the therapy office visit charge	40% <a href="#">coinsurance</a>	Non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
	Inpatient services	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
<b>If you are pregnant</b>	Office visits	\$45.00 <a href="#">copayment</a> / office visit and 10% <a href="#">coinsurance</a> for other outpatient services; <a href="#">deductible</a> does not apply to the office visit charge	40% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">deductible</a> and <a href="#">coinsurance</a> 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	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Coverage is limited to 60 visits/year
	<a href="#">Rehabilitation services</a>	\$45.00 <a href="#">copayment</a> / therapy office visit and 10% <a href="#">coinsurance</a> for other outpatient services;	40% <a href="#">coinsurance</a>	Rehabilitation services: Coverage is limited to 20 visits/year for physical therapy; 20 visits/year for

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)	
		<a href="#">deductible</a> does not apply to the therapy office visit charge		occupational therapy; and 20 visits/year for speech therapy. Habilitation services:
	<a href="#">Habilitation services</a>	\$45.00 <a href="#">copayment</a> / therapy office visit and 10% <a href="#">coinsurance</a> for other outpatient services; <a href="#">deductible</a> does not apply to the therapy office visit charge	40% <a href="#">coinsurance</a>	Coverage is limited to 20 visits/year for physical therapy; 20 visits/year for occupational therapy; and 20 visits/year for speech therapy.
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	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.
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	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"> <li>• All CPAP purchases and rentals</li> <li>• Purchases over \$1,000</li> <li>• All other rentals as stated on our website</li> </ul> Benefits may not be payable if you do not obtain prior authorization.
	<a href="#">Hospice services</a>	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Hospice services require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	Not covered	Coverage limited to one exam/year.
	Children's glasses	No charge	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:

<b>Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a>.)</b>		
<ul style="list-style-type: none"><li>• Abortion (except in cases of rape, incest, or when the life of the mother is endangered)</li><li>• Acupuncture</li><li>• Bariatric Surgery</li><li>• Cosmetic Surgery</li></ul>	<ul style="list-style-type: none"><li>• Dental Care</li><li>• Infertility Treatment</li><li>• Long Term Care</li><li>• Non-emergency care when traveling outside the U.S.</li></ul>	<ul style="list-style-type: none"><li>• Private Duty Nursing</li><li>• Routine eye care (Adult)</li><li>• Routine Foot Care</li><li>• Weight Loss Programs</li></ul>
<b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)</b>		
<ul style="list-style-type: none"><li>• Chiropractic Care</li></ul>	<ul style="list-style-type: none"><li>• Hearing Aids</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: for the U.S. Department of Labor, Employee Benefits Security Administration 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the Department of Health and Human Services at 1-877-267-2323 x 61565 or [www.cciio.cms.gov](http://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](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: WPS at 1-800-332-6451. You may also contact your state insurance department at 1-800-236-8517 or the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**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](#) \$3,500.00
- [Specialist copayment](#) \$90.00
- 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*)

<b>Total Example Cost</b>	<b>\$12,800.00</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$3,500.00
Copayments	\$100.00
Coinsurance	\$600.00
<i>What isn't covered</i>	
Limits or exclusions	\$10.00
<b>The total Peg would pay is</b>	<b>\$4,210.00</b>

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

- The [plan's](#) overall [deductible](#) \$3,500.00
- [Specialist copayment](#) \$90.00
- 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*)

<b>Total Example Cost</b>	<b>\$7,400.00</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$100.00
Copayments	\$2,860.00
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$2,960.00</b>

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

- The [plan's](#) overall [deductible](#) \$3,500.00
- [Specialist copayment](#) \$90.00
- 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*)

<b>Total Example Cost</b>	<b>\$1,900.00</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$1,300.00
Copayments	\$600.00
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,900.00</b>