WPS HEALTH INSURANCE

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: 07/01/2017 – 06/30/2018

Mellen Schools-Northern School District Trust

Coverage for: Individual/Family | **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, at www.wpsic.com or call 1-800-223-6048. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary /or call 1-800-223-6048 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For preferred providers: $2,000/ Single Coverage or $4,000/Family; For non-preferred providers: $2,000/Single Coverage or $4,000/Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For preferred providers: $2,000 Single Coverage/ $4,000 For non-preferred providers: $2,500 Single Coverage /$5,000 Family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://connect.wpsic.com/Gateway/commercialGateway/unauth/fadHome.do or call 1-800-223-6048 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	20% coinsurance	Includes telehealth visits through Teladoc
	Specialist visit	0% coinsurance	20% coinsurance	None
	Preventive care/screening/ immunization	No charge	20% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. You also have no charge for immunizations provided by a nonparticipating provider.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	20% coinsurance	Certain genetic tests and high-technology imaging require prior authorization. Benefits may not be payable if you fail to obtain prior authorization.
	Imaging (CT/PET scans, MRIs)	0% coinsurance	20% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.wpsic.com/files/2017-express-scripts-formulary.pdf	Generic drugs	0% coinsurance	0% coinsurance	Covers up to a 30-day supply retail/90-day supply home delivery; however, specialty drugs are always limited to a 30-day supply. If brand dispensed when generic available, you are responsible for dollar amount difference between brand and generic. Specialty drugs and drugs provided by an entity other than a pharmacy require prior authorization. Benefits may not be payable if you fail to obtain prior authorization
	Preferred brand drugs	0% coinsurance	0% coinsurance	
	Non-preferred brand drugs	0% coinsurance	0% coinsurance	
	Specialty drugs	0% coinsurance	0% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	20% coinsurance	None
	Physician/surgeon fees	0% coinsurance	20% coinsurance	None
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	None
	Emergency medical transportation	0% coinsurance	0% coinsurance	
	Urgent care	0% coinsurance	0% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	20% coinsurance	All non-emergent inpatient hospital stays require prior authorization. Benefits may not

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
				be payable if you fail to obtain prior authorization.
	Physician/surgeon fees	0% coinsurance	20% coinsurance	All non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you fail to obtain prior authorization.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	20% coinsurance	All non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you fail to obtain prior authorization.
	Inpatient services	0% coinsurance	20% coinsurance	
If you are pregnant	Office visits	0% coinsurance	20% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). All non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you fail to obtain prior authorization.
	Childbirth/delivery professional services	0% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	20% coinsurance	Limited to 100 visits per year
	Rehabilitation services	0% coinsurance	20% coinsurance	None
	Habilitation services	0% coinsurance	20% coinsurance	
	Skilled nursing care	0% coinsurance	20% coinsurance	Limited to 30 days combined for in & out of network providers. All non-emergent admissions require prior authorization. Benefits may not be payable if you fail to obtain prior authorization.
	Durable medical equipment	0% coinsurance	20% coinsurance	Prior authorization required for: • All CPAP purchases and rentals • Purchases over $1,000 • All other rentals as stated on our website Benefits may not be payable if you fail to obtain prior authorization.
	Hospice services	0% coinsurance	20% coinsurance	Hospice services require prior authorization. Benefits may not be payable if you fail to obtain prior authorization.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	0% coinsurance	20% coinsurance	None
	Children's glasses	Not covered	Not covered	Not Covered
	Children's dental check-up	Not covered	Not covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Abortion (except when the life of the mother is endangered) • Bariatric Surgery • Cosmetic Surgery	• Infertility treatment • Long Term Care • Non-emergency care when traveling outside the U.S.	• Private Duty Nursing • Routine Foot Care • Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture, limited to adults over age 18 for postoperative nausea and vomiting, nausea and vomiting due to anti-neoplastc 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 18, every three years	• Routine eye care (Adult), limited to eye exams

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: for the U.S. Department of Labor, Employee Benefits Security Administration 1-866-444-3272 or www.dol.gov/ebsa, or the Department of Health and Human Services at 1-877-267-2323 x 61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: WPS at 1-800-223-6048. You may also contact your state insurance department at 1-800-236-8517 or the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	$2,000
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$2,010**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	$2,000
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,000**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

■ The plan's overall deductible	$2,000
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

WPS HEALTH INSURANCE

2017 SUMMARY OF PLAN CHANGES

Northern School District Trust

THIS NOTIFICATION CONTAINS IMPORTANT INFORMATION ABOUT YOUR HEALTH INSURANCE

PLEASE READ CAREFULLY

PLEASE FORWARD TO ALL OF YOUR COVERED EMPLOYEES

We are updating your current plan with changes required by the Patient Protection and Affordable Care Act (PPACA). Effective on your group's 2017 renewal, your plan will be issued new Summary Plan Description(s) or benefit books with the changes described below.

1. Coverage will be added for the following:
   a. ambulance services to or from your home for covered hospice care services
   b. health and behavior intervention services when billed with a medical diagnosis
   c. telemedicine services provided by a health care provider at a distant site to a covered person at an originating site via interactive audio-visual telecommunication (this is NOT the same as telehealth visits with Teladoc)
2. Autism limits will be increased to comply with the revised 2017 minimum amounts: $30,079 for non-intensive level services and $60,158 for intensive-level services. ***(except for Ashland)***
3. Iron supplement drops for asymptomatic members age 6-12 months will be removed from the definition of Preventive Drugs.
4. Glucose monitors purchased at a pharmacy will be subject to the applicable copayment ***(applies only to plans with drug copayments)***
5. Gender reassignment surgery will no longer be excluded.
6. Benefits for hospital services provided to a newborn (i.e. circumcision) will be subject to the applicable deductible and coinsurance amounts.
7. Exclusions for the following will be added:
   a. non-emergency health care services received outside of the United States
   b. fertility preservation services, i.e., medications for which the primary purpose is to preserve fertility
8. The maximum out-of-pocket limit ("MOOP") will be increased to $ 7,150 single/$14,300 family for IN-NETWORK medical benefits – this includes ALL copayments ***(Not applicable to HDHP plans)***

Additionally, the Aspirus network will no longer be offered as a narrow network.

Please note this is not a complete description of the changes. These changes include updates to existing language within your current Summary Plan Description. If you have any questions about these changes, please contact your Sales Representative or Agency Representative listed on the enclosed renewal notice.

New summary plan descriptions will be available on-line within 30 days after your plan's renewal date. If you would prefer to receive a paper copy, please contact our Member Services Department.