



Group HSA-Qualified HDHP

Non-Embedded Deductible



A cost-effective HSA-qualified high-deductible health plan (HDHP) featuring flexible plan options, and generous preventive health benefits.

- In-network preventive care covered 100%, no calendar year maximum
- Participant annual maximum: \$2,000,000

This plan features a non-embedded deductible. Family deductible must be satisfied before this plan will pay benefits. One person can satisfy family deductible. 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. HSA is administered and/or maintained by a participating financial institution. WPS does not operate or administer HSAs.

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

| PLAN OPTIONS - INDIVIDUAL | | | | | |
|---------------------------|-------------|----------------|-----------------------|----------------|--|
| Deductibles | Coinsurance | | Out-of-Pocket Maximum | | |
| | In-Network | Out-of-Network | In-Network | Out-of-Network | |
| \$1,200* | 100% | 70% | \$1,200 | No limit | |
| | 90% | 60% | \$3,000 | No limit | |
| | 80% | 50% | \$5,000 | No limit | |
| \$1,500 | 100% | 70% | \$1,500 | No limit | |
| | 80% | 50% | \$5,000 | No limit | |
| \$2,000 | 100% | 70% | \$2,000 | No limit | |
| | 80% | 50% | \$5,000 | No limit | |
| \$2,500 | 100% | 70% | \$2,500 | No limit | |
| | 80% | 50% | \$5,000 | No limit | |
| \$3,000 | 100% | 70% | \$3,000 | No limit | |
| | 80% | 50% | \$5,000 | No limit | |
| \$3,500 | 100% | 70% | \$3,500 | No limit | |
| | 80% | 50% | \$5,000 | No limit | |
| \$5,500 | 100% | 70% | \$5,500 | No limit | |

| PLAN OPTIONS - FAMILY | | | | | |
|-----------------------|-------------|----------------|-----------------------|----------------|--|
| Deductibles | Coinsurance | | Out-of-Pocket Maximum | | |
| | In-Network | Out-of-Network | In-Network | Out-of-Network | |
| \$2,400* | 100% | 70% | \$2,400 | No limit | |
| | 90% | 60% | \$6,000 | No limit | |
| | 80% | 50% | \$10,000 | No limit | |
| \$3,000 | 100% | 70% | \$3,000 | No limit | |
| | 80% | 50% | \$10,000 | No limit | |
| \$4,000 | 100% | 70% | \$4,000 | No limit | |
| | 80% | 50% | \$10,000 | No limit | |
| \$5,000 | 100% | 70% | \$5,000 | No limit | |
| | 80% | 50% | \$10,000 | No limit | |
| \$6,000 | 100% | 70% | \$6,000 | No limit | |
| | 80% | 50% | \$10,000 | No limit | |
| \$7,000 | 100% | 70% | \$7,000 | No limit | |
| | 80% | 50% | \$10,000 | No limit | |
| \$11,000 | 100% | 70% | \$11,000 | No limit | |

| Summary of Services | Preferred Providers (In-Network) | All Other Providers (Out-of-Network) |
|---|------------------------------------|--------------------------------------|
| PREVENTIVE CARE <ul style="list-style-type: none"> • A & B Preventive Services (Preventive services rated A or B by the U.S. Preventive Services Task Force (USPSTF) are covered at 100%, including recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women. See policy for a complete listing of A and B services.) | 100% | Deductible & Coinsurance |
| HOSPITAL SERVICES <ul style="list-style-type: none"> • Room and Board, Miscellaneous Hospital Expenses, and Intensive Care Unit (pre-certification required*) • Outpatient Facility Fees • Outpatient Radiology, Pathology, and Lab Services | Deductible & Coinsurance | Deductible & Coinsurance |
| EMERGENCY SERVICES <ul style="list-style-type: none"> • Emergency Room Facility Fees • Emergency Room Care (including physician charges & miscellaneous expenses) • Ambulance (prior approval required for non-emergency transport*) | Preferred Deductible & Coinsurance | Preferred Deductible & Coinsurance |

| Summary of Services (Continued) | Preferred Providers (In-Network) | All Other Providers (Out-of-Network) |
|--|--|---|
| TRANSPLANTS <i>(determined by WPS to be medically necessary; prior approval required*)</i> Heart • Heart/Lung • Lung • Liver • Pancreas Bone Marrow • Kidney/Liver • Kidney/Pancreas Centers of Excellence providers listed in the provider directory are Preferred Providers for transplant procedures. | Deductible & Coinsurance | Deductible, then 50% |
| SINGLE KIDNEY TRANSPLANTS AND DIALYSIS TREATMENTS | Deductible & Coinsurance | Deductible & Coinsurance |
| PROFESSIONAL SERVICES • Office Visits <i>(including chiropractors)</i> • Maternity Services <i>(except those covered as preventive)</i> • Medical and Surgical Services • Corneal Transplants, Bone and Skin Grafts • Rehabilitative Therapy <i>(occupational/physical/speech/respiratory/massage; up to 40 visits per calendar year)</i> • Radiation and Chemotherapy Services • Cardiac Rehabilitation Services • Oral Surgery and Dental Repair <i>(due to an injury)</i> • Independent Anesthesiologist, Pathologist, and Radiologist Services • X-ray and Lab Services | Deductible & Coinsurance | Deductible & Coinsurance |
| HOME HEALTH CARE | | |
| • Home Health Services <i>(up to 40 per year)</i> | Deductible & Coinsurance | Deductible & Coinsurance |
| • Home IV Therapy and Supplies <i>(prior approval required*)</i> | Deductible & Coinsurance | Deductible & Coinsurance |
| OTHER HEALTH CARE SERVICES | | |
| • Breast Reconstruction <i>(following a mastectomy)</i> | Deductible & Coinsurance | Deductible & Coinsurance |
| • Autism Services <i>(subject to limits as stated in the policy)</i> | Deductible & Coinsurance | Deductible & Coinsurance |
| • Hearing Aids** <i>(One per ear, per child, every three years)</i> | Deductible & Coinsurance | Deductible & Coinsurance |
| • Implantable Hearing Devices** | Deductible & Coinsurance | Deductible & Coinsurance |
| • Durable Medical Equipment <i>(DME over \$500 requires prior approval)</i> | Deductible & Coinsurance | Deductible & Coinsurance |
| • Diabetic Equipment and Self-management Education Programs | Deductible & Coinsurance | Deductible & Coinsurance |
| • Skilled Nursing Care Facility <i>(up to 30 days per confinement)</i> | Deductible & Coinsurance | Deductible & Coinsurance |
| ALCOHOLISM, DRUG ABUSE, AND NERVOUS OR MENTAL DISORDERS | | |
| • Inpatient Hospital Services <i>(requires pre-certification*)</i> | Deductible & Coinsurance | Deductible & Coinsurance |
| • Outpatient Services | Deductible & Coinsurance | Deductible & Coinsurance |
| • Transitional Treatment Arrangements <i>(requires pre-certification*)</i> | Deductible & Coinsurance | Deductible & Coinsurance |
| PRESCRIPTION DRUGS <i>(including insulin, disposable diabetic supplies, oral contraceptives, contraceptive patch, NuvaRing, and transplant drugs; prior approval required for certain drugs*)</i> • Mail order benefits available • Mandatory generic substitution program applies • Specialty drugs obtained in a physician's office, outpatient department of a hospital, or home health agency require prior approval. Without prior approval benefits may not be payable under the policy. | (1) Deductible, then Preferred coinsurance (2) No Drug Coverage | |

*Prior approval or pre-certification are required to receive certain benefits; without them, benefits may be denied or substantially limited.

**Available only to children under the age of 18 who are certified as deaf or hearing impaired by a physician or audiologist.

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

IMPORTANT: This plan summary provides only a general description of benefits and limitations. You can find a detailed description of coverage in the applicable group certificate. Coverage is subject to all the terms and conditions of the certificate and any endorsements. If there's ever a discrepancy between the certificate and this plan summary, the certificate has final authority.

Additional Plan Information

Benefit Payment Information

Benefit payments are subject to the applicable: calendar year deductible and coinsurance options you select; annual out-of-pocket limits; applicable copays; participant lifetime maximum benefit; exclusions, limitations, and other policy terms and conditions.

Dependent Children/Students, Domestic Partners

WPS group plans include coverage for married dependents to age 26 and unmarried dependents to age 27. (See policy for details.) Optional domestic partner benefits are also available. There may be tax consequences to employees who enroll dependents or domestic partners that do not meet the IRC § 152 definitions of dependents/spouses. Employees should consult with a tax advisor prior to enrolling for this coverage.

Waiting Periods for Pre-existing Conditions

After a waiting period of twelve months, we'll pay benefits under this plan for a pre-existing condition. (Late enrollees may be subject to a different waiting period, as detailed in the policy.)

We'll shorten the waiting period if the participant had previous qualifying coverage and no lapse in coverage of 63 days or more (not including probationary periods). Waiting periods don't apply to participants under 19.

We define a pre-existing condition as a physical or mental condition for which medical advice, diagnosis, care, or treatment was recommended or received within six months before the first day of coverage or the first day of the probationary period, whichever is earlier. The waiting period applies to transplants. Pre-existing conditions don't include pregnancy, pre- or post-natal care, or any complications of pregnancy. Pre-existing conditions do include symptoms of an illness or injury that would cause an ordinarily prudent person to seek care.

Premium and Renewal Terms

We determine your group's premium based on a number of factors, including your group's characteristics and the various benefit design options you select.

You submit the initial monthly premium, along with your completed application materials, to us. Then, you submit all subsequent premium payments to us along with a copy of the premium notice. For coverage to continue, we need to receive the premium as required by the policy. A participant's coverage depends on his or her eligibility under the terms and conditions of your WPS group master policy.

Small Employers' Right to Information

Upon request, employers with 2-50 employees can receive:

- Information on our right to change premium rates and the factors involved
- Additional information about renewability and pre-existing condition provisions
- Benefits and premiums available through other WPS Health Insurance plans for which you may qualify

If you're interested in receiving any of this information, please contact your WPS representative.

Grievance Procedure

If a participant has a question or concern that can't be resolved by our Member Services staff, he or she can file a written grievance detailing the reason(s) for disagreeing with our benefit or claim payment decision.

At WPS, we define a "grievance" as meaning any dissatisfaction with the provision of services or claims practices of an insurer offering a health benefit plan or administration of a health plan by the insurer that is expressed in writing to the insurer by, or on behalf of, a member.

Written requests and copies of any supporting information (such as letters, medical records, clinical reports, or other relevant documents that show the medical reason(s) why we should change our decision) should be sent to:

WPS Grievance/Appeal Committee
1717 W. Broadway—P.O. Box 7062
Madison, WI 53707-7062
FAX: 608-223-3603

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 nonparticipating provider for a covered service, benefit payments to such nonparticipating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your 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

COPAYMENT 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 your identification card or visiting the WPS Health Insurance Web site at www.wpsic.com.

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: cosmetic treatment • reconstructive surgery except as stated in the policy • preparation, fitting, or purchase of eyeglasses or contact lenses • vision therapy • custodial or rest care • medical supplies and durable medical equipment for comfort, personal hygiene, or convenience • dental services, drugs, devices, and supplies, except as stated in the policy • housekeeping, shopping, or meal preparation services • outpatient food, food supplements, or vitamins • maintenance or supportive care • motor vehicles, lifts for wheelchairs and scooters, and stair lifts • amounts that exceed our determination of a charge • foot orthotics, special shoes (other than diabetic shoes) or devices unless they're a permanent part of an orthopedic leg brace • wigs or prosthetic hair pieces, transplants, or implants • sales tax or any tax, levy, or assessment by any federal or state agency or local political subdivision • physical, speech, occupational, massage, or respiratory therapy and psychotherapy except as stated in the policy • charges for health clubs/spas, aerobics, conditioning, and related programs and materials • services provided in a holistic medicine or premenstrual syndrome clinic or sleep therapy clinic • therapy and testing for allergies unless approved by The American Academy of Allergy, Asthma and Immunology • genetic testing except as stated in the policy • telephone, computer, or Internet consultations or services • cochlear implants and related services except as stated in the policy • preparation, fitting, or purchase of hearing aids and other internal or external hearing devices, including related services except as stated in the policy • health care services for your convenience or the convenience of a physician, hospital, or other health care provider.

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. 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.

Health care services: furnished by the U.S. Veterans Administration, Medicare, or any federal or state agency, or local political subdivision (except when we're the primary payer or coverage is required by law) • for any injury/illness caused by atomic or thermonuclear explosion or resulting radiation, or any type of military action • which aren't medically necessary as determined by us • which are experimental or investigative, except for certain drugs used to treat HIV • for routine foot care and treatment of foot conditions, except as stated in the policy • for health education, marriage counseling; complementary, alternative or holistic medicine, or other programs to provide complete personal fulfillment.

Health care services: for or used in conjunction with, transplants of human and nonhuman body parts, tissues, or substances • provided to or received by a member as a collateral in connection with treatment of any person who isn't a participant under this certificate • provided before the effective date of the policy, after coverage ends, or during any waiting periods for pre-existing conditions • for obesity, weight reduction, dietetic control, or morbid obesity except as stated in the policy • used in educational or vocational training or

testing • for an injury/illness caused by engaging in an illegal occupation or commission of, or attempt to commit, a felony • for any intentionally self-inflicted injury/illness except for injuries resulting from an act of domestic violence or an illness • provided in connection with, resulting/arising from services not covered under this policy • for which you have no obligation to pay • for which proof of claim isn't provided to us • not supported by medical records or other relevant sources • provided while in custody of law-enforcement officials or in a local, state, or federal correctional institution, except as stated by law • not specifically identified as being covered by the policy.

Health care services for: or leading to sex transformation surgery, and sex hormones related to such surgery • reversal of sterilization • artificial insemination or fertilization methods, related services, and medications, including in vivo, and in vitro fertilization, embryo transfer, gamete intra-fallopian transfer (GIFT), and similar procedures • follicle-stimulating hormone (FSH) activity or ovulatory stimulant medications • Retinoids, Minoxidil, Rogaine, or their medical equivalent in topical form, unless medically necessary • abortion procedures except as stated in the policy • contraceptive devices except as stated in the policy • drugs or hormones to stimulate human biological growth, except as stated in the policy • treatment, services, supplies, and drugs related to sexual dysfunction, impotence, and performance (including Viagra and similar medications).

In addition to the general exclusions, the copay prescription drug coverage doesn't cover: administration of a covered drug by injection or other means • devices, appliances, or durable medical equipment • refills of covered drugs beyond the number prescribed, or after one year from the date they were prescribed • covered drugs usually not charged or when amount charged is less than the copay • drugs covered elsewhere under the policy • covered drugs completely consumed at the time and place the provider dispenses them except for specialty drugs • anabolic steroids • progesterone crystals and powder in any compounded dosage form • costs related to the mailing, sending or delivery of prescription legend drugs • prescription or refill of drugs, medicines, medications, or supplies that are lost, stolen, spilled, spoiled, or damaged • any drug or medicine that is available in prescription strength without a prescription except as stated in the policy • more than one prescription for the same covered drug or therapeutic equivalent medication prescribed by one or more providers until at least 75% of the previous retail prescription has been used by the member. If the drug or therapeutic equivalent medication is dispensed at a mail-order service, then at least 60% of the previous prescription must have been used by the member • drugs and medicines not covered under the policy • prescription legend drugs when multiple drug options are available and the least expensive is not tried first.

In addition to the general exclusions, coverage for temporomandibular joint disorders doesn't include: dental treatments, services and supplies that permanently alter the teeth or bite • behavioral modification • postural training • hypnosis therapy.

In addition to the general exclusions, the transplant coverage doesn't include: stem cell transplants and related expenses except for the diagnoses stated in the policy • lodging expenses, including meals • expenses related to the recipient's transportation, except for medically-necessary, professionally-licensed ambulance services • the purchase price of any stem cell, bone marrow, organ, or tissue which is sold rather than donated • health care services not ordered by a physician or surgeon • transplants involving nonhuman or artificial organs or tissues • human to human stem cell, bone marrow, organ, or tissue transplants other than those covered by the policy.



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