WPS INDIVIDUAL PREFERRED PLAN SUMMARY

Effective dates 1/1/10 or later

WPS HEALTH INSURANCE®

A traditional PPO plan for individuals and families featuring in- and out-of-network benefits and a wide range of plan design options.

- Participant lifetime maximum benefit: $5,000,000
- Dependent children: 27
- Routine care covered, with no calendar year maximum

PLAN OPTIONS - INDIVIDUAL/FAMILY

Deductible		Coinsurance			Out-of-Pocket Max§	
In-Network Individual/Family	Out-of-Network Individual/Family	In	Out	Max Individual/Family	In-Network Individual/Family	Out-of-Network Individual/Family
$500/$1,500	$1,000/$3,000	100%	80%	$5,000/$15,000	$500/$1,500	$2,000/$6,000
$500/$1,500	$1,000/$3,000	90%	70%	$5,000/$15,000	$1,000/$3,000	$2,500/$7,500
$500/$1,500	$1,000/$3,000	90%	70%	$10,000/$30,000	$1,500/$4,500	$4,000/$12,000
$500/$1,500	$1,000/$3,000	80%	60%	$5,000/$15,000	$1,500/$4,500	$3,000/$9,000
$500/$1,500	$1,000/$3,000	80%	60%	$10,000/$30,000	$2,500/$7,500	$5,000/$15,000
$1,000/$3,000	$2,000/$6,000	100%	80%	$5,000/$15,000	$1,000/$3,000	$3,000/$9,000
$1,000/$3,000	$2,000/$6,000	90%	70%	$5,000/$15,000	$1,500/$4,500	$3,500/$10,500
$1,000/$3,000	$2,000/$6,000	90%	70%	$10,000/$30,000	$2,000/$6,000	$5,000/$15,000
$1,000/$3,000	$2,000/$6,000	80%	60%	$5,000/$15,000	$2,000/$6,000	$4,000/$12,000
$1,000/$3,000	$2,000/$6,000	80%	60%	$10,000/$30,000	$3,000/$9,000	$6,000/$18,000
$1,500/$4,500	$3,000/$9,000	100%	80%	$5,000/$15,000	$1,500/$4,500	$4,000/$12,000
$1,500/$4,500	$3,000/$9,000	90%	70%	$5,000/$15,000	$2,000/$6,000	$4,500/$13,500
$1,500/$4,500	$3,000/$9,000	90%	70%	$10,000/$30,000	$2,500/$7,500	$6,000/$18,000
$1,500/$4,500	$3,000/$9,000	80%	60%	$5,000/$15,000	$2,500/$7,500	$5,000/$15,000
$1,500/$4,500	$3,000/$9,000	80%	60%	$10,000/$30,000	$3,500/$10,500	$7,000/$21,000
$2,000/$6,000	$4,000/$12,000	100%	80%	$5,000/$15,000	$2,000/$6,000	$5,000/$15,000
$2,000/$6,000	$4,000/$12,000	90%	70%	$5,000/$15,000	$2,500/$7,500	$5,500/$16,500
$2,000/$6,000	$4,000/$12,000	90%	70%	$10,000/$30,000	$3,000/$9,000	$7,000/$21,000
$2,000/$6,000	$4,000/$12,000	80%	60%	$5,000/$15,000	$3,000/$9,000	$6,000/$18,000
$2,000/$6,000	$4,000/$12,000	80%	60%	$10,000/$30,000	$4,000/$12,000	$8,000/$24,000
$2,500/$7,500	$5,000/$15,000	100%	80%	$5,000/$15,000	$2,500/$7,500	$6,000/$18,000
$2,500/$7,500	$5,000/$15,000	90%	70%	$5,000/$15,000	$3,000/$9,000	$6,500/$19,500
$2,500/$7,500	$5,000/$15,000	90%	70%	$10,000/$30,000	$3,500/$10,500	$8,000/$24,000
$2,500/$7,500	$5,000/$15,000	80%	60%	$5,000/$15,000	$3,500/$10,500	$7,000/$21,000
$2,500/$7,500	$5,000/$15,000	80%	60%	$10,000/$30,000	$4,500/$13,500	$9,000/$27,000
$3,500/$10,500	$7,000/$21,000	100%	80%	$5,000/$15,000	$3,500/$10,500	$8,000/$24,000
$3,500/$10,500	$7,000/$21,000	90%	70%	$5,000/$15,000	$4,000/$12,000	$8,500/$25,500
$3,500/$10,500	$7,000/$21,000	90%	70%	$10,000/$30,000	$4,500/$13,500	$10,000/$30,000
$3,500/$10,500	$7,000/$21,000	80%	60%	$5,000/$15,000	$4,500/$13,500	$9,000/$27,000
$3,500/$10,500	$7,000/$21,000	80%	60%	$10,000/$30,000	$5,500/$16,500	$11,000/$33,000
$5,000/$15,000	$10,000/$30,000	100%	80%	$5,000/$15,000	$5,000/$15,000	$11,000/$33,000
$5,000/$15,000	$10,000/$30,000	90%	70%	$5,000/$15,000	$5,500/$16,500	$11,500/$34,500
$5,000/$15,000	$10,000/$30,000	90%	70%	$10,000/$30,000	$6,000/$18,000	$13,000/$39,000
$5,000/$15,000	$10,000/$30,000	80%	60%	$5,000/$15,000	$6,000/$18,000	$12,000/$36,000
$5,000/$15,000	$10,000/$30,000	80%	60%	$10,000/$30,000	$7,000/$21,000	$14,000/$42,000

PLAN OPTIONS - INDIVIDUAL/FAMILY (CONT.)

Deductible		Coinsurance			Out-of-Pocket Max§	
In-Network Individual/Family	Out-of-Network Individual/Family	In	Out	Max Individual/Family	In-Network Individual/Family	Out-of-Network Individual/Family
$6,000/$18,000	$12,000/$36,000	100%	80%	$5,000/$15,000	$6,000/$18,000	$13,000/$39,000
$6,000/$18,000	$12,000/$36,000	90%	70%	$5,000/$15,000	$6,500/$19,500	$13,500/$40,500
$6,000/$18,000	$12,000/$36,000	90%	70%	$10,000/$30,000	$7,000/$21,000	$15,000/$45,000
$6,000/$18,000	$12,000/$36,000	80%	60%	$5,000/$15,000	$7,000/$21,000	$14,000/$42,000
$6,000/$18,000	$12,000/$36,000	80%	60%	$10,000/$30,000	$8,000/$24,000	$16,000/$48,000
$7,500/$22,500	$15,000/$45,000	100%	80%	$5,000/$15,000	$7,500/$22,500	$16,000/$48,000
$7,500/$22,500	$15,000/$45,000	90%	70%	$5,000/$15,000	$8,000/$24,000	$16,500/$49,500
$7,500/$22,500	$15,000/$45,000	90%	70%	$10,000/$30,000	$8,500/$25,500	$18,000/$54,000
$7,500/$22,500	$15,000/$45,000	80%	60%	$5,000/$15,000	$8,500/$25,500	$17,000/$51,000
$7,500/$22,500	$15,000/$45,000	80%	60%	$10,000/$30,000	$9,500/$28,500	$19,000/$57,000

General information: Benefit payments are subject to the applicable: selected calendar year deductible and coinsurance, copays, out-of-pocket maximums, participant lifetime maximum, exclusions, limitations and other terms and conditions of the policy. In-network and out-of-network deductible and coinsurance amounts must be satisfied separately. Plan provides benefits for health care services that are: for the treatment of a covered illness or injury, medically necessary as determined by us, ordered by a "physician" as defined in the policy, and within the scope of the provider's license.

§ See back cover for explanation of out-of-pocket maximum calculation.

SUMMARY OF SERVICES

Services	Preferred Providers (In-Network)	All Other Providers (Out-of-Network)
PREVENTIVE CARE		
• Routine Medical Exams+	$25 copay then 100%, or Deductible & Coinsurance	Deductible & Coinsurance
• Routine Labs	Coinsurance, or if no copay Deductible & Coinsurance	Deductible & Coinsurance
• Well-baby Care *(office visits)*+	$25 copay then 100% or Deductible & Coinsurance	Deductible & Coinsurance
• Blood Lead Tests to Age 5	Coinsurance, or if no copay Deductible & Coinsurance	Deductible & Coinsurance
• Mammograms and Pap Tests	Coinsurance, or if no copay Deductible & Coinsurance	Deductible & Coinsurance
• Immunizations *(except for travel)*	100%	100% to age 6
HOSPITAL SERVICES		
• 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	Coinsurance, or if no copay Deductible & Coinsurance	Deductible & Coinsurance

SUMMARY OF SERVICES (CONT.)

Services	Preferred Providers (In-Network)	All Other Providers (Out-of-Network)
EMERGENCY SERVICES		
• Emergency Room Facility Fees	Preferred Deductible & Coinsurance	
• Emergency Room Care *(including physician charges & miscellaneous expenses)*	Preferred Deductible & Coinsurance	
• Ambulance *(prior approval required for non-emergency transport*)*	Preferred Deductible & Coinsurance	
TRANSPLANTS *(determined by WPS to be medically necessary; prior approval required*)* • Heart • Heart/Lung • Lung • Liver • Pancreas • Bone Marrow • Kidney/Pancreas • Kidney/Liver	Deductible & Coinsurance	Deductible then 50% of charges
SINGLE KIDNEY TRANSPLANTS AND DIALYSIS TREATMENTS *(up to $30,000 per year; prior approval required*)*	Deductible & Coinsurance	Deductible & Coinsurance
PROFESSIONAL SERVICES		
• Office Visits+ *(including chiropractors)*	$25 copay then 100% or 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 *(occupational/physical/speech/respiratory/ massage; up to 40 visits per calendar year)*	Deductible & Coinsurance	Deductible & Coinsurance
• Radiation and Chemotherapy Services	Deductible & Coinsurance	Deductible & Coinsurance
• Cardiac Rehabilitation Services *(up to 48 sessions)*	Deductible & Coinsurance	Deductible & Coinsurance
• Independent Anesthesiologist	Preferred Deductible & Coinsurance	
• Independent Pathologist and Radiologist Services	Preferred Coinsurance, or if no copay Preferred Deductible & Coinsurance	
• X-ray and Lab Services	Coinsurance, or if no copay Deductible & Coinsurance	Deductible & Coinsurance

SUMMARY OF SERVICES (CONT.)

Services	Preferred Providers (In-Network)	All Other Providers (Out-of-Network)
HOME HEALTH CARE		
• Home Health Services *(up to 40 per year; prior approval required*)*	Deductible & Coinsurance	Deductible & Coinsurance
• Home IV Therapy and Supplies *(prior approval required*)*	Deductible & Coinsurance	Deductible & Coinsurance
OTHER HEALTH CARE SERVICES		
• Breast Reconstruction *(following a mastectomy)*	Deductible & Coinsurance	Deductible & Coinsurance
• Autism Services	Deductible & Coinsurance	Deductible & Coinsurance
• Hearing Aids** *(One per ear, per child, every three years)*	Deductible & Coinsurance	Deductible & Coinsurance
• Cochlear Implants**	Deductible & Coinsurance	Deductible & Coinsurance
• Durable Medical Equipment *(DME over $500 requires prior approval)*	Deductible & Coinsurance	Deductible & Coinsurance
• Diabetic Equipment and Self-management Education Programs	Deductible & Coinsurance	Deductible & Coinsurance
• Skilled Nursing Care Facility *(up to 30 days per confinement)*	Deductible & Coinsurance	Deductible & Coinsurance
PRESCRIPTION DRUGS		
(including insulin, disposable diabetic supplies, oral contraceptives, contraceptive patch, NuvaRing, and transplant drugs; prior approval required for certain drugs)*	1) No Drug Coverage 2) $15 generic, $40-preferred, $60-all others† 3) $250 drug deductible then 50%‡	Preferred reimbursement level
• First tier is for generic drugs; second tier is for preferred brand-name drugs; third tier is for all other drugs		
• Disposable diabetic supplies not subject to copays or drug deductibles		
• Mail order: 90-day supply for 2 ½ times the 30-day copay		
• 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.		

+$25 office visit copay applies for $500, $1,000, $1,500, and $2,000 deductibles.

†Available for $500, and $1,000, $1,500, and $2,000 deductibles only.

‡Available for $2,500, $3,500, $5,000, $6,000 and $7,500 deductibles only.

*Prior approval is required to receive certain benefits; without prior approval, 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.

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 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 COPAYMENT AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQURED 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.

EXCLUSIONS

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. 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. • 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. • 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 the 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 the policy. • 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. • Follicle-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, except as specifically stated in the policy. • Health care services not provided by a physician or any of the health care providers listed in section "Covered Expenses" of the policy. • 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, except as stated in the policy. • 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 the policy. • Health care services provided during any waiting periods for pre-existing conditions, including any complications of

EXCLUSIONS (CONT.)

such pre-existing conditions. • Health care services for obesity, weight reduction, dietetic control or morbid obesity, except as specifically stated in the policy; 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 the policy. • Oral surgical services, except as specifically stated in the policy. • 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. • 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 allogenic 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 allogenic 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 the policy. • 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, Asthma, 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, except as specifically stated in the policy • 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, except as stated in the policy. • 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, except as stated in the policy. • Nutritional counseling, except as specifically stated in the policy. • Health care services provided for your convenience or for the convenience of a physician, hospital, or other health care provider.

§ **How Out-of-Pocket Maximum is Calculated.**

To calculate your annual out-of-pocket maximum for a particular plan option, multiply your portion of the coinsurance percentage you select by the coinsurance maximum. Then, add the deductible.

For example, if you choose an annual $1,500 deductible with coinsurance of 90%/70% to $5,000, here's how the individual annual out-of-pocket maximum for services provided by in-network providers is calculated:

The amount of coinsurance you're responsible for is 10% (100% minus 90%).

.10 x $5,000 = $ 500
Deductible($1,500) + $ 500
Your annual out-of-pocket maximum is $2,000

This example is per participant. The family annual out-of-pocket maximum is three times the individual.

WPS HEALTH INSURANCE®
1717 W. Broadway, P.O. Box 8190
Madison, WI 53708-8190
www.wpsic.com

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.