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 888-915-2493. 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 888-915-2493 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. Treatment of temporomandibular joint disorders requires prior authorization which may include surgery, therapy, and other services described elsewhere in the SBC (i.e., primary care visit) or benefit reduces to 50% of allowed amount.
	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 (i.e. CT/PET scans, and MRIs) 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 certain durable medical equipment, orthotics, and prosthetics: • Purchases over $1,000 • All other rentals and purchases as stated on our website or benefit reduces to 50% of allowed amount. 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 888-915-2493. 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.