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 Oshkosh School District Benefits Team at 920-547-9157. 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 920-547-9157 for a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0** person / **$0** family per calendar yar for all providers.	This plan is unique and has no deductibles only copayments. See the Common Medical Events chart below for your costs for services this plan covers
Are there services covered before you meet your deductible?	All services are covered before you meet your deductible.	This plan is unique and has no deductibles only copayments. 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 do not have to meet other deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$5,000** individual / **$10,000** Family per calendar year for all providers. Medical & Prescriptions Included.	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 limit 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, penalties, and health care this plan doesn't cover and penalties for failure to obtain pre-authorization for services.	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?	If the medical service is a covered service by the plan, you can access an y provider for the same coverage benefit.	This plan does have a contracted provider network. You might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing).
Do you need a referral to see a specialist?	No.	This plan will allow you to see a specialist of your choice 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 All Providers	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	A Primary care visit to treat an injury or illness	$100 copayment per Physician/Office visit Chiropractic Care: $100 copayment per visit	Chiropractic limited to 5 copayments per 30 days of treatment. Contact your Benefits Team to receive a referral that could reduce your cost share and extend visits if medical necessary
	Three Waves Healthcare, including School/sports Physicals	No Charge	
	School/Sports Physicals at all other Providers	$25 copayment per Physician/Office visit	
	Pediatric Care Office Visit	$25 copayment per Physician/Office visit	
	Telemedicine – Premise Health App	No Charge	
	Specialist visit	$150 copayment per Physician/Office visit	
	Preventive care/screening/ immunization	No Charge	Preventive/Well Care is covered as defined in the Patient Protection & Affordable Care Act, as amended & described by the Health Resources & Services Administration (HRSA).
If you have a test	Diagnostic test (x-ray, blood work, also including Ultrasounds, EKG and Echocardiograms)	$100 copayment per Office or Imaging Facility visit	Preauthorization is required for inpatient and outpatient imaging (MRI, MRA, PET Scans, CT Scans and Nuclear Medicine). Failure to obtain preauthorization may result in a reduction of benefits.
	Imaging (CT/PET scans, MRIs)	Freestanding Office Setting: $100 copayment Freestanding Radiology Center: $1,000 copayment Outpatient Hospital: $1,000 copayment	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at 858-551-8111 or www.ventegra.com	Tier 1 – Typically Generic Drugs	Retail: $5 copayment/prescription Mail Order: $10 copayment/prescription	Covers up to a 30-day supply at retail and up to a 90-day supply through mail order. Drugs required as part of evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, **as required by the Affordable Care Act are covered at 100% not subject**
	Tier 2 – Typically Preferred Brand Drugs	Retail: $40 copayment/prescription Mail Order: $80 copayment/prescription	
	Tier 3 – Typically Non-Preferred Brand Drugs	Retail: $80 copayment/prescription Mail Order: $160 copayment/prescription	
	Tier 4 – Typically Specialty drugs	Contact Rescrybe at 715-301-0899	

Common Medical Event	Services You May Need	What You Will Pay All Providers	Limitations, Exceptions, & Other Important Information
			to any copay.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$1,000 copayment/per instance	Preauthorization is required for outpatient surgeries. Failure to obtain preauthorization may result in a reduction of benefits. Contact Oshkosh School District Benefits Team at 920-547-9157 to receive a referral that could reduce your cost share.
	Physician/surgeon fees	No Charge	
If you need immediate medical attention	Emergency room care	Facility Services: $250 copayment/visit	Copay waived if admitted to the hospital. Ground, water, and air ambulance included. Ambulance: Must meet medical necessity requirements.
	Emergency medical transportation	$250 copayment per transport	
	Urgent care	$250 copayment/visit	Urgent Care copay applies to any urgent care facility.
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,000 copayment/admission	Preauthorization is required for outpatient surgeries and procedures. Failure to obtain preauthorization may result in a reduction of benefits. Contact Oshkosh School District Benefits Team at 920-547-9157 to receive a referral that could reduce your cost share.
	Physician/surgeon fees	No Charge	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$100 copayment/visit	Preauthorization may be required based on the services and location of those services being rendered. Failure to obtain preauthorization may result in a reduction of benefits. Contact Oshkosh School District Benefits Team at 920-547-9157 to receive a referral that could reduce your cost share.
	Inpatient services	$1,000 copayment/admission	
If you are pregnant	Office visits	Routine Prenatal Office Visits: No Charge	Preventive Care services, as required under the Affordable Care Act, may be covered at no charge. Preauthorization is required for inpatient hospital stays in excess of 48 hrs. (vaginal delivery) or 96 hrs. (c-section). Contact Oshkosh School
	Childbirth/delivery professional services	No Charge	
	Childbirth/delivery facility services	$1,000 copayment/instance	

Common Medical Event	Services You May Need	What You Will Pay All Providers	Limitations, Exceptions, & Other Important Information
			District Benefits Team at 920-547-9157 to receive a referral that could reduce your cost share.
If you need help recovering or have other special health needs	Home health care • Home Care Visits • Home Dialysis • Home Infusion Therapy • Other Home Care Services/Supplies	$100 copayment/visit, limited to 5 copayments in any calendar month	Limited to a maximum of 60 visits per Plan Year. Preauthorization is required. Failure to obtain pre-authorization may result in a reduction of benefits. Contact Oshkosh School District Benefits Team at 920-547-9157 to receive a referral that could reduce your cost share and extend your visit limitation if medically necessary.
	Rehabilitation services	$100 copayment per provider, per date of service	Benefit maximum(s) are for office and outpatient visits combined. Limited to 5 copays per calendar month. Contact Oshkosh School District Benefits Team at 920-547-9157 to receive a referral that could reduce your cost and extend your visit limitations if medically necessary. **Physical & Occupational Therapy:** 40 visits/Plan Year **Speech Therapy:** 20 visits/Plan Year **Cardiac Rehab:** 36 visits/Plan Year **Pulmonary Rehab:** 20 visits/Plan Year
	Habilitation services	Please see the Summary Plan Description for Benefits & Coverage Infromation	
	Skilled nursing care	$1,000 copayment per confinement; copay is waived if the stay is immediately after the Acute Admission, with no gap in care	Limited to a maximum of 30 visit per Plan Year. Preauthorization is required. Failure to obtain pre-authorization may result in a reduction of benefits. Contact Oshkosh School District Benefits Team at 920-547-9157 to receive a referral that could reduce your cost share and extend your visit limitation if medically necessary.
	Durable medical equipment, including Orthotics (Custom Molded only – 1 pary every 3 years) and Prosthetics	$150 copayment per calendar month for rental, $250 copayment per date of purchase of Durable Medical Equipment	Preauthorization is required for purchases over $500 and/or any Medical Equipment Rental. Failure to obtain preauthorization may result in a reduction of benefits. Contact Oshkosh School District Benefits Team at 920-547-9157 to receive a referral that could

Common Medical Event	Services You May Need	What You Will Pay All Providers	Limitations, Exceptions, & Other Important Information
			reduce your cost share.
	Hospice services (Home Care or Inpatient Hospice)	$100 copayment/visit, limited to 5 copays in any calendar month	
If your child needs dental or eye care	Children's eye exam	No Charge	One Routine Vision Exam will be covered per Plan Year, including the refraction.
	Children's glasses	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Oral health check-ups are covered as part of your child's wellness visit with his/her family Physician under Preventive Care.

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
- Dental Care (Adult)
- Glasses for a child
- Routine foot care
- Dental care (Pediatric)
- Infertility Treatment
- Weight loss program
- Cosmetic surgery
- Dental Check-up
- Long-term care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic Care (Limited to maximum of 24 visits per Plan Year)
- Private-duty nursing ($50,000 maximum per Plan Year. $100,000 maximum per Lifetime)
- Hearing Aids (one item/ear every 3 years for children 18 years of age or under
- Routine Eye Care (Adult) (One Routine Vision Exam will be covered per plan year, including refraction)
- Non-emergency care when traveling outside the U.S.

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: the 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: : the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA(3272) or www.dol.gov/ebsa/healthreform. A list of states with Consumer Assistance Programs is available at www.HealthCare.gov and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

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 1-800-615-7020.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-615-7020.
Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-615-7020.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-615-7020.

*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 $0**
- **Specialist copayments $150**
- **Hospital (facility) copayment $1,000**
- **Other copayment Based on services**

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	$3,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,060**

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible $0**
- **Specialist copayments $150**
- **Hospital (facility) copayment $1,000**
- **Other copayment Based on services**

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	$2,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,420**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible $0**
- **Specialist copayments $150**
- **Hospital (facility) copayment $1,000**
- **Other copayment Based on services**

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	$0
Copayments	$2,800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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