

# WPS Group HSA-Qualified HDHP PLAN SUMMARY



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

- Preventive care covered 100%, no calendar year maximum
- Participant Lifetime Maximum Benefit: \$5,000,000

## PLAN OPTIONS - SINGLE

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

## PLAN OPTIONS - FAMILY

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

Amounts shown above may change as determined by IRS regulations. Deductibles and out-of-pocket maximums apply annually. \*Each year, your plan's deductible will be automatically adjusted to reflect federal guidelines and remain HSA-qualified. NOTE: Family deductible must be satisfied before this plan will pay benefits. One person can satisfy family deductible. +HSA is administered and/or maintained by a participating financial institution. WPS does not operate or administer HSAs.

Summary of Services	Preferred Providers (In-Network)	All Other Providers (Out-of-Network)
<b>Preventive Care</b> (no calendar year maximum)		
• Routine Medical Exams	100%	Deductible & Coinsurance
• Routine Labs	100%	Deductible & Coinsurance
• Well-baby Care to Age 4 (office visits)	100%	Deductible & Coinsurance
• Blood Lead Tests to Age 5	100%	Deductible & Coinsurance
• Mammograms and Pap Tests	100%	Deductible & Coinsurance
• Colonoscopy (screening only, one per 5 years paid at 100%) <sup>†</sup>	100%	Deductible & Coinsurance
• Immunizations (except for travel)	100%	100%
<b>Hospital Services</b>		
• Room and Board, Miscellaneous Hospital Expenses, and Intensive Care Unit (prior approval required*)	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 (including physician charges & miscellaneous expenses)	Preferred Provider Deductible & Coinsurance	

Summary of Services (Continued)	Preferred Providers (In-Network)	All Other Providers (Out-of-Network)
<ul style="list-style-type: none"> <li>Ambulance (up to \$2,000 ground/\$10,000 air; prior approval required for non-emergency transport*)</li> </ul>	Preferred Provider Deductible & Coinsurance	
<b>Transplants</b> (determined by WPS to be medically necessary; prior approval required*) Heart • Heart/Lung • Lung • Liver • Pancreas • Bone Marrow (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) Centers of Excellence providers listed in the provider directory are Preferred Providers for transplant procedures.	Deductible & Coinsurance	Deductible, then 50% of charges
<b>Kidney Transplants and Dialysis Treatments</b> (up to \$30,000 per year; prior approval required*)	Deductible & Coinsurance	Deductible & Coinsurance
<b>Professional Services</b>		
<ul style="list-style-type: none"> <li>Office Visits (including chiropractors)</li> </ul>	Deductible & Coinsurance	Deductible & Coinsurance
<ul style="list-style-type: none"> <li>Maternity Services (prenatal, delivery, and postnatal care)</li> </ul>	Deductible & Coinsurance	Deductible & Coinsurance
<ul style="list-style-type: none"> <li>Medical and Surgical Services</li> </ul>	Deductible & Coinsurance	Deductible & Coinsurance
<ul style="list-style-type: none"> <li>Corneal Transplants, Bone and Skin Grafts</li> </ul>	Deductible & Coinsurance	Deductible & Coinsurance
<ul style="list-style-type: none"> <li>Rehabilitative Therapy (occupational/physical/speech/respiratory; up to 40 visits per calendar year)</li> </ul>	Deductible & Coinsurance	Deductible & Coinsurance
<ul style="list-style-type: none"> <li>Radiation and Chemotherapy Services</li> </ul>	Deductible & Coinsurance	Deductible & Coinsurance
<ul style="list-style-type: none"> <li>Cardiac Rehabilitation Services (up to 48 sessions)</li> </ul>	Deductible & Coinsurance	Deductible & Coinsurance
<ul style="list-style-type: none"> <li>Oral Surgery and Dental Repair (due to an injury)</li> </ul>	Deductible & Coinsurance	Deductible & Coinsurance
<ul style="list-style-type: none"> <li>Independent Anesthesiologist, Pathologist, and Radiologist Services</li> </ul>	Preferred Provider Deductible & Coinsurance	
<ul style="list-style-type: none"> <li>X-ray and Lab Services</li> </ul>	Deductible & Coinsurance	Deductible & Coinsurance
<b>Home Health Care</b>		
<ul style="list-style-type: none"> <li>Home Health Services (up to 40 per year; prior approval required*)</li> </ul>	Deductible & Coinsurance	Deductible & Coinsurance
<ul style="list-style-type: none"> <li>Home IV Therapy and Supplies (prior approval required*)</li> </ul>	Deductible & Coinsurance	Deductible & Coinsurance
<b>Other Health Care Services</b>		
<ul style="list-style-type: none"> <li>Breast Reconstruction (following a mastectomy)</li> </ul>	Deductible & Coinsurance	Deductible & Coinsurance
<ul style="list-style-type: none"> <li>Durable Medical Equipment (DME costing more than \$500 requires prior approval or benefits reduced to 50%)</li> </ul>	Deductible & Coinsurance	Deductible & Coinsurance
<ul style="list-style-type: none"> <li>Diabetic Equipment and Self-management Education Programs</li> </ul>	Deductible & Coinsurance	Deductible & Coinsurance
<ul style="list-style-type: none"> <li>Temporomandibular Joint (TMJ) Disorders (diagnosis and non-surgical treatment up to \$1,250 per year)</li> </ul>	Deductible & Coinsurance	Deductible & Coinsurance
<ul style="list-style-type: none"> <li>Skilled Nursing Care Facility (up to 30 days per confinement)</li> </ul>	Deductible & Coinsurance	Deductible & Coinsurance
<b>Prescription Drugs</b> (including insulin, disposable diabetic supplies, oral contraceptives, contraceptive patch, and transplant drugs; prior approval required for certain drugs*)		
<ul style="list-style-type: none"> <li>Mail order benefits available</li> <li>Discounts available on prescription drugs through the Medco Health prescription discount program</li> <li>Mandatory generic substitution program applies</li> </ul>	<b>Choose One:</b>	(1) Deductible, then in-network coinsurance (2) No Drug Coverage
<b>Alcoholism, Drug Abuse, and Nervous or Mental Disorders</b> (Up to a combined maximum benefit of \$7,000 per participant, per year. Once we've paid the stated maximum we'll pay benefits at 50% for one more inpatient day, one transitional treatment, and one outpatient visit for treatment of a nervous or mental disorder only.)		
	<b>Inpatient Hospital Services:</b> Preferred Providers: Deductible, then 100% up to 30 days or \$7,000 of covered charges, which ever is first All Other Providers: Deductible, then 90% up to 30 days or \$7,000 of covered charges, whichever is first <b>Outpatient Services:</b> Preferred Providers: Deductible, then 100% of the next \$2,000; All Other Providers: Deductible, then 90% of the next \$2,000 <b>Transitional Treatment Arrangements:</b> Preferred Providers: Deductible, then 100% of the next \$3,000; All Other Providers: Deductible, then 90% of the next \$3,000	
<b>Networks Available</b> (Prior approval not required for in-network benefits when using the Patient Choice network)	<ul style="list-style-type: none"> <li>Aspirus • Coulee • HealthEOS Plus • NCHPP (51+ only)</li> <li>Northern • Patient Choice • SEARCH • Southern • Statewide</li> </ul>	

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

† All others subject to deductible and coinsurance.

Note: 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 disagreement between the certificate and this brochure, 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

WPS group plans include coverage for unmarried dependent children to age 19 and full-time students to age 25.

## 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 dependent children under age 18, provided the child didn't have a lapse in coverage of 63 days or more.

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 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 co-payment, 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](http://www.wpsic.com).

## Exclusions

Except as specifically stated in the policy, WPS group plans don't cover: cosmetic treatment or surgery • reconstructive surgery except as stated in the policy • preparation, fitting, or purchase of eyeglasses or contact lenses • vision, sleep, or massage therapy • custodial or rest care • medical supplies and durable medical equipment for comfort, personal hygiene, or convenience • dental services, drugs, devices, and supplies • professional services not provided by a physician • housekeeping, shopping, or meal preparation services • outpatient food, food supplements, or vitamins unless specifically stated in the policy • maintenance or supportive care • room, board, services, and supplies furnished by a hospital if admitted on a Friday or Saturday, unless admitted on an emergency basis • motor vehicles, lifts for wheelchairs and scooters, and stair lifts • amounts that exceed our determination of a charge • 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, or occupational therapy and psychotherapy except as stated in the policy • maintenance therapy for chronic conditions • charges for health clubs/spas, aerobics, conditioning, and related programs and materials • services provided in a holistic medicine or premenstrual syndrome clinic • therapy and testing for allergies unless approved by The American Academy of Allergy and Immunology • genetic testing unless stated in the policy • telephone, computer, or Internet consultations or services • smoking deterrents • cochlear implants and related 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 the policy • health care services for your convenience or the convenience of a physician, hospital, or other health care provider.

Health care services: for any injury/illness arising out/in course of any employment for wage/profit/gain • 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 as stated in the policy • for health education, marriage counseling; complimentary, 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 by a member of the patient's immediate family or anyone else living with him/her • 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 • Retin-A, Minoxidil, Rogaine, or their medical equivalent in topical form, unless medically necessary • abortion procedures • contraceptive devices unless 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) as stated in the policy.

In addition to the general exclusions, the copay prescription drug coverage doesn't cover: oral contraceptives for birth control, unless stated in the policy • 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 • 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: bone marrow 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 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 bone marrow, organ, or tissue transplants other than those covered by the policy.

Please refer to the certificate for a more detailed description of exclusions, limitations, and restrictions. Coverage is subject to all terms and conditions of the certificate and any endorsements. If there's ever a disagreement between the certificate and this brochure, the certificate has final authority.



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