WPS HEALTH INSURANCE

Trevor Wilmot Consolidated Grade School
Outline of Benefits – Copay Plan
Effective July 1, 2023

PROVISION/BENEFIT	PREFERRED PROVIDERS What you pay	NON-PREFERRED PROVIDERS What you pay
Deductible		
Per Covered Person	$4,000	$8,000
Per Family	$8,000	$16,000
Coinsurance		
Coinsurance	0%	30%
Annual Out-of-Pocket Limit (includes deductible and coinsurance)		
Per Covered Person	$4,000	$17,000
Per Family	$8,000	$34,000
Maximum Annual Out-of-Pocket Limit (includes deductible, coinsurance & all copayments)		
Per Covered Person	$7,350	Not Applicable
Per Family	$14,700	Not Applicable
Covered Expenses (not including covered drugs and covered supplies dispenses by a pharmacy)		
PROVISION/BENEFIT	**PREFERRED PROVIDERS What you pay**	**NON-PREFERRED PROVIDERS What you pay**
Ambulance services**	Deductible and Coinsurance	Preferred Provider Deductible and Coinsurance
Chiropractic office visit/manipulations	$50 Copayment, then 0%	Deductible and Coinsurance
Contraceptives	You have no cost sharing responsibility	Deductible and Coinsurance
Diagnostic x-rays, ultrasounds, Doppler imaging, ECG, and laboratory services** – outpatient	Coinsurance	Deductible and Coinsurance
Durable medical equipment**	Deductible and Coinsurance	Deductible and Coinsurance
Emergency Medical Care	Deductible, Coinsurance, or applicable Copayment	Preferred Provider Deductible, Coinsurance, or applicable Copayment
Emergency room – visit charge only	$500 Copayment, then 0%	$500 Copayment, then 0%
Emergency room services (excluding high technology imaging)	Coinsurance	Preferred Provider Coinsurance
High Technology Imaging (MRI, MRA, MRV, CT, CCTA, PET, SPECT) ** - outpatient	Deductible and Coinsurance	Deductible and Coinsurance
Home care – limited to 40 visits per year	Deductible and Coinsurance	Deductible and Coinsurance
Hospital inpatient services**	Deductible and Coinsurance	Deductible and Coinsurance
Immunizations	You have no cost sharing responsibility	You have no cost sharing responsibility
Injections - outpatient	Coinsurance	Deductible and Coinsurance
Kidney disease treatment	Deductible and Coinsurance	Deductible and Coinsurance
Maternity services	Deductible and Coinsurance	Deductible and Coinsurance
Medical supplies	Deductible and Coinsurance	Deductible and Coinsurance
Nutritional counseling	You have no cost sharing responsibility	Deductible and Coinsurance
Office visits – visit charge only Primary Care Practitioner, Psychologist, Psychiatrist, Licensed Mental Health Professional	$50 Copayment, then 0%-Waived for the first three visits	Deductible and Coinsurance
Specialist	$100 Copayment, then 0%	Deductible and Coinsurance
Convenient Care Clinic	$50 Copayment, then 0%	Deductible and Coinsurance
Teladoc ®	$0 Copayment, then 0%	Not Applicable
Preventive care services* (includes routine eye exams for children and adults)	You have no cost sharing responsibility	Deductible and Coinsurance
Surgical services	Deductible and Coinsurance	Deductible and Coinsurance
Therapy visits (physical/ speech/occupational) Office setting Home or outpatient hospital setting	 $50 Copayment, then 0% Deductible and Coinsurance	 Deductible and Coinsurance Deductible and Coinsurance
Transplant services** Inpatient services Outpatient services	 Deductible and Coinsurance Deductible and Coinsurance	 Deductible, 50% Coinsurance Deductible and Coinsurance
Urgent Care – visit charge only Copayment could be higher depending on the specialty of the physician providing treatment	$50 Copayment, then 0%	Deductible and Coinsurance unless Emergency Medical Care (see benefit above)
Urgent Care Services (excluding high technology imaging)	Coinsurance	Deductible and Coinsurance unless Emergency Medical Care (see benefit above)
All other health care services – unless otherwise stated in your plan	Deductible and Coinsurance	Deductible and Coinsurance
Covered Drugs and Covered Supplies (Covered drugs or covered supplies dispensed by a non-preferred pharmacy are limited to the amount that would have been payable if dispensed by a preferred pharmacy.)		
	Copayment for prescription drugs and certain diabetic supplies dispensed by a preferred retail pharmacy:	Copayment for prescription drugs and certain diabetic supplies dispensed by a non-preferred retail pharmacy:
Generic drug Preferred brand-name drug Brand-name drug Specialty drug**	$20 $50 $100 25% to $350 • Oral chemotherapy drugs are limited to $100 copayment per 30-day supply • Home delivery is 2.5 times the retail pharmacy copayment	$20 $50 $100 25% to $350 • Oral chemotherapy drugs are limited to $100 copayment per 30-day supply • Home delivery is 2.5 times the retail pharmacy copayment
Preventive drugs: As required by the Affordable Care Act and defined in the Policy. Also includes additional preventive drugs at no cost to you (refer to $0 Drug List for details). Includes Expanded Preventive Drug List	You have no cost sharing responsibility.	You have no cost sharing responsibility.
Covered Drugs and Covered Supplies Limitations for Preferred and Non-Preferred Pharmacies		
Retail pharmacy copayments applied as follows:	1-30-day supply = one copayment 31-60-day supply = two copayments 61-90-day supply = three copayments	
Limitations	Retail and Home Delivery: 90-day supply Specialty drugs and Chemotherapy drugs: 30-day supply Smoking Cessation – Limited to 180-day supply	
Mandatory generic & Step therapy	Applicable If brand is dispensed when a generic is available, you are responsible for the cost difference between brand and generic (does not apply to your out-of-pocket limit).	

This is a brief summary of benefits created from a sales quote presentation. Finalized benefits will take precedence over any benefit information presented in this outline.

* Includes preventive screenings as required by the United States Preventive Services Task Force (USPSTF)

** Some services may require prior authorization. Please go to our website wpshealth.com for further information.