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

Deductible		Coins	urance	rance 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 ^a 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

Teladoc[®] Copay: \$0

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 PLANS

Benefit Options¹

Deductible		Coinsı	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
\$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
\$4,500/\$9,000	\$9,000/\$18,000	0%	30%	\$4,500/\$9,000	\$18,000/\$36,000	\$7,350/\$14,700	3
\$4,500/\$9,000	\$9,000/\$18,000	10%	30%	\$6,000/\$12,000	\$13,500/\$27,000	\$7,350/\$14,700	3
\$4,500/\$9,000	\$9,000/\$18,000	20%	40%	\$7,350/\$14,700	\$15,000/\$30,000	\$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.

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.

WPS HEALTHYCHOICES WISCONSIN LARGE GROUP COPAY PLANS

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

Teladoc[®] Copay: \$0

90-Day Retail Drug Supply at 3x 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	Free PCP Visits ²
\$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.

²The Annual Out-of-Pocket includes deductible, coinsurance, and copays. Copays include Prescription Drug copays.

³These 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 PLANS

Benefit Options¹

Deductible		Coinsı	irance	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	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
\$4,500/\$9,000	\$9,000/\$18,000	0%	30%	\$4,500/\$9,000	\$18,000/\$36,000	3
\$4,500/\$9,000	\$9,000/\$18,000	10%	30%	\$6,000/\$12,000	\$13,500/\$27,000	3
\$4,500/\$9,000	\$9,000/\$18,000	20%	40%	\$7,350/\$14,700	\$15,000/\$30,000	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.

²The Annual Out-of-Pocket includes deductible, coinsurance, and copays. Copays include Prescription Drug copays.

³These 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.

Modical Event Services You May Need Preferred Provider Preferred Provider Noise Previous If you visit a bank comp provider's provider in the information office or citic Previous and the information Coppy Deductible/Consumme Previous You pay a Scooppy/visit for a Telador* visit Coppy If you visit a bank comp provider's provider information office or citic Previous and the information Previous and the informatin Previous and the information Previous and the informati	C		Your cost i	f you use a	
try ou visit a head in the construction of lice visit is the production of lice visit is the productis the productis the production of lice visit is the productis the	Common Medical Event	Services You May Need	Preferred Provider		Notes
Carbon providence office or clinicProventive carefacements (Presentive carefacements)Copy (SODeductible/Consurance Deductible/ConsuranceYou pay a \$0 copy/vioit for a Teladord" vioit MoreIf you have a test in a physiciant in a physiciant (Copy and tests)Consurance Deductible/ConsuranceDeductible/ConsuranceNoneIf you have a test (Copy and tests)Deductible/Consurance Deductible/ConsuranceDeductible/ConsurancePrior authorzation is required for most high technology imaging services."If you need regis hospitalPrior authorzation is required for most high technology imaging technology imaging technology imaging services."Deductible/ConsuranceDeductible/ConsuranceIf you need regis to tract your illines Spotially drugsDeductible/ConsuranceDeductible/ConsuranceNoneIf you need ourpatient surgery autrory committiesDeductible/ConsuranceDeductible/ConsuranceNoneIf you need ourpatient surgery autrory committiesDeductible/ConsuranceDeductible/ConsuranceNoneIf you need autrory committies		Primary care office visit	Сорау	Deductible/Coinsurance	You pay a \$0 copay/visit for a Teladoc® visit
Care providers office or clinitMore practitioner office with Proventive care/screaming in a physician?CoppsDeductible/Coinsurance SONoneIf you have a test in a physician?Coinsurance CoinsuranceDeductible/CoinsurancePolice authorization is required for most high tochnowingIf you have a test in a physician?Coinsurance CoinsuranceDeductible/CoinsurancePolice authorization is required for most high tochnowing magnet sortices."If you have a test in a physician?Generic drugsDeductible/CoinsurancePolice authorization is required for most high tochnowing magnet sortices."If you need drugs to trest your filters reconstructGeneric drugsDeductible/CoinsuranceDeductible/CoinsurancePolice authorization is required for most high tochnowing magnet sortices."If you need drugs to trest your filters reconstructGeneric drugsDeductible/CoinsuranceDeductible/CoinsuranceSo dy acyspice your filters so dy acyspice for a structure drug for authorization is required for most high tructure drugs magnet sortices."If you need drugs to trest your filters reconstructureFedered band drugsDeductible/CoinsuranceDeductible/CoinsuranceNoneIf you need mimediate methed transportFedered band drugsDeductible/CoinsuranceDeductible/CoinsuranceNoneIf you need mimediatemethed related for decisi relationFedered band-weitDeductible/CoinsuranceDeductible/CoinsuranceNoneIf you need mimediatemethed relationFedered band-weitDeductible/CoinsuranceDeductible/C	If vou visit a health	Specialist office visit	Сорау	Deductible/Coinsurance	None
Product best of the Sole of the	care provider's	Other practitioner office visit	Сорау	Deductible/Coinsurance	You pay a \$0 copay/visit for a Teladoc® visit
If you have a test in a physician's office or outpained department of a hospital (COTAPURE)/WINKING (COT	office or clinic	Preventive care/screening	\$0	Deductible/Coinsurance	None
f you have a test method or outpatient consurance body function or outpatient body function or outpatient or outpatient body function or outpatient body function or outpatient body function or outpatient bo		Immunizations	\$0 \$0		Immunizations for travel are not covered
Interplate OCTAMERAME/INRV, and CVFEE/SECE same) Deductible/Coinsurance Deductible/Coinsurance Itechnology imaging services." If you need drugs or condition** Generic drugs Peterod brand-name drugs Copay 30-day supply for 3 x copa; for a copay; infinit 0 of asy upply for 3 x copa; for a copay; prior authorization** If you need or condition** Peterod brand-name drugs Deductible/Coinsurance Deductible/Coinsurance None Special by drugs 269% up to \$350 Deductible/Coinsurance None None If you need immediate medici. Facility foe (og. ambulatory super: carter) Deductible/Coinsurance Deductible/Coinsurance None If you need immediate medici. Emergency room In-network Deductible/Coinsurance Prior authorization is required for one-mergency room If you have a hospital stay Facility foe (og., hospital room) Deductible/Coinsurance Prior authorization is required for elective inpatient stays" If you have a hospital stay Facility foe (og., hospital room) Deductible/Coinsurance Prior authorization is required for elective inpatient stays" If you have a hospital stay Provican/surgen fee Deductible/Coinsurance Prior authorization is required for elective inpatient stays" <	If you have a test in a physician's office or outpatient	ultrasounds, Doppler imaging, ECG, and laboratory services)	Coinsurance	Deductible/Coinsurance	
Hyou need drugs to breat your illness to breat your illness to read your illness to read your illness home delayers 90-day supply limit for apsoidly drugs: home delayers 90-day supply for 2.5 x relial social; prior authorizationHyou need outpatient surger angery center)Deductible/Coinsurance Physician/surgeon feesDeductible/CoinsuranceDeductible/CoinsuranceHyou need outpatient surger fryou need entriesEnergency room visitER CopayER CopayCopay waive if admitted inpatient directly from emergency room emergency room emergency redical transportationDeductible/CoinsuranceCopay waive if admitted inpatient directly from emergency room emergency redical transportationHyou need encregency redical transportationIn-network Deductible/CoinsurancePrior authorization is required for non-emergency transport*Hyou have a bospital stateFolity fee (e.g., hospital roomDeductible/CoinsurancePrior authorization is required for non- encregency medical transport*Hyou have a substance abuse prior authorization is required for non-emergency transport*Prior authorization is required for non- encred*Hyou have a thospital statePrior authorization is required for elective inpatient stays*Hyou have meedial hostith/substance abuse needialDeductible/CoinsurancePolicatible/CoinsuranceHyou have thospital stateDeductible/CoinsurancePrior authorization is required for elective inpatient stays*Hyou have meedialRecity fee (e.g., hospital roomDeductible/CoinsurancePrior authorization* stays*Hyou have t	department of a hospital	(CCTA/MRA/MRI/MRV, and	Deductible/Coinsurance	Deductible/Coinsurance	
Problemed and sums problemed and sums of real our line and sugs of copy in the analysis of the analysis of copy in the analysis of copy in the analysis of copy in the analysis of the analysis of copy in the analysis of the analysi		Generic drugs			
Or Contribution Non-preferred brand drugs Control Procession Specially drugs 26% up to \$350 None Specially drugs 26% up to \$350 None Hyou have outpatient surgery canten Physician/surgeon fees Deductible/Coinsurance Deductible/Coinsurance None Hyou need immediate medical attention Emergency room visit ER Copay ER Copay Copay waived if admitted inpatient directly from emergency room Hyou need immediate medical attention Emergency room visit ER Copay Phior authorization is required for non-emergency transport Hyou have a hospital stary Paletid emergency room In-network Deductible/Coinsurance Perior authorization is required for elective inpatient starys Hyou have a hospital stary Physician/surgeon fee Deductible/Coinsurance Deductible/Coinsurance None Hyou have mental health, or substarce abuse needs Physician/surgeon fee Deductible/Coinsurance Deductible/Coinsurance None Hyou are pregnant remetal health, room Deductible/Coinsurance Deductible/Coinsurance None None Hyou have mental health, root Deductible/Coinsurance Deductible/Coinsurance <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 outpatient surgery center)Paciality fee (e.g., ambulatory urgery center)Deductible/CoinsuranceDeductible/CoinsuranceNoneIf you need medical attentionEmergency room visitER CopayER CopayCopay vaived if admitted inpatient directly from emergency room sinvicesIf you need medical transportationRelated emergency room sinvicesIn-network CoinsurancePrior authorization is required for non-emergency transport*If you have a hospital staryFacility fee (e.g., hospital room)Deductible/CoinsuranceDeductible/CoinsurancePrior authorization is required for electve inpatient stays*If you have a hospital staryMertal health/substance abuse (In-alt health/substance abuse (Intal health/substance abuse (Intal health/substance abuse (Intal health/substance abuse (Intal health/substance abuse) (Intal health/substance abuse)Deductible/CoinsuranceDeductible/CoinsurancePrior authorization is required for elective inpatient stays*If you are pregen theodePrematel and p	or condition**	Non-preferred brand drugs			
if you have outpatient surgery outpatient surgery provided if admitted inpatient directly from emergency room visit Deductible/Coinsurance Deductible/Coinsurance None If you need attention Emergency room visit ER Copay ER Copay Copay waived if admitted inpatient directly from emergency room If you need attention Related emergency room envices In-network Deductible/Coinsurance Prior authorization is required for non-emergency transportation If you have a hospital stay Pacifity fee (e.g., hospital room) Deductible/Coinsurance Deductible/Coinsurance Prior authorization is required for onlective inpatient stays ^{et} If you have a hospital stay Mental health/substance abuse outpatient office vieits Deductible/Coinsurance Deductible/Coinsurance Prior authorization is required for elective inpatient stays ^{et} If you have a hospital stay outpatient office vieits Mental health/substance abuse inpatient services Deductible/Coinsurance Deductible/Coinsurance You pay a \$0 copay/visit for a Teladoc ⁺ visit If you are pregnant Mental health/substance abuse inpatient services Deductible/Coinsurance Deductible/Coinsurance Prior authorization is required for elective inpatient stays ^{et} If you are pregnant Penatal and postnatal care Deductible/Coinsurance Deductible/Coinsura			25% up	to \$350	
Physician/surgeon tees Deductible/Consurance Deductible/Consurance Deductible/Consurance None If you need immediate medica attention Emergency room visit ER Copay ER Copay Copay waived if admitted inpatient directly from emergency room emergency modical transportation If you have a hospital stay Related emergency endical transportation In-network Deductible/Coinsurance Prior authorization is required for non-emergency transport* If you have a hospital stay Realth/substance abuse outpatient office visits Deductible/Coinsurance Deductible/Coinsurance Prior authorization is required for elective inpatient stays* If you have mental health/substance abuse needs Mental health/substance abuse inpatient office visits DeCP copay Deductible/Coinsurance Prior authorization is required for elective inpatient stays* If you have mental health/substance abuse needs Mental health/substance abuse intaction services Deductible/Coinsurance Deductible/Coinsurance None If you are pregnant Mental health/substance abuse incensed state Deductible/Coinsurance Deductible/Coinsurance None If you are pregnant Perinati and postnatal care Deductible/Coinsurance Deductible/Coinsurance None If you are pregnant	If you have		Deductible/Coinsurance	Deductible/Coinsurance	None
frou need immediate medica attentionreflected emergency room Related emergency room attentionIn-network CoinsuranceRelated emergency room transport*Related emergency medical transportationIn-network Deductible/CoinsurancePrior authorization is required for non-emergency transport*If you have a hospital stayFacility fee (e.g., hospital room)Deductible/CoinsuranceDeductible/CoinsurancePrior authorization is required for relective inpatient stays*If you have a mental health/cubstance abuse updatient office visitsDeductible/CoinsuranceDeductible/CoinsuranceYou pay a \$0 copay/visit for a Teladoc* visitIf you have mends health, or substance abuse inpatient servicesDeductible/CoinsuranceDeductible/CoinsuranceYou pay a \$0 copay/visit for a Teladoc* visitIf you have mends health, or substance abuse inpatient servicesDeductible/CoinsuranceDeductible/CoinsuranceYou pay a \$0 copay/visit for a Teladoc* visitIf you are pregnant tf you are pregnant health health/substance abuse inpatient servicesDeductible/CoinsuranceDeductible/CoinsurancePrior authorization is required for relective inpatient stays*If you are pregnant tf you are pregnant health need servicesDeductible/CoinsuranceDeductible/CoinsuranceUp to 30 days per confinement; prior authorization is required for an elective admission* required	outpatient surgery	Physician/surgeon fees	Deductible/Coinsurance	Deductible/Coinsurance	None
Immediate medicationMealand emergency from strentionIn-network CoinsuranceMoneImagency medical transportationIn-network Deductible/CoinsurancePrior authorization is required for non-emergency transport*If you have a hospital stayFacility fee (e.g., hospital room)Deductible/CoinsuranceDeductible/CoinsurancePrior authorization is required for elective inpatient stays*If you have a hospital stayMental health/substance abuse outpatient office visitsDeductible/CoinsuranceDeductible/CoinsuranceYou pay a \$0 copat/visit for a Teladoc® visitIf you have mental health/substance abuse inpatient servicesDeductible/CoinsuranceDeductible/CoinsuranceYou pay a \$0 copat/visit for a Teladoc® visitIf you are pregnant fer untal health/substance abuse inpatient servicesDeductible/CoinsuranceDeductible/CoinsuranceYou pay a \$0 copat/visit for a Teladoc® visitIf you are pregnant fer untal health/substance abuse inpatient servicesDeductible/CoinsuranceDeductible/CoinsuranceYou pay a \$0 copat/visit for a Teladoc® visitIf you are pregnant fer untal health/substance abuse incevicesDeductible/CoinsuranceDeductible/CoinsuranceYou pay a \$0 copat/visit for a Teladoc® visitIf you are pregnant fer untal health/substanceDeductible/CoinsuranceDeductible/CoinsuranceNoneIf you are pregnant fer untal health/substanceDeductible/CoinsuranceDeductible/CoinsuranceUp to 30 days per confinement; prior authorization i required for a elective admission"If you are pregnant heave other special heave other special <td><i></i> .</td> <td>Emergency room visit</td> <td>ER Copay</td> <td>ER Copay</td> <td></td>	<i></i> .	Emergency room visit	ER Copay	ER Copay	
Emergency medical transportationInnetwork Deductible/CoinsurancePrior authorization is required for non-emergency transport*If you have a hospital stayFacility fee (e.g., hospital room)Deductible/CoinsuranceDeductible/CoinsurancePrior authorization is required for elective inpatient stays*If you have mental health, or substance abuse needsMental health/substance abuse outpatient servicesPCP copayDeductible/CoinsuranceYou pay a \$0 copay/visit for a Teladoc* visitIf you have mental health, or substance abuse needsMental health/substance abuse outpatient servicesDeductible/CoinsuranceDeductible/CoinsurancePrior authorization is required for elective inpatient stays*If you are pregna tf you are pregna tf you are pregna tf you end all inpatient servicesDeductible/CoinsuranceDeductible/CoinsurancePrior authorization is required for elective inpatient stays*If you are pregna tf you are pregna tf you are pregna tf you end all inpatient servicesDeductible/CoinsuranceDeductible/CoinsuranceDeductible/CoinsuranceIf you are pregna tf you are pregna tf you are pregna tf you are pregna tf you ended help recovering or have other special head bilitative services (therap)Deductible/CoinsuranceDeductible/CoinsuranceDeductible/CoinsuranceIf you chief belop recovering or have other special head the during facilityDeductible/CoinsuranceDeductible/CoinsuranceUp to 30 days per confinement; prior authorization's required for an elective admission's tora elective admission's required for an elective admission's tora admission's requir	immediate medical				None
If you have a hospital stayFacility tee (e.g., nospital room)Deductible/CoinsuranceDeductible/CoinsuranceDeductible/CoinsuranceNoneIf you have mental health, or substance abuse needsMental health/substance abuse inpatient servicesPCP copayDeductible/CoinsuranceYou pay a \$0 copay/visit for a Teladoc* visitIf you have mental health/substance abuse needsMental health/substance abuse inpatient servicesDeductible/CoinsuranceDeductible/CoinsurancePrior authorization is required for elective inpatient stays*If you are pregnant If you are pregnant from health careDeductible/CoinsuranceDeductible/CoinsuranceDeductible/CoinsuranceNoneIf you are pregnant from health careDeductible/CoinsuranceDeductible/CoinsuranceDeductible/CoinsuranceNoneIf you are pregnant from health careDeductible/CoinsuranceDeductible/CoinsuranceDeductible/CoinsuranceNoneIf you are pregnant from health careDeductible/CoinsuranceDeductible/CoinsuranceDeductible/CoinsuranceUp to 40 visits per yearNoneNoneDeductible/CoinsuranceDeductible/CoinsuranceDeductible/CoinsuranceUp to 30 days per confinement; prior authorization is required for an elective admission*If you child needs health heedsDeductible/CoinsuranceDeductible/CoinsurancePrior authorization is required for all CPAP purchases; purchases abilited nursing facilityIf you are pregnant health heedsDeductible/CoinsuranceDeductible/CoinsurancePrior authorization is required for all CPAP purchases; p	attention		In-network Deductible/Coinsurance		
If you have mental health, or substance abuse needsMental health/substance abuse outpatient office visitsPCP copayDeductible/CoinsuranceYou pay a \$0 copay/visit for a Teladoc* visitIf you have mental health, or substance abuse needsMental health/substance abuse inpatient servicesDeductible/CoinsuranceDeductible/CoinsurancePrior authorization is required for elective inpatient stays*Mental health/substance abuse needsMental health/substance abuse transitional treatmentDeductible/CoinsuranceDeductible/CoinsurancePrior authorization is required for elective inpatient stays*Martal health/substance abuse recevsPrenatal and postnatal careDeductible/CoinsuranceDeductible/CoinsuranceNoneIf you are pregnantPrenatal and postnatal careDeductible/CoinsuranceDeductible/CoinsuranceNonePernetal nealth/substance abuse transitional treatmentDeductible/CoinsuranceDeductible/CoinsuranceNoneIf you are pregnantPrenatal and postnatal careDeductible/CoinsuranceDeductible/CoinsuranceNonePernetal nealth careDeductible/CoinsuranceDeductible/CoinsuranceUp to 40 visits per yearNoneSkilled nursing care in a licensed skilled nursing facilityDeductible/CoinsuranceDeductible/CoinsuranceUp to 30 days per confinement; prior authorization is required for all CPAP purchases; purchased stated on our websiteIf you rehid help precovering or have other special health heedsDeductible/CoinsuranceDeductible/CoinsuranceUp to 30 days per confinement; prior authorization is <br< td=""><td>If you have a</td><td>Facility fee (e.g., hospital room)</td><td>Deductible/Coinsurance</td><td>Deductible/Coinsurance</td><td></td></br<>	If you have a	Facility fee (e.g., hospital room)	Deductible/Coinsurance	Deductible/Coinsurance	
If you have mental health, or substance abuse needsoutpatient office visitsPCP copayDeductible/CoinsuranceYou pay a \$0 copay/visit for a feladoe* visitMental health/substance abuse inpatient servicesDeductible/CoinsuranceDeductible/CoinsurancePrior authorization is required for elective inpatient stays*Mental health/substance abuse transitional treatmentDeductible/CoinsuranceDeductible/CoinsurancePrior authorization is required for elective inpatient stays*If you are pregnant If you need help recovering or have other special health needsPrenatal and postnatal careDeductible/CoinsuranceDeductible/CoinsuranceDeductible/CoinsuranceIf you need help recovering or have other special health needsHome health careDeductible/CoinsuranceDeductible/CoinsuranceUp to 40 visits per yearSkilled nursing care in a licensed skilled nursing facilityDeductible/CoinsuranceDeductible/CoinsuranceUp to 30 days per confinement; prior authorization is required for al elective admission*If your child needs dental or eye careRoutine eye examDeductible/CoinsuranceDeductible/CoinsuranceUp to 30 days per confinement; prior authorization is required for all CPAP purchases; purchases over \$1,000; and all other retails as stated on our websiteIf your child needs dental or eye careRoutine eye examSoDeductible/CoinsurancePrior authorization is required for hospice services*If your child needs dental or eye careRoutine eye examDeductible/CoinsuranceDeductible/CoinsuranceUp to 30 days per confinement; prior authori	hospital stay	Physician/surgeon fee	Deductible/Coinsurance	Deductible/Coinsurance	None
mental health, or substance abuse needsMental health/substance abuse inpatient servicesDeductible/CoinsuranceDeductible/CoinsurancePrior authorization is required for elective inpatient stays*Mental health/substance abuse transitional treatmentDeductible/CoinsuranceDeductible/CoinsuranceDeductible/CoinsuranceNoneHyou are pregnant f you need help recovering or have other special health needsPrenatal and postnatal careDeductible/CoinsuranceDeductible/CoinsuranceDeductible/CoinsuranceNoneH you need help recovering or have other special health needsHome health careDeductible/CoinsuranceDeductible/CoinsuranceUp to 40 visits per yearMental endering recovering or have other special health needsDeductible/CoinsuranceDeductible/CoinsuranceUp to 30 days per confinement; prior authorization* required for all cPAP purchases; purchases over \$1,000; and all other rentals as stated on our websiteIf your child needsRoutine eye examS0Deductible/CoinsurancePrior authorization* required for hospice services*If your child needsRoutine eye examS0Deductible/CoinsurancePrior authorization is required for hospice services*If your child needsRoutine eye examS0Deductible/CoinsurancePrior authorization is required for hospice services*If your child needsRoutine eye examS0Deductible/CoinsurancePrior authorization is required for hospice services*If your child needsRoutine eye examS0Deductible/CoinsurancePrior authorization is required for h	If you have		PCP copay	Deductible/Coinsurance	You pay a \$0 copay/visit for a Teladoc® visit
Mental health/substance abuse transitional treatmentDeductible/CoinsuranceDeductible/CoinsuranceDeductible/CoinsuranceNoneIf you are pregnantPrenatal and postnatal careDeductible/CoinsuranceDeductible/CoinsuranceDeductible/CoinsuranceNoneDelivery 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 yearSkilled nursing care in a licensed skilled nursing facilityDeductible/CoinsuranceDeductible/CoinsuranceUp to 30 days per confinement; prior authorization is required for an elective admission*health needsDeductible/CoinsuranceDeductible/CoinsuranceDeductible/CoinsurancePrior authorization is required for an elective admission*f your child needsDeductible/CoinsuranceDeductible/CoinsuranceDeductible/CoinsurancePrior authorization is required for an elective admission*f your child needsMoneDeductible/CoinsuranceDeductible/CoinsurancePrior authorization is required for an elective admission*f your child needsRoutine eye examS0Deductible/CoinsurancePrior authorization is required for hospice services*f your child needsGlassesNot coveredNot coveredNot coveredNot covered	mental health, or substance abuse		Deductible/Coinsurance	Deductible/Coinsurance	· . ·
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 exam\$0Deductible/CoinsurancePrior authorization is required for hospice services*If your child needs dental or eye careRoutine eye exam\$0Deductible/CoinsuranceNot coveredIf your child needs dental or eye careRoutine eye exam\$0Deductible/CoinsuranceNot coveredIf your child needs dental or eye careNot coveredNot coveredNot coveredNot covered	needs		Deductible/Coinsurance	Deductible/Coinsurance	None
Delivery and an inpatient servicesDeductible/CoinsuranceDeductible/CoinsuranceNoneIf you need help recovering or have other special health needsHome health careDeductible/CoinsuranceDeductible/CoinsuranceUp to 40 visits per yearSkilled nursing care in a licensed skilled nursing facilityDeductible/CoinsuranceDeductible/CoinsuranceUp to 30 days per confinement; prior authorization is required for an elective admission*Durable medical equipmentDeductible/CoinsuranceDeductible/CoinsurancePrior authorization is required for all CPAP purchases; purchases over \$1,000; and all other rentals as stated on our websiteIf your child needs dental or eye careRoutine eye exam\$0Deductible/CoinsurancePrior authorization is required for hospice services*If your child needs dental or eye careRoutine eye exam\$0Deductible/CoinsuranceNot coveredNot coveredNot coveredNot coveredNot coveredNot covered		Prenatal and postnatal care	Deductible/Coinsurance	Deductible/Coinsurance	None
If you need help recovering or have other special health needsRehabilitative services (therapy)PCP copayDeductible/CoinsuranceNoneSkilled nursing care in a licensed skilled nursing facilityDeductible/CoinsuranceDeductible/CoinsuranceUp to 30 days per confinement; prior authorization is required for an elective admission*have other special health needsDurable medical equipmentDeductible/CoinsuranceDeductible/CoinsurancePrior authorization* required for all CPAP purchases; purchases over \$1,000; and all other rentals as stated on our websiteHospice serviceDeductible/CoinsuranceDeductible/CoinsurancePrior authorization is required for hospice services*If your child needs dental or eye careRoutine eye exam\$0Deductible/CoinsurancePrior authorization is required for hospice services*If your child needs dental or eye careRoutine eye examNot coveredNot coveredNot covered	If you are pregnant		Deductible/Coinsurance	Deductible/Coinsurance	None
If 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 all CPAP purchases; purchases over \$1,000; and all other rentals as stated on our websiteIf your child needs dental or eye careRoutine eye exam\$0Deductible/CoinsurancePrior authorization is required for hospice services*If your child needs dental or eye careRoutine eye exam\$0Deductible/CoinsuranceNot coveredNot coveredIf your child needs dental or eye careRoutine eye exam\$0Deductible/CoinsuranceNot coveredNot covered		Home health care	Deductible/Coinsurance	Deductible/Coinsurance	Up to 40 visits per year
Iconsed skilled nursing facility Deductible/Coinsurance Deductible/Coinsurance Prior authorization* required for an elective admission* have other special health needs Durable medical equipment Deductible/Coinsurance Deductible/Coinsurance Prior authorization* required for all CPAP purchases; purchases over \$1,000; and all other rentals as stated on our website Hospice service Deductible/Coinsurance Deductible/Coinsurance Prior authorization is required for hospice services* Routine eye exam \$0 Deductible/Coinsurance Prior authorization is required for hospice services* Glasses Not covered Not covered Not covered		Rehabilitative services (therapy)	PCP copay	Deductible/Coinsurance	None
Interventing of have other special health needs Durable medical equipment Deductible/Coinsurance Deductible/Coinsurance Prior authorization* required for all CPAP purchases; purchases over \$1,000; and all other rentals as stated on our website Hospice service Deductible/Coinsurance Deductible/Coinsurance Prior authorization* required for hospice services* If your child needs dental or eye care Routine eye exam \$0 Deductible/Coinsurance Not covered Not covered Not covered Not covered Not covered Not covered Not covered	If you need help		Deductible/Coinsurance	Deductible/Coinsurance	
If your child needs dental or eye care Routine eye exam \$0 Deductible/Coinsurance None If your child needs dental or eye care Glasses Not covered Not covered Not covered	have other special health needs	Durable medical equipment	Deductible/Coinsurance	Deductible/Coinsurance	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
Dontal check-up Ivot covered Ivot covered Ivot 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 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 under age 18 every thre Chiropractic care 	the cost of one hearing aid, per ear, for each custome e years

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: 608-327-6319

WPS HEALTHYCHOICES WISCONSIN LARGE GROUP HSA-QUALIFIED PLANS

Plan Summary*

HSA—Non-Embedded Deductible

Deductible		Coins	urance	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	10%	30%	\$3,000/\$6,000 ¹	\$6,750/\$13,500 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	10%	30%	\$3,500/\$7,000 ¹	\$7,250/\$14,500 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	10%	30%	\$4,000/\$8,000 ²	\$7,750/\$15,000 ²
\$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.

WPS HEALTHYCHOICES WISCONSIN LARGE GROUP HSA-QUALIFIED PLANS

Plan Summary*

HSA—Embedded Deductible

Deductible		Coins	urance	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	10%	30%	\$4,500/\$9,000	\$8,250/\$16,500	
\$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	10%	30%	\$5,000/\$10,000	\$8750/\$17,500	
\$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	10%	30%	\$5,375/\$10,750	\$9,250/\$18,500	
\$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	10%	30%	\$5,625/\$11,250	\$9,750/\$19,500	
\$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	10%	30%	\$5,875/\$11,750	\$10,250/\$20,500	
\$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.

C ommon				
Common 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 [®] 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	tible/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 Deduc	tible/Coinsurance	None
immediate medical attention	Emergency medical transportation	In-network Deduc	ctible/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 $\ensuremath{^{\circledast}}$ 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
16	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 expenses necessary 	imental or not medically			
Other Covered Services (This isn't a complete list. Check your policy for c	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 custome 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: 608-327-6319

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.

