CITY OF WISCONSIN RAPIDS
BENEFIT OUTLINE
EFFECTIVE: JANUARY 1, 2025

PROVISION/BENEFIT	PARTICIPATING PROVIDERS What you pay	NON-PARTICIPATING PROVIDERS What you pay*
Deductible:		
Single Coverage	$1,800	$1,800
Family Coverage	$3,600	$3,600
Participating and non-participating deductible amounts mutually satisfy one another.	The single coverage deductible does not apply under a family plan. One or more members of the family must meet the family coverage deductible before benefits are paid.	
Coinsurance		
Coinsurance	10%	30%
Annual Out-of-Pocket Limit (includes deductible and coinsurance):		
Single Coverage	$2,400	$4,800
Family Coverage	$4,800	$9,600
Participating and non-participating annual out-of-pocket amounts mutually satisfy one another.	The single coverage out-of-pocket limit does not apply under a family plan. One or more members of the family must meet the family coverage out-of-pocket limit before benefits are paid.	
Covered Expenses (not including covered drugs and covered supplies dispenses by a pharmacy)		
PROVISION/BENEFIT	**PARTICIPATING PROVIDERS What you pay**	**NON-PARTICIPATING PROVIDERS What you pay**
Allergy care	Deductible and Coinsurance	Deductible and Coinsurance
Ambulance services	Deductible and Coinsurance	Participating Provider Deductible and Coinsurance
Anesthesia services	Deductible and Coinsurance	Deductible and Coinsurance
Autism Services	Deductible and Coinsurance	Deductible and Coinsurance
Behavioral health services	Deductible and Coinsurance	Deductible and Coinsurance
Chiropractic office visit/manipulations	Deductible and Coinsurance	Deductible and Coinsurance
Colonoscopy-routine screening Limited to the first one each five years; additional colonoscopies in the five-period are subject to deductible and coinsurance	0% (deductible waived)	Deductible and Coinsurance
Colonoscopy – non-routine	Deductible and Coinsurance	Deductible and Coinsurance
Contraceptives	0% (deductible waived)	Deductible and Coinsurance
Custom-molded orthotics for the feet	Deductible and Coinsurance	Deductible and Coinsurance
Diagnostic x-ray and laboratory services – outpatient	Deductible and Coinsurance	Deductible and Coinsurance
Durable medical equipment	Deductible and Coinsurance	Deductible and Coinsurance

PROVISION/BENEFIT	PARTICIPATING PROVIDERS What you pay	NON-PARTICIPATING PROVIDERS What you pay*
Emergency room services	Deductible and Coinsurance	Participating Provider Deductible and Coinsurance
Hearing aids and implantable hearing devices Limited to children under the age of 18; hearing aids limited to one aid per ear once every three years	Deductible and Coinsurance	Deductible and Coinsurance
Home care – limited to 40 visits per year	Deductible and Coinsurance	Deductible and Coinsurance
Hospital inpatient services	Deductible and Coinsurance	Deductible and Coinsurance
Immunizations	0% (deductible waived)	0% (deductible waived)
Injections (other than immunizations)	Deductible and Coinsurance	Deductible and Coinsurance
Kidney disease treatment	Deductible and Coinsurance	Deductible and Coinsurance
Lead poisoning screening	0% (deductible waived)	100% (Not Covered)
Lenses and frames or external contact lenses: Coverage limited to following cataract surgery; aphakia and keratoconus	Deductible and Coinsurance	Deductible and Coinsurance
Mammograms: non-routine Includes coverage for 3-D mammograms	Deductible and Coinsurance	Deductible and Coinsurance
Mammograms: routine Includes coverage for 3-D mammograms Limited to one per calendar year	0% (deductible waived)	0% (deductible waived)
Maternity services	Deductible and Coinsurance	Deductible and Coinsurance
Medical supplies	Deductible and Coinsurance	Deductible and Coinsurance
Nutritional counseling	0% (deductible waived)	Deductible and Coinsurance
Office visits	Deductible and Coinsurance	Deductible and Coinsurance
Oral surgical services Limited to the 12 procedures listed in the Policy	Deductible and Coinsurance	Deductible and Coinsurance
Preventive care services (includes routine eye exams for children and adults)	0% (deductible waived)	100% (Not Covered)
Shoes: diabetic and orthopedic	Deductible and Coinsurance	Deductible and Coinsurance
Surgical services, other than oral surgical services	Deductible and Coinsurance	Deductible and Coinsurance
Telehealth visits (through our approved telehealth service provider)	Deductible and Coinsurance	100% (Not Covered)
Telemedicine (not the same as telehealth)	Deductible and Coinsurance	Deductible and Coinsurance
Temporomandibular Joint Disorder Treatment	Deductible and Coinsurance	Deductible and Coinsurance
Therapy visits (physical/ speech/occupational)	Deductible and Coinsurance	Deductible and Coinsurance
Transplant services	Deductible and Coinsurance	100% (Not Covered)
Vision examinations – non-routine	Deductible and Coinsurance	Deductible and Coinsurance
All other health care services – unless otherwise stated in your Policy	Deductible and Coinsurance	Deductible and Coinsurance

Covered Drugs and Covered Supplies	
Prescription drugs and certain diabetic supplies ***(Drugs and covered supplies dispensed by a non-participating pharmacy are not covered.)***	Participating Provider Deductible and Coinsurance
Preventive drugs – as required by the Affordable Care Act and defined in the Policy Also includes additional preventive drugs at no cost to you (refer to $0 Drug List for details).	0% (Deductible waived)

**Out-of-network services are subject to usual, reasonable and customary ("UCR") amounts. The UCR amount may be less than what the health care provider bills and you may be responsible for the difference between what the health care provider bills and the UCR amount (often referred to as "balance billing"). These amounts do not apply to the overall deductible and out-of-pocket maximums noted above.*