WPS Health Insurance: Preferred Provider Plan

Coverage Period: 1/1/17-12/31/17

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for: Individual & Family | Plan Type: PPO**

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.wpsic.com or by calling 1-800-223-6048.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Preferred Provider: $400 Person/$800 Family. Non-Preferred Provider: $800 Person/$1,600 Family. Doesn't apply to preventive services, injections, x-rays, labs, office, Teladoc & ER visits by a preferred provider and drugs purchased at a pharmacy. Copays don't count toward the **deductible.**	You must pay all the costs up to the **deductible** amount before the policy begins to pay for covered services you use. Check your certificate to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered servicers after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services the policy covers.
Is there an out–of–pocket limit on my expenses?	Yes. Preferred Providers: $650 Person/ $1,300 Family (excludes copays), up to a maximum out-of-pocket (includes copays) of $7,150 Person/$14,300 Family. For Non-Preferred Providers: $2,300 per Person /$4,600 Family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Penalties, premiums, balance-billed charges, and health care the policy doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. see www.wpsic.com or call 1-800-223-6048 for a list of preferred providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No, You don't need a referral to see a specialist	You can see the **specialist** you choose without permission from WPS.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-800-223-6048 or visit us at www.wpsic.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.wpsic.com or call 1-800-223-6048 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If a non-preferred **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-preferred hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **preferred providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	30% coinsurance	You pay a $10 copay/visit for telehealth visits through Teladoc
	Specialist visit	$20 copay/visit	30% coinsurance	You pay a $10 copay/visit for telehealth visits through Teladoc
	Other practitioner office visit	$20 copay/visit	30% coinsurance	None
	Preventive care/screening/immunization	0% coinsurance	30% coinsurance	You pay $0 for immunizations.
If you have a test	Diagnostic test (x-ray, blood work)	5% coinsurance	30% coinsurance	Certain genetic tests require prior authorization
	Imaging (CT/PET scans, MRIs)	5% coinsurance	30% coinsurance	MRA, MRS and PET scans require prior authorization

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.wpsic.com.	Generic drugs	$10 retail copay/$20 home delivery copay per prescription	$10 retail copay/$20 home delivery copay per prescription	Limited to: Retail: 30-day supply; Home Delivery: 90-day supply. Certain drugs require prior authorization.
	Preferred brand drugs	$40 retail copay/$80 home delivery copay per prescription	$40 retail copay/$80 home delivery copay per prescription	Limited to: Retail: 30-day supply; Home Delivery: 90-day supply. Certain drugs require prior authorization.
	Non-preferred brand drugs	$60 retail copay /$120 home delivery copay per prescription	$60 retail copay /$120 home delivery copay per prescription	Limited to: Retail: 30-day supply; Home Delivery: 90-day supply. Certain drugs require prior authorization.
	Specialty drugs	$60 retail copay /$120 home delivery copay per prescription	$60 retail copay /$120 home delivery copay per prescription	Limited to a 30-day supply. Certain drugs require prior authorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	5% coinsurance	30% coinsurance	None
	Physician/surgeon fees	5% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room services	$100 copay for ER facility fee; 5% ER miscellaneous charges	$100 copay for ER facility fee; 5% ER miscellaneous charges	Deductible amounts are waived
	Emergency medical transportation	5% coinsurance	5% coinsurance	None
	Urgent care	$100 co-pay for ER facility fee; 5% ER miscellaneous charges	$100 co-pay for ER facility fee; 5% ER miscellaneous charges	Deductible amounts are waived
If you have a hospital stay	Facility fee (e.g., hospital room)	5% coinsurance	30% coinsurance	Non-emergency admissions require prior authorization
	Physician/surgeon fee	5% coinsurance	30% coinsurance	None

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 co-pay/office visits and 5% co-insurance other outpatient services	30% coinsurance	None
	Mental/Behavioral health inpatient services	5% coinsurance	30% coinsurance	Non-emergency admissions require prior authorization
	Substance use disorder outpatient services	$20 co-pay/office visits and 5% co-insurance other outpatient services	30% coinsurance	None
	Substance use disorder inpatient services	5% coinsurance	30% coinsurance	Non-emergency admissions require prior authorization
If you are pregnant	Prenatal and postnatal care	5% coinsurance	30% coinsurance	None
	Delivery and all inpatient services	5% coinsurance	30% coinsurance	None
If you need help recovering or have other special health needs	Home health care	5% coinsurance	5% coinsurance	Limited to 40 visits per year. Deductible amounts waived
	Rehabilitation services	5% coinsurance	30% coinsurance	None
	Habilitation services	5% coinsurance	30% coinsurance	None
	Skilled nursing care	5% coinsurance	30% coinsurance	Limited to 30 days confinement in a skilled nursing facility. Non-emergency admissions require prior authorization
	Durable medical equipment	5% coinsurance	30% coinsurance	Prior authorization required for: All CPAP purchases and rentals Purchases over $1,000. All other rentals as stated on our website
	Hospice service	5% coinsurance	5% coinsurance	Hospice services require prior authorization. Deductible amounts waived
If your child needs dental or eye care	Eye exam	0% coinsurance	30% coinsurance	None
	Glasses	100%	100%	Not Covered
	Dental check-up	100%	100%	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Bariatric Surgery
- Cosmetic Surgery
- Dental Check-Up
- Eyeglasses
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside U.S.
- Private duty nursing
- Routine foot care, unless associated with a specific medical diagnosis
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture - limited to adults over age 18 for postoperative nausea and vomiting, nausea and vomiting due to anti-neoplastic agents, and postoperative dental pain
- Chiropractic Care
- Dental Care (adult), 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, every three years
- Routine eye care (adult), limited to eye exams

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact WPS at 1-800-223-6048. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: For group health coverage subject to ERISA, contact WPS at 1-800-223-6048 or www.wpsic.com. You may also contact your state insurance department at 1-800-236-8517. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. For non-federal governmental group health plans and church plans that are group health plans, contact WPS at 1-800-223-6048. You may also contact your state insurance department at 1-800-236-8517.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $3,990
- **Patient pays** $3,550

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,500
Copays	$90
Coinsurance	$960
Limits or exclusions	$0
Total	**$3,550**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,300
- **Patient pays** $2,100

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,600
Copays	$480
Coinsurance	$20
Limits or exclusions	$0
Total	**$2,100**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

WPS Health Insurance: Preferred Provider Plan

Coverage Period: 1/1/17-12/31/17

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for: Individual & Family | Plan Type: HDHP**

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.wpsic.com or by calling 1-800-223-6048.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Preferred Provider: $1,500 Per Single Coverage/$3,000 Per Family Coverage. Non-Preferred Provider: $1,500 Per Single Coverage/$3,000 Per Family Coverage. Doesn't apply to preventive services by a preferred provider and preventive drugs purchased at a pharmacy.	You must pay all the costs up to the **deductible** amount before the policy begins to pay for covered services you use. Check your certificate to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered servicers after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services the policy covers.
Is there an out–of–pocket limit on my expenses?	Yes. For Preferred Providers: $1,500 Per Single Coverage/$3,000 Per Family Coverage. For Non-Preferred Providers: $3,000 Per Single Coverage/$6,000 Per Family Coverage.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Penalties, premiums, balance-billed charges, and health care the policy doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for specific services, such as office visits.
Does this plan use a network of providers?	Yes. see www.wpsic.com or call 1-800-223-6048 for a list of preferred providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No, You don't need a referral to see a specialist	You can see the **specialist** you choose without permission from WPS.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-800-223-6048 or visit us at www.wpsic.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.wpsic.com or call 1-800-223-6048 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If a non-preferred **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-preferred hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **preferred providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	30% coinsurance	Includes telehealth visits through Teledoc
	Specialist visit	0% coinsurance	30% coinsurance	Includes telehealth visits through Teledoc
	Other practitioner office visit	0% coinsurance	30% coinsurance	None
	Preventive care/screening/immunization	0% coinsurance	30% coinsurance	You pay $0 for immunizations
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	30% coinsurance	Certain genetic tests require prior authorization
	Imaging (CT/PET scans, MRIs)	0% coinsurance	30% coinsurance	MRA, MRS and PET scans require prior authorization

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.wpsic.com.	Generic drugs	0% coinsurance	0% coinsurance	Limited to: Retail: 30-day supply; Home Delivery: 90-day supply. Certain drugs require prior authorization.
	Preferred brand drugs	0% coinsurance	0% coinsurance	Limited to: Retail: 30-day supply; Home Delivery: 90-day supply. Certain drugs require prior authorization.
	Non-preferred brand drugs	0% coinsurance	0% coinsurance	Limited to: Retail: 30-day supply; Home Delivery: 90-day supply. Certain drugs require prior authorization.
	Specialty drugs	0% coinsurance	0% coinsurance	Limited to a 30-day supply. Certain drugs require prior authorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	30% coinsurance	None
	Physician/surgeon fees	0% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room services	0% coinsurance	0% coinsurance	None
	Emergency medical transportation	0% coinsurance	0% coinsurance	None
	Urgent care	0% coinsurance	0% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	30% coinsurance	Non-emergency admissions require prior authorization
	Physician/surgeon fee	0% coinsurance	30% coinsurance	None

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	0% coinsurance	30% coinsurance	None
	Mental/Behavioral health inpatient services	0% coinsurance	30% coinsurance	Non-emergency admissions require prior authorization
	Substance use disorder outpatient services	0% coinsurance	30% coinsurance	None
	Substance use disorder inpatient services	0% coinsurance	30% coinsurance	Non-emergency admissions require prior authorization
If you are pregnant	Prenatal and postnatal care	0% coinsurance	30% coinsurance	None
	Delivery and all inpatient services	0% coinsurance	30% coinsurance	None
If you need help recovering or have other special health needs	Home health care	0% coinsurance	30% coinsurance	Limited to 40 visits per year
	Rehabilitation services	0% coinsurance	30% coinsurance	None
	Habilitation services	0% coinsurance	30% coinsurance	None
	Skilled nursing care	0% coinsurance	30% coinsurance	Limited to 30 days confinement in a skilled nursing facility. Non-emergency admissions require prior authorization
	Durable medical equipment	0% coinsurance	30% coinsurance	Prior authorization required for: All CPAP purchases and rentals Purchases over $1,000. All other rentals as stated on our website
	Hospice service	0% coinsurance	30% coinsurance	Hospice services require prior authorization
If your child needs dental or eye care	Eye exam	0% coinsurance	30% coinsurance	None
	Glasses	100%	100%	Not Covered
	Dental check-up	100%	100%	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Bariatric Surgery
- Cosmetic Surgery
- Dental Check-Up
- Eyeglasses
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside US
- Routine foot care, unless associated with a specific medical diagnosis
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture - limited to adults over age 18 for postoperative nausea and vomiting, nausea and vomiting due to anti-neoplastic agents, and postoperative dental pain
- Chiropractic Care
- Dental Care (adult), 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
- Private duty nursing
- Routine eye care (adult), limited to eye exams

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact WPS at 1-800-223-6048. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:.

For group health coverage subject to ERISA, contact WPS at 1-800-223-6048 or www.wpsic.com. You may also contact your state insurance department at 1-800-236-8517. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

For non-federal governmental group health plans and church plans that are group health plans, contact WPS at 1-800-223-6048. You may also contact your state insurance department at 1-800-236-8517.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,040
- **Patient pays** $1,500

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,500
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$1,500**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,900
- **Patient pays** $1,500

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,500
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$2,500**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

WPS Health Insurance: Preferred Provider Plan

Coverage Period: 1/1/17-12/31/17

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for: Individual & Family | Plan Type: HDHP**

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.wpsic.com or by calling 1-800-223-6048.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Preferred Provider: $2,500 Per Single Coverage/$5,000 Per Family Coverage. Non-Preferred Provider: $2,500 Per Single Coverage/$5,000 Per Family Coverage. Doesn't apply to preventive services by a preferred provider and preventive drugs purchased at a pharmacy.	You must pay all the costs up to the **deductible** amount before the policy begins to pay for covered services you use. Check your certificate to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered servicers after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services the policy covers.
Is there an out–of–pocket limit on my expenses?	Yes. For Preferred Providers: $2,500 Per Single Coverage/$5,000 Per Family Coverage. For Non-Preferred Providers: $4,000 Per Single Coverage/$8,000 Per Family Coverage.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Penalties, premiums, balance-billed charges, and health care the policy doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for specific services, such as office visits.
Does this plan use a network of providers?	Yes. see www.wpsic.com or call 1-800-223-6048 for a list of preferred providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No, You don't need a referral to see a specialist	You can see the **specialist** you choose without permission from WPS.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-800-223-6048 or visit us at www.wpsic.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.wpsic.com or call 1-800-223-6048 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If a non-preferred **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-preferred hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **preferred providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	30% coinsurance	Includes telehealth visits through Teledoc
	Specialist visit	0% coinsurance	30% coinsurance	Includes telehealth visits through Teledoc
	Other practitioner office visit	0% coinsurance	30% coinsurance	None
	Preventive care/screening/immunization	0% coinsurance	30% coinsurance	You pay $0 for immunizations
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	30% coinsurance	Certain genetic tests require prior authorization
	Imaging (CT/PET scans, MRIs)	0% coinsurance	30% coinsurance	MRA, MRS and PET scans require prior authorization

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.wpsic.com.	Generic drugs	0% coinsurance	0% coinsurance	Limited to: Retail: 30-day supply; Home Delivery: 90-day supply. Certain drugs require prior authorization.
	Preferred brand drugs	0% coinsurance	0% coinsurance	Limited to: Retail: 30-day supply; Home Delivery: 90-day supply. Certain drugs require prior authorization.
	Non-preferred brand drugs	0% coinsurance	0% coinsurance	Limited to: Retail: 30-day supply; Home Delivery: 90-day supply. Certain drugs require prior authorization.
	Specialty drugs	0% coinsurance	0% coinsurance	Limited to a 30-day supply. Certain drugs require prior authorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	30% coinsurance	None
	Physician/surgeon fees	0% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room services	0% coinsurance	0% coinsurance	None
	Emergency medical transportation	0% coinsurance	0% coinsurance	None
	Urgent care	0% coinsurance	0% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	30% coinsurance	Non-emergency admissions require prior authorization
	Physician/surgeon fee	0% coinsurance	30% coinsurance	None

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	0% coinsurance	30% coinsurance	None
	Mental/Behavioral health inpatient services	0% coinsurance	30% coinsurance	Non-emergency admissions require prior authorization
	Substance use disorder outpatient services	0% coinsurance	30% coinsurance	None
	Substance use disorder inpatient services	0% coinsurance	30% coinsurance	Non-emergency admissions require prior authorization
If you are pregnant	Prenatal and postnatal care	0% coinsurance	30% coinsurance	None
	Delivery and all inpatient services	0% coinsurance	30% coinsurance	None
If you need help recovering or have other special health needs	Home health care	0% coinsurance	30% coinsurance	Limited to 40 visits per year
	Rehabilitation services	0% coinsurance	30% coinsurance	None
	Habilitation services	0% coinsurance	30% coinsurance	None
	Skilled nursing care	0% coinsurance	30% coinsurance	Limited to 30 days confinement in a skilled nursing facility. Non-emergency admissions require prior authorization
	Durable medical equipment	0% coinsurance	30% coinsurance	Prior authorization required for: All CPAP purchases and rentals Purchases over $1,000 All other rentals as stated on our website
	Hospice service	0% coinsurance	30% coinsurance	Hospice services require prior authorization
If your child needs dental or eye care	Eye exam	0% coinsurance	30% coinsurance	None
	Glasses	100%	100%	Not Covered
	Dental check-up	100%	100%	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Bariatric Surgery
- Cosmetic Surgery
- Dental Check-Up
- Eyeglasses
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside US
- Routine foot care, unless associated with a specific medical diagnosis
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture - limited to adults over age 18 for postoperative nausea and vomiting, nausea and vomiting due to anti-neoplastic agents, and postoperative dental pain
- Chiropractic Care
- Dental Care (adult), 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
- Private duty nursing
- Routine eye care (adult), limited to eye exams

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact WPS at 1-800-223-6048. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:.

For group health coverage subject to ERISA, contact WPS at 1-800-223-6048 or www.wpsic.com. You may also contact your state insurance department at 1-800-236-8517. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

For non-federal governmental group health plans and church plans that are group health plans, contact WPS at 1-800-223-6048. You may also contact your state insurance department at 1-800-236-8517.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,040
- **Patient pays** $2,500

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,500
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$2,500**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,900
- **Patient pays** $2,500

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,500
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$2,500**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.