## Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

**Preferred Provider Plan HDHP $3,000 Deductible**

<table>
<thead>
<tr>
<th>Coverage Period: 8/1/2019 – 6/30/2020</th>
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<tbody>
<tr>
<td>Coverage for: Individual/Family</td>
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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.wpshealth.com](http://www.wpshealth.com) or call 1-800-223-6048. 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](https://www.healthcare.gov/sbc-glossary) or call 1-800-223-6048 to request a copy.

### Important Questions | Answers | Why This Matters:
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**What is the overall deductible?** | For preferred **providers**: $3,000/Covered Person or $6,000/Family; For non-preferred **providers**: $3,000/Covered Person or $6,000/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** services 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/](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**: $3,000/Covered Person or $6,000/Family Coverage; For non-preferred **providers**: $5,000/Covered Person or $10,000/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**, 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://connect.wpsic.com/Gateway/commercialGateway/unauth/fadHome.do](https://connect.wpsic.com/Gateway/commercialGateway/unauth/fadHome.do) or call 1-800-223-6048 for a list of network providers. | 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.