WPS HEALTH PLAN HEALTHYSELECT LARGE GROUP HMO VALUE PLANS

Benefit Options[1]

Primary Care Practitioner/Specialist
Office Visit Copay Options: $25/$50 ▪ $35/$70 ▪ $50/$100 Teladoc® Copay: $0

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

Emergency Room
Copay Options: $300 ▪ $500

90-Day Retail Drug Supply at 3x Copay

Deductible	Coinsurance	Annual Out-of-Pocket Limit[2]	In-Network[3] Annual Maximum Out-of-Pocket Individual/Family	Free PCP Visits[4]
In-Network Individual/Family	In-Network	In-Network Individual/Family		
$500/$1,000	0%	$500/$1,000	$7,350/$14,700	3
$500/$1,000	10%	$3,500/$7,000	$7,350/$14,700	3
$500/$1,000	20%	$6,500/$13,000	$7,350/$14,700	3
$1,000/$2,000	10%	$2,500/$5,000	$7,350/$14,700	3
$1,000/$2,000	20%	$4,000/$8,000	$7,350/$14,700	3
$1,000/$2,000	0%	$1,000/$2,000	$7,350/$14,700	3
$1,000/$2,000	10%	$4,000/$8,000	$7,350/$14,700	3
$1,500/$3,000	10%	$3,000/$6,000	$7,350/$14,700	3
$1,500/$3,000	20%	$4,500/$9,000	$7,350/$14,700	3
$1,500/$3,000	0%	$1,500/$3,000	$7,350/$14,700	3
$1,500/$3,000	10%	$4,500/$9,000	$7,350/$14,700	3
$2,000/$4,000	10%	$3,500/$7,000	$7,350/$14,700	3
$2,000/$4,000	20%	$5,000/$10,000	$7,350/$14,700	3
$2,000/$4,000	0%	$2,000/$4,000	$7,350/$14,700	3
$2,000/$4,000	10%	$5,000/$10,000	$7,350/$14,700	3

[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.

[4]These 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® HEALTH PLAN

WPS HEALTH PLAN HEALTHYSELECT LARGE GROUP HMO VALUE PLANS

Benefit Options[1]

Deductible	Coinsurance	Annual Out-of-Pocket Limit[2]	In-Network[3] Annual Maximum Out-of-Pocket Individual/Family	Free PCP Visits[4]
In-Network Individual/Family	In-Network	In-Network Individual/Family		
$2,500/$5,000	10%	$4,000/$8,000	$7,350/$14,700	3
$2,500/$5,000	20%	$5,500/$11,000	$7,350/$14,700	3
$2,500/$5,000	0%	$2,500/$5,000	$7,350/$14,700	3
$2,500/$5,000	10%	$5,500/$11,000	$7,350/$14,700	3
$3,000/$6,000	10%	$4,500/$9,000	$7,350/$14,700	3
$3,000/$6,000	20%	$6,000/$12,000	$7,350/$14,700	3
$3,000/$6,000	0%	$3,000/$6,000	$7,350/$14,700	3
$3,000/$6,000	10%	$6,000/$12,000	$7,350/$14,700	3
$3,500/$7,000	0%	$3,500/$7,000	$7,350/$14,700	3
$3,500/$7,000	10%	$5,000/$10,000	$7,350/$14,700	3
$3,500/$7,000	20%	$6,500/$13,000	$7,350/$14,700	3
$4,000/$8,000	0%	$4,000/$8,000	$7,350/$14,700	3
$4,000/$8,000	10%	$5,500/$11,000	$7,350/$14,700	3
$4,000/$8,000	20%	$7,000/$14,000	$7,350/$14,700	3
$4,500/$9,000	0%	$4,500/$9,000	$7,350/$14,700	3
$4,500/$9,000	10%	$6,000/$12,000	$7,350/$14,700	3
$4,500/$9,000	20%	$7,350/$14,700	$7,350/$14,700	3
$5,000/$10,000	0%	$5,000/$10,000	$7,350/$14,700	3
$5,000/$10,000	10%	$6,500/$13,000	$7,350/$14,700	3
$5,000/$10,000	20%	$7,350/$14,700	$7,350/$14,700	3
$5,500/$11,000	0%	$5,500/$11,000	$7,350/$14,700	3
$5,500/$11,000	10%	$7,000/$14,000	$7,350/$14,700	3
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[1]Additional benefit options may be available for experience-rated groups.

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Drug Coverage Options: $10/$35/$60/25% to $350 ▪ $15/$45/$80/25% to $350 ▪ $20/$50/$100/25% to $350

Emergency Room
Copay Options: $300 ▪ $500

90-Day Retail Drug Supply at 3x Copay

Deductible	Coinsurance	Annual Out-of-Pocket Limit[2]	Free PCP Visits[3]
In-Network Individual/Family	In-Network	In-Network Individual/Family	
$500/$1,000	0%	$500/$1,000	3
$500/$1,000	10%	$3,500/$7,000	3
$500/$1,000	20%	$6,500/$13,000	3
$1,000/$2,000	10%	$2,500/$5,000	3
$1,000/$2,000	20%	$4,000/$8,000	3
$1,000/$2,000	0%	$1,000/$2,000	3
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$2,000/$4,000	10%	$3,500/$7,000	3
$2,000/$4,000	20%	$5,000/$10,000	3
$2,000/$4,000	0%	$2,000/$4,000	3
$2,000/$4,000	10%	$5,000/$10,000	3

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WPS HEALTH PLAN HEALTHYSELECT LARGE GROUP HMO PLANS

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$2,500/$5,000	20%	$5,500/$11,000	3
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$2,500/$5,000	10%	$5,500/$11,000	3
$3,000/$6,000	10%	$4,500/$9,000	3
$3,000/$6,000	20%	$6,000/$12,000	3
$3,000/$6,000	0%	$3,000/$6,000	3
$3,000/$6,000	10%	$6,000/$12,000	3
$3,500/$7,000	0%	$3,500/$7,000	3
$3,500/$7,000	10%	$5,000/$10,000	3
$3,500/$7,000	20%	$6,500/$13,000	3
$4,000/$8,000	0%	$4,000/$8,000	3
$4,000/$8,000	10%	$5,500/$11,000	3
$4,000/$8,000	20%	$7,000/$14,000	3
$4,500/$9,000	0%	$4,500/$9,000	3
$4,500/$9,000	10%	$6,000/$12,000	3
$4,500/$9,000	20%	$7,350/$14,700	3
$5,000/$10,000	0%	$5,000/$10,000	3
$5,000/$10,000	10%	$6,500/$13,000	3
$5,000/$10,000	20%	$7,350/$14,700	3
$5,500/$11,000	0%	$5,500/$11,000	3
$5,500/$11,000	10%	$7,000/$14,000	3
$5,500/$11,000	20%	$7,350/$14,700	3

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

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

[3]These 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 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	Copay	Not Covered	You pay a $0 copay/visit for a Teladoc® visit
	Specialist office visit	Copay	Not Covered	None
	Other practitioner office visit	Copay	Not Covered	You pay a $0 copay/visit for a Teladoc® visit
	Preventive care/screening	$0	Not Covered	None
	Immunizations	$0	Not Covered	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	Not Covered	None
	High Technology Imaging (CCTA/MRA/MRI/MRV, and CT/PET/SPECT scans)	Deductible/Coinsurance	Not Covered	Prior authorization is required for most high technology imaging services.*
If you need drugs to treat your illness or condition**	Generic drugs	Copay 25% up to $350	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	Not Covered	None
	Physician/surgeon fees	Deductible/Coinsurance	Not Covered	None
If you need immediate medical attention	Emergency room visit	ER Copay	ER Copay	None
	Related emergency room services	Participating 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	Not Covered	Prior authorization is required for elective inpatient stays*
	Physician/surgeon stay	Deductible/Coinsurance	Not Covered	None
If you have mental health or substance abuse needs	Mental health/substance abuse outpatient office visits	PCP Copay	Not Covered	You pay a $0 copay/visit for a Teladoc® visit
	Mental health/substance abuse inpatient services	Deductible/Coinsurance	Not Covered	Prior authorization is required for elective inpatient stays*
	Mental health/substance abuse transitional treatment	Deductible/Coinsurance	Not Covered	None
If you are pregnant	Prenatal and postnatal care	Deductible/Coinsurance	Not Covered	None
	Delivery and all inpatient services	Deductible/Coinsurance	Not Covered	None
If you need help recovering or have other special health needs	Home health care	Deductible/Coinsurance	Not Covered	Up to 40 visits per year
	Rehabilitative services (therapy)	PCP Copay	Not Covered	None
	Skilled nursing care in a licensed skilled nursing facility	Deductible/Coinsurance	Not Covered	Up to 30 days per confinement; prior authorization is required for an elective admission*
	Durable medical equipment	Deductible/Coinsurance	Not Covered	Prior authorization required for: ▪ All CPAP purchases ▪ Purchases over $1,000 ▪ All other rentals as stated on our website
	Hospice service	Deductible/Coinsurance	Not Covered	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 not medically necessary or experimental	▪ 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 also 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 Support 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 7062
Madison, WI 53707-7062
Fax: 608-327-6320

WPS HEALTH PLAN

WPS HEALTH PLAN HEALTHYSELECT LARGE GROUP HMO | PLAN SUMMARY: HIGH DEDUCTIBLE HEALTH PLANS (HDHP)

Benefit Options*

HSA-Qualified HDHP Non-Embedded Deductible

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

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.

HSAs are administered and/or maintained by a participating financial institution. WPS Health Plan does not operate or administer HSAs. Each year, your plan's deductible will be automatically adjusted to reflect federal guidelines and remain HSA-qualified.

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

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

HSA-Qualified HDHP Embedded Deductible

Deductible	Coinsurance	Annual Out-of-Pocket Limit[3]
In-Network Individual/Family	In-Network	In-Network Individual/Family
$3,000/$6,000	0%	$3,000/$6,000
$3,000/$6,000	10%	$4,500/$9,000
$3,000/$6,000	20%	$6,000/$12,000
$3,500/$7,000	0%	$3,500/$7,000
$3,500/$7,000	10%	$5,000/$10,000
$3,500/$7,000	20%	$6,500/$13,000
$4,000/$8,000	0%	$4,000/$8,000
$4,000/$8,000	10%	$5,375/$10,750
$4,000/$8,000	20%	$6,750/$13,500
$4,500/$9,000	0%	$4,500/$9,000
$4,500/$9,000	10%	$5,625/$11,250
$4,500/$9,000	20%	$6,750/$13,500
$5,000/$10,000	0%	$5,000/$10,000
$5,000/$10,000	10%	$5,875/$11,750
$5,000/$10,000	20%	$6,750/$13,500
$6,350/$12,700	0%	$6,350/$12,700
$7,500/$15,000	0%	$7,500/$15,000

These plans feature an embedded deductible. Once a family member reaches the individual deductible amount, these plans will begin to pay benefits for him or her only. Once the family deductible amount is reached, this plan will begin to pay benefits for each member of the family. HSAs are administered and/or maintained by a participating financial institution. WPS Health Plan does not operate or administer HSAs.

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

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

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	Not Covered	Includes telehealth visits with a Teladoc® provider
	Specialist office visit	Deductible/Coinsurance	Not Covered	None
	Other practitioner office visit	Deductible/Coinsurance	Not Covered	Includes telehealth visits with a Teladoc® provider
	Preventive care/screening	$0	Not Covered	None
	Immunizations	$0	Not Covered	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	Not Covered	None
	High Technology Imaging (CCTA/MRA/MRI/MRV, and CT/PET/SPECT scans)	Deductible/Coinsurance	Not Covered	Prior authorization is required for most high technology imaging services.*
If you need drugs to treat your illness or condition**	Generic drugs	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	Not Covered	None
	Physician/surgeon fees	Deductible/Coinsurance	Not Covered	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	Not Covered	Prior authorization is required for elective inpatient stays*
	Physician/surgeon stay	Deductible/Coinsurance	Not Covered	None
If you have mental health or substance abuse needs	Mental health/substance abuse outpatient office visits	Deductible/Coinsurance	Not Covered	Includes telehealth visits with a Teladoc® provider
	Mental health/substance abuse inpatient services	Deductible/Coinsurance	Not Covered	Prior authorization is required for elective inpatient stays*
	Mental health/substance abuse transitional treatment	Deductible/Coinsurance	Not Covered	None
If you are pregnant	Prenatal and postnatal care	Deductible/Coinsurance	Not Covered	None
	Delivery and all inpatient services	Deductible/Coinsurance	Not Covered	None
If you need help recovering or have other special health needs	Home health care	Deductible/Coinsurance	Not Covered	Up to 40 visits per year
	Rehabilitative services (therapy)	Deductible/Coinsurance	Not Covered	None
	Skilled nursing care in a licensed skilled nursing facility	Deductible/Coinsurance	Not Covered	Up to 30 days per confinement; prior authorization is required for an elective admission*
	Durable medical equipment	Deductible/Coinsurance	Not Covered	Prior authorization required for: ▪ All CPAP purchases ▪ Purchases over $1,000 ▪ All other rentals as stated on our website
	Hospice service	Deductible/Coinsurance	Not Covered	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 not medically necessary or experimental	▪ 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

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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.

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If a participant has a question or concern that can't be resolved by our Customer Support 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 7062
Madison, WI 53707-7062
Fax: 608-327-6320

WPS HEALTH PLAN

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: 800-223-6029
Mail: WPS Health Plan
P.O. Box 8190
Madison, WI 53708-8190

WPS HEALTH PLAN

29114-085-2209