



# WPS Bridge65<sup>SM</sup>

*Fixed-Rate Coverage from Age 60 to Medicare*

**WPS**  
HEALTH INSURANCE<sup>®</sup>



## Right Here for You.

Since 1946, WPS' mission has been to provide affordable, comprehensive health coverage for our friends and neighbors here in Wisconsin.

If you're looking for a strong, stable company to provide the protection and security you and your family need, WPS is right here for you.

**WPS**  
HEALTH INSURANCE®

Insuring **Wisconsin's** Health Since 1946

# Your Health Insurance Bridge to Medicare.

WPS Bridge65 is designed for people ages 60 to 64, who need health insurance but are not yet eligible for Medicare. The WPS Bridge65 plan includes most of the options available on WPS Individual Preferred and Individual HSA plans, with an important difference: WPS Bridge65 lets you “lock” your rate until age 65.

## One Fixed Rate for Up to 5 Years.

The WPS Bridge65 rate guarantee helps you more accurately plan for the future. Once you enroll, your monthly premium is guaranteed not to change—for up to five years—so there’s no need to worry about unexpected rate increases.<sup>+</sup>

## Customize Your Plan and Save for the Future.

Like our other individual health insurance plans, WPS Bridge65 offers a range of coinsurance and deductible levels, as well as prescription drug options, so you can build a plan that is right for you. The WPS Bridge65 HSA-qualified plan allows you to save for current and future medical expenses in a tax-free health savings account (HSA). Then, when you become eligible for Medicare, you can even use your HSA balance to pay your Medicare Part B and D premiums.



### Do I Qualify?

If you are between the ages of 60 and 64, are a U.S. citizen or resident legal alien, and a Wisconsin resident, you can apply for WPS Bridge65.

WPS Bridge65 is an individual health insurance plan. If you are married and your spouse also qualifies for WPS Bridge65, he or she can enroll in WPS Bridge65 on a separate policy.

<sup>+</sup> Unless you make a benefit change, your eligibility changes, you add/remove dependents, change your address, state and/or federal health insurance mandates require WPS to change your benefits, or WPS discontinues the plan.



## Optional Dental Coverage — Lock It In!



In partnership with Delta Dental of Wisconsin, we offer optional dental coverage at an attractive rate to WPS

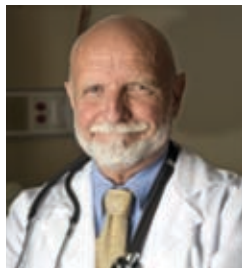
Bridge65 members. You can choose any dentist for a variety of routine and major dental services. From cleanings and X-rays, to fillings and crowns, our optional dental coverage provides the essential coverage you need for a healthy smile. Dental rates can also be locked for up to 5 years.

## Visit the Doctors You Know and Trust.

The WPS Bridge65 plans provide convenient access to the physicians and health care facilities you know and trust throughout Wisconsin. In addition to a broad selection of high-quality preferred (in-network) providers, you'll also enjoy out-of-network benefits. That means we'll pay for covered services regardless of the physician or facility you choose.

Simply select the right network to suit your needs and budget.

- The comprehensive WPS Statewide Network offers access and freedom of choice in Wisconsin, as well as in parts of Illinois, Iowa, and Minnesota.
- Our cost-effective regional networks offer access to Preferred Providers close to home.



And with the Beech Street national network Wrap, you and your family are covered anywhere you travel in the U.S.\*

\* Beech Street national network Wrap not included with the Aspirus Network or Western Preferred Network. Services received out-of-network in the U.S. or in foreign countries pays at the out-of-network or all other providers benefit level.



## Save on Vision Care and Eyewear.



Take advantage of our vision care discount program to save on eye exams, frames, lenses, and even laser vision correction when you visit providers in the EyeMed Vision Care Network. Your WPS ID card is all you need to receive your discount. For more information about participating providers and discount levels, call EyeMed toll-free at 1-866-559-5252.

## Service Rooted in Midwestern Values.

We live and work in Wisconsin, too, which is why we go the extra mile to make using your health coverage a seamless experience—from the moment you present your ID card at the doctor's office to the instant we process your claim. Our streamlined claims processing system handles claims quickly and efficiently, enhancing cost-effectiveness and accuracy. And our highly trained, caring Member Services staff is right here in Wisconsin to answer your questions.

## Next Steps.

1. Read the plan summaries on the following pages to get familiar with plan options, covered services, and exclusions.
2. Review the enclosed rate quote. If the rate quote was not enclosed, contact your local agent or WPS at **1-800-351-9925** to obtain a free, no-obligation quote.
3. If the rate quote you received meets your approval, complete and return the enclosed application. You can also apply online at [www.wpsic.com](http://www.wpsic.com).

## WPS BRIDGE65 PPO - PLAN SUMMARY

A traditional PPO plan for individuals aged 60 to 64 featuring in- and out-of-network benefits and a wide range of plan design options.

- Participant lifetime maximum benefit: \$5,000,000
- Routine care covered, with no calendar year maximum
- Dependent children: to age 27
- Spouse must apply separately

## PLAN OPTIONS - INDIVIDUAL/CHILDREN

Deductible		Coinsurance			Out-of-Pocket Max	
In-Network Individual/Children	Out-of-Network Individual/Children	In	Out	Max Individual/Children	In-Network Individual/Children	Out-of-Network Individual/Children
\$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/Children	Out-of-Network Individual/Children	In	Out	Max Individual/Children	In-Network Individual/Children	Out-of-Network Individual/Children
\$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.

## SUMMARY OF SERVICES

Services	Preferred Providers (In-Network)	All Other Providers (Out-of-Network)
<b>PREVENTIVE CARE</b>		
• Routine Medical Exams <sup>+</sup>	\$25 copay then 100%, or Deductible & Coinsurance	Deductible & Coinsurance
• Routine Labs	Coinsurance, or if no copay Deductible & Coinsurance	Deductible & Coinsurance
• Mammograms and Pap Tests	Coinsurance, or if no copay Deductible & Coinsurance	Deductible & Coinsurance
• Immunizations <i>(except for travel)</i>	100%	100% to age 6
<b>HOSPITAL SERVICES</b>		
• Room and Board, Miscellaneous Hospital Expenses, and Intensive Care Unit <i>(prior approval required*)</i>	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)
<b>EMERGENCY SERVICES</b>		
• 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	
<b>TRANSPLANTS</b> (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
<b>SINGLE KIDNEY TRANSPLANTS AND DIALYSIS TREATMENTS</b> (up to \$30,000 per year; prior approval required*)		
	Deductible & Coinsurance	Deductible & Coinsurance
<b>PROFESSIONAL SERVICES</b>		
• 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)
<b>HOME HEALTH CARE</b>		
• 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
<b>OTHER HEALTH CARE SERVICES</b>		
• 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
<b>PRESCRIPTION DRUGS</b>		
(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†	Preferred reimbursement level
• First tier is for generic drugs; second tier is for preferred brand-name drugs; third tier is for all other drugs	3) \$250 drug deductible then 50%‡	
• 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.

## WPS BRIDGE65 HSA-QUALIFIED HDHP PLAN SUMMARY

An HSA-qualified high-deductible health plan (HDHP) for individuals age 60 to 64 featuring in- and out-of-network benefits and a wide range of plan design options.

- Participant lifetime maximum benefit: \$5,000,000
- Routine care covered, with no calendar year maximum
- Dependent children: to age 27
- Spouse must apply separately

### PLAN OPTIONS - INDIVIDUAL/CHILDREN

Deductible		Coinsurance		Out-of-Pocket Max	
In-Network Individual/Children	Out-of-Network Individual/Children	In	Out	In-Network Individual/Children	Out-of-Network Individual/Children
\$2,000/\$4,000	\$2,000/\$4,000	100%	80%	\$2,000/\$4,000	\$3,000/\$6,000
\$2,000/\$4,000	\$2,000/\$4,000	80%	60%	\$5,000/\$10,000	\$6,000/\$12,000
\$2,500/\$5,000	\$2,500/\$5,000	100%	80%	\$2,500/\$5,000	\$3,500/\$7,000
\$2,500/\$5,000	\$2,500/\$5,000	80%	60%	\$5,000/\$10,000	\$6,000/\$12,000
\$3,000/\$6,000	\$3,000/\$6,000	100%	80%	\$3,000/\$6,000	\$4,000/\$8,000
\$3,000/\$6,000	\$3,000/\$6,000	80%	60%	\$5,000/\$10,000	\$6,000/\$12,000
\$3,500/\$7,000	\$3,500/\$7,000	100%	80%	\$3,500/\$7,000	\$4,500/\$9,000
\$3,500/\$7,000	\$3,500/\$7,000	80%	60%	\$5,000/\$10,000	\$6,000/\$12,000
\$5,500/\$11,000	\$5,500/\$11,000	100%	80%	\$5,500/\$11,000	\$6,500/\$13,000

**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. Family deductible must be satisfied before this plan pays benefits. One person can satisfy family deductible. 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.

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

### SUMMARY OF SERVICES

Services	Preferred Providers (In-Network)	All Other Providers (Out-of-Network)
<b>PREVENTIVE CARE</b>		
• Routine Medical Exams and Labs	Deductible & Coinsurance	Deductible & Coinsurance
• Mammograms and Pap Tests	Deductible & Coinsurance	Deductible & Coinsurance
• Immunizations <i>(except for travel)</i>	100%	100% to age 6

## SUMMARY OF SERVICES (CONT.)

Services	Preferred Providers (In-Network)	All Other Providers (Out-of-Network)
<b>HOSPITAL SERVICES</b>		
• Room and Board, Miscellaneous Hospital Expenses, and Intensive Care Unit <i>(prior approval required*)</i>	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 Deductible & Coinsurance	
• Emergency Room Care <i>(including physician charges &amp; miscellaneous expenses)</i>	Preferred Deductible & Coinsurance	
• Ambulance <i>(prior approval required for non-emergency transport*)</i>	Preferred Deductible & Coinsurance	
<b>TRANSPLANTS</b>		
<i>(determined by WPS to be medically necessary; prior approval required*)</i>	Deductible & Coinsurance	Deductible then 50% of charges
• Heart • Heart/Lung • Lung • Liver • Pancreas • Bone Marrow • Kidney/Pancreas • Kidney/Liver		
<b>SINGLE KIDNEY TRANSPLANTS AND DIALYSIS TREATMENTS</b>		
<i>(up to \$30,000 per year; prior approval required*)</i>	Deductible & Coinsurance	Deductible & Coinsurance
<b>PROFESSIONAL SERVICES</b>		
• Office Visits <i>(including chiropractors)</i>	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 <i>(occupational/physical/speech/respiratory/massage; up to 40 visits per calendar year)</i>	Deductible & Coinsurance	Deductible & Coinsurance

## SUMMARY OF SERVICES (CONT.)

Services	Preferred Providers (In-Network)	All Other Providers (Out-of-Network)
<b>PROFESSIONAL SERVICES (CONT.)</b>		
• Radiation and Chemotherapy Services	Deductible & Coinsurance	Deductible & Coinsurance
• Cardiac Rehabilitation Services <i>(up to 48 sessions)</i>	Deductible & Coinsurance	Deductible & Coinsurance
• Independent Anesthesiologist, Pathologist, and Radiologist Services	Preferred Deductible & Coinsurance	
• X-ray and Lab Services	Deductible & Coinsurance	Deductible & Coinsurance
<b>HOME HEALTH CARE</b>		
• Home Health Services <i>(up to 40 per year; prior approval required*)</i>	Deductible & Coinsurance	Deductible & Coinsurance
• Home IV Therapy and Supplies <i>(prior approval required*)</i>	Deductible & Coinsurance	Deductible & Coinsurance
<b>OTHER HEALTH CARE SERVICES</b>		
• Breast Reconstruction <i>(following a mastectomy)</i>	Deductible & Coinsurance	Deductible & Coinsurance
• Autism Services	Deductible & Coinsurance	Deductible & Coinsurance
• Hearing Aids** <i>(One per ear, per child, every three years)</i>	Deductible & Coinsurance	Deductible & Coinsurance
• Cochlear Implants**	Deductible & Coinsurance	Deductible & Coinsurance
• Durable Medical Equipment <i>(DME with a purchase price greater than \$500 requires prior approval or benefits payable at 50%)</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

## SUMMARY OF SERVICES (CONT.)

Services	Preferred Providers (In-Network)	All Other Providers (Out-of-Network)
<b>PRESCRIPTION DRUGS</b> <i>(including insulin, disposable diabetic supplies, oral contraceptives, contraceptive patch, NuvaRing, and transplant drugs; prior approval required for certain drugs*)</i>	<b>Choose One:</b> (1) Deductible, then in-network coinsurance (2) No Drug Coverage	
<ul style="list-style-type: none"><li>• Mail order benefits available</li><li>• Mandatory generic substitution program applies</li><li>• 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.</li></ul>		

\*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 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-ment, 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](http://www.wpsic.com).

## OPTIONAL DENTAL COVERAGE

Optional dental coverage that includes a variety of routine, basic, and major dental services.

- Annual Maximum Benefit: \$500 per individual, with opportunity to be as much as \$1500 *(Includes Maximum Benefit Bonus – Unused annual \$500 maximum will be rolled for use in future years up to \$1,500.)*
- Annual Deductible: \$50 per individual
- Out-of-pocket savings for all services provided by Delta Dental PPO dentists
- Higher out-of-pocket costs for services provided by non-Delta Dental PPO dentists
- To find a Delta Dental PPO dentist, visit [www.deltadentalwi.com](http://www.deltadentalwi.com)
- Dependent children: to age 27

Summary of Services	Coinsurance*	Frequency
<b>DIAGNOSTIC &amp; PREVENTIVE CARE</b>		
• Regular Cleanings	80%	2 per year
• Routine Exams	80%	2 per year
• Bitewing X-rays	80%	1 set per year
• Full mouth X-rays	80%	1 every 5 years
• Sealants - per Tooth	80%	1 per lifetime to age 19
• Emergency Exam	80%	
<b>RESTORATIVE SERVICES<sup>+</sup></b>		
• Fillings	50%	6 month waiting period
• Simple Extractions	50%	6 month waiting period
• Oral Surgery	50%	12 month waiting period
• Endodontic Services	50%	12 month waiting period
• Periodontic Services**	50%	12 month waiting period
• Crowns	50%	24 month waiting period <sup>+</sup>
• Prosthodontics Fixed	50%	24 month waiting period <sup>+</sup>
• Prosthodontics Removable	50%	24 month waiting period <sup>+</sup>

Waiting period waived with proof of continuous insurance coverage from Delta Dental of Wisconsin for at least two years

\* Percent we pay after \$50 deductible is met.

\*\* Provides additional Evidence-Based Integrated Care Plan benefits for people with specific medical conditions.

<sup>+</sup> Replacement of a defective existing appliance 10 years after its original placement date.

<sup>‡</sup> Predetermination of benefits is strongly encouraged before restorative services are scheduled.

## OPTIONAL DENTAL COVERAGE (CONT.)

### Monthly Dental Rates Effective 4/1/2010

Age	Adult Rate	# of Children	Child Rate
60	\$30.41	1	\$16.86
61	\$29.91	2	\$33.72
62	\$29.33	3+	\$58.04
63	\$28.67		
64	\$27.90		

**Important**— This plan summary provides only a general description of benefits and limitations. A detailed description of coverage is 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.

*Plan underwritten by:*



## ADDITIONAL PLAN INFORMATION

### Who can apply?

You're eligible to apply for our individual plans if you are:

- A U.S. citizen or a resident legal alien.
- Between the ages of 60 and 64.
- A Wisconsin resident.

### Renewing your plan

We'll guarantee your rate until age 65 unless one of the following occurs:

- You make a change to your plan (e.g., you change deductible amounts or switch to a new network).
- Your eligibility changes
- Your address changes
- State and/or federal health insurance mandates require WPS to change your benefits.
- We discontinue the plan.

Barring the factors mentioned above, you can keep your policy until age 65 as long as you continue to pay your premium (as required by your policy) and you remain eligible for coverage.

### Pre-existing Conditions

A participant may have had an illness or injury, whether physical or mental, for which medical advice, diagnosis, care or treatment was recommended or received within 12 months prior to a participant's effective date of coverage under this policy. If so, benefits are not payable for expenses incurred as a result of that illness or injury and any complications of any such illness or injury until the participant has been insured under this policy for 12 months in a row. No benefits are payable for charges for treatment, services, supplies or other expenses incurred during the waiting period for any such illness or injury and any complications of any such illness or injury. Charges for covered expenses for treatment of a pre-existing illness or injury and any complications of any such illness or injury which are incurred after the expiration of the waiting period for it are eligible for benefits as provided under this policy. We'll shorten the 12 calendar-month waiting period for a participant by the number of days he/she was continuously covered for such illness or injury under an immediately prior WPS health insurance policy. If a dependent child is born

or is legally adopted by the customer while he/she has family coverage under this policy, the child doesn't have a waiting period for any such illness or injury.

Medical conditions are not considered pre-existing conditions if they are both:

- Disclosed on the enrollment application and
- Not excluded or limited by an exclusion rider upon evaluation by our Underwriting Department

### Transplants

There is no waiting period for a covered transplant. Transplants may be subject to the waiting period for pre-existing conditions, as detailed above.

### Prior Approval of Health Care Services

Our prior approval is required in order for you to receive benefits for charges for covered expenses for certain health care services covered under your policy. Services that may require prior approval include but are not limited to: home care services, transplants, hospice care, and others. Please see the policy for more detailed information.

### Preadmission Certification

You, a family member, physician, hospital, or other health care provider must notify WPS about any emergency or non-emergency inpatient hospitalization to request preadmission certification of the services.

- For a scheduled inpatient hospital admission, WPS must be notified at least 3 business days in advance.
- For an emergency inpatient hospitalization, WPS must be notified within 2 business days after admission.

WPS will review the request and, if approved, authorize the hospital admission. If you do not notify WPS, benefits for covered services will be reduced. Please see the policy for more detailed information.

## ADDITIONAL PLAN INFORMATION

### Preauthorization

We do not pay benefits for health care services that are experimental, investigative, or not medically necessary or excluded from coverage, as determined by us. To ensure that services are covered, we recommend that you or your treating providers request preauthorization for services including but not limited to: transplants, new medical or biomedical technology, methods of treatment by diet or exercise, new surgical methods or techniques, acupuncture or similar methods, sleep studies, and sclerotherapy. Please see the policy for more detailed information.

### Grievance Procedure

Situations might arise when you have a question or concern about your benefits or our claim payment decisions. Most benefit and claim questions or concerns can be resolved informally by contacting our WPS Member Services Department. Our in-state toll-free telephone number is **1-800-765-4977**. Our Member Services address is:

WPS Health Insurance  
Attention: Member Services  
1717 W. Broadway, P.O. Box 8688  
Madison, WI 53708

If your question or concern can't be resolved by our Member Services Department, you or an authorized representative can file a grievance as follows:

- Write down your claim or benefit concern including the reason you disagree with our payment or coverage decision.
- Mail, deliver, or fax your written grievance, along with copies of any related materials (such as letters or other supporting documents), to us at the following address:

WPS Health Insurance  
Attention: Grievance/Appeal Committee  
1717 W. Broadway, P.O. Box 7062  
Madison, WI 53707  
Fax: 1-608-223-3603

If your life, health, or ability to regain maximum function is in serious jeopardy, or your pain can't

be managed without the care or treatment being grieved, call us toll-free at **1-800-765-4977** and we can expedite the grievance process for you.

You can designate a representative to act for you by sending us a signed letter of authorization with your written grievance. We'll provide a prompt, complete, and unbiased review of your request and our decision. If you designate a representative, we'll send the results to him or her instead of to you. The results will include our claim or benefit decision, the reason for our decision, and identify the policy provisions on which we based our decision.

## 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

## EXCLUSIONS (CONT.)

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 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.

**IMPORTANT:** This brochure provides only a general description of benefits, limitations, and exclusions. You can find a detailed description of coverage in the applicable policy issued to you. Coverage is subject to all the terms and conditions of the policy and any endorsements.

If there's ever discrepancy between the policy and this brochure, the policy has final authority.



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