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, call 1-800-374-1835 or visit us at http://www.nipponlifebenefits.com/member-service/wi-state-specific-requirements/. 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 call 1-800-374-1835 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Preferred Provider $1,500 member/$3,000 family; Non-Preferred Provider $3,000 member/$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. Preferred Provider services for preventive care and Non-Preferred Provider services for child immunizations 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?	Preferred Provider $6,650 member/$13,300 family; Non-Preferred Provider $13,300 member/$26,600 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, health care this plan doesn't cover, penalties for failure to obtain pre-authorization for services and the difference between the Generic Drug price and the Preferred or Non-	Even though you pay these expenses, they don't count toward the out–of–pocket limit.

	Preferred Brand Name Drug price when a generic equivalent drug is available.	
Will you pay less if you use a network provider?	Yes. See http://www.nipponlifebenefits.com/member-service/ or call 1-800-374-1835 for a list of preferred 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.
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	10% coinsurance	30% coinsurance	None
	Specialist visit	10% coinsurance	30% coinsurance	None
	Preventive care/screening/ immunization	No charge; deductible does not apply	child immunizations – no charge up to the allowed amount; excess not covered; other care – 30% coinsurance	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.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance; Emergency services – 10% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance; Emergency services – 10% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.nipponlifebenefits.com/member-service/	Generic drugs (Tier 1)	10% coinsurance	30% coinsurance	Coinsurance does not apply to generic and single source contraceptives for women. Covers up to a 30-day supply (retail prescription); up to a 90-day supply (mail order prescription).
	Preferred brand drugs (Tier 2)	10% coinsurance	30% coinsurance	
	Non-preferred brand drugs (Tier 3)	10% coinsurance	30% coinsurance	
	Specialty drugs	10% coinsurance	30% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	None
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	10% coinsurance	30% coinsurance	Non-Preferred Provider non-emergency services subject to deductible and 30% coinsurance.
	Emergency medical transportation	10% coinsurance	10% coinsurance	
	Urgent care	10% coinsurance	30% 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 have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Preauthorization is required. Non-compliance penalty of 30% up to $10,000.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	30% coinsurance	Preauthorization is required for inpatient services. Non-compliance penalty of 30% up to $10,000.
	Inpatient services	10% coinsurance	30% coinsurance	
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	Cost sharing does not apply to 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).
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	100 visits/year
	Rehabilitation services	10% coinsurance	30% coinsurance	30 visits/year. Includes physical, occupational and speech therapy.
	Habilitation services	10% coinsurance	30% coinsurance	
	Skilled nursing care	10% coinsurance	30% coinsurance	60 days for each confinement. Preauthorization is required. Non-compliance penalty of 30% up to $10,000.
	Durable medical equipment	10% coinsurance	30% coinsurance	Excludes motorized carts, scooters and strollers (except for wheelchairs), non-hospital type beds and lift chairs.
	Hospice services	10% coinsurance	30% coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Private Duty Nursing
- Routine eye care
- 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 up to $500/year
- Chiropractic Care
- Non-emergency care when traveling outside the

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 group health coverage subject to ERISA, [Name of Group: Address: Telephone Number:]
• For group health coverage subject to ERISA, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
[• For non-federal governmental group health plans, the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.]
[• Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.]
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: the plan: English and Non-English 1-800-374-1835; Japanese 1-800-971-0638; Korean 1-800-827-8713 or Wisconsin Department of Insurance at 1-800-236-8517 or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact 1-800-236-8517 or e-mail http://oci.wi.gov/consinfo.htm.

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 1-800-374-1835.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-374-1835.
[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** [1-800-374-1835.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-374-1835.

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	$1,500
Specialist copayment	$1,500
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,660**

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

The plan's overall deductible	$1,500
Specialist copayment	$1,500
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$1,500
Copayments	$0
Coinsurance	$600
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,120**

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

The plan's overall deductible	$1.500
Specialist copayment	$1,500
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1,500
Copayments	$0
Coinsurance	$40
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,540**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: [insert]. *Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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