

# WPS HealthyChoices Illinois Large Group Copay Plan

<b>Office Visit Copay Options</b>	<b>Primary Care Practitioner/Specialist</b>
Choice of:	\$25/\$50
	\$35/\$70
<b>Drug Coverage Options</b>	<b>Generic/Preferred Brand/Brand/Specialty</b>
Choice of:	\$10/\$35/\$60/25% to \$250
	\$15/\$45/\$80/25% to \$250
	\$20/\$50/\$100/25% to \$250

Deductible		Coinsurance		Annual Out-of-Pocket Limit*	
In-Network Individual/Family	Out-of-Network Individual/Family	In-Network	Out-of-Network	In-Network Individual/Family	Out-of-Network Individual/Family
\$250/\$500	\$500/\$1,000	0%	30%	\$250/\$500	\$9,500/\$19,000
\$250/\$500	\$500/\$1,000	10%	30%	\$3,250/\$6,500	\$9,500/\$19,000
\$250/\$500	\$500/\$1,000	20%	40%	\$6,250/\$12,500	\$12,500/\$25,000
\$500/\$1,000	\$1,000/\$2,000	0%	30%	\$500/\$1,000	\$10,000/\$20,000
\$500/\$1,000	\$1,000/\$2,000	10%	30%	\$3,500/\$7,000	\$10,000/\$20,000
\$500/\$1,000	\$1,000/\$2,000	20%	40%	\$6,500/\$13,000	\$13,000/\$26,000
\$1,000/\$2,000	\$2,000/\$4,000	0%	30%	\$1,000/\$2,000	\$11,000/\$22,000
\$1,000/\$2,000	\$2,000/\$4,000	10%	30%	\$2,500/\$5,000	\$6,500/\$13,000
\$1,000/\$2,000	\$2,000/\$4,000	10%	30%	\$4,000/\$8,000	\$11,000/\$22,000
\$1,000/\$2,000	\$2,000/\$4,000	20%	40%	\$4,000/\$8,000	\$8,000/\$16,000
\$1,500/\$3,000	\$3,000/\$6,000	0%	30%	\$1,500/\$3,000	\$12,000/\$24,000
\$1,500/\$3,000	\$3,000/\$6,000	10%	30%	\$3,000/\$6,000	\$7,500/\$15,000
\$1,500/\$3,000	\$3,000/\$6,000	10%	30%	\$4,500/\$9,000	\$12,000/\$24,000
\$1,500/\$3,000	\$3,000/\$6,000	20%	40%	\$4,500/\$9,000	\$9,000/\$18,000
\$2,000/\$4,000	\$4,000/\$8,000	0%	30%	\$2,000/\$4,000	\$13,000/\$26,000
\$2,000/\$4,000	\$4,000/\$8,000	10%	30%	\$3,500/\$7,000	\$8,500/\$17,000
\$2,000/\$4,000	\$4,000/\$8,000	10%	30%	\$5,000/\$10,000	\$13,000/\$26,000
\$2,000/\$4,000	\$4,000/\$8,000	20%	40%	\$5,000/\$10,000	\$10,000/\$20,000
\$2,500/\$5,000	\$5,000/\$10,000	0%	30%	\$2,500/\$5,000	\$14,000/\$28,000
\$2,500/\$5,000	\$5,000/\$10,000	10%	30%	\$4,000/\$8,000	\$9,500/\$19,000
\$2,500/\$5,000	\$5,000/\$10,000	10%	30%	\$5,500/\$11,000	\$14,000/\$28,000
\$2,500/\$5,000	\$5,000/\$10,000	20%	40%	\$5,500/\$11,000	\$11,000/\$22,000
\$3,000/\$6,000	\$6,000/\$12,000	0%	30%	\$3,000/\$6,000	\$15,000/\$30,000
\$3,000/\$6,000	\$6,000/\$12,000	10%	30%	\$4,500/\$9,000	\$10,500/\$21,000
\$3,000/\$6,000	\$6,000/\$12,000	10%	30%	\$6,000/\$12,000	\$15,000/\$30,000

\*Annual Out-of-Pocket Limit includes deductible, coinsurance, and all copays.

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# WPS HealthyChoices Illinois Large Group Copay Plan

Deductible		Coinsurance		Annual Out-of-Pocket Limit*	
In-Network Individual/Family	Out-of-Network Individual/Family	In-Network	Out-of-Network	In-Network Individual/Family	Out-of-Network Individual/Family
\$3,000/\$6,000	\$6,000/\$12,000	20%	40%	\$6,000/\$12,000	\$12,000/\$24,000
\$3,500/\$7,000	\$7,000/\$14,000	0%	30%	\$3,500/\$7,000	\$11,500/\$23,000
\$3,500/\$7,000	\$7,000/\$14,000	10%	30%	\$5,000/\$10,000	\$11,500/\$23,000
\$3,500/\$7,000	\$7,000/\$14,000	20%	40%	\$6,500/\$13,000	\$13,000/\$26,000
\$4,000/\$8,000	\$8,000/\$16,000	0%	30%	\$4,000/\$8,000	\$17,000/\$34,000
\$4,000/\$8,000	\$8,000/\$16,000	10%	30%	\$5,500/\$11,000	\$12,500/\$25,000
\$4,000/\$8,000	\$8,000/\$16,000	20%	40%	\$7,000/\$14,000	\$14,000/\$28,000
\$5,000/\$10,000	\$10,000/\$20,000	0%	30%	\$5,000/\$10,000	\$19,000/\$38,000
\$5,000/\$10,000	\$10,000/\$20,000	10%	30%	\$6,500/\$13,000	\$14,500/\$29,000
\$5,500/\$11,000	\$11,000/\$22,000	0%	30%	\$5,500/\$11,000	\$15,500/\$31,000
\$5,500/\$11,000	\$11,000/\$22,000	10%	30%	\$7,000/\$14,000	\$15,500/\$31,000

\*Annual Out-of-Pocket Limit includes deductible, coinsurance, and all copays.

# WPS HealthyChoices Illinois Large Group Copay Plan—Benefit Summary

Common Medical Event	Services You May Need	Your cost if you use an		Notes
		In-Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit	Copay	Deductible/coinsurance	You pay a \$10 copay/visit for a Teladoc® visit
	Specialist visit	Copay	Deductible/coinsurance	None
	Other practitioner office visit	Copay	Deductible/coinsurance	Chiropractic and osteopathic treatment is subject to applicable deductible and coinsurance
	Preventive care/screening	\$0	Deductible/coinsurance	None
	Immunizations	\$0	\$0	Immunizations for travel purposes are not covered
If you have a test in a physician's office	Diagnostic test (X-ray, blood work)	Coinsurance	Deductible/coinsurance	None
	Imaging (CT/PET scans, MRIs)	Coinsurance	Deductible/coinsurance	Prior authorization is required for PET scans, MRAs, and MRSs*
If you need drugs to treat your illness or condition**	Generic drugs	Copay		30-day supply limit for retail and all specialty drugs; home delivery 90-day supply for 2.5 x retail copay; drugs may require prior authorization*
	Preferred brand drugs	Copay		
	Non-preferred brand drugs	Copay		
	Specialty drugs	25% (up to \$250 per drug)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible/coinsurance	Deductible/coinsurance	None
	Physician/surgeon fees	Deductible/coinsurance	Deductible/coinsurance	None
If you need immediate medical attention	Emergency room services	\$300 Copay	\$300 Copay	None
	Related emergency room services	In-network coinsurance		None
	Emergency medical transportation	In-network deductible/coinsurance		Prior authorization required for non-emergency transport*
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible/coinsurance	Deductible/coinsurance	Prior authorization required*
	Physician/surgeon fees	Deductible/coinsurance	Deductible/coinsurance	None
If you have mental illness or substance use needs	Mental/substance use outpatient office visits	PCP Copay	Deductible/coinsurance	None
	Mental/substance use inpatient services	Deductible/coinsurance	Deductible/coinsurance	Prior authorization is required for elective admissions*
If you are pregnant	Prenatal and postnatal care	Deductible/coinsurance	Deductible/coinsurance	None
	Delivery and all inpatient services	Deductible/coinsurance	Deductible/coinsurance	None
If you need help recovering or have other special health needs	Home health care	Deductible/coinsurance	Deductible/coinsurance	None
	Rehabilitative services (therapy)	PCP Copay	Deductible/coinsurance	None
	Skilled nursing care in a licensed skilled nursing facility	Deductible/coinsurance	Deductible/coinsurance	Prior authorization required for elective admissions* Up to 30 days per confinement
	Durable medical equipment	Deductible/coinsurance	Deductible/coinsurance	Prior authorization required* for: ▪ All CPAP purchases and rentals ▪ Purchases over \$1,000 ▪ Rentals on the prior authorization list on our website
	Hospice service	Deductible/coinsurance	Deductible/coinsurance	Prior authorization is required for hospice services*
If your child needs dental or eye care	Routine eye exam	\$0	Deductible/coinsurance	None
	Glasses	Not covered	Not covered	Not covered
	Dental check-up	Not covered	Not covered	Not covered

All services are subject to terms and conditions of the policy. \*If a prior authorization is required and one is not obtained, benefits may not be payable. \*\*Certain drug limitations, including mandatory generics, may apply. Please review the full policy.

# WPS HealthyChoices Illinois Large Group Copay Plan—Benefit Summary

## Excluded Services and Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy for other excluded services.)		
▪ Cosmetic surgery	▪ Long-term care	▪ Routine foot care, unless associated with a specific medical diagnosis
▪ Any service deemed experimental or not medically necessary	▪ Eyeglasses	▪ Weight-loss programs
▪ Acupuncture	▪ Non-emergency care when traveling outside the U.S.	
Other Covered Services (This isn't a complete list. Check your policy for other covered services and costs for these services.)		
<ul style="list-style-type: none"> <li>▪ Bariatric surgery</li> <li>▪ Hearing aids</li> <li>▪ Private-duty nursing</li> <li>▪ Routine eye care, limited to eye exams</li> </ul>	<ul style="list-style-type: none"> <li>▪ Dental care, limited to certain oral surgical procedures, treatment of an injury, and extraction of teeth and sealants on existing teeth related to treatment of neoplastic disease</li> <li>▪ Chiropractic and osteopathic care</li> <li>▪ Infertility treatment, limited to the benefits as stated in the policy</li> </ul>	

### Benefit Payment Information

Benefit payments are subject to the applicable: calendar year deductible and coinsurance options you select; annual out-of-pocket limits; applicable copays; exclusions, limitations, and other policy terms and conditions.

### Dependent Children, Domestic Partners

WPS group plans include coverage for dependents to age 26. (See policy for details.) Domestic partner and civil union benefits are also available. There may be tax consequences to employees who enroll dependents or domestic partners that do not meet the IRC § 152 definitions of dependents/spouses. Employees should consult with a tax advisor prior to enrolling for this coverage.

### Premium and Renewal Terms

We determine your group's premium based on a number of factors, including your group's characteristics and the various benefit design options you select.

You submit the initial monthly premium, along with your completed application materials, to us. Then, you submit all subsequent premium payments to us along with a copy of the premium notice. For coverage to continue, we need to receive the premium as required by the policy. A participant's coverage depends on his or her eligibility under the terms and conditions of your WPS group master policy.

### Appeal Procedure

If a participant has a question, concern, or complaint that can't be resolved by our Customer Service team, he or she can file an appeal detailing the reason(s) for disagreeing with our benefit or claim payment decision.

At WPS, we define a "complaint" as meaning any dissatisfaction by you either orally or in writing.

Written requests and copies of any supporting information (such as letters, medical records, clinical reports, or other relevant documents that show the medical reason(s) why we should change our decision) should be sent to:

WPS Grievance/Appeals  
P.O. Box 7062  
Madison, WI 53707-7062  
FAX: 608-977-9920

Preventive care services include routine exams, screenings, immunizations, and other services ranked A or B by the U.S. Preventive Services Task Force.

# WPS HealthyChoices Illinois Large Group HSA Plan

HSA—NON-EMBEDDED DEDUCTIBLE					
Deductible		Coinsurance		Annual Out-of-Pocket Limit	
In-Network Single Person Plan/Family Plan	Out-of-Network Single Person Plan/Family Plan	In-Network	Out-of-Network	In-Network Individual/Family	Out-of-Network Individual/Family
\$1,500/\$3,000	\$1,500/\$3,000	0%	30%	\$1,500/\$3,000 <sup>1</sup>	\$6,000/\$12,000 <sup>1</sup>
\$1,500/\$3,000	\$1,500/\$3,000	20%	40%	\$4,500/\$9,000 <sup>2</sup>	\$7,500/\$15,000 <sup>2</sup>
\$2,000/\$4,000	\$2,000/\$4,000	0%	30%	\$2,000/\$4,000 <sup>1</sup>	\$6,500/\$13,000 <sup>1</sup>
\$2,000/\$4,000	\$2,000/\$4,000	20%	40%	\$5,000/\$10,000 <sup>2</sup>	\$8,000/\$16,000 <sup>2</sup>
\$2,500/\$5,000	\$2,500/\$5,000	0%	30%	\$2,500/\$5,000 <sup>1</sup>	\$7,000/\$14,000 <sup>1</sup>
\$2,500/\$5,000	\$2,500/\$5,000	20%	40%	\$5,500/\$11,000 <sup>2</sup>	\$8,500/\$17,000 <sup>2</sup>

The deductibles listed are non-embedded deductibles. If a single person is on the plan, the member must satisfy the individual plan deductible before the plan will pay benefits. If more than one person is on the plan, it is a family plan. Families must satisfy the family deductible before the plan will pay benefits. One family member can satisfy the family deductible.

Deductibles and out-of-pocket maximums apply annually. In-network and out-of-network deductible and coinsurance amounts must be satisfied separately. HSA is administered and/or maintained by a participating financial institution. WPS does not operate or administer HSAs. Each year, your plan's deductible will be automatically adjusted to reflect federal guidelines and remain HSA-qualified.

<sup>1</sup>This plan features a non-embedded annual out-of-pocket limit. If an employee has family coverage, the family annual out-of-pocket must be satisfied before this plan will pay 100% of covered benefits. One person can satisfy the family annual out-of-pocket.

<sup>2</sup>This plan features an embedded annual out-of-pocket limit. If an employee has family coverage, the individual annual out-of-pocket must be satisfied before this plan will pay 100% of covered benefits for that family member.

# WPS HealthyChoices Illinois Large Group HSA Plan

HSA—EMBEDDED DEDUCTIBLE					
Deductible		Coinsurance		Annual Out-of-Pocket Limit	
In-Network Individual/Family	Out-of-Network Individual/Family	In-Network	Out-of-Network	In-Network Individual/Family	Out-of-Network Individual/Family
\$3,000/\$6,000	\$3,000/\$6,000	0%	30%	\$3,000/\$6,000	\$7,500/\$15,000
\$3,000/\$6,000	\$3,000/\$6,000	20%	40%	\$6,000/\$12,000	\$9,000/\$18,000
\$3,500/\$7,000	\$3,500/\$7,000	0%	30%	\$3,500/\$7,000	\$8,000/\$16,000
\$3,500/\$7,000	\$3,500/\$7,000	20%	40%	\$6,500/\$13,000	\$9,500/\$19,000
\$4,000/\$8,000	\$4,000/\$8,000	0%	30%	\$4,000/\$8,000	\$8,500/\$17,000
\$4,000/\$8,000	\$4,000/\$8,000	20%	40%	\$6,750/\$13,500	\$10,000/\$20,000
\$4,500/\$9,000	\$4,500/\$9,000	0%	30%	\$4,500/\$9,000	\$9,000/\$18,000
\$4,500/\$9,000	\$4,500/\$9,000	20%	40%	\$6,750/\$13,500	\$10,500/\$21,000
\$5,000/\$10,000	\$5,000/\$10,000	0%	30%	\$5,000/\$10,000	\$9,500/\$19,000
\$5,000/\$10,000	\$5,000/\$10,000	20%	40%	\$6,750/\$13,500	\$11,000/\$22,000
\$6,750/\$13,500	\$6,750/\$13,500	0%	30%	\$6,750/\$13,500	\$11,500/\$23,000

This plan features an embedded deductible. Once a family member reaches the individual deductible amount, this plan will begin to pay benefits for that family member only. Once the family deductible amount is reached, this plan will begin to pay benefits for all members of the family. Deductibles and out-of-pocket maximums apply annually. In-network and out-of-network deductible and coinsurance amounts must be satisfied separately. HSA is administered and/or maintained by a participating financial institution. WPS does not operate or administer HSAs.

Each year, your plan's deductible will be automatically adjusted to reflect federal guidelines and remain HSA-qualified.

These plans feature an embedded annual out-of-pocket limit. If an employee has family coverage, the individual annual out-of-pocket must be satisfied before this plan will pay 100% of covered benefits for that family member.

# WPS HealthyChoices Illinois Large Group HSA Plan—Benefit Summary

Common Medical Event	Services You May Need	Your cost if you use an		Notes*
		In-Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit	Deductible/coinsurance	Deductible/coinsurance	Includes telehealth visits with a Teladoc® provider
	Specialist visit	Deductible/coinsurance	Deductible/coinsurance	None
	Other practitioner office visit	Deductible/coinsurance	Deductible/coinsurance	None
	Preventive care/screening	\$0	Deductible/coinsurance	None
	Immunizations	\$0	\$0	Immunizations for travel purposes are not covered
If you have a test in a physician's office	Diagnostic test (X-ray, blood work)	Deductible/coinsurance	Deductible/coinsurance	None
	Imaging (CT/PET scans, MRIs)	Deductible/coinsurance	Deductible/coinsurance	Prior authorization is required for PET scans, MRAs, MRSs*
If you need drugs to treat your illness or condition**	Generic drugs	In-network deductible/coinsurance		30-day supply limit for retail and all specialty drugs; home delivery 90-day supply for 2.5 x retail copay; drugs may require prior authorization*
	Preferred brand drugs			
	Non-preferred brand drugs			
	Specialty drugs			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible/coinsurance	Deductible/coinsurance	None
	Physician/surgeon fees	Deductible/coinsurance	Deductible/coinsurance	None
If you need immediate medical attention	Emergency room services	In-network deductible/coinsurance		None
	Emergency medical transportation	In-network deductible/coinsurance		Prior authorization required for non-emergency transport*
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible/coinsurance	Deductible/coinsurance	Prior authorization required*
	Physician/surgeon fees	Deductible/coinsurance	Deductible/coinsurance	None
If you have mental illness or substance use needs	Mental/substance use outpatient office visits	Deductible/coinsurance	Deductible/coinsurance	None
	Mental/substance use inpatient services	Deductible/coinsurance	Deductible/coinsurance	Prior authorization is required for elective admissions*
If you are pregnant	Prenatal and postnatal care	Deductible/coinsurance	Deductible/coinsurance	None
	Delivery and all inpatient services	Deductible/coinsurance	Deductible/coinsurance	None
If you need help recovering or have other special health needs	Home health care	Deductible/coinsurance	Deductible/coinsurance	None
	Rehabilitative services (therapy)	Deductible/coinsurance	Deductible/coinsurance	None
	Skilled nursing care in a licensed skilled nursing facility	Deductible/coinsurance	Deductible/coinsurance	Prior authorization is required for elective admissions* Up to 30 days per confinement
	Durable medical equipment	Deductible/coinsurance	Deductible/coinsurance	Prior authorization required* for: ▪ All CPAP purchases and rentals ▪ Purchases over \$1,000 ▪ Rentals on the prior authorization list on our website
	Hospice service	Deductible/coinsurance	Deductible/coinsurance	Prior authorization is required for hospice services*
If your child needs dental or eye care	Routine eye exam	\$0	Deductible/coinsurance	None
	Glasses	Not covered	Not covered	Not covered
	Dental check-up	Not covered	Not covered	Not covered

All services are subject to terms and conditions of the policy. \*If a prior authorization is required and one is not obtained, benefits may not be payable. \*\*Certain drug limitations, including mandatory generics, may apply. Please review the full policy.

# WPS HealthyChoices Illinois Large Group HSA Plan—Benefit Summary

## Excluded Services and Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy for other excluded services.)		
▪ Cosmetic surgery	▪ Long-term care	▪ Routine foot care, unless associated with a specific medical diagnosis
▪ Any service deemed experimental or not medically necessary	▪ Eyeglasses	▪ Weight-loss programs
▪ Acupuncture	▪ Non-emergency care when traveling outside the U.S.	
Other Covered Services (This isn't a complete list. Check your policy for other covered services and costs for these services.)		
▪ Bariatric surgery	▪ Dental care, limited to certain oral surgical procedures, treatment of an injury, and extraction of teeth and sealants on existing teeth related to treatment of neoplastic disease	
▪ Hearing aids	▪ Chiropractic and osteopathic care	
▪ Private-duty nursing	▪ Infertility treatment, limited to the benefits as stated in the policy	
▪ Routine eye care, limited to eye exams		

### Benefit Payment Information

Benefit payments are subject to the applicable: calendar year deductible and coinsurance options you select; annual out-of-pocket limits; applicable copays; exclusions, limitations, and other policy terms and conditions.

### Dependent Children, Domestic Partners

WPS group plans include coverage for dependents to age 26. (See policy for details.) Domestic partner and civil union benefits are also available. There may be tax consequences to employees who enroll dependents or domestic partners that do not meet the IRC § 152 definitions of dependents/spouses. Employees should consult with a tax advisor prior to enrolling for this coverage.

### Premium and Renewal Terms

We determine your group's premium based on a number of factors, including your group's characteristics and the various benefit design options you select.

You submit the initial monthly premium, along with your completed application materials, to us. Then, you submit all subsequent premium payments to us along with a copy of the premium notice. For coverage to continue, we need to receive the premium as required by the policy. A participant's coverage depends on his or her eligibility under the terms and conditions of your WPS group master policy.

**IMPORTANT:** This brochure and summary of benefits provides only a general description of benefits, limitations, and exclusions. You can find a detailed description of coverage in the applicable policy issued to you. Coverage is subject to all the terms and conditions of the policy and any endorsements. If there's ever a discrepancy between the policy and this brochure, the policy has final authority.

### Appeal Procedure

If a participant has a question, concern, or complaint that can't be resolved by our Customer Service team, he or she can file an appeal detailing the reason(s) for disagreeing with our benefit or claim payment decision.

At WPS, we define a "complaint" as meaning any dissatisfaction by you either orally or in writing.

Written requests and copies of any supporting information (such as letters, medical records, clinical reports, or other relevant documents that show the medical reason(s) why we should change our decision) should be sent to:

WPS Grievance/Appeals  
P.O. Box 7062  
Madison, WI 53707-7062  
FAX: 608-977-9920

Preventive care services include routine exams, screenings, immunizations, and other services ranked A or B by the U.S. Preventive Services Task Force.

