# WPS HealthyChoices Illinois Large Group Copay Plan

| Office Visit Copay Options | Primary Care Practitioner/Specialist |
|---|---|
| Choice of: | $25/$50 |
| | $35/$70 |
| | $50/$100 |
| **Emergency Room Copay Options** | |
| Choice of: | $300/$500 |
| **Drug Coverage Options** | **Generic/Preferred Brand/Brand/Specialty** |
| Choice of: | $10/$35/$60/25% to $350 |
| | $15/$45/$80/25% to $350 |
| | $20/$50/$100/25% to $350 |

| 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 |
| $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 | 10% | 30% | $2,500/$5,000 | $6,500/$13,000 |
| $1,000/$2,000 | $2,000/$4,000 | 20% | 40% | $4,000/$8,000 | $8,000/$16,000 |
| $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% | $4,000/$8,000 | $11,000/$22,000 |
| $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 | 20% | 40% | $4,500/$9,000 | $9,000/$18,000 |
| $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% | $4,500/$9,000 | $12,000/$24,000 |
| $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 | 20% | 40% | $5,000/$10,000 | $10,000/$20,000 |
| $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% | $5,000/$10,000 | $13,000/$26,000 |
| $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 | 20% | 40% | $5,500/$11,000 | $11,000/$22,000 |
| $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% | $5,500/$11,000 | $14,000/$28,000 |
| $3,000/$6,000 | $6,000/$12,000 | 10% | 30% | $4,500/$9,000 | $10,500/$21,00 |
| $3,000/$6,000 | $6,000/$12,000 | 20% | 40% | $6,000/$12,000 | $12,000/$24,000 |
| $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% | $6,000/$12,000 | $15,000/$30,000 |

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

*Continued on next page*

# 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 |
| $3,500/$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 |
| $5,000/$10,000 | $10,000/$20,000 | 20% | 40% | $7,350/$14,700 | $16,000/$32,000 |
| $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 |
| $5,500/$11,000 | $11,000/$22,000 | 20% | 40% | $7,350/$14,700 | $17,000/$34,000 |

*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 In-Network Provider | Your cost if you use an Out-of-Network Provider | Notes |
|---|---|---|---|---|
| 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 specialty drugs; home delivery 90-day supply for 2.5 x retail copay; retail 90-day supply for 3 x copay; drugs may require prior authorization* |
| | Preferred brand drugs | Copay | | |
| | Non-preferred brand drugs | Copay | | |
| | Specialty drugs | 25% (up to $350 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 | ER Copay | ER 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 | You pay a $10 copay/visit for a Teladoc® visit |
| | 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*<br>Up to 30 days per confinement |
| | Durable medical equipment | Deductible/coinsurance | Deductible/coinsurance | Prior authorization required* for:<br>▪ All CPAP purchases and rentals<br>▪ Purchases over $1,000<br>▪ 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.*

## 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<br>▪ Hearing aids<br>▪ Private-duty nursing<br>▪ Routine eye care, limited to eye exams | ▪ 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<br>▪ Chiropractic and osteopathic care<br>▪ Infertility treatment, limited to the benefits as stated in the policy |

**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:

Appeal Committee
Wisconsin Physicians Service Insurance Corporation
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-Qualified High-Deductible Health Plan (HDHP)

| HSA-Qualified HDHP—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[1] | $6,000/$12,000[1] |
| $1,500/$3,000 | $1,500/$3,000 | 20% | 40% | $4,500/$9,000[2] | $7,500/$15,000[2] |
| $2,000/$4,000 | $2,000/$4,000 | 0% | 30% | $2,000/$4,000[1] | $6,500/$13,000[1] |
| $2,000/$4,000 | $2,000/$4,000 | 20% | 40% | $5,000/$10,000[2] | $8,000/$16,000[2] |
| $2,500/$5,000 | $2,500/$5,000 | 0% | 30% | $2,500/$5,000[1] | $7,000/$14,000[1] |
| $2,500/$5,000 | $2,500/$5,000 | 20% | 40% | $5,500/$11,000[2] | $8,500/$17,000[2] |

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.

[1]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.

[2]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-Qualified High-Deductible Health Plan (HDHP)

| HSA-Qualified HDHP—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 |
| $6,350/$12,700 | $6,350/$12,700 | 0% | 30% | $6,350/$12,700 | $10,850/$21,700 |
| $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-Qualified High-Deductible Health Plan (HDHP)—Benefit Summary

| Common Medical Event | Services You May Need | Your cost if you use an In-Network Provider | Your cost if you use an Out-of-Network Provider | Notes* |
|---|---|---|---|---|
| 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 specialty drugs; retail and home delivery 90-day supply; 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 | Includes telehealth visits with a Teladoc® provider |
| | 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:<br>▪ All CPAP purchases and rentals<br>▪ Purchases over $1,000<br>▪ 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-Qualified High-Deductible Health Plan (HDHP)—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<br>▪ Hearing aids<br>▪ Private-duty nursing<br>▪ Routine eye care, limited to eye exams | ▪ 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<br>▪ Chiropractic and osteopathic care<br>▪ Infertility treatment, limited to the benefits as stated in the policy |

**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:

Appeal Committee
Wisconsin Physicians Service Insurance Corporation
P.O. Box 7062
Madison, WI 53707-7062
FAX: 608-327-6319

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.

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

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