LARGE GROUP COPAY VALUE PLAN

Benefit Options[1]

Primary Care Practitioner/Specialist Office Visit
Copay Options: $35/$70 · $50/$100 · $75/$150

Telehealth
Teladoc Health Copay: $0

Emergency Room Visit
Copay Options: $500 · $750

$0 Preventive & Maintenance/Preferred Generic/Generic/Preferred Brand/Non-Preferred Brand/Specialty Drug Coverage
Options: $20/$40/$75/$150/25% • $15/$30/$50/$100/25%

90-Day Retail Drug Supply at 3x Copay

Deductible		Coinsurance		Annual Out-of-Pocket Limit[2]		In-Network[3] Annual Maximum Out-of-Pocket
In-Network Individual/Family	Out-of-Network Individual/Family	In-Network	Out-of-Network	In-Network Individual/Family	Out-of-Network Individual/Family	
$1,000/$2,000	$2,000/$4,000	0%	30%	$1,000/$2,000	$11,000/$22,000	$9,200/$18,400
$1,000/$2,000	$2,000/$4,000	10%	30%	$2,500/$5,000	$6,500/$13,000	$9,200/$18,400
$1,000/$2,000	$2,000/$4,000	20%	40%	$4,000/$8,000	$8,000/$16,000	$9,200/$18,400
$1,500/$3,000	$3,000/$6,000	0%	30%	$1,500/$3,000	$12,000/$24,000	$9,200/$18,400
$1,500/$3,000	$3,000/$6,000	10%	30%	$3,000/$6,000	$7,500/$15,000	$9,200/$18,400
$1,500/$3,000	$3,000/$6,000	20%	40%	$4,500/$9,000	$9,000/$18,000	$9,200/$18,400
$2,000/$4,000	$4,000/$8,000	0%	30%	$2,000/$4,000	$13,000/$26,000	$9,200/$18,400
$2,000/$4,000	$4,000/$8,000	10%	30%	$3,500/$7,000	$8,500/$17,000	$9,200/$18,400
$2,000/$4,000	$4,000/$8,000	20%	40%	$5,000/$10,000	$10,000/$20,000	$9,200/$18,400

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

Options continue on next page

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

[3]The 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.

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™
A HEALTH SOLUTIONS COMPANY

LARGE GROUP COPAY VALUE PLANS

Benefit Options[1]

Deductible		Coinsurance		Annual Out-of-Pocket Limit[2]		In-Network[3] Annual Maximum Out-of-Pocket
In-Network Individual/Family	Out-of-Network Individual/Family	In-Network	Out-of-Network	In-Network Individual/Family	Out-of-Network Individual/Family	
$2,500/$5,000	$5,000/$10,000	0%	30%	$2,500/$5,000	$14,000/$28,000	$9,200/$18,400
$2,500/$5,000	$5,000/$10,000	10%	30%	$4,000/$8,000	$9,500/$19,000	$9,200/$18,400
$2,500/$5,000	$5,000/$10,000	20%	40%	$5,500/$11,000	$11,000/$22,000	$9,200/$18,400
$3,000/$6,000	$6,000/$12,000	0%	30%	$3,000/$6,000	$15,000/$30,000	$9,200/$18,400
$3,000/$6,000	$6,000/$12,000	10%	30%	$4,500/$9,000	$10,500/$21,000	$9,200/$18,400
$3,000/$6,000	$6,000/$12,000	20%	40%	$6,000/$12,000	$12,000/$24,000	$9,200/$18,400
$3,500/$7,000	$7,000/$14,000	0%	30%	$3,500/$7,000	$16,000/$32,000	$9,200/$18,400
$3,500/$7,000	$7,000/$14,000	10%	30%	$5,000/$10,000	$11,500/$23,000	$9,200/$18,400
$3,500/$7,000	$7,000/$14,000	20%	40%	$6,500/$13,000	$13,000/$26,000	$9,200/$18,400
$4,000/$8,000	$8,000/$16,000	0%	30%	$4,000/$8,000	$17,000/$34,000	$9,200/$18,400
$4,000/$8,000	$8,000/$16,000	10%	30%	$5,500/$11,000	$12,500/$25,000	$9,200/$18,400
$4,000/$8,000	$8,000/$16,000	20%	40%	$7,000/$14,000	$14,000/$28,000	$9,200/$18,400
$4,500/$9,000	$9,000/$18,000	0%	30%	$4,500/$9,000	$18,000/$36,000	$9,200/$18,400
$4,500/$9,000	$9,000/$18,000	10%	30%	$6,000/$12,000	$13,500/$27,000	$9,200/$18,400
$4,500/$9,000	$9,000/$18,000	20%	40%	$7,500/$15,000	$15,000/$30,000	$9,200/$18,400
$5,000/$10,000	$10,000/$20,000	0%	30%	$5,000/$10,000	$19,000/$38,000	$9,200/$18,400
$5,000/$10,000	$10,000/$20,000	10%	30%	$6,500/$13,000	$14,500/$29,000	$9,200/$18,400
$5,000/$10,000	$10,000/$20,000	20%	40%	$8,000/$16,000	$16,000/$32,000	$9,200/$18,400
$5,500/$11,000	$11,000/$22,000	0%	30%	$5,500/$11,000	$20,000/$40,000	$9,200/$18,400
$5,500/$11,000	$11,000/$22,000	10%	30%	$7,000/$14,000	$15,500/$31,000	$9,200/$18,400
$5,500/$11,000	$11,000/$22,000	20%	40%	$8,500/$17,000	$17,000/$34,000	$9,200/$18,400
$6,000/$12,000	$12,000/$24,000	0%	30%	$6,000/$12,000	$21,000/$42,000	$9,200/$18,400
$6,000/$12,000	$12,000/$24,000	10%	30%	$7,500/$15,000	$16,500/$33,000	$9,200/$18,400
$6,000/$12,000	$12,000/$24,000	20%	40%	$9,000/$18,000	$18,000/$36,000	$9,200/$18,400
$7,000/$14,000	$14,000/$28,000	0%	30%	$7,000/$14,000	$23,000/$46,000	$9,200/$18,400
$7,000/$14,000	$14,000/$28,000	10%	30%	$8,500/$17,000	$18,500/$37,000	$9,200/$18,400
$7,000/$14,000	$14,000/$28,000	20%	40%	$9,200/$18,400	$20,000/$40,000	$9,200/$18,400
$9,200/$18,400	$18,400/$36,800	0%	30%	$9,200/$18,400	$27,400/$54,800	$9,200/$18,400

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

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

[3]The 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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90-Day Retail Drug Supply at 3x Copay

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In-Network Individual/Family	Out-of-Network Individual/Family	In-Network	Out-of-Network	In-Network Individual/Family	Out-of-Network Individual/Family
$1,000/$2,000	$2,000/$4,000	0%	30%	$1,000/$2,000	$11,000/$22,000
$1,000/$2,000	$2,000/$4,000	10%	30%	$2,500/$5,000	$6,500/$13,000
$1,000/$2,000	$2,000/$4,000	20%	40%	$4,000/$8,000	$8,000/$16,000
$1,500/$3,000	$3,000/$6,000	0%	30%	$1,500/$3,000	$12,000/$24,000
$1,500/$3,000	$3,000/$6,000	10%	30%	$3,000/$6,000	$7,500/$15,000
$1,500/$3,000	$3,000/$6,000	20%	40%	$4,500/$9,000	$9,000/$18,000
$2,000/$4,000	$4,000/$8,000	0%	30%	$2,000/$4,000	$13,000/$26,000
$2,000/$4,000	$4,000/$8,000	10%	30%	$3,500/$7,000	$8,500/$17,000
$2,000/$4,000	$4,000/$8,000	20%	40%	$5,000/$10,000	$10,000/$20,000

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

Options continue on next page

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Benefit Options[1]

Deductible		Coinsurance		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
$2,500/$5,000	$5,000/$10,000	0%	30%	$2,500/$5,000	$14,000/$28,000
$2,500/$5,000	$5,000/$10,000	10%	30%	$4,000/$8,000	$9,500/$19,000
$2,500/$5,000	$5,000/$10,000	20%	40%	$5,500/$11,000	$11,000/$22,000
$3,000/$6,000	$6,000/$12,000	0%	30%	$3,000/$6,000	$15,000/$30,000
$3,000/$6,000	$6,000/$12,000	10%	30%	$4,500/$9,000	$10,500/$21,000
$3,000/$6,000	$6,000/$12,000	20%	40%	$6,000/$12,000	$12,000/$24,000
$3,500/$7,000	$7,000/$14,000	0%	30%	$3,500/$7,000	$16,000/$32,000
$3,500/$7,000	$7,000/$14,000	10%	30%	$5,000/$10,000	$11,500/$23,000
$3,500/$7,000	$7,000/$14,000	20%	40%	$6,500/$13,000	$13,000/$26,000
$4,000/$8,000	$8,000/$16,000	0%	30%	$4,000/$8,000	$17,000/$34,000
$4,000/$8,000	$8,000/$16,000	10%	30%	$5,500/$11,000	$12,500/$25,000
$4,000/$8,000	$8,000/$16,000	20%	40%	$7,000/$14,000	$14,000/$28,000
$4,500/$9,000	$9,000/$18,000	0%	30%	$4,500/$9,000	$18,000/$36,000
$4,500/$9,000	$9,000/$18,000	10%	30%	$6,000/$12,000	$13,500/$27,000
$4,500/$9,000	$9,000/$18,000	20%	40%	$7,500/$15,000	$15,000/$30,000
$5,000/$10,000	$10,000/$20,000	0%	30%	$5,000/$10,000	$19,000/$38,000
$5,000/$10,000	$10,000/$20,000	10%	30%	$6,500/$13,000	$14,500/$29,000
$5,000/$10,000	$10,000/$20,000	20%	40%	$8,000/$16,000	$16,000/$32,000
$5,500/$11,000	$11,000/$22,000	0%	30%	$5,500/$11,000	$20,000/$40,000
$5,500/$11,000	$11,000/$22,000	10%	30%	$7,000/$14,000	$15,500/$31,000
$5,500/$11,000	$11,000/$22,000	20%	40%	$8,500/$17,000	$17,000/$34,000
$6,000/$12,000	$12,000/$24,000	0%	30%	$6,000/$12,000	$21,000/$42,000
$6,000/$12,000	$12,000/$24,000	10%	30%	$7,500/$15,000	$16,500/$33,000
$6,000/$12,000	$12,000/$24,000	20%	40%	$9,000/$18,000	$18,000/$36,000
$7,000/$14,000	$14,000/$28,000	0%	30%	$7,000/$14,000	$23,000/$46,000
$7,000/$14,000	$14,000/$28,000	10%	30%	$8,500/$17,000	$18,500/$37,000
$7,000/$14,000	$14,000/$28,000	20%	40%	$9,200/$18,400	$20,000/$40,000
$9,200/$18,400	$18,400/$36,800	0%	30%	$9,200/$18,400	$27,400/$54,800

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

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

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.

Common Medical Event	Services You May Need	Your cost if you use a		Notes
		Preferred Provider	Non-Preferred Provider	
If you visit a health care provider's office or clinic	Primary care office visit	Copay	Deductible/Coinsurance	You pay a $0 copay/visit for a Teladoc Health visit
	Specialist office visit	Copay	Deductible/Coinsurance	None
	Other practitioner office visit	Copay	Deductible/Coinsurance	You pay a $0 copay/visit for a Teladoc Health visit
	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 department of a hospital	Diagnostic tests (x-rays, ultrasounds, Doppler imaging, ECG, and laboratory services)	Coinsurance	Deductible/Coinsurance	None
	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.*
If you need drugs to treat your illness or condition**	Preferred generic drugs	Copay	Not covered	30-day supply limit for specialty drugs; home delivery 90-day supply for 2.5 x retail copay; retail 90-day supply for 3 x copay; drugs may require prior authorization*
	Generic drugs			
	Preferred brand-name drugs			
	Non-preferred brand drugs			
	Specialty drugs	Copayment is 25% of the drug cost/prescription (retail & home delivery); 30% coinsurance***		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible/Coinsurance	Deductible/Coinsurance	None
	Physician/surgeon fees	Deductible/Coinsurance	Deductible/Coinsurance	None
If you need immediate medical attention	Emergency room visit	ER Copay	ER Copay	Copay waived if admitted inpatient directly from emergency room
	Related emergency room services	In-network Deductible/Coinsurance		None
	Emergency medical transportation	In-network Deductible/Coinsurance		Prior authorization is required for non-emergency transport*
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible/Coinsurance	Deductible/Coinsurance	Prior authorization is required for elective inpatient stays*
	Physician/surgeon fee	Deductible/Coinsurance	Deductible/Coinsurance	None
If you have mental health, or substance abuse needs	Mental health/substance abuse outpatient office visits	PCP copay	Deductible/Coinsurance	You pay a $0 copay/visit for a Teladoc® visit
	Mental health/substance abuse inpatient services	Deductible/Coinsurance	Deductible/Coinsurance	Prior authorization is required for elective inpatient stays*
	Mental health/substance abuse transitional treatment	Deductible/Coinsurance	Deductible/Coinsurance	None
If you are pregnant	Prenatal and postnatal care	Deductible/Coinsurance	Deductible/Coinsurance	None
	Delivery and all inpatient services	Deductible/Coinsurance	Deductible/Coinsurance	None
If you need help recovering or have other special health needs	Home health care	Deductible/Coinsurance	Deductible/Coinsurance	25 Combined PT/OT/ST visit limit; 6 Massage Therapy visit limit
	Rehabilitative services (therapy)	PCP copay	Deductible/Coinsurance	
	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*
	Durable medical equipment	Deductible/Coinsurance	Deductible/Coinsurance	Prior authorization* required for all CPAP and BIPAP 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*
If your child needs dental or eye care	Routine eye exam	$0	Deductible/Coinsurance	None
	Glasses	Not covered	Not covered	Not covered
	Dental check-up	Not covered	Not covered	Not covered

Preventive care services include routine exams, screenings, immunizations, and other services rated 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.

***Coinsurance for certain specialty drugs considered non-essential health benefits under the plan do not apply to your out-of-pocket limit.

Please see your Summary of Benefits Coverage "Important Questions" regarding the plan's out-of-pocket limit.

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 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 customer 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.

LARGE GROUP HSA-QUALIFIED PLANS

Plan Summary*

HSA—Non-Embedded Deductible

Deductible		Coinsurance		Annual Out-of-Pocket Limit	
In-Network Single Person Plan/ Family Plan	Out-of-Network Single Person Plan/Family Plan	In-Network	Out-of-Network	In-Network Individual/Family	Out-of-Network Individual/Family
$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[1]	$7,750/$15,500[1]
$2,500/$5,000	$2,500/$5,000	20%	40%	$5,500/$11,000[2]	$8,500/$17,000[2]
$3,000/$6,000	$3,000/$6,000	0%	30%	$3,000/$6,000[1]	$7,500/$15,000[1]
$3,000/$6,000	$3,000/$6,000	10%	30%	$4,500/$9,000[2]	$8,250/$16,500[2]
$3,000/$6,000	$3,000/$6,000	20%	40%	$6,000/$12,000[2]	$9,000/$18,000[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 may be automatically adjusted to reflect federal guidelines and remain HSA-qualified.

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

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LARGE GROUP HSA-QUALIFIED PLANS

Plan Summary*

HSA—Embedded Deductible

Deductible		Coinsurance		Annual Out-of-Pocket Limit	
In-Network Individual/Family	Out-of-Network Individual/Family	In-Network	Out-of-Network	In-Network Individual/Family	Out-of-Network Individual/Family
$3,500/$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	$8,750/$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%	$5,500/$11,000	$9,250/$18,500
$4,000/$8,000	$4,000/$8,000	20%	40%	$7,000/$14,000	$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%	$6,000/$12,000	$9,750/$19,500
$4,500/$9,000	$4,500/$9,000	20%	40%	$7,500/$15,000	$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%	$6,500/$13,000	$10,250/$20,500
$5,000/$10,000	$5,000/$10,000	20%	40%	$8,000/$16,000	$11,000/$22,000
$6,000/$12,000	$6,000/$12,000	0%	30%	$6,000/$12,000	$10,500/$21,000
$6,500/$13,000	$6,500/$13,000	0%	30%	$6,500/$13,000	$11,000/$22,000
$7,000/$14,000	$7,000/$14,000	0%	30%	$7,000/$14,000	$11,500/$23,000
$7,500/$15,000	$7,500/$15,000	0%	30%	$7,500/$15,000	$12,000/$24,000
$8,300/$16,600	$8,300/$16,600	0%	30%	$8,300/$16,600	$12,800/$25,600

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.

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Common Medical Event	Services You May Need	Your cost if you use a		Notes
		Preferred Provider	Non-Preferred Provider	
If you visit a health care provider's office or clinic	Primary care office visit	Deductible/Coinsurance	Deductible/Coinsurance	Includes telehealth visits with a Teladoc Health provider
	Specialist office visit	Deductible/Coinsurance	Deductible/Coinsurance	None
	Other practitioner office visit	Deductible/Coinsurance	Deductible/Coinsurance	Includes telehealth visits with a Teladoc Health provider
	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 department of a hospital	Diagnostic tests (x-rays, ultrasounds, Doppler imaging, ECG, and laboratory services)	Deductible/Coinsurance	Deductible/Coinsurance	None
	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.*
If you need drugs to treat your illness or condition**	Preferred generic drugs	Deductible/Coinsurance	Not covered	30-day supply limit for specialty drugs; 90-day supply limit for retail and home delivery drugs; drugs may require prior authorization*
	Generic drugs			
	Preferred brand-name drugs			
	Non-preferred brand drugs			
	Specialty drugs			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible/Coinsurance	Deductible/Coinsurance	None
	Physician/surgeon fees	Deductible/Coinsurance	Deductible/Coinsurance	None
If you need immediate medical attention	Emergency room visit	In-network Deductible/Coinsurance		None
	Emergency medical transportation	In-network Deductible/Coinsurance		Prior authorization is required for non-emergency transport*
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible/Coinsurance	Deductible/Coinsurance	Prior authorization is required for elective inpatient stays*
	Physician/surgeon stay	Deductible/Coinsurance	Deductible/Coinsurance	None
If you have mental health, or substance abuse needs	Mental health/substance abuse outpatient office visits	Deductible/Coinsurance	Deductible/Coinsurance	Includes telehealth visits with a Teladoc® provider
	Mental health/substance abuse inpatient services	Deductible/Coinsurance	Deductible/Coinsurance	Prior authorization is required for elective inpatient stays*
	Mental health/substance abuse transitional treatment	Deductible/Coinsurance	Deductible/Coinsurance	None
If you are pregnant	Prenatal and postnatal care	Deductible/Coinsurance	Deductible/Coinsurance	None
	Delivery and all inpatient services	Deductible/Coinsurance	Deductible/Coinsurance	None
If you need help recovering or have other special health needs	Home health care	Deductible/Coinsurance	Deductible/Coinsurance	Up to 40 visits per year
	Rehabilitative services (therapy)	Deductible/Coinsurance	Deductible/Coinsurance	25 Combined PT/OT/ST visit limit; 6 Massage Therapy visit limit
	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*
	Durable medical equipment	Deductible/Coinsurance	Deductible/Coinsurance	Prior authorization* required for all CPAP and BIPAP 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*
If your child needs dental or eye care	Routine eye exam	$0	Deductible/Coinsurance	None
	Glasses	Not covered	Not covered	Not covered
	Dental check-up	Not covered	Not covered	Not covered

Preventive care services include routine exams, screenings, immunizations, and other services rated 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 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 customer 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.

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