WPS HEALTH INSURANCE

Wausau School District
Outline of Benefits – HDHP Plan
Effective January 1, 2020

PROVISION/BENEFIT	PREFERRED PROVIDERS What you pay	NON-PREFERRED PROVIDERS What you pay***
Deductible: Non-embedded HDHP - *(one person, in a family, can satisfy the family deductible amounts noted below)* ***(Note: Out-of-Network deductible amounts will credit toward in-network deductible, but not vice versa)***		
Single	$1,500	$1,500
Family	$3,000	$3,000
Coinsurance		
Coinsurance	10%	30%
Annual Out-of-Pocket Limit (includes deductible and coinsurance): Non-embedded HDHP - *(one person, in a family, can satisfy the family amounts noted below)* ***(Note: Out-of-Network out-of-pocket amounts will credit toward in-network out-of-pocket amounts, but not vice versa)***		
Single	$2,000	$3,000
Family	$4,000	$6,000
Maximum Annual Out-of-Pocket Limit (includes deductible, coinsurance and copayments): Embedded HDHP ***(Note: Out-of-Network maximum out-of-pocket amounts will credit toward in-network maximum out-of-pocket amounts, but not vice versa)***		
Per Covered Person	$6,650	$6,650
Per Family	$13,300	$13,300
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
Behavioral health Therapy services Outpatient/Transitional services Inpatient services**	 Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance	 Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance
Chiropractic office visit/manipulations	Deductible and Coinsurance	Deductible and Coinsurance
Contraceptives	0%	Deductible and Coinsurance
Diagnostic x-ray and laboratory services – outpatient**	Deductible and Coinsurance	Deductible and Coinsurance
Durable medical equipment**	Deductible and Coinsurance	Deductible and Coinsurance
Emergency Medical Care	Deductible and Coinsurance	Preferred Provider Deductible and Coinsurance
Emergency room – visit charge only	Deductible and Coinsurance	Preferred Provider Deductible and Coinsurance
Emergency room services	Deductible and Coinsurance	Preferred Provider 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	0%	Deductible and Coinsurance
Injections - outpatient	Deductible and Coinsurance	Deductible and Coinsurance
Kidney disease treatment	Deductible and Coinsurance	Deductible and Coinsurance
Maternity services	Deductible and Coinsurance	Deductible and Coinsurance

<table>
<tr><th>PROVISION/BENEFIT</th><th>PREFERRED PROVIDERS
What you pay</th><th>NON-PREFERRED PROVIDERS
What you pay***</th></tr>
<tr><td>Medical supplies</td><td>Deductible and Coinsurance</td><td>Deductible and Coinsurance</td></tr>
<tr><td>Nutritional counseling</td><td>0%</td><td>Deductible and Coinsurance</td></tr>
<tr><td>Office visits – visit charge only
Primary Care Practitioner
Specialist</td><td>
Deductible and Coinsurance
Deductible and Coinsurance</td><td>
Deductible and Coinsurance
Deductible and Coinsurance</td></tr>
<tr><td>Preventive care services* (includes routine eye exams for children and adults)</td><td>0%</td><td>Deductible and Coinsurance</td></tr>
<tr><td>Surgical services</td><td>Deductible and Coinsurance</td><td>Deductible and Coinsurance</td></tr>
<tr><td>Therapy visits (physical/ speech/occupational)
Office setting
Home or outpatient hospital setting</td><td>
Deductible and Coinsurance
Deductible and Coinsurance</td><td>
Deductible and Coinsurance
Deductible and Coinsurance</td></tr>
<tr><td>Transplant services**
Inpatient services
Outpatient services</td><td>
Deductible and Coinsurance
Deductible and Coinsurance</td><td>
Deductible and Coinsurance
Deductible and Coinsurance</td></tr>
<tr><td>Urgent Care</td><td>Deductible and Coinsurance</td><td>Deductible and Coinsurance unless Emergency Medical Care (see benefit above)</td></tr>
<tr><td>All other health care services – unless otherwise stated in your plan</td><td>Deductible and Coinsurance</td><td>Deductible and Coinsurance</td></tr>
<tr><td colspan="3">Covered Drugs and Covered Supplies</td></tr>
<tr><td>Prescription drugs and certain diabetic supplies</td><td colspan="2">Copayments apply after the deductible has been met.
<table>
<tr><td></td><td>Retail & Home Delivery</td></tr>
<tr><td></td><td>90-day supply</td></tr>
<tr><td>Generic</td><td>$5 Copayment</td></tr>
<tr><td>Preferred Brand-Name</td><td>$20 Copayment</td></tr>
<tr><td>Brand-Name</td><td>$40 Copayment</td></tr>
<tr><td>Specialty Medications**</td><td>25% to $100 (limited to 30-day supply)</td></tr>
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Oral chemotherapy drugs are limited to $100 copayment</td></tr>
<tr><td>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).</td><td colspan="2">0% (Deductible and Copayment waived)</td></tr>
<tr><td>Limitations</td><td colspan="2">Retail: 30 and 90-day supply Home Delivery: 90-day supply
Specialty drugs and Chemotherapy drugs: 30-day supply
Smoking Cessation – Limited to 180-day supply</td></tr>
<tr><td>Mandatory generic & Step therapy</td><td colspan="2">Applicable – If a brand drug is dispensed when a generic equivalent is available, you are responsible for the brand copayment plus the difference in cost between the brand and generic, unless your physician specifically instructs to “dispense as written.” This difference is not applied to the out-of-pocket limits noted above.</td></tr>
<tr><td>Specialty drugs**</td><td colspan="2">Specialty drugs are prescription legend drugs that we determine to be: (a) associated with a high level of clinical management and/or patient monitoring; (b) associated with special handling or distribution requirements; or (c) generally high cost.</td></tr>
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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.

***Out-of-network services are subject to maximum allowable fees. The maximum allowable fee may be less than what the health care provider bills and you may be responsible for the difference between what the health care provider bills and the maximum allowable fee (often referred to as “balance billing”). *These amounts do not apply to the overall deductible and out-of-pocket maximums noted above*.