

 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 www.welcometouhc.com or by calling 1-866-673-6293. 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 www.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: \$3,500 Individual / \$7,000 Family non-Network: \$7,500 Individual / \$15,000 Family Per calendar year.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	Network: \$6,350 Individual / \$12,700 Family non-Network: \$12,700 Individual / \$25,400 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	Premiums, <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover and penalties for failure to obtain <u>preauthorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.welcometouhc.com or call 1-866-673-6293 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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
		Network Provider (You will pay the least)	Non-Network 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	\$30 <u>copay</u> per visit	20% <u>coinsurance</u>	Virtual visits (Telehealth) - \$10 <u>copay</u> per visit by a Designated Virtual Network Provider. If you receive services in addition to office visit, additional <u>copays</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply e.g. surgery.
	Specialist visit	\$60 <u>copay</u> per visit	20% <u>coinsurance</u>	If you receive services in addition to office visit, additional <u>copays</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply e.g. surgery.
	Preventive care/ <u>screening</u> /immunization	No Charge	* 20% <u>coinsurance</u>	Includes <u>preventive</u> health services specified in the health care reform law. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. * <u>Deductible</u> / <u>coinsurance</u> may not apply to certain services.
If you have a test	Diagnostic test (x-ray, blood work)	0% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> required for non-Network for certain services or benefit reduces to 50% of allowed.
	Imaging (CT/PET scans, MRIs)	0% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> required for non-Network or benefit reduces to 50% of allowed.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network 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 www.welcometouhc.com .	Tier 1 - Your Lowest-Cost Option	Retail: \$10 <u>copay</u> Mail-Order: \$25 <u>copay</u>	Retail: \$10 <u>copay</u>	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply. If you use a non-Network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the <u>allowed amount</u> . Copay is per prescription order up to the day supply limit listed above. You may need to obtain certain drugs, including certain <u>specialty drugs</u> , from a pharmacy designated by us. Certain drugs may have a <u>preauthorization</u> requirement or may result in a higher cost. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your <u>plan</u> . Not all drugs are covered. Certain preventive medications and Tier 1 contraceptives are covered at No Charge.
	Tier 2 - Your Midrange-Cost Option	Retail: \$35 <u>copay</u> Mail-Order: \$87.50 <u>copay</u>	Retail: \$35 <u>copay</u>	
	Tier 3 - Your Midrange-Cost Option	Retail: \$70 <u>copay</u> Mail-Order: \$175 <u>copay</u>	Retail: \$70 <u>copay</u>	
	Tier 4 - Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> required for certain services for non-Network or benefit reduces to 50% of allowed.
	Physician/surgeon fees	0% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$350 <u>copay</u> per visit	\$350 <u>copay</u> per visit	None
	<u>Emergency medical transportation</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$100 <u>copay</u> per visit	20% <u>coinsurance</u>	If you receive services in addition to <u>urgent care</u> visit, additional <u>copays</u> , <u>deductibles</u> , or <u>coinsurance</u> may <u>apply</u> e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> required for non-Network or benefit reduces to 50% of allowed.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Physician/surgeon fees	0% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% <u>coinsurance</u>	20% <u>coinsurance</u>	Network partial <u>hospitalization</u> /intensive outpatient treatment: 0% <u>coinsurance</u> <u>Preauthorization</u> required for certain services for non- <u>Network</u> or benefit reduces to 50% of allowed.
	Inpatient services	0% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> required for non- <u>Network</u> or benefit reduces to 50% of allowed.
If you are pregnant	Office visits	No Charge	20% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>deductibles</u> , or <u>coinsurance</u> may apply.
	Childbirth/delivery professional services	0% <u>coinsurance</u>	20% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	0% <u>coinsurance</u>	20% <u>coinsurance</u>	Inpatient <u>preauthorization</u> apply for non- <u>Network</u> if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of allowed.
If you need help recovering or have other special health needs	Home health care	0% <u>coinsurance</u>	20% <u>coinsurance</u>	Limited to 60 visits per calendar year. <u>Preauthorization</u> required for non- <u>Network</u> or benefit reduces to 50% of allowed.
	<u>Rehabilitation services</u>	\$30 <u>copay</u> per outpatient visit	20% <u>coinsurance</u>	Limits per calendar year: Physical, Speech, Occupational, Pulmonary: 20 visits; Cardiac: 36 visits. <u>Preauthorization</u> required for certain services for non- <u>Network</u> or benefit reduces to 50% of allowed.
	Habilitation services	\$30 <u>copay</u> per outpatient visit	20% <u>coinsurance</u>	Services provided under and limits are combined with Rehabilitation services above. <u>Preauthorization</u> required for certain services for non- <u>Network</u> or benefit reduces to 50% of allowed.
	<u>Skilled nursing care</u>	0% <u>coinsurance</u>	20% <u>coinsurance</u>	Skilled Nursing is limited to 30 days per calendar year. (Inpatient Rehabilitation limited to 60 days). <u>Preauthorization</u> required for non- <u>Network</u> or benefit reduces to 50% of allowed.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Durable medical equipment	0% coinsurance	20% coinsurance	Covers 1 per type of DME (including repair/replace) every 3 years. Preauthorization required for non-Network DME over \$1,000 or no coverage.
	Hospice services	0% coinsurance	20% coinsurance	Preauthorization required for non-Network before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	No coverage for Eye exam.
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Dental check-up.

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.)				
• Acupuncture	• Bariatric Surgery	• Cosmetic Surgery	• Dental Care (Adult/Child)	• Glasses
• Infertility Treatment	• Long-Term Care	• Non-emergency care when traveling outside the U.S.	• Private-Duty Nursing	• Routine eye care (Adult/Child)
• 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: 1-866-444-3272 or www.dol.gov/ebsa/healthreform for the U.S. Department of Labor, Employee Benefits Security Administration, or 1-877-267-2323 x61565 or www.cciio.cms.gov for the U.S. Department of Health and Human Services. You may also contact us at 1-866-673-6293. 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: 1-866-673-6293 ; or the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Wisconsin Office of the Commissioner of Insurance at 1-800-236-8517 or www.oci.wi.gov.

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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-673-6293 .

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-673-6293 .

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-673-6293 .

Navajo (Dine): Dinek'ehgo shika at' ohwol ninisingo, kwijigo holne' 1-866-673-6293 .

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*—————