

 **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> : \$4,500.00 / Covered Person or \$9,000.00 / Family;<br>For non-preferred <a href="#">providers</a> : \$9,000.00 / Covered Person or \$18,000.00 / 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;<br>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<br>(You will pay the least)  | Non-Preferred Provider<br>(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 0% <a href="#">coinsurance</a> for other outpatient services; <a href="#">deductible</a> does not apply to the office visit charge | 30% <a href="#">coinsurance</a>  | \$0 <a href="#">copayment</a> / telehealth visit charge with our approved telehealth provider<br><br>\$10.00 <a href="#">copayment</a> / office visit charge for a preferred convenient care clinic visit  |
|  | <a href="#">Specialist</a> visit                       | \$90.00 <a href="#">copayment</a> / office visit and 0% <a href="#">coinsurance</a> for other outpatient services; <a href="#">deductible</a> does not apply to the office visit charge | 30% <a href="#">coinsurance</a>  | None   |
|  | <a href="#">Preventive care/screening/immunization</a> | No charge   | <a href="#">30% 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)    | 0% <a href="#">coinsurance</a>  | 30% <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)                           | 0% <a href="#">coinsurance</a>  | 30% <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.<br><br>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<br>(You will pay the least)  | Non-Preferred Provider<br>(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.<br><br>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.<br><br><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)   |  |
| If you have outpatient surgery   | Facility fee (e.g., ambulatory surgery center)   | 0% <a href="#">coinsurance</a>  | 30% <a href="#">coinsurance</a>   | None   |
|  | Physician/surgeon fees                           | 0% <a href="#">coinsurance</a>  | 30% <a href="#">coinsurance</a>   | None   |
| If you need immediate medical attention  | <a href="#">Emergency room care</a>              | \$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 | \$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> | 0% <a href="#">coinsurance</a>  | 0% <a href="#">coinsurance</a>  |  |
|  | <a href="#">Urgent care</a>                      | \$45.00 <a href="#">copayment</a> / urgent office visit and 0% <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 0% <a href="#">coinsurance</a> for other urgent care services; <a href="#">deductible</a> does not apply                                    |  |

| Common Medical Event   | Services You May Need                     | What You Will Pay   |   | Limitations, Exceptions, & Other Important Information   |
|--|---|---|---|--|
|  |   | Preferred Provider<br>(You will pay the least)  | Non-Preferred Provider<br>(You will pay the most) |  |
|  |   | to the urgent office visit charge   | to the urgent office visit charge                 |  |
| <b>If you have a hospital stay</b>   | Facility fee (e.g., hospital room)        | 0% <a href="#">coinsurance</a>  | 30% <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                    | 0% <a href="#">coinsurance</a>  | 30% <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 0% <a href="#">coinsurance</a> for other outpatient services; <a href="#">deductible</a> does not apply to the therapy office visit charge | 30% <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                        | 0% <a href="#">coinsurance</a>  | 30% <a href="#">coinsurance</a>                   |  |
| <b>If you are pregnant</b>   | Office visits                             | \$45.00 <a href="#">copayment</a> / office visit and 0% <a href="#">coinsurance</a> for other outpatient services; <a href="#">deductible</a> does not apply to the office visit charge                 | 30% <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 | 0% <a href="#">coinsurance</a>  | 30% <a href="#">coinsurance</a>                   |  |
|  | Childbirth/delivery facility services     | 0% <a href="#">coinsurance</a>  | 30% <a href="#">coinsurance</a>                   |  |
| <b>If you need help recovering or have other special health needs</b>            | <a href="#">Home health care</a>          | 0% <a href="#">coinsurance</a>  | 30% <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 0% <a href="#">coinsurance</a> for other outpatient services;  | 30% <a href="#">coinsurance</a>                   | Rehabilitation services:<br>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<br>(You will pay the least)  | Non-Preferred Provider<br>(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.<br>Habilitation services:   |
|   | <a href="#">Habilitation services</a>     | \$45.00 <a href="#">copayment</a> / therapy office visit and 0% <a href="#">coinsurance</a> for other outpatient services; <a href="#">deductible</a> does not apply to the therapy office visit charge | 30% <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>      | 0% <a href="#">coinsurance</a>  | 30% <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> | 0% <a href="#">coinsurance</a>  | 30% <a href="#">coinsurance</a>                   | Coverage is limited to a single purchase of a type of durable medical equipment every three years.<br>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>          | 0% <a href="#">coinsurance</a>  | 30% <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:

| 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> .) |   |   |
|---|---|---|
| <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>• Cosmetic Surgery</li></ul>       | <ul style="list-style-type: none"><li>• Dental Care</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>• Routine eye care (Adult)</li><li>• Routine Foot Care</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 <a href="#">plan</a> document.)  |   |   |
| <ul style="list-style-type: none"><li>• Bariatric Surgery</li><li>• Chiropractic Care</li></ul>   | <ul style="list-style-type: none"><li>• Hearing Aids</li><li>• Infertility Treatment</li></ul>  | <ul style="list-style-type: none"><li>• Private Duty Nursing</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 1-877-527-9431 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](#) \$4,500.00
- [Specialist copayment](#) \$90.00
- 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*)

|                           |                    |
|---------------------------|--------------------|
| <b>Total Example Cost</b> | <b>\$12,800.00</b> |
|---------------------------|--------------------|

**In this example, Peg would pay:**

| <i>Cost Sharing</i>               |                   |
|-----------------------------------|-------------------|
| Deductibles                       | \$4,500.00        |
| Copayments                        | \$100.00          |
| Coinsurance                       | \$0               |
| <i>What isn't covered</i>         |                   |
| Limits or exclusions              | \$10.00           |
| <b>The total Peg would pay is</b> | <b>\$4,610.00</b> |

**Managing Joe's type 2 Diabetes**

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

- The [plan's](#) overall [deductible](#) \$4,500.00
- [Specialist copayment](#) \$90.00
- 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*)

|                           |                   |
|---------------------------|-------------------|
| <b>Total Example Cost</b> | <b>\$7,400.00</b> |
|---------------------------|-------------------|

**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](#) \$4,500.00
- [Specialist copayment](#) \$90.00
- 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*)

|                           |                   |
|---------------------------|-------------------|
| <b>Total Example Cost</b> | <b>\$1,900.00</b> |
|---------------------------|-------------------|

**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> |