

## WPS INDIVIDUAL HSA-QUALIFIED HDHP PLAN SUMMARY



An HSA-qualified high-deductible health plan (HDHP) for individuals and families featuring in- and out-of-network benefits and a variety of plan design options.

- Participant lifetime maximum benefit: \$5,000,000
- Dependent children/full-time students: 19/25

### PLAN OPTIONS - INDIVIDUAL

Deductibles	Coinsurance		Out-of-Pocket Maximum	
	In-Network	Out-of-Network	In-Network	Out-of-Network
\$1,100+	100%	80%	\$1,100	\$2,100
	90%	70%	\$3,000	\$4,000
	80%	60%	\$5,000	\$6,000
\$1,500	100%	80%	\$1,500	\$2,500
	80%	60%	\$5,000	\$6,000
\$2,000	100%	80%	\$2,000	\$3,000
	80%	60%	\$5,000	\$6,000
\$2,850	100%	80%	\$2,850	\$3,850
	80%	60%	\$5,000	\$6,000
\$3,500	100%	80%	\$3,500	\$4,500
	80%	60%	\$5,000	\$6,000
\$5,500	100%	80%	\$5,500	\$6,500

### PLAN OPTIONS - FAMILY

Deductibles	Coinsurance		Out-of-Pocket Maximum	
	In-Network	Out-of-Network	In-Network	Out-of-Network
\$2,200+	100%	80%	\$2,200	\$4,200
	90%	70%	\$6,000	\$8,000
	80%	60%	\$10,000	\$12,000
\$3,000	100%	80%	\$3,000	\$5,000
	80%	60%	\$10,000	\$12,000
\$4,000	100%	80%	\$4,000	\$6,000
	80%	60%	\$10,000	\$12,000
\$5,650	100%	80%	\$5,650	\$7,650
	80%	60%	\$10,000	\$12,000
\$7,000	100%	80%	\$7,000	\$9,000
	80%	60%	\$10,000	\$12,000
\$11,000	100%	80%	\$11,000	\$13,000

An out-of-network deductible of an equivalent amount to the in-network deductible applies. Deductibles and out-of-pocket maximums apply annually. In-network and out-of-network deductible and coinsurance amounts must be satisfied separately. Family deductible must be satisfied before this plan will pay benefits. One person can satisfy family deductible. Covered expenses must qualify as medically necessary.

+Each year, your plan's deductible will be automatically adjusted to reflect federal guidelines and remain HSA-qualified.

HSA is administered and/or maintained by a participating financial institution. WPS does not operate or administer HSAs.

## WPS INDIVIDUAL HSA-QUALIFIED HDHP PLAN SUMMARY (CONT.)

Summary of Services	Preferred Providers (In-Network)	All Other Providers (Out-of-Network)
<b>PREVENTIVE CARE</b>		
• Routine Medical Exams and Labs <i>(paid up to \$500 calendar year maximum)</i>	Deductible & Coinsurance	Deductible & Coinsurance
• Well-baby Care to Age 4 <i>(office visits)</i>	Deductible & Coinsurance	Deductible & Coinsurance
• Blood Lead Tests to Age 5	Deductible & Coinsurance	Deductible & Coinsurance
• Mammograms and Pap Tests	Deductible & Coinsurance	Deductible & Coinsurance
• Immunizations <i>(except for travel)</i>	100%	100% to age 6
<b>HOSPITAL SERVICES</b>		
• Room and Board, Miscellaneous Hospital Expenses, and Intensive Care Unit <i>(prior approval required*)</i>	Deductible & Coinsurance	Deductible & Coinsurance
• Outpatient Facility Fees	Deductible & Coinsurance	Deductible & Coinsurance
• Outpatient Radiology, Pathology, and Lab Services	Deductible & Coinsurance	Deductible & Coinsurance
<b>EMERGENCY SERVICES</b>		
• Emergency Room Facility Fees	Preferred Provider Deductible & Coinsurance	
• Emergency Room Care <i>(including physician charges &amp; miscellaneous expenses)</i>	Preferred Provider Deductible & Coinsurance	
• Ambulance <i>(up to \$2,000 ground/\$10,000 air; prior approval required for non-emergency transport*)</i>	Preferred Provider Deductible & Coinsurance	
<b>TRANSPLANTS</b>		
<i>(determined by WPS to be medically necessary; prior approval required*)</i> Heart • Heart/Lung • Lung Liver • Pancreas • Bone Marrow <i>(as stated in the policy, up to a separate lifetime maximum benefit of \$500,000 for Preferred Providers and \$250,000 for all other providers)</i>	Deductible & Coinsurance	Deductible then 50% of charges

## WPS INDIVIDUAL HSA-QUALIFIED HDHP PLAN SUMMARY (CONT.)

Summary of Services	Preferred Providers (In-Network)	All Other Providers (Out-of-Network)
<b>KIDNEY TRANSPLANTS AND DIALYSIS TREATMENTS</b> <i>(up to \$30,000 per year; prior approval required*)</i>	Deductible & Coinsurance	Deductible & Coinsurance
<b>PROFESSIONAL SERVICES</b>		
• Office Visits <i>(including chiropractors)</i>	Deductible & Coinsurance	Deductible & Coinsurance
• Maternity Services	Not Covered	Not Covered
• Medical and Surgical Services	Deductible & Coinsurance	Deductible & Coinsurance
• Corneal Transplants, Bone and Skin Grafts	Deductible & Coinsurance	Deductible & Coinsurance
• Rehabilitative Therapy <i>(occupational/physical/speech/respiratory; up to 40 visits per calendar year)</i>	Deductible & Coinsurance	Deductible & Coinsurance
• Radiation and Chemotherapy Services	Deductible & Coinsurance	Deductible & Coinsurance
• Cardiac Rehabilitation Services <i>(up to 48 sessions)</i>	Deductible & Coinsurance	Deductible & Coinsurance
• Independent Anesthesiologist, Pathologist, and Radiologist Services	Preferred Provider	Deductible & Coinsurance
• X-ray and Lab Services	Deductible & Coinsurance	Deductible & Coinsurance
<b>HOME HEALTH CARE</b>		
• Home Health Services <i>(up to 40 per year; prior approval required*)</i>	Deductible & Coinsurance	Deductible & Coinsurance
• Home IV Therapy and Supplies <i>(prior approval required*)</i>	Deductible & Coinsurance	Deductible & Coinsurance
<b>OTHER HEALTH CARE SERVICES</b>		
• Breast Reconstruction <i>(following a mastectomy)</i>	Deductible & Coinsurance	Deductible & Coinsurance
• Durable Medical Equipment <i>(DME costing more than \$500 requires prior approval or benefits payable at 50%)</i>	Deductible & Coinsurance	Deductible & Coinsurance
• Diabetic Equipment and Self-management Education Programs	Deductible & Coinsurance	Deductible & Coinsurance

## WPS INDIVIDUAL HSA-QUALIFIED HDHP PLAN SUMMARY (CONT.)

Summary of Services	Preferred Providers (In-Network)	All Other Providers (Out-of-Network)
<b>OTHER HEALTH CARE SERVICES (CONT.)</b>		
<ul style="list-style-type: none"> <li>Temporomandibular Joint (TMJ) Disorders <i>(diagnosis and non-surgical treatment up to \$1,250 per year)</i></li> </ul>	Deductible & Coinsurance	Deductible & Coinsurance
<ul style="list-style-type: none"> <li>Skilled Nursing Care Facility <i>(up to 30 days per confinement)</i></li> </ul>	Deductible & Coinsurance	Deductible & Coinsurance

\* Prior approval is required to receive certain benefits; without prior approval, benefits may be denied or substantially limited.

**Note:** All benefits are subject to the applicable limitations and exclusions as defined in the policy. Annual benefit limitations apply per calendar year.

### NOTICE:

LIMITED BENEFITS WILL BE PAID WHEN NONPARTICIPATING (OUT-OF NETWORK) PROVIDERS ARE USED.

You should be aware that when you elect to utilize the services of a non-participating provider for a covered service, benefit payments to such nonparticipating providers are not based upon the amount billed. The basis of your benefit payment will be determined according to you policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. **YOU RISK PAYING MORE THAN THE COINSURANCE, DEDUCTIBLE, AND CO-PAYMENT AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION.** Nonparticipating providers may bill enrollees for any amount up to the billed charge after the plan has paid its portion of the bill. Participating providers have agreed to accept discounted payment for covered services with no additional billing to the enrollee other than copayment, coinsurance, and deductible amounts.

You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll-free telephone number on you identification card or visiting the WPS Health Insurance Web site at [www.wpsic.com](http://www.wpsic.com).

# WPS INDIVIDUAL HSA-QUALIFIED HDHP PLAN SUMMARY (CONT.)

## Summary of Services

### Preferred Providers (In-Network)

### All Other Providers (Out-of-Network)

#### **PRESCRIPTION DRUGS**

*(including insulin, disposable diabetic supplies, and transplant drugs; prior approval required for certain drugs\*)*

#### **Choose One:**

- (1) Deductible, then in-network coinsurance
- (2) No Drug Coverage

- Mail order benefits available
- Mandatory generic substitution program applies

**General Exclusions:** This is an outline of the limitations and exclusions. It is designed for convenient reference. Consult the policy for a complete list of limitations and exclusions. The following aren't covered under the policy. The policy provides no benefits for:

Health care services provided in connection with any injury or illness arising out of, or in the course of, any employment for wage or profit for which an employer is required to carry workers' compensation insurance. If workers' compensation laws or any similar laws apply to you, this exclusion applies regardless of whether benefits under workers' compensation laws or any similar laws have been claimed, paid, waived or compromised, or whether you're covered under workers' compensation insurance.

This exclusion does not apply to health care services provided in connection with any injury or illness arising out of, or in the course of, any employment for wage or profit: (1) by a sole proprietor or partner if they elect not to become an employee under Section 102.075, Wisconsin Statutes, as amended; or (2) by a corporate officer if they elect not to become an employee under Section 102.076, Wisconsin Statutes, as amended; or similar laws of the state in which the participant works. The sole proprietor, partner or corporate officer must provide us with written proof of such election. However, (1) and/or (2) of this paragraph do not apply to participants employed in one of more of the following occupations as defined by the National Council on Compensation Insurance, Inc. (NCCI) as amended: aircraft or helicopter operation, asbestos, athletic team, atomic energy, farm, fire, fireworks, hay baling and drivers, mining NOC, police officers and drivers, salvage operation, sawmill, and trucking.

Health care services furnished by the U.S. Veterans Administration, except for such health care services for which under applicable federal law the policy is the primary payer and the U.S. Veterans Administration is the secondary payer. • Health care services furnished by any federal or state agency or a local political subdivision when you are not liable for the costs in the absence of insurance, unless such coverage under the policy is required by any state or federal law. • Health care services covered by Medicare, if you have or are eligible for Medicare, to the extent benefits are or would be available from Medicare, except for such health care services for which under applicable federal law the policy is the primary payer and Medicare is the secondary payer. Please also see section "Coverage with Medicare". • Cosmetic treatment or surgery. • Reconstructive surgery, except for such surgery required: (a) to repair a

significant defect caused by an injury; (b) to repair a defect caused by congenital anomaly causing a functional impairment of a dependent child; (c) incidental to a mastectomy; or (d) due to a physical illness. • Health care services which aren't medically necessary for the treatment of an illness or injury, as determined by us. Please see section "Preauthorization Procedure". • Routine medical exams, including eye exams and hearing exams, and related services, unless specifically stated in the policy. • Well baby care, except as specifically stated in the policy. • Routine eye and hearing exams; preparation, fitting, or purchase of eyeglasses or contact lenses, except as specifically stated in this policy; vision therapy, including orthoptic therapy and pleoptic therapy; or eye refractive surgery. • Health care services provided at any nursing facility or convalescent home or expense in any place that's primarily for rest, for the aged or for drug abuse or alcoholism treatment. • Custodial care or rest care. • Health care services which are experimental or investigative, except for the investigational drugs used to treat the HIV virus as described in Section 632.895 (9), Wisconsin Statutes, as amended. • Medical supplies and durable medical equipment for your comfort, personal hygiene or convenience, including, but not limited to: air conditioners; air cleaners; humidifiers; physical fitness equipment; physician's equipment; disposable supplies, other than colostomy supplies; or self-help devices not medical in nature. • Sterilization procedures; reversal of sterilization procedures. • Therapy services such as recreational therapy, educational therapy, physical fitness, or exercise programs, except as specifically stated in subsection "Cardiac Rehabilitation Services" and "Therapy". • Artificial insemination or fertilization methods, including, but not limited to, in vivo and in vitro fertilization, embryo transfer, gamete intra fallopian transfer (GIFT), and similar procedures and related hospital, professional and diagnostic services and medications that are incidental to such insemination or fertilization methods. In addition, infertility diagnostic services or infertility evaluation and management services, and related services that are provided after the commencement of the participant's infertility treatment are not covered under this policy. • Folicle-stimulating hormone (FSH), activity medications, or ovulatory stimulant medications, including, but not limited to, Menotropins, Chorionic Gonadotropins, Urofollitropins and Clomiphene Citrate. • Health care services not specifically identified as being covered under the policy. • Dental treatment, services, procedures, drugs, medicines, devices and supplies. **Continued on back**

**General Exclusions: (Cont.)**

except as specifically stated in subsection "Dental Services". • Health care services not provided by a physician or any of the health care providers listed in section "Covered Expenses". • Health care services provided: (a) in the examination, treatment or removal of all or part of corns, callosities, hypertrophy or hyperplasia of the skin or subcutaneous tissues of the feet which are billed as routine and not associated with a medical diagnosis; (b) in the cutting or trimming or toenails which are billed as routine or associated with a medical diagnosis, except for the medical diagnosis of diabetes; in the non-operative partial removal of toenails which are billed as routine or not associated with a medical diagnosis. • Abortion procedures for the termination of pregnancy. • Health education; marriage counseling; complimentary, alternative or holistic medicine; or other programs with an objective to provide complete personal fulfillment. • Health care services for, or used in connection with, transplants of human and non-human body parts, tissues or substances, implants of artificial or natural organs or any complications of such transplants or implants, except as specifically stated in subsection "Transplants". • Health care services provided during any waiting periods for pre-existing conditions, including any complications of such pre-existing conditions. • Health care services for obesity, weight reduction, dietetic control or morbid obesity, except as specifically stated in subsection "Nutritional Counseling"; obesity surgery for GERD. • Maintenance care or supportive care. • Room, board, services and supplies that are furnished to you by a hospital on the Friday and Saturday of the weekend of hospital admission if you are admitted as a registered resident patient to the hospital on one of those days, unless your hospital admission is medically necessary or such admission is required to provide you with emergency medical care of a covered illness or injury. • Health care services provided in connection with the temporomandibular joint or TMJ syndrome, except as specifically stated in subsection "Temporomandibular Joint Disorder". • Oral surgical services, except as specifically stated in subsection "Temporomandibular Joint Disorder". • Health care services provided in connection with a health care service not covered under the policy. An example would be inpatient hospital services in connection with a health care service not covered under the policy. • That portion of the amount billed for a health care service covered under the policy that exceeds our determination of the charge for such health care service. • Health care services for which you have no obligation to pay. • Contraceptive devices including, but not limited to, intrauterine devices (IUD), subdermal contraceptive implants (Norplant) and related health care services; oral contraceptives for birth control; injections of medication for birth control. • Health care services resulting or arising from complications of, or incidental to, any health care service not covered under the policy. • Stem cell transplants and related health care services, including high dose chemotherapy and component procedures such as, but not limited to, autologous and allogeneic bone marrow, peripheral blood or cord blood stem cell harvest, rescue and reinfusion, for any illness or injury, except for the following ten diagnoses: (a) acute and chronic leukemia; (b) aplastic anemia; (c) Albers-Schoenberg syndrome (infantile malignant osteopetrosis); (d) combined immunodeficiency; (e) Wiskott-Aldrich syndrome; (f) Hodgkin's and non-Hodgkin's lymphomas; (g) neuroblastoma; (h) multiple myeloma; (i) Ewing's sarcoma; and (j) myelodysplastic syndrome. • Stem cell transplants and related health care services, including high dose chemotherapy

and component procedures such as but not limited to autologous and allogeneic bone marrow, peripheral blood or cord blood stem cell harvest, rescue and reinfusion, for the treatment of tumors of the breast or metastases thereof, for the diagnoses of thalassemia, sickle cell anemia, polycythemia vera, and solid tumors. • Health care services for which proof of claim isn't provided to us in accordance with subsection "Proof of Claim". • Health care services and prescription legend drugs provided in the connection with alcoholism, drug abuse and nervous or mental disorders. • Health care services not for or related to an illness or injury, other than as specifically stated in the policy. • Indirect services provided by health care providers for services such as, but are not limited to: creation of a laboratory's standards, procedures, and protocols; calibrating equipment; supervising the testing; setting up parameters for test results; and reviewing quality assurance data. • Dental repair of your sound natural teeth due to an accident caused by chewing resulting in damage to your sound natural teeth. • Maintenance therapy for chronic conditions. • Treatment of weak, strained, flat, unstable or unbalanced feet; arch supports; heel wedges; lifts; orthopedic shoes; or the fitting of orthotics to aid walking or running. • Medications, drugs, or hormones to stimulate human biological growth, unless there is a laboratory-confirmed physician's diagnosis of the participant's growth hormone deficiency. • Sleep therapy, or services provided in a premenstrual syndrome clinic or holistic medicine clinic. • Massage therapy, except as specifically stated in subsection "Therapy". • Therapy and testing for treatment of allergies, including, but not limited to services related to clinical ecology, environmental allergy, allergic immune system dysregulation, sublingual antigen(s), RAST test, extracts, neutralization tests and/or treatment unless such therapy or testing is approved by The American Academy of Allergy and Immunology. • Treatment, services and supplies, including, but not limited to, surgical services, devices and drugs for, or used in connection with, sexual dysfunction, including, but not limited to, impotence, or for the purpose of enhancing or affecting sexual performance, regardless of whether the origin of the sexual dysfunction is organic or psychological in nature, including, but not limited to, Viagra, Caverject, MUSE, Yohimbine, Cialis, Levitra or their generic equivalent, penile implants and sex therapy. • Genetic testing of a participant, including, but not limited to any test using DNA to determine the presence of a genetic disease or disorder. This exclusion does not apply to: (a) amniocentesis provided during a participant's pregnancy; (b) chorionic villus sampling provided during a participant's pregnancy; (c) identification of infectious agents such as the influenza virus; or (d) molecular testing of pathological specimens. • Telephone, computer or internet consultations between a participant and any health care provider, completion of claim forms or forms necessary for a participant's return to work or school or for an appointment a participant did not attend. • Smoking deterrents, such as, but not limited to, prescription legend drugs, patches, gum, hypnosis. • Cochlear implants, and all health care services provided in connection with cochlear implants. • Durable medical equipment or prosthetics that have special features. • Maternity services. • Preparation, fitting or purchase of hearing aids and other internal or external hearing devices, including related services. • Nutritional counseling, except as specifically stated in subsection "Nutritional Counseling". • Health care services provided for your convenience or for the convenience of a physician, hospital, or other health care provider.



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**Important** — This plan summary provides only a general description of benefits and limitations. You can find a detailed description of coverage in the applicable policy. Coverage is subject to all the terms and conditions of the policy and any endorsements. The policy is your contract of insurance. If there's ever a discrepancy between the policy and this plan summary, the policy has final authority.