WPS HEALTH PLAN HEALTHYSELECT LARGE GROUP POS VALUE PLAN

Benefit Options*

Primary Care Practitioner/Specialist
Office Visit Copay Options: $25/$50 ▪ $35/$70 ▪ $50/$100

Emergency Room
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[1]		In-Network[2] Annual Maximum Out-of-Pocket Individual/Family	Free PCP Visits[3]
In-Network Individual/Family	Out-of-Network Individual/Family	In-Network	Out-of-Network	In-Network Individual/Family	Out-of-Network Individual/Family		
$500/$1,000	$1,000/$2,000	0%	30%	$500/$1,000	$10,000/$20,000	$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

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

Options continue on next page

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

[2]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.

[3]This plan allows the copayment to be waived for the first three office visits with a primary care practiitioner (PCP), psychiatrist, psychologist, 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 HEALTH PLAN

WPS HEALTH PLAN HEALTHYSELECT LARGE GROUP POS VALUE PLAN

Benefit Options*

Deductible		Coinsurance		Annual Maximum Out-of-Pocket Limit[1]		In-Network[2] Annual Maximum Out-of-Pocket Individual/Family	Free PCP Visits[3]
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	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/$14,701	3
$3,500/$7,000	$7,000/$14,000	10%	30%	$5,000/$10,000	$11,500/$23,000	$7,350/$14,702	3
$3,500/$7,000	$7,000/$14,000	20%	40%	$6,500/$13,000	$13,000/$26,000	$7,350/$14,703	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

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

Options continue on next page

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

[2]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.

[3]This plan allows the copayment to be waived for the first three office visits with a primary care practiitioner (PCP), psychiatrist, psychologist, 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® HEALTH PLAN

WPS HEALTH PLAN HEALTHYSELECT LARGE GROUP POS PLAN

Benefit Options*

Primary Care Practitioner/Specialist
Office Visit Copay Options: $25/$50 ▪ $35/$70 ▪ $50/$100

Emergency Room
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[1]		Free PCP Visits[2]
In-Network Individual/Family	Out-of-Network Individual/Family	In-Network	Out-of-Network	In-Network Individual/Family	Out-of-Network Individual/Family	
$500/$1,000	$1,000/$2,000	0%	30%	$500/$1,000	$10,000/$20,000	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

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Options continue on next page

[1]The Annual Maximum Out-of-Pocket includes deductible, coinsurance, and copays. Copays include prescription drug copays.

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WPS HEALTH PLAN

WPS HEALTH PLAN HEALTHYSELECT LARGE GROUP POS PLAN

Benefit Options*

Deductible		Coinsurance		Annual Maximum Out-of-Pocket Limit[1]		Free PCP Visits[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	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

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

[1]The Annual Maximum Out-of-Pocket includes deductible, coinsurance, and copays. Copays include prescription drug copays.

[2]This plan allows the copayment to be waived for the first three office visits with a primary care practiitioner (PCP), psychiatrist, psychologist, 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 HEALTH PLAN

Common Medical Event	Services You May Need	Your cost if you use a		Notes
		Participating Provider	Non-Participaring Provider	
If you visit a health care provider's office or clinic	Primary care office visit	Copay	Deductible/Coinsurance	You pay a $10 copay/visit for a Teladoc® visit
	Specialist office visit	Copay	Deductible/Coinsurance	None
	Other practitioner office visit	Copay	Deductible/Coinsurance	You pay a $10 copay/visit for a Teladoc® 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**	Generic drugs	Copay	Not Covered	30-day supply limit for specialty drugs; home delivery 90-day supply for 2.5x retail copay; retail 90-day supply for 3x copay: drugs may require prior authorization*
	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	ER Copay	ER Copay	None
	Related emergency room services	Participating Provider Coinsurance		None
	Emergency medical transportation	Participating Provider 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	PCP copay	Deductible/Coinsurance	You pay a $10 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	Up to 40 visits per year
	Rehabilitative services (therapy)	PCP copay	Deductible/Coinsurance	None
	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 purchases and rentals ▪ Purchases over $1,000 ▪ 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 ranked A or B by the U.S. Preventive Services Task Force.
*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.
All services are subject to terms and conditions of the policy.

WPS® HEALTH PLAN

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	▪ Weight-loss programs
▪ Bariatric surgery	▪ Long-term care	▪ Private duty nursing
▪ Cosmetic surgery	▪ Eyeglasses	▪ Non-emergency care when traveling outside the U.S.
▪ Any service deemed experimental or not medically necessary	▪ Routine foot care, unless associated with a specific medical diagnosis	

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 member 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 Health Plan 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 Health Plan group master policy.

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

At WPS Health Plan, we define a "grievance" as meaning any dissatisfaction with us or our administration of your health benefit plan that you express to us in writing.

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

WPS Health Plan, Inc.
Grievance/Appeals
P.O. Box 11625
Green Bay, WI 54307-1626
Fax: 920-490-6922

WPS HEALTH PLAN

WPS HEALTH PLAN HEALTHYSELECT LARGE GROUP POS PLANS
HSA-QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN (HDHP)
Benefit Options*

HSA-Qualified HDHP–Non-Embedded Deductible

Deductible		Coinsurance		Annual Out-of-Pocket Limit	
In-Network Single Person Plan/ Family Plan	Out-of-Network Single Person Plan/ Family Plan	In-Network	Out-of-Network	In-Network Individual/Family	Out-of-Network Individual/Family
$1,500/$3,000	$1,500/$3,000	0%	30%	$1,500/$3,000[1]	$6,000/$12,000[1]
$1,500/$3,000	$1,500/$3,000	20%	40%	$4,500/$9,000[2]	$7,500/$15,000[2]
$2,000/$4,000	$2,000/$4,000	0%	30%	$2,000/$4,000[1]	$6,500/$13,000[1]
$2,000/$4,000	$2,000/$4,000	20%	40%	$5,000/$10,000[2]	$8,000/$16,000[2]
$2,500/$5,000	$2,500/$5,000	0%	30%	$2,500/$5,000[1]	$7,000/$14,000[1]
$2,500/$5,000	$2,500/$5,000	20%	40%	$5,500/$11,000[2]	$8,500/$17,500[2]

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

These plans feature a non-embedded deductible. If an employee has family coverage, the family deductible must be satisfied before these plans will pay benefits. One person 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.

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

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

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

HSAs are administered and/or maintained by a participating financial institution. WPS Health Plan does not operate or administer HSAs.

WPS HEALTH PLAN

HSA-Qualified HDHP–Embedded Deductible

Deductible		Coinsurance		Annual Out-of-Pocket Limit	
In-Network Individual/Family	Out-of-Network Individual/Family	In-Network	Out-of-Network	In-Network Individual/Family	Out-of-Network Individual/Family
$3,000/$6,000	$3,000/$6,000	0%	30%	$3,000/$6,000	$7,500/$15,000
$3,000/$6,000	$3,000/$6,000	20%	40%	$6,000/$12,000	$9,000/$18,000
$3,500/$7,000	$3,500/$7,000	0%	30%	$3,500/$7,000	$8,000/$16,000
$3,500/$7,000	$3,500/$7,000	20%	40%	$6,500/$13,000	$9,500/$19,000
$4,000/$8,000	$4,000/$8,000	0%	30%	$4,000/$8,000	$8,500/$17,000
$4,000/$8,000	$4,000/$8,000	20%	40%	$6,750/$13,500	$10,000/$20,000
$4,500/$9,000	$4,500/$9,000	0%	30%	$4,500/$9,000	$9,000/$10,000
$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. HSAs are administered and/or maintained by a participating financial institution. WPS Health Plan does not operate or administer HSAs.

WPS HEALTH PLAN

Common Medical Event	Services You May Need	Your cost if you use a		Notes
		Participating Provider	Non-Participating 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® provider
	Specialist office visit	Deductible/Coinsurance	Deductible/Coinsurance	None
	Other practitioner office visit	Deductible/Coinsurance	Deductible/Coinsurance	Includes telehealth visits with a Teladoc® 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**	Generic drugs	Participating Deductible/Coinsurance	Not Covered	30-day supply limit for specialty drugs; retail and home delivery 90-day supply; drugs may require prior authorization*
	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	Participating Deductible/Coinsurance		None
	Emergency medical transportation	Participating 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	Include 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	None
	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 purchases and rentals ▪ Purchases over $1,000 ▪ 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	Not Covered	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 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.

WPS® HEALTH PLAN

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	▪ Weight-loss programs
▪ Bariatric surgery	▪ Long-term care	▪ Private duty nursing
▪ Cosmetic surgery	▪ Eyeglasses	▪ Non-emergency care when traveling outside the U.S.
▪ Any service deemed experimental or not medically necessary	▪ Routine foot care, unless associated with a specific medical diagnosis	

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 member 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 Health Plan 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 Health Plan group master policy.

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

At WPS Health Plan, we define a "grievance" as meaning any dissatisfaction with us or our administration of your health benefit plan that you express to us in writing.

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

WPS Health Plan, Inc.
Grievance/Appeals
P.O. Box 11625
Green Bay, WI 54307
Fax: 920-490-6922

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.

Visit: wpshealth.com/healthplan
Call: 866-841-6575
Mail: WPS Health Plan
P.O. Box 11625
Green Bay, WI 54307-1625

WPS HEALTH PLAN

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