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 changes in medical costs. (If there is a tie, the benefit is applied to the policy year in which it is eligible.)

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

- Routine medical exams and Labs (paid up to $500 calendar year maximum)
- Well-baby care to Age 4 (office visits)
- Blood Lead Tests to Age 5
- Mammograms and Pap Tests
- Immunizations (except for travel) 100% 100% to age 6

**Hospital Services**

- Preferred Provider Deductible & Coinsurance
- Outpatient Facility Fee
- Outpatient Radiology, Pathology, and Lab Services
- Ambulance

**Emergency Services**

- Emergency Room Facility Fee
- Emergency Room Care (including physician charges & miscellaneous expenses)
- Preferred Provider Deductible & Coinsurance
- Preferred Provider Deductible & Coinsurance
- Ambulance (up to $2,000 ground/$10,000 air; prior approval required)

**Transplants**

- Deductible & Coinsurance
- Deductible then 50% of charges

**Other Health Care Services (Cont.)**

- Temporomandibular Joint (TMJ) Disorders (diagnosis and non-surgical treatment up to $1,250 per year)
- Skilled Nursing Care Facility (up to 30 days per confinement)

**Summary of Services**

<table>
<thead>
<tr>
<th>Preferred Providers (In-Network)</th>
<th>All Other Providers (Out-Of-Network)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Provider Deductible &amp; Coinsurance</td>
<td>Preferred Provider Deductible &amp; Coinsurance</td>
</tr>
</tbody>
</table>

**Prescription Drugs**

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

**Notices**

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 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 copay, 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.

**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:

- Injurious acts
- Coverage which would be available from Medicare, except for such coverage under the policy is required by any state or federal law
- Services which are experimental or investigatory, except for the investigational drugs used to treat the HIV virus as described in Section 132.905, 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 ostomy supplies; or self-help devices not medical in nature + Drug rehabilitation facilities + Dental treatment, services, procedures, drugs, medications, devices, and supplies + Unnecessary treatment + Unnecessary treatment

**DIFFERENCES:** Notice: 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.