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 888-950-0060. 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 888-950-0060 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For preferred providers: $2,000 / Covered Person or $4,000 / Family; For non-preferred providers: $16,000 / Covered Person or $32,000 / Family.	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.
Are there services covered before you meet your deductible?	Yes. Preventive care and most services requiring a copayment are covered before you meet your deductible.	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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For preferred providers: $6,000 / Covered Person or $12,000 / Family; (includes copayments). For non-preferred providers: $24,000 / Covered Person or $48,000 / Family.	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.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, prior authorization penalties, 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://onlineaccess.hps.md Disclaimer: No Payment due at time of service at PayMedix Participating Providers. Questions, please call 1-888-477-7968	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
		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	$25 copayment, deductible does not apply	50% coinsurance	$0 copayment / Teladoc ® visit charge Virtual visits and telephonic visits have the same cost sharing as in-office visits.
	Specialist visit	$50 copayment, deductible does not apply	50% coinsurance	Virtual visits and telephonic visits are the same as in-office visits.
	Preventive care/screening/ immunization	No charge, deductible does not apply	50% coinsurance	You may have to pay for services that aren't preventive care. Ask your provider if the services you need are preventive care. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$50 copayment, deductible does not apply	50% coinsurance	Certain genetic tests and high-technology imaging require prior authorization or benefit reduces to 50% of allowed amount.
	Imaging (CT/PET scans, MRIs)	$500 copayment deductible does not apply	50% 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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.smithrx.com/ or by calling 1-844-454-5201	Tier 1 generic drugs	Retail 30-day: $10 copayment Mail order: $20 copayment	Not covered	For purposes of this section, the provider is a pharmacy. The medical deductible does not apply to prescription drugs purchased from a pharmacy. Covers up to a 30-day supply (retail subscription); 90-day supply mail order prescription). Please contact SmithRx for more information on obtaining specialty drugs through the Connect360 program.
	Tier 2 preferred brand drugs	Retail 30-day: $40 copayment Mail order: $80 copayment	Not covered	
	Tier 3 non-preferred brand drugs	Retail 30-day: $80 copayment Mail order: $160 copayment	Not covered	
	Tiers 4 and 5 - Specialty drugs	Not covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$900 copayment, after deductible	50% coinsurance	Prior authorization may be required, or benefit reduces to 50% of allowed amount.
	Physician/surgeon fees	No charge after deductible	50% coinsurance	None
If you need immediate medical attention	Emergency room care	$500 copayment deductible does not apply	50% coinsurance*	Copayment is waived if admitted. *Only in the case of a true emergency will the preferred provider benefit will apply. Non-emergency medical transportation requires prior authorization or benefit reduces to 50% of allowed amount.
	Emergency medical transportation	$100 copayment, deductible does not apply	50% coinsurance*	
	Urgent care	$100 copayment , deductible does not apply	50% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,500 copayment deductible does not apply	50% coinsurance	All non-emergent inpatient hospital stays require prior authorization or benefit reduces to 50% of allowed amount.
	Physician/surgeon fees	No Charge, after deductible	50% coinsurance	All non-emergent inpatient hospital stays require prior authorization or benefit reduces to 50% of allowed amount.

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 mental health, behavioral health, or substance abuse services	Outpatient services	**Office Visit** – $25 copayment, deductible does not apply **Facility** - $900 Copay after deductible	50% coinsurance	$0 copayment / Teladoc ® visit charge All non-emergent inpatient hospital stays require prior authorization or benefit reduces to 50% of allowed amount.
	Inpatient services	$1,500 copayment deductible does not apply	50% coinsurance	
If you are pregnant	Office visits	PCP: $25 copayment Specialist: $50 copayment deductible does not apply	50% 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). All non-emergent inpatient hospital stays require prior authorization or benefit reduces to 50% of allowed amount.
	Childbirth/delivery professional services	No Charge, after deductible	50% coinsurance	
	Childbirth/delivery facility services	$1,500 copayment deductible does not apply	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	$50 copayment, deductible does not apply	50% coinsurance	90 visits/year for home health care; 45 visits/year for private duty nursing-includes in home setting where required and medically necessary.
	Rehabilitation services	$50 copayment, deductible does not apply	50% coinsurance	Coverage is limited to 25 visits/year for each therapy type. Includes physical therapy, speech therapy, and occupational therapy.
	Habilitation services	$50 copayment, deductible does not apply	50% coinsurance	
	Skilled nursing care	$1,500 copayment deductible does not apply	50% coinsurance	Coverage is limited to 90 days/year combined in a skilled nursing facility or inpatient rehabilitation facility. All non-emergent admissions require prior authorization or benefit reduces to 50% of allowed amount.

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)	
	Durable medical equipment	**Orthotics:** $350 copayment, deductible does not apply **Prosthetics:** $500 copayment, deductible does not apply **All other DME:** $350 copayment, deductible does not apply	50% coinsurance	Prior authorization required for: • Purchases over $1,000 • All other rentals and purchases as stated on our website Benefits may not be payable if you do not obtain prior authorization. Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	No Charge, deductible does not apply	50% coinsurance	Hospice services require prior authorization or benefit reduces to 50% of allowed amount.
If your child needs dental or eye care	Children's eye exam	No charge; deductible does not apply	No charge; deductible does not apply	Plan coverage limited to one exam per year to age 19.
	Children's glasses	Not covered	Not covered	No coverage for glasses.
	Children's dental check-up	No charge after deductible	Not covered	Plan coverage limited to one exam per year to 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
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside - the US
- Routine Foot Care
- Routine Eye Care (Adult)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture Services	• Chiropractic Care • Dental Care-(Child to age 19 limited to check-ups)	• Private Duty Nursing- includes in home setting where required and medically necessary • Routine Eye Care (Child to age 19)

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, 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 888-950-0060. 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.

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 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 (888) 915-4001.
Hmong (Hmoob): Kev pab nyob rau hauv Hmoob hu (888) 915-4001.
Traditional Chinese (傳統中文): 有關中文協助,請致電 (888) 915-4001.
German (Deutsch): Für Hilfe in deutscher Sprache rufen (888) 915-4001.

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	$2,000
Specialist copayment	$50
Hospital (facility) copayment	$1,500
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$2,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$4,000**

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

The plan's overall deductible	$2,000
Specialist copayment	$50
Hospital (facility) copayment	$1,500
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,620
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,620**

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

The plan's overall deductible	$2,000
Specialist copayment	$50
Hospital (facility) copayment	$1,500
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,300
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,000**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

Nondiscrimination and Language Access Policy

Discrimination is Against the Law

Wisconsin Physicians Service Insurance Corporation (WPS)/The EPIC Life Insurance Company (collectively, WPS/EPIC) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)). WPS/EPIC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

WPS/EPIC:

Provides people with disabilities reasonable modifications and free auxiliary aids and services to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language assistance services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need any these services, contact us at the phone number on the attached correspondence, your ID card, or the number listed on wpshealth.com/contact.

If you believe that WPS/EPIC 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:

WPS/EPIC
Nondiscrimination Grievance Coordinator
P.O. Box 7458 Madison, WI 53707
Email: WPSNondiscrimination@wpsic.com

You can file a grievance in person, by mail, or by email. If you need help filing a grievance, the Nondiscrimination Grievance 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; by mail at U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, D.C., 20201; or by phone at 800–368–1019, 800–537–7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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Medicare Supplement Insurance Plans

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Notice of Availability of Language Assistance Services and Auxiliary Aids

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call the number on your Member ID card or speak to your provider.

SPANISH: ATENCIÓN: Si habla español, los servicios de asistencia con el idioma están disponibles para usted sin cargo. También se encuentran disponibles de forma gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al número que figura en la tarjeta de identificación de miembro o hable con su proveedor.

HMONG: NCO NTSOOV: Yog hais tias koj hais lus Hmoob, peb yeej muaj kev pab txhais lus dawb rau koj. Peb los kuj tseem muaj cov khoom siv thiab cov kev pab los npaj lwm yam ntaub ntawv uas yuav muab tau coj los saib dawb. Hu xov tooj mus rau tus xov tooj nyob ntawm koj daim ID Ua Tswv Cuab los sis nrog koj tus kws kho mob tham.

TRADITIONAL CHINESE: 請注意：如果您說中文，您可以免費獲得語言協助服務。另免費提供適當的輔助工具和服務並以無障礙格式提供資訊。請致電您的會員 **ID** 卡上的電話號碼或聯絡您的提供者。

GERMAN: HINWEIS: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie die Nummer auf Ihrer Versichertenkarte an oder sprechen Sie mit Ihrem Dienstleister.

ARABIC: تنبيه: إذا كنت تتحدث العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. تتوفر أيضًا المساعدات والخدمات المساعدة المناسبة لتوفير المعلومات بتنسيقات يسهل الوصول إليها مجانًا. اتصل بالرقم الموجود على بطاقة **ID** هوية العضو الخاصة بك أو تحدث مع مقدم الخدمة الخاص بك.

RUSSIAN: ВНИМАНИЕ: если вы говорите на русском языке, вам могут предоставить бесплатные услуги перевода. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также можно получить бесплатно. Позвоните по номеру, указанному на вашей идентификационной карточке участника плана, или обратитесь к своему врачу.

KOREAN: 주의 사항: 한국어를 구사하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 액세스 가능한 형식으로 정보를 제공하기 위해 적절한 보조 도구 및 서비스도 무료로 제공됩니다. 가입자 **ID** 카드에 기재된 전화번호로 연락하시거나 귀하의 의료 제공자에게 문의하시길 바랍니다.

VIETNAMESE: CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí sẽ có sẵn cho quý vị. Các hỗ trợ và dịch vụ phụ trợ phù hợp để cung cấp thông tin ở định dạng dễ tiếp cận cũng được cung cấp miễn phí. Hãy gọi số trên thẻ ID Thành viên của quý vị hoặc nói chuyện với nhà cung cấp của quý vị.

PENNSYLVANIA DUTCH: WICHDICH: Wann du Deitsch schwetzscht un hoscht Druwwel fer Englisch verschtehe, kenne mer epper beigriege fer dich helfe unni as es dich ennich eppes koschte zeelt. Mir kenne dich helfe aa wann du Druwwel hoscht fer heere odder sehne. Mir kenne Schtofft lauder mache odder iesier fer lese un sell koscht dich aa nix. Ruf die Nummer uff dei Member ID Card uff odder schwetz mit dei Provider.

LAO: ຂ້ອນໃສ່ໃຈ: ຖ້າທ່ານເວົ້າພາສາລາວ, ຈະມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາຟຣີໃຫ້ແກ່ທ່ານ. ການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການເສີມທີ່ເໝາະສົມ ເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້ ແມ່ນມີໃຫ້ແບບບໍ່ໄດ້ເສຍຄ່າອີກດ້ວຍ. ໂທຫາເບີທີ່ຢູ່ໃນບັດປະຈຳຕົວສະມາຊິກຂອງທ່ານ ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

FRENCH: ATTENTION : Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et des services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le numéro figurant sur votre carte d'adhérent ou parlez à votre prestataire.

POLISH: UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Odpowiednie materiały pomocnicze i usługi zapewniające informacje w dostosowanych formatach są również dostępne bezpłatnie. Należy zadzwonić pod numer podany na karcie członkowskiej lub porozmawiać z lekarzem prowadzącym.

HINDI: ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएँ उपलब्ध हैं। सुलभ प्रारूप में सूचना उपलब्ध कराने के लिए उपयुक्त सहायक साधन और सेवाएं भी निःशुल्क उपलब्ध हैं। अपने सदस्य आईडी कार्ड पर दिए गए नंबर पर कॉल करें या अपने प्रदाता से बात करें।

ALBANIAN: KINI PARASYSH: Nëse flisni shqip, ofrohen shërbime falas të ndihmës gjuhësore. Ndihmat dhe shërbimet e përshtatshme ndihmëse për të ofruar informacion në formate të aksesueshme janë gjithashtu të disponueshme pa pagesë. Telefononi numrin në kartën tuaj të identitetit të Anëtarit ose flisni me ofruesin tuaj të shërbimit.

TAGALOG: BIGYANG-PANSIN: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyo sa tulong sa wika. Ang mga naaangkop na pantulong na suporta at serbisyo upang magbigay ng impormasyon sa mga naa-access na format ay makukuha rin nang libre. Tawagan ang numero sa iyong card ng Member ID o makipag-usap sa iyong provider.