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, contact Personify Health (aka HealthComp) at 1-833-549-2899. 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 1-833-549-2899 to request a copy.

Important Questions	Answers			Why This Matters:
What is the overall deductible?	**Tier I WHHS/WTMF*** None	**Tier II Blue Shield Preferred PPO Network Provider** *Per Calendar Year* $500/Individual $1,000/Family	**Tier III Non-Preferred Network Provider** *Per Calendar Year* $2,500/Individual $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. Emergency Medical Transportation, Emergency Room Care Facility Charges, and Tier II Preventive Care Services			The plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
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?	**Tier I WHHS/WTMF*** $200/Individual $400/Family *Applies to ER services only*	**Tier II Blue Shield Preferred PPO Network Provider** *Per Calendar Year* $2,300/Individual $4,600/Family	**Tier III Non-Preferred Network Provider** *Per Calendar Year* $4,500/Individual $8,000/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.

Important Questions	Answers	Why This Matters:
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. *WTMF Value Providers can be found on the HR Intranet Website (Please note that the coinsurance waiver is applicable to the specific physician, not the clinic site) See www.healthcomp.com or call 1-833-549-2899 for a list of Tier II Blue Shield Preferred PPO Network providers.	You pay the least if you use a WHHS/WTMF provider. You pay more if you use a Tier II Blue Shield Preferred PPO Network provider. You will pay the most if you use a Tier III non-preferred 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 Tier II provider might use a Tier III non-preferred 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
		Tier I WHHS/WTMF* (You will pay the least)	Tier II Blue Shield Preferred PPO Network provider	Tier III Non-Preferred 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	No charge	20% coinsurance	40% coinsurance	None
	Specialist visit	No charge	20% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunization	No charge	No charge Deductible waived	**Family Planning** 40% coinsurance **Other Services** Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier I WHHS/WTMF* (You will pay the least)	Tier II Blue Shield Preferred PPO Network provider	Tier III Non-Preferred Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	**Outpatient Hospital** No charge **Freestanding** Not applicable	20% coinsurance	40% coinsurance	Tier III: Outpatient Hospital benefit is up to $1,500 per day + additional charges.
	Imaging (CT/PET scans, MRIs)	**Outpatient Hospital** No charge **Freestanding** Not covered	20% coinsurance	40% coinsurance	Precertification may be required for certain services. If you don't get precertification, benefits could be reduced by 100%. Tier III: Outpatient Hospital benefit is up to $1,500 per day + additional charges.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com	Generic drugs (Tier 1)	Not applicable	**Retail** $4/prescription **Mail order** $8/prescription	**Retail** $4/prescription + 25% coinsurance	Up to 34 day supply at retail and 90 days at mail order. If you select a Brand Drug when a Generic Drug equivalent is available, you are responsible for the difference in cost plus the Generic Drug Copayment.
	Preferred brand drugs (Tier 2)	Not applicable	**Retail** $25/prescription **Mail order** $50/prescription	**Retail** $25/prescription + 25% coinsurance	
	Non-preferred brand drugs (Tier 3 & Tier 4)	Not applicable	**Retail** $40/prescription **Mail order** $80/prescription	**Retail** $40/prescription + 25% coinsurance	
	Specialty drugs	Not applicable	$40/prescription	Not covered	Up to 34 day supply.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier I WHHS/WTMF* (You will pay the least)	Tier II Blue Shield Preferred PPO Network provider	Tier III Non-Preferred Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	15% coinsurance	25% coinsurance Up to $1,500 per day + additional charges.	Services received at Fremont Surgical Center and Precision SurgiCenter are not covered. Precertification may be required for certain services. If you don't get precertification, benefits could be reduced by 100%.
	Physician/surgeon fees	No charge	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	**Facility** $50/visit **Physician** No charge	**Facility** $50/visit Deductible waived **Physician** 20% coinsurance		None
	Emergency medical transportation	Not applicable	20% coinsurance Deductible waived		None
	Urgent care	No charge	20% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	15% coinsurance	25% coinsurance Up to $1,500 per day + additional charges.	Precertification is required. If you don't get precertification, benefits could be reduced by 100%.
	Physician/surgeon fees	No charge	20% coinsurance	40% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier I WHHS/WTMF* (You will pay the least)	Tier II Blue Shield Preferred PPO Network provider	Tier III Non-Preferred Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	**Office visit** 20% coinsurance **Other** No charge	**Partial Hospitalization** 25% coinsurance Up to $1,500 per day + additional charges **Office visit & Other** 40% coinsurance	Precertification may be required for facility services. If you don't get precertification, benefits could be reduced by 100%.
	Inpatient services	No charge	**Physician** 20% coinsurance **Hospital** 15% coinsurance **Residential Care** No charge	**Physician** 40% coinsurance **Residential Care & Hospital services** 25% coinsurance Up to $1,500 per day + additional charges	Precertification is required. If you don't get precertification, benefits could be reduced by 100%.
If you are pregnant	Office visit	No charge	No charge Deductible waived	40% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, a copayment coinsurance and deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	No charge	15% coinsurance	25% coinsurance Up $1,500 a day + additional charges.	Precertification is only required for stays exceeding 48 hours after delivery (or 96 hours after C-section). If you don't get precertification when required, benefits could be reduced by 100%.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier I WHHS/WTMF* (You will pay the least)	Tier II Blue Shield Preferred PPO Network provider	Tier III Non-Preferred Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	Covered at the Tier 2 benefit level when Precertification is obtained	Limited to 100 visits per Calendar Year. Precertification is required. If you don't get precertification, benefits could be reduced by 100%.
	Rehabilitation services	No charge	20% coinsurance	40% coinsurance	Includes Physical, Occupational, Respiratory and Speech Therapies. Tier III: Outpatient Hospital benefit is up to $1,500 per day + additional charges.
	Habilitation services				
	Skilled nursing care	**Hospital** No charge **Freestanding** Not applicable	15% coinsurance	**Hospital** 25% coinsurance Up to $1,500 per day + additional charges. **Freestanding** 15% coinsurance	Limited to 100 days per Calendar Year. Precertification is required. If you don't get precertification, benefits could be reduced by 100%.
	Durable medical equipment	Not applicable	20% coinsurance	40% coinsurance	Precertification may be required for certain services. If you don't get precertification, benefits could be reduced by 100%.
	Hospice services	Not applicable	15% coinsurance	Covered at the Tier 2 benefit level when Precertification is obtained	Precertification may be required for certain services. If you don't get precertification, benefits could be reduced by 100%.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	Must enroll in separate vision plan.
	Children's glasses	Not covered	Not covered	Not covered	Must enroll in separate vision plan.
	Children's dental check-up	Not covered	Not covered	Not covered	Must enroll in separate dental plan.

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.)

- Cosmetic Care
- Dental Care (Adult)
- Hearing Aids
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine Eye Care (Adult)
- 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.)

- Acupuncture (Limited to 25 visits per Calendar Year)
- Bariatric
- Chiropractic Care (Limited to 25 visits per Calendar Year)
- Infertility Treatment

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: HealthEquity/WageWorks 855-556-5737 or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 on how 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: Personify Health (aka HealthComp) at 1-833-549-2899 or 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 the 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 1-833-549-2899.

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 (Tier 1) $0**
- **Specialist coinsurance (Tier 1) 0%**
- **Hospital (facility) coinsurance (Tier 1) 0%**
- **Other (Tests) coinsurance (Tier 1) 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	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$70**

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

- **The plan's overall deductible (Tier 2) $500**
- **Specialist coinsurance (Tier 1) 0%**
- **Hospital (facility) coinsurance (Tier 1) 0%**
- **Other (Brand drugs) copayment $25**

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	$10
Copayments	$900
Coinsurance	$00
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$930**

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

- **The plan's overall deductible (Tier 2) $500**
- **Specialist coinsurance (Tier 1) 0%**
- **Hospital (ER) copayment (Tier 1) $50**
- **Other (Physical Therapy) 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	$200
Copayments	$50
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$450**

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