WPS HEALTHYCHOICES WISCONSIN LARGE GROUP COPAY VALUE PLAN

Benefit Options¹

Primary Care Practitioner/Specialist Office Visit

Copay Options: \$25/\$50 • \$35/\$70 • \$50/\$100

Emergency Room Visit

Copay Options: \$300 • \$500

Generic/Preferred Brand/Brand/Specialty Drug Coverage

Options: \$10/\$35/\$60/25% to \$350 • \$15/\$45/\$80/25% to \$350 • \$20/\$50/\$100/25% to \$350

90-Day Retail Drug Supply at 3x Copay • 90 day Home Delivery Drug Supply at 2.5x Copay

Deductible		Coins	urance Annual Out-of-Pocket Limit ²				
In-Network Individual/Family	Out-of-Network Individual/Family	In- Network	Out-of- Network	In-Network Individual/Family	Out-of-Network Individual/Family	In-Network ³ Annual Maximum Out-of-Pocket	Free PCP Visits⁴
\$500/\$1,000	\$1,000/\$2,000	0%	30%	\$500/\$1,000	\$10,000/\$20,000	\$7,350/\$14,700	3
\$500/\$1,000	\$1,000/\$2,000	10%	30%	\$3,500/\$7,000	\$10,000/\$20,000	\$7,350/\$14,700	3
\$500/\$1,000	\$1,000/\$2,000	20%	40%	\$6,500/\$13,000	\$13,000/\$26,000	\$7,350/\$14,700	3
\$1,000/\$2,000	\$2,000/\$4,000	10%	30%	\$2,500/\$5,000	\$6,500/\$13,000	\$7,350/\$14,700	3
\$1,000/\$2,000	\$2,000/\$4,000	20%	40%	\$4,000/\$8,000	\$8,000/\$16,000	\$7,350/\$14,700	3
\$1,000/\$2,000	\$2,000/\$4,000	0%	30%	\$1,000/\$2,000	\$11,000/\$22,000	\$7,350/\$14,700	3
\$1,000/\$2,000	\$2,000/\$4,000	10%	30%	\$4,000/\$8,000	\$11,000/\$22,000	\$7,350/\$14,700	3
\$1,500/\$3,000	\$3,000/\$6,000	10%	30%	\$3,000/\$6,000	\$7,500/\$15,000	\$7,350/\$14,700	3
\$1,500/\$3,000	\$3,000/\$6,000	20%	40%	\$4,500/\$9,000	\$9,000/\$18,000	\$7,350/\$14,700	3
\$1,500/\$3,000	\$3,000/\$6,000	0%	30%	\$1,500/\$3,000	\$12,000/\$24,000	\$7,350/\$14,700	3
\$1,500/\$3,000	\$3,000/\$6,000	10%	30%	\$4,500/\$9,000	\$12,000/\$24,000	\$7,350/\$14,700	3
\$2,000/\$4,000	\$4,000/\$8,000	10%	30%	\$3,500/\$7,000	\$8,500/\$17,000	\$7,350/\$14,700	3
\$2,000/\$4,000	\$4,000/\$8,000	20%	40%	\$5,000/\$10,000	\$10,000/\$20,000	\$7,350/\$14,700	3
\$2,000/\$4,000	\$4,000/\$8,000	0%	30%	\$2,000/\$4,000	\$13,000/\$26,000	\$7,350/\$14,700	3
\$2,000/\$4,000	\$4,000/\$8,000	10%	30%	\$5,000/\$10,000	\$13,000/\$26,000	\$7,350/\$14,700	3

¹Additional benefit options may be available for experience-rated groups.

²The Annual Out-of-Pocket Limit includes only deductible and coinsurance amounts. It does not include copays.

³The Annual Maximum Out-of-Pocket includes deductible, coinsurance, and copays. Copays include Prescription Drug copays. The Annual Maximum Out-of-Pocket listed is for in-network services only.

⁴These plans waive the copayment on the first three visits with a primary care practitioner (PCP), psychologist, psychiatrist, or licensed mental health professional.

All plans have an embedded deductible and embedded out-of-pocket limit: These plans feature an embedded deductible where an individual deductible must be satisfied before this plan will pay benefits for that individual. Additionally, these plans feature an embedded out-of-pocket limit where the individual out-of-pocket limit must be satisfied before this plan will pay 100% of covered benefits for that individual. Deductibles and out-of-pocket maximums apply annually.

Options continue on next page



WPS HEALTHYCHOICES WISCONSIN LARGE GROUP COPAY VALUE PLAN

Benefit Options¹

Deductible		Coins	urance	Annual Out-o	f-Pocket Limit ²		
In-Network Individual/Family	Out-of-Network Individual/Family	In- Network	Out-of- Network	In-Network Individual/Family	Out-of-Network Individual/Family	In-Network ³ Annual Maximum Out-of-Pocket	Free PCP Visits⁴
\$2,500/\$5,000	\$5,000/\$10,000	10%	30%	\$4,000/\$8,000	\$9,500/\$19,000	\$7,350/\$14,700	3
\$2,500/\$5,000	\$5,000/\$10,000	20%	40%	\$5,500/\$11,000	\$11,000/\$22,000	\$7,350/\$14,700	3
\$2,500/\$5,000	\$5,000/\$10,000	0%	30%	\$2,500/\$5,000	\$14,000/\$28,000	\$7,350/\$14,700	3
\$2,500/\$5,000	\$5,000/\$10,000	10%	30%	\$5,500/\$11,000	\$14,000/\$28,000	\$7,350/\$14,700	3
\$3,000/\$6,000	\$6,000/\$12,000	10%	30%	\$4,500/\$9,000	\$10,500/\$21,000	\$7,350/\$14,700	3
\$3,000/\$6,000	\$6,000/\$12,000	20%	40%	\$6,000/\$12,000	\$12,000/\$24,000	\$7,350/\$14,700	3
\$3,000/\$6,000	\$6,000/\$12,000	0%	30%	\$3,000/\$6,000	\$15,000/\$30,000	\$7,350/\$14,700	3
\$3,000/\$6,000	\$6,000/\$12,000	10%	30%	\$6,000/\$12,000	\$15,000/\$30,000	\$7,350/\$14,700	3
\$3,500/\$7,000	\$7,000/\$14,000	0%	30%	\$3,500/\$7,000	\$11,500/\$23,000	\$7,350/\$14,700	3
\$3,500/\$7,000	\$7,000/\$14,000	10%	30%	\$5,000/\$10,000	\$11,500/\$23,000	\$7,350/\$14,700	3
\$3,500/\$7,000	\$7,000/\$14,000	20%	40%	\$6,500/\$13,000	\$13,000/\$26,000	\$7,350/\$14,700	3
\$4,000/\$8,000	\$8,000/\$16,000	0%	30%	\$4,000/\$8,000	\$17,000/\$34,000	\$7,350/\$14,700	3
\$4,000/\$8,000	\$8,000/\$16,000	10%	30%	\$5,500/\$11,000	\$12,500/\$25,000	\$7,350/\$14,700	3
\$4,000/\$8,000	\$8,000/\$16,000	20%	40%	\$7,000/\$14,000	\$14,000/\$28,000	\$7,350/\$14,700	3
\$5,000/\$10,000	\$10,000/\$20,000	0%	30%	\$5,000/\$10,000	\$19,000/\$38,000	\$7,350/\$14,700	3
\$5,000/\$10,000	\$10,000/\$20,000	10%	30%	\$6,500/\$13,000	\$14,500/\$29,000	\$7,350/\$14,700	3
\$5,000/\$10,000	\$10,000/\$20,000	20%	40%	\$7,350/\$14,700	\$16,000/\$32,000	\$7,350/\$14,700	3
\$5,500/\$11,000	\$11,000/\$22,000	0%	30%	\$5,500/\$11,000	\$15,500/\$31,000	\$7,350/\$14,700	3
\$5,500/\$11,000	\$11,000/\$22,000	10%	30%	\$7,000/\$14,000	\$15,500/\$31,000	\$7,350/\$14,700	3
\$5,500/\$11,000	\$11,000/\$22,000	20%	40%	\$7,350/\$14,700	\$17,000/\$34,000	\$7,350/\$14,700	3

¹Additional benefit options may be available for experience-rated groups.

²The Annual Out-of-Pocket Limit includes only deductible and coinsurance amounts. It does not include copays.

³The Annual Maximum Out-of-Pocket includes deductible, coinsurance, and copays. Copays include Prescription Drug copays. The Annual Maximum Out-of-Pocket listed is for in-network services only.

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All plans have an embedded deductible and embedded out-of-pocket limit: These plans feature an embedded deductible where an individual deductible must be satisfied before this plan will pay benefits for that individual. Additionally, these plans feature an embedded out-of-pocket limit where the individual out-of-pocket limit must be satisfied before this plan will pay 100% of covered benefits for that individual. Deductibles and out-of-pocket maximums apply annually.

Options continue on next page

WPS HEALTHYCHOICES WISCONSIN LARGE GROUP COPAY PLAN

Benefit Options¹

Primary Care Practitioner/Specialist Office Visit

Copay Options: \$25/\$50 • \$35/\$70 • \$50/\$100

Emergency Room Visit

Copay Options: \$300 • \$500

Generic/Preferred Brand/Brand/Specialty Drug Coverage

Options: \$10/\$35/\$60/25% to \$350 • \$15/\$45/\$80/25% to \$350 • \$20/\$50/\$100/25% to \$350

90-Day Retail Drug Supply at 3x Copay • 90 day Home Delivery Drug Supply at 2.5x Copay

Deductible		Coinsurance		Annual Maximum Out-of-Pocket Limit ²		
In-Network Individual/Family	Out-of-Network Individual/Family	In- Network	Out-of- Network	In-Network Individual/Family	Out-of-Network Individual/Family	Free PCP Visits ³
\$500/\$1,000	\$1,000/\$2,000	0%	30%	\$500/\$1,000	\$10,000/\$20,000	3
\$500/\$1,000	\$1,000/\$2,000	10%	30%	\$3,500/\$7,000	\$10,000/\$20,000	3
\$500/\$1,000	\$1,000/\$2,000	20%	40%	\$6,500/\$13,000	\$13,000/\$26,000	3
\$1,000/\$2,000	\$2,000/\$4,000	10%	30%	\$2,500/\$5,000	\$6,500/\$13,000	3
\$1,000/\$2,000	\$2,000/\$4,000	20%	40%	\$4,000/\$8,000	\$8,000/\$16,000	3
\$1,000/\$2,000	\$2,000/\$4,000	0%	30%	\$1,000/\$2,000	\$11,000/\$22,000	3
\$1,000/\$2,000	\$2,000/\$4,000	10%	30%	\$4,000/\$8,000	\$11,000/\$22,000	3
\$1,500/\$3,000	\$3,000/\$6,000	10%	30%	\$3,000/\$6,000	\$7,500/\$15,000	3
\$1,500/\$3,000	\$3,000/\$6,000	20%	40%	\$4,500/\$9,000	\$9,000/\$18,000	3
\$1,500/\$3,000	\$3,000/\$6,000	0%	30%	\$1,500/\$3,000	\$12,000/\$24,000	3
\$1,500/\$3,000	\$3,000/\$6,000	10%	30%	\$4,500/\$9,000	\$12,000/\$24,000	3
\$2,000/\$4,000	\$4,000/\$8,000	10%	30%	\$3,500/\$7,000	\$8,500/\$17,000	3
\$2,000/\$4,000	\$4,000/\$8,000	20%	40%	\$5,000/\$10,000	\$10,000/\$20,000	3
\$2,000/\$4,000	\$4,000/\$8,000	0%	30%	\$2,000/\$4,000	\$13,000/\$26,000	3
\$2,000/\$4,000	\$4,000/\$8,000	10%	30%	\$5,000/\$10,000	\$13,000/\$26,000	3

¹Additional benefit options may be available for experience-rated groups.

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Options continue on next page



WPS HEALTHYCHOICES WISCONSIN LARGE GROUP COPAY PLAN

Benefit Options¹

Deductible		Coinsurance		Annual Maximum		
In-Network Individual/Family	Out-of-Network Individual/Family	In- Network	Out-of- Network	In-Network Individual/Family	Out-of-Network Individual/Family	Free PCP Visits ³
\$2,500/\$5,000	\$5,000/\$10,000	10%	30%	\$4,000/\$8,000	\$9,500/\$19,000	3
\$2,500/\$5,000	\$5,000/\$10,000	20%	40%	\$5,500/\$11,000	\$11,000/\$22,000	3
\$2,500/\$5,000	\$5,000/\$10,000	0%	30%	\$2,500/\$5,000	\$14,000/\$28,000	3
\$2,500/\$5,000	\$5,000/\$10,000	10%	30%	\$5,500/\$11,000	\$14,000/\$28,000	3
\$3,000/\$6,000	\$6,000/\$12,000	10%	30%	\$4,500/\$9,000	\$10,500/\$21,000	3
\$3,000/\$6,000	\$6,000/\$12,000	20%	40%	\$6,000/\$12,000	\$12,000/\$24,000	3
\$3,000/\$6,000	\$6,000/\$12,000	0%	30%	\$3,000/\$6,000	\$15,000/\$30,000	3
\$3,000/\$6,000	\$6,000/\$12,000	10%	30%	\$6,000/\$12,000	\$15,000/\$30,000	3
\$3,500/\$7,000	\$7,000/\$14,000	0%	30%	\$3,500/\$7,000	\$11,500/\$23,000	3
\$3,500/\$7,000	\$7,000/\$14,000	10%	30%	\$5,000/\$10,000	\$11,500/\$23,000	3
\$3,500/\$7,000	\$7,000/\$14,000	20%	40%	\$6,500/\$13,000	\$13,000/\$26,000	3
\$4,000/\$8,000	\$8,000/\$16,000	0%	30%	\$4,000/\$8,000	\$17,000/\$34,000	3
\$4,000/\$8,000	\$8,000/\$16,000	10%	30%	\$5,500/\$11,000	\$12,500/\$25,000	3
\$4,000/\$8,000	\$8,000/\$16,000	20%	40%	\$7,000/\$14,000	\$14,000/\$28,000	3
\$5,000/\$10,000	\$10,000/\$20,000	0%	30%	\$5,000/\$10,000	\$19,000/\$38,000	3
\$5,000/\$10,000	\$10,000/\$20,000	10%	30%	\$6,500/\$13,000	\$14,500/\$29,000	3
\$5,000/\$10,000	\$10,000/\$20,000	20%	40%	\$7,350/\$14,700	\$16,000/\$32,000	3
\$5,500/\$11,000	\$11,000/\$22,000	0%	30%	\$5,500/\$11,000	\$15,500/\$31,000	3
\$5,500/\$11,000	\$11,000/\$22,000	10%	30%	\$7,000/\$14,000	\$15,500/\$31,000	3
\$5,500/\$11,000	\$11,000/\$22,000	20%	40%	\$7,350/\$14,700	\$17,000/\$34,000	3

¹Additional benefit options may be available for experience-rated groups.

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Medical Event Services Preferred Provider Non-Preferred Provider Non-Preferred Provider Preferred file visit Copay Deductible/Consume You pay a \$10 copay/with for a Teladoc* visit Order provider Preferred file visit Copay Deductible/Consume You pay a \$10 copay/with for a Teladoc* visit Order provider Preferred file visit Copay Deductible/Consume You pay a \$10 copay/with for a Teladoc* visit Other practitioner office visit Copay Deductible/Consume You pay a \$10 copay/with for a Teladoc* visit Instrumentations \$0 S0 S0 Immunizations None Instrumentations \$0 S0 Deductible/Consume None None Instrumentations Consume Deductible/Consume Preferred transme they None Preferred transme they None Interminizations for transme Deductible/Consume Deductible/Consume Preferred transme they Preferred transme they None Interminizations for transme transme transme Preferred transme they Deductible/Consume Preferred transme transme Preferred transme transme transme None <t< th=""><th>Common</th><th></th><th>Your cost i</th><th>f you use a</th><th></th></t<>	Common		Your cost i	f you use a	
Type visit a health Care providers office or clinit care providers office or clinit former practitioner office visit Decrement of the practitioner office visit Decrement of t	Common Medical Event	Services You May Need	Preferred Provider		Notes
You with a hear office or clinitOther practices or with Proventive card/screamingCorpsy \$0Deductible/ConsumersoYou pay a \$10 copus/wait for a Toladoc" wait NoneProventive card/screaming\$0Deductible/ConsumersoNoneNoneIf you have a test in a phasiciants Office or clinitDeductible/ConsumersoNoneNoneIf you have a test in a phasiciants Office or clinitDeductible/ConsumersoDeductible/ConsumersoNoneIf you have a test in a phasiciants Office or clinitDeductible/ConsumersoDeductible/ConsumersoPrior authorization in required for most high heathorization in required for most high prior authorization in required for most high prior autho		Primary care office visit	Сорау	Deductible/Coinsurance	You pay a \$10 copay/visit for a Teladoc $^{\scriptscriptstyle (\! B\!)}$ visit
Care providers office or clinic You pair discognitions Coppy with the site discolution of the provide conservance provide conservances of the provide conservance and pair discolution of the provide conservance office or outpatient in a physiciants You pair and the provide conservance provide conservance construction You pair and the provide conservance provide conservance construction Power and the provide conservance provide conservance provide conservance construction Power and the provide conservance provide conservance provide conservance provide conservance provide conservance provide conservance Power and the provide conservance provide conservance provide conservance provide conservance provide conservance Power and the provide conservance provide conservance provide conservance provide conservance provide conservance provide conservance provide conservance Power and the provide conservance provide conservance proprovide conservance provide conservance provide conservance prop	If vou visit a health	Specialist office visit	Сорау	Deductible/Coinsurance	None
Production Substrate Deductible/Consurance Substrate/Consurance Note If you have a test in a physician's in physician's in a physician	care provider's	Other practitioner office visit	Сорау	Deductible/Coinsurance	You pay a \$10 copay/visit for a Teladoc $^{\ensuremath{\mathbb{R}}}$ visit
If you have a test in a physician's office or outpatient of a hospital department of a hospital or condition*** Reginants tests (name, hospital department of a concil drugs Consurance beductible/Consurance Deductible/Consurance Prior authorization is required for most high technology imaging services.** If you need drugs or condition*** Concil drugs Coppy Coppy On-day supply for 2.5 heat copy; total 90-day supply for 2.5 heat copy; total 90-da	office or clinic	Preventive care/screening	\$0	Deductible/Coinsurance	None
f you have a test media do not appendix CCG, and laboratory services.Code consuranceDeductible/CoinsuranceDeductible/CoinsuranceNonef you need drug horspristGeneic drugs (CCT/NR/NR/MR/MR/MR/MR/MR/MR/MR/MR/MR/MR/MR/MR/MR		Immunizations	\$0 \$0		Immunizations for travel are not covered
Non-prism OCTAMERAME/UNRY, and CVFEETSECT scame Deductible/Coinsurance Deductible/Coinsurance Methods If you need drugs or condition** Generic drugs Peterod brand-name drugs Copey 30-day supply for 3 x copa; for a scape; real 90-day supply for 3 x copa; for a subscinct 90-day supply for 3 x copa; for a subsci 10-day scape; for a subsci 10-day scape; for a subs	If you have a test in a physician's office or outpatient	ultrasounds, Doppler imaging, ECG, and laboratory services)	Coinsurance	Deductible/Coinsurance	
If you need drugs to treat your illness to treat your illness to read your illness to read your illness home delayers 90-day supply (init for 2 so readi copary read 90-day supply (init for 2 so readi home delayers 90-day supply (init for 3 copary, drugs interest specially see (a.g., ambulatory suppry controlDeductible/CoinsuranceDeductible/CoinsuranceNoneIf you need entrieds attentionEmergency room visitEmergency room lin-network Deductible/CoinsuranceCopay waive il admitted inpatient directly from emergency medical transport ationNoneIf you have a hospital stateFolity (se (a.g., hospital non envicesDeductible/CoinsurancePrior authorization is required for non-emergency transport is required for relective inpatient stays*If you have a hospital statePedity (se (a.g., hospital non envicesDeductible/CoinsurancePrior authorization is required for rono- envicesIf you have a hospital statePedity (se (a.g., hospital non envicesDeductible/CoinsurancePrior authorization is required for rono- envicesIf you have a hospital statePedity (se (a.g., hospital non envicesDeductible/CoinsurancePrior authorization is required for relective inpatient stays*If you have a hospital statePedity (se (a.g., hospital state)Deductible/CoinsurancePour authorization is required for relective inpatient stays* <td>department of a hospital</td> <td>(CCTA/MRA/MRI/MRV, and</td> <td>Deductible/Coinsurance</td> <td>Deductible/Coinsurance</td> <td></td>	department of a hospital	(CCTA/MRA/MRI/MRV, and	Deductible/Coinsurance	Deductible/Coinsurance	
ProductionPreference brand-name drugs Non-prefered brand-name drugsCopayPreference brand-name drugs Pretail 00-day supply for 3.5 cyclical copay; retail 00-day supply for 3.5 cyclical copay; retail 00-day supply for 3.5 cyclical copa; retail 00-day supply for 3.5 cyclical copa; for 3.5 cyclical copa; retail 00-day supply for 3.5 cyclical copa; for 3.5 cyclical copa;<		Generic drugs			
Or Contraction Moni-protored and arging Prior authorization Specially drugs Specially drugs Deductible/Coinsurance Deductible/Coinsurance None Hyou have outpatient surgery Physician/surgeon fees Deductible/Coinsurance Deductible/Coinsurance Copay waived if admitted inpatient directly from emergency room Hyou need immediate medical attention Emergency room visit ER Copay ER Copay Prior authorization is required for non-emergency transport Hyou have a hospital star Priority fee (e.g., hospital room) Deductible/Coinsurance Deductible/Coinsurance Prior authorization is required for non-emergency transport If you have a hospital star Priority fee (e.g., hospital room) Deductible/Coinsurance Deductible/Coinsurance Prior authorization is required for elective inpatient stays ^e If you have mental health, or substarce abuse needs Prior lauthorization is required for elective inpatient envices Deductible/Coinsurance Deductible/Coinsurance None If you are pregnant recovering or heres and adoptication area Deductible/Coinsurance Deductible/Coinsurance None If you are pregnant recovering or heres and adoptication Deductible/Coinsurance Deductible/Coinsurance None <t< td=""><td>If you need drugs to treat your illness</td><td>Preferred brand-name drugs</td><td>Сорау</td><td>Сорау</td><td>home delivery 90-day supply for 2.5 x retail copay;</td></t<>	If you need drugs to treat your illness	Preferred brand-name drugs	Сорау	Сорау	home delivery 90-day supply for 2.5 x retail copay;
If you have outpatient surgery contactiont surgery centeryPaciality fee (e.g., ambulatory surgery centery)Deductible/CoinsuranceDeductible/CoinsuranceNoneIf you need mimediate medical attentionEmergency room visitER CopayER CopayCopay vaived if admitted inpatient directly from emergency roomIf you need mimediate medical attentionRealed emergency room servicesIn-network CoinsurancePrior authorization is required for non-emergency transport*If you have a hospital stryFacility fee (e.g., hospital room)Deductible/CoinsuranceDeductible/CoinsurancePrior authorization is required for elective inpatient stays*If you have a hospital stryFacility fee (e.g., hospital room)Deductible/CoinsuranceDeductible/CoinsurancePrior authorization is required for elective inpatient stays*If you have a hospital stryMental health/substance abuse (Priscian/surgeon feeDeductible/CoinsuranceDeductible/CoinsurancePrior authorization is required for elective inpatient stays*If you have mental health/substance abuse needsDeductible/CoinsuranceDeductible/CoinsurancePrior authorization is required for elective inpatient stays*If you are pregna transitional treatmentDeductible/CoinsuranceDeductible/CoinsurancePrior authorization is required for elective inpatient stays*If you are pregna transportationDeductible/CoinsuranceDeductible/CoinsurancePrior authorization is required for elective inpatient stays*If you are pregna transional treatmentDeductible/CoinsuranceDeductible	or condition**	Non-preferred brand drugs			
if you have outpatient surgery center) buddettele/Coinsurance Deductible/Coinsurance None Myou need immediate medication Emergency room visit ER Copay ER Copay Copay weight dimited impatient directly from emergency room If you need iteration Related emergency room services In-network Deductible/Coinsurance Prior authorization is required for non-emergency transportation If you have a hospital stay Pacility fee (e.g., hospital room) Deductible/Coinsurance Deductible/Coinsurance Prior authorization is required for non-emergency transport* If you have a hospital stay Mental health/substance abuse outpatient office visits Deductible/Coinsurance Deductible/Coinsurance Prior authorization is required for all copay/visit for a Teladoc* visit If you have mental health/substance abuse needs Mental health/substance abuse outpatient services Deductible/Coinsurance Deductible/Coinsurance Prior authorization is required for all copay/visit for a Teladoc* visit If you are pregnation Mental health/substance abuse inpatient services Deductible/Coinsurance Deductible/Coinsurance Prior authorization is required for all copay/visit for a Teladoc* visit If you are pregnation Prenatal and postnatal care Deductible/Coinsurance Deductible/Coinsurance None		Specialty drugs			
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If you are pregnantDelivery and all inpatient servicesDeductible/CoinsuranceDeductible/CoinsuranceDeductible/CoinsuranceNoneIf you need help recovering or have other special health needsHome health careDeductible/CoinsuranceDeductible/CoinsuranceUp to 40 visits per yearIf you need help recovering or have other special health needsSkilled nursing care in a licensed skilled nursing facilityDeductible/CoinsuranceDeductible/CoinsuranceUp to 30 days per confinement; prior authorization is required for an elective admission*If your child needs dental or eye careRoutine eye examDeductible/CoinsuranceDeductible/CoinsurancePrior authorization is required for hospice services*If your child needs dental or eye careRoutine eye examS0Deductible/CoinsurancePrior authorization is required for hospice services*If your child needs dental or eye careRoutine eye examS0Deductible/CoinsurancePrior authorization is required for hospice services*If your child needs dental or eye careRoutine eye examS0Deductible/CoinsuranceNot coveredIf your child needs dental or eye careRoutine eye examNot coveredNot coveredNot covered	needs		Deductible/Coinsurance	Deductible/Coinsurance	None
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Image: Processing of the processing	If you need help	Ũ	Deductible/Coinsurance	Deductible/Coinsurance	
If your child needs dental or eye care Routine eye exam \$0 Deductible/Coinsurance None If source of the eye exam Not covered Not covered Not covered	have other special		Deductible/Coinsurance	Deductible/Coinsurance	Prior authorization* required for all CPAP purchases; purchases over \$1,000; and all other rentals as
If your child needs dental or eye care Glasses Not covered Not covered		Hospice service	Deductible/Coinsurance	Deductible/Coinsurance	Prior authorization is required for hospice services*
dental or eye care		Routine eye exam	\$0	Deductible/Coinsurance	None
	If your child needs dental or eve care	Glasses	Not covered	Not covered	Not covered
		Dental check-up	Not covered	Not covered	Not covered

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

Acupuncture	 Infertility treatment 		 Routine foot care, unless associated with a specific medical diagnosis
Bariatric surgery	Long-term care		Weight loss programs
Cosmetic surgery	 Eyeglasses 		 Private duty nursing
 Non-emergency care when traveling outside the U.S. 	 Any service deemed expenses necessary 	rimental or not medically	
Other Covered Services (This isn't a complete list. Check your policy f	or other covered services and	costs for these services.)	
 Routine eye care, limited to eye exams 		• Hearing aids, limited to the cost of one hearing aid, per ear, for each custome	
 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 		 under age 18 every three years Chiropractic care 	

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 up to age 26. (See policy for details.) Optional domestic partner benefits may be 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 (unless choosing to make payments using Electronic Funds Transfer), 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 (unless choosing to make payments using Electronic Funds Transfer). 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.

Grievance Procedure

We strive to resolve all complaints over the phone on the first call. We encourage you to call if you have any concerns.

Customers may submit a written explanation of dissatisfaction, which will be treated as a grievance. At WPS, we define a "grievance" as meaning any dissatisfaction with the provision of services or claims practices of an insurer offering a health benefit plan or administration of a health plan by the insurer that is expressed in writing to the insurer by, or on behalf of, a customer.

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

WPS HEALTHYCHOICES WISCONSIN LARGE GROUP HSA-QUALIFIED HDHP PLANS

Plan Summary*

HSA—Non-Embedded Deductible

Dedu	Deductible Coinsu		urance	Annual Out-o	f-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/\$17,500 ²

The deductibles listed are non-embedded deductibles. If a single person is on the plan, the customer must satisfy the single person 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.

An out-of-network deductible of an equivalent amount to the in-network deductible applies. Deductibles and out-of-pocket maximums apply annually. In-network and out-of-network deductible and coinsurance amounts must be satisfied separately. An 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.

¹This plan features a non-embedded annual out-of-pocket limit. If an employee has family coverage, the family annual out-of-pocket limit must be satisfied before this plan will pay 100% of covered benefits. One person can satisfy the family annual out-of-pocket limit. ²This plan features an embedded annual out-of-pocket limit. If an employee has family coverage, the individual out-of-pocket limit must be satisfied before this plan will pay 100% of covered benefits for that family member.

HSA—Embedded Deductible

Dedu	Deductible Co		surance	Annual Out-o	f-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

These plans have an embedded deductible and embedded out-of-pocket limit. These plans feature an embedded deductible where an individual deductible must be satisfied before this plan will pay benefits for that individual. Additionally, these plans feature an embedded out-of-pocket limit where the individual out-of-pocket limit must be satisfied before this plan will play 100% of covered benefits for that individual. Deductibles and out-of-pocket maximums apply annually. In-network and out-of-network deductible and coinsurance amounts must be satisfied separately. An HSA is administered and/or maintained by a participating financial institution. WPS does not operate or administer HSAs.

*Additional benefit options may be available for experience-rated groups.

Common		Your cost		
Medical Event	Services You May Need	Preferred Provider	Non-Preferred Provider	Notes
	Primary care office visit	Deductible/Coinsurance	Deductible/Coinsurance	Includes telehealth visits with a Teladoc $^{\ensuremath{\mathfrak{B}}}$ provider
If you visit a health	Specialist office visit	Deductible/Coinsurance	Deductible/Coinsurance	None
care provider's	Other practitioner office visit	Deductible/Coinsurance	Deductible/Coinsurance	Includes telehealth visits with a Teladoc® provider
office or clinic	Preventive care/screening	\$0	Deductible/Coinsurance	None
	Immunizations	\$0	\$0	Immunizations for travel are not covered
If you have a test in a physician's office or outpatient	Diagnostic tests (x-rays, ultrasounds, Doppler imaging, ECG, and laboratory services)	Deductible/Coinsurance	Deductible/Coinsurance	None
department of a hospital	High Technology Imaging (CCTA/MRA/MRI/MRV, and CT/PET/SPECT scans)	Deductible/Coinsurance	Deductible/Coinsurance	Prior authorization is required for most high technology imaging services.*
	Generic drugs			
If you need drugs to treat your illness	Preferred brand-name drugs	In-network Deduc	stible/Coinsurance	30-day supply limit for specialty drugs; 90-day supply limit for retail and home delivery drugs; drugs
or condition**	Non-preferred brand drugs			may require prior authorization*
	Specialty drugs			
If you have	Facility fee (e.g., ambulatory surgery center)	Deductible/Coinsurance	Deductible/Coinsurance	None
outpatient surgery	Physician/surgeon fees	Deductible/Coinsurance	Deductible/Coinsurance	None
If you need	Emergency room visit	In-network Deductible/Coinsurance		None
immediate medical attention	Emergency medical transportation	In-network Deduc	stible/Coinsurance	Prior authorization is required for non-emergency transport*
If you have a	Facility fee (e.g., hospital room)	Deductible/Coinsurance	Deductible/Coinsurance	Prior authorization is required for elective inpatient stays*
hospital stay	Physician/surgeon stay	Deductible/Coinsurance	Deductible/Coinsurance	None
If you have	Mental health/substance abuse outpatient office visits	Deductible/Coinsurance	Deductible/Coinsurance	Includes telehealth visits with a Teladoc® provider
mental health, or substance abuse	Mental health/substance abuse inpatient services	Deductible/Coinsurance Deductible/Coinsurance		Prior authorization is required for elective inpatient stays*
needs	Mental health/substance abuse transitional treatment	Deductible/Coinsurance	Deductible/Coinsurance	None
	Prenatal and postnatal care	Deductible/Coinsurance	Deductible/Coinsurance	None
If you are pregnant	Delivery and all inpatient services	Deductible/Coinsurance	Deductible/Coinsurance	None
	Home health care	Deductible/Coinsurance	Deductible/Coinsurance	Up to 40 visits per year
	Rehabilitative services (therapy)	Deductible/Coinsurance	Deductible/Coinsurance	None
If you need help recovering or	Skilled nursing care in a licensed skilled nursing facility	Deductible/Coinsurance	Deductible/Coinsurance	Up to 30 days per confinement; prior authorization is required for an elective admission*
have other special health needs	Durable medical equipment	Deductible/Coinsurance	Deductible/Coinsurance	Purchases over \$1,000, rentals over \$750 per month, and all CPAP purchases require prior authorization*
	Hospice service	Deductible/Coinsurance	Deductible/Coinsurance	None
	Routine eye exam	\$0	Deductible/Coinsurance	None
If your child needs dental or eye care	Glasses	Not covered	Not covered	Not covered
	Dental check-up	Not covered	Not covered	Not covered

Preventive care services include routine exams, screenings, immunizations, and other services ranked A or B by the U.S. Preventive Services Task Force. 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.)					
Acupuncture	 Infertility treatment 		 Routine foot care, unless associated with a specific medical diagnosis 		
Bariatric surgery	 Long-term care 		Weight loss programs		
Cosmetic surgery	• Eyeglasses		 Private duty nursing 		
 Non-emergency care when traveling outside the U.S. 	 Any service deemed experimental or not medically necessary 				
Other Covered Services (This isn't a complete list. Check your policy for other covered services and costs for these services.)					
 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 		 Hearing aids, limited to the cost of one hearing aid, per ear, for each custom under age 18 every three years Chiropractic care 			

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 up to age 26. (See policy for details.) Optional domestic partner benefits may be 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 (unless choosing to make payments using Electronic Funds Transfer), 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 (unless choosing to make payments using Electronic Funds Transfer). 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.

Grievance Procedure

We strive to resolve all complaints over the phone on the first call. We encourage you to call if you have any concerns.

Customers may submit a written explanation of dissatisfaction, which will be treated as a grievance. At WPS, we define a "grievance" as meaning any dissatisfaction with the provision of services or claims practices of an insurer offering a health benefit plan or administration of a health plan by the insurer that is expressed in writing to the insurer by, or on behalf of, a customer.

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

IMPORTANT: This 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.

