Outline of Coverage

MEDICARE SUPPLEMENT INSURANCE

Basic Plan, Cost-Sharing Plans, and Plan Rider Options

Rates effective January 1, 2019

WPS HEALTH INSURANCE

Local. Honest. Independent.

WPS Medicare Supplement Plan Quick Comparison[1]

	Medicare Supplement Benefits	Basic Plan	25% Cost-Sharing Plan	50% Cost-Sharing Plan
Medicare Part A	Hospitalization	Optional riders to pay 100% or 50% of deductible	75% of Part A deductible	50% of Part A deductible
	Skilled Nursing Facility Care	Up to $170.50 per day for 21st through 100th day	Up to $127.87 per day for 21st through 100th day	Up to $85.25 per day for 21st through 100th day
	Hospice Care	Plan pays 100% of Medicare copayments/coinsurance	75% of Medicare copayments/ coinsurance	50% of Medicare copayments/ coinsurance
	Blood (first three pints)	Plan pays 100% of Medicare copayments/coinsurance	75% of Medicare copayments/ coinsurance	50% of Medicare copayments/coinsurance
Medicare Part B	Medicare Part B Deductible	Optional rider	Not available	Not available
	Medicare Part B Excess Charges	Optional rider	Not available	Not available
	Home Health Care	Plan pays for 40 visits (up to 365 with optional rider)	Plan pays for 40 visits (up to 365 with optional rider)	Plan pays for 40 visits (up to 365 with optional rider)
	Foreign Travel Emergency Medical Care (up to plan limits)	Optional rider	Not available	Not available
	Out-of-Pocket Limits	–	Yes	Yes
	Silver&Fit® Exercise and Healthy Aging Program[2]	Yes	Not available	Not available
	Discounts on Eye Care, Eyewear, and Hearing Aids[2]	Yes	Yes	Yes
	Additional Preventive Care	Yes	Not available	Not available

[1]IMPORTANT: This chart provides a basic overview. Limits may apply. Please see plan summaries on the following pages for details. If there is ever a discrepancy between the policy and this outline of coverage, the policy has final authority.

[2]Vision, hearing, and fitness discount programs are not part of the insurance policy and are offered at no additional charge. The Silver&Fit program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). Silver&Fit is a federally registered trademark of ASH.

Outline of Medicare Supplement Coverage

The Wisconsin Insurance Commissioner has set standards for Medicare supplement insurance. This policy meets these standards. The policy, along with Medicare, may not cover all of your medical costs. You should review carefully all policy limitations. For an explanation of these standards and other important information, see the "Wisconsin Guide to Health Insurance for People with Medicare" given to you when you applied for this policy. Do not buy this policy if you did not get this guide.

Premium Information
We can only raise your premium if we raise the premium for all policies like yours in this state, you enter a new age category, your residence changes such that you move to a new rating area, or if there is a change in Medicare benefits. If your policy was issued as an under age 65 policy due to a disability, when you turn age 65, your premiums will remain at the disabled rates.

Disclosures
Use this outline to compare benefits and premiums among policies.

Read Your Policy Very Carefully
This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

Right to Return Policy
If you find that you're not satisfied with your policy, you may return it to: WPS Health Insurance, P.O. Box 8190, Madison, WI 53708-8190. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments directly to you.

Policy Replacement
If you're replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

Notice
This policy may not fully cover all of your medical costs.

Neither WPS Health Insurance nor its agents are connected with the federal Medicare program.

Medicare Supplement Part A—Hospital Services—per benefit period

Your benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Per Benefit Period	Medicare Pays	Plan Pays	You Pay
Hospitalization Semiprivate room and board, general nursing, and miscellaneous hospital services and supplies.	First 60 days	All but the $1,364 deductible	$0, **or**	$1,364 deductible, or
			☐ Part A 100% Rider[1] **or,**	$0
			☐ Part A 50% Rider[2]	$682
	61st to 90th days	All but $341 per day	$341 a day	$0
	91st day and after while using 60 lifetime reserve days	All but $682 per day	$682 a day	$0
	Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare eligible expenses[3]	$0
	Beyond the additional 365 days	$0	$0	100%
Skilled Nursing Facility Care You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.	First 20 days	All approved amounts	$0	$0
	21st through 100th day	All but $170.50 per day	Up to $170.50 per day	$0
	101st day and after	$0	$0	100%
WPS Medicare supplement insurance also provides benefits for certain skilled nursing care and services that don't qualify for Medicare benefits. We'll pay benefits at the maximum daily rate established for the State of Wisconsin Medical Assistance Program, up to an additional 30 days for each confinement. You may request a policy for more details.				
Inpatient Psychiatric Care Inpatient psychiatric care in a participating psychiatric hospital.		190 days per lifetime	An additional 175 days per lifetime	Expenses beyond 365 days per lifetime
Blood	First 3 pints	$0	First 3 pints	$0
	Additional amounts	100%	$0	$0
Hospice Care Available as long as your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited coinsurance or copayment for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult the "Medicare & You" handbook for more details.

[1]This is an optional rider. You may purchase this benefit by checking the box on the application and paying the premium.

[2]This optional rider may reduce your premium when you pay 50% of Medicare Part A deductible.

[3]NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid as provided in the policy's "Core Benefits."

Medicare Supplement Policies—Part B Benefits

Medicare Part B Benefits	Per Calendar Year	Medicare Pays	Plan Pays	You Pay
Medical Expenses Eligible expense for physician's services, inpatient and outpatient medical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First $185 of Medicare-approved amounts[4]	$0	$0, **or**	$185, **or**
			☐ Optional Part B Deductible Rider[5]	$0
	Remainder of Medicare-approved amounts	Generally 80%	Generally 20%, **or**	Charges exceeding eligible charges, **or**
			☐ Optional Part B Copayment or Coinsurance rider[6], **or**	No more than $20 per office visit and $50 per emergency room visit, **or**
			☐ Optional Medicare Part B Excess Charges Rider[5]	$0
Blood	First 3 pints	$0	All costs	$0
	Next $185 of Medicare-approved amounts[4]	$0	$0, **or**	$185, **or**
			☐ Optional Part B Deductible Rider[5]	$0
	Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services Tests for diagnostic services		100%	$0	$0
Home Health Care		100% of charges for visits considered medically necessary by Medicare	40 visits, **or**	All expenses beyond 40 visits per year, **or**
			☐ Optional Additional Home Health Care Rider[5]	All expenses beyond 365 visits per year

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "Medicare & You" for more details. The dollar benefits shown are based on the amounts payable by Medicare for 2019. They will change in future years as Medicare benefits are changed.

[4]Once you have been billed $185 of Medicare-approved amounts for covered services, your Medicare Part B Deductible will have been met for the calendar year.

[5]This is an optional rider. You may purchase this benefit by checking the box on the application and paying the premium.

[6]This is an optional rider that may decrease your premium when you pay copayments for medical and emergency room visits.

Foreign Travel Emergency Medical Care Benefits

Services	Medicare Pays	Plan Pays	You Pay
Foreign Travel Emergency Medical Care This benefit rider can be added at any time without answering medical questions. See page 15 for details.	$0	$0	All charges while traveling outside the U.S., **or**
		☐ Optional Foreign Travel Emergency Rider[1]	$250 deductible and 20% of emergency medical charges that begin in the first 60 days of your trip up to the $100,000 lifetime maximum

Other Wisconsin-Mandated Benefits[2]

Services	Medicare Pays	Plan Pays	You Pay
• Kidney Transplants • Dialysis Treatments • Kidney Disease Care • Diabetic Equipment • Certain Diabetic Supplies • Diabetes Self-Management Education Programs • Chiropractic Care • Breast Reconstruction after a Mastectomy • Hospital, Ambulatory Surgery Center, and Anesthesia Charges for Dental Care (limited to specific conditions and circumstances)	80% of Medicare-eligible charges (after Part B deductible)	20% of Medicare-eligible charges (after Part B deductible), **or**	Charges exceeding 20% of the Medicare eligible charges (Plus $185 if you have not chosen the Medicare Part B Deductible Rider), **or**
		☐ Optional Medicare Part B Excess Charges Rider[1]	$0
	Wisconsin-mandated benefits may apply for services denied by Medicare. Mandated benefits for kidney transplants, dialysis treatments, and kidney disease care are subject to a $30,000 maximum per calendar year. All other benefits are payable at 100% of usual, customary, and reasonable charges. See page 11 for more information.		

Preventive Health Care Benefits

Medicare covers services that are medically necessary as well as Medicare-covered routine services (below).

Services	Medicare Pays	Plan Pays	You Pay
• Routine Eye Exams and Eye Refractions • Routine Hearing Exams • Other Preventive Services not covered 100% by Medicare	$0	Unlimited—Applies to Medicare Part B preventive services with no maximum benefit amount	$0
Preventive Services (Preventive services rated A or B by the U.S. Preventive Services Task Force. Visit medicare.gov for complete list of covered services.)	100% of the Medicare-eligible charges (no Part B deductible)	$0, **or**	Charges exceeding Medicare-eligible charges, **or**
		☐ Optional Medicare Part B Excess ChargesRider[1]	$0
Other immunizations not covered by Medicare	$0	Up to $100 per calendar year	Charges exceeding $100 per calendar year

[1]This is an optional rider. You may purchase this benefit by checking the box on the application and paying the premium.
[2]These benefits are required under Wisconsin law and are payable under the policy when the services are not covered by Medicare. When services are covered by Medicare Part B, WPS Medicare supplement insurance benefits will also apply.

Outline of Medicare Supplement Insurance

25% COST-SHARING PLAN

After Medicare pays its portion, you will pay one quarter of what remains of most covered services until you reach the annual out-of-pocket limit of $2,780 each calendar year. The amounts that count toward your annual limit are noted with diamonds (◊) in the chart below. Once you reach the annual limit, the policy pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, the annual out-of-pocket limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges"). You will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

Medicare Supplement Part A—Hospital Services—per benefit period

Your benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Per Benefit Period	Medicare Pays	Plan Pays	You Pay
Hospitalization Semiprivate room and board, general nursing, and miscellaneous hospital services and supplies.	First 60 days	All but the $1,364 deductible	$1,023 (75% of Part A deductible)	◊ $341 (25% of Part A deductible)
	61st to 90th days	All but $341 per day	$341 a day	$0
	91st day and after while using 60 lifetime reserve days	All but $682 per day	$682 a day	$0
	Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare eligible expenses[3]	$0
	Beyond the additional 365 days	$0	$0	100%
Skilled Nursing Facility Care You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.	First 20 days	All approved amounts	$0	$0
	21st through 100th day	All but $170.50 per day	Up to $127.87 per day	◊ Up to $42.63 per day
	101st day and after	$0	$0	100%
WPS Medicare supplement insurance also provides benefits for certain skilled nursing care and services that don't qualify for Medicare benefits. We'll pay benefits at the maximum daily rate established for the State of Wisconsin Medical Assistance Program, up to an additional 30 days for each confinement. You may request a policy for more details.				
Inpatient Psychiatric Care Inpatient psychiatric care in a participating psychiatric hospital.		190 days per lifetime	An additional 175 days per lifetime	Expenses beyond 365 days per lifetime
Blood	First 3 pints	$0	75%	◊ 25%
	Additional amounts	100%	$0	$0
Hospice Care Available as long as your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited coinsurance or co-payment for outpatient drugs and inpatient respite care	75% of Medicare copayment/coinsurance	◊ 25% of Medicare copayment/coinsurance

[3]NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid as provided in the policy's "Core Benefits."

25% COST-SHARING PLAN

Outline of Medicare Supplement Insurance

Medicare Supplement Policies—Part B Benefits

Medicare Part B Benefits	Per Calendar Year	Medicare Pays	Plan Pays	You Pay
Medical Expenses Eligible expense for physician's services, inpatient and outpatient medical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First $185 of Medicare-approved amounts[1]	$0	$0	◊ $185 (Part B deductible)
	Preventive benefits for Medicare-covered services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
	Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	◊ Generally 5%
Blood	First 3 pints	$0	75%	◊ 25%
	Next $185 of Medicare-approved amounts[1]	$0	$0	◊ $185 (Part B deductible)
	Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	◊ Generally 5%
Clinical Laboratory Services Tests for diagnostic services.		100%	$0	$0
Home Health Care		100% of charges for visits considered medically necessary by Medicare	40 visits, **or**	All expenses beyond 40 visits per calendar year
			☐ Optional Additional Home Health Care Rider[2]	All expenses beyond 365 visits per calendar year

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "Medicare & You" for more details. The dollar benefits shown are based on the amounts payable by Medicare for 2019. They will change in future years as Medicare benefits are changed.

[1]Once you have been billed $185 of Medicare-approved amounts for covered services, your Medicare Part B Deductible will have been met for the calendar year.

[2]This is an optional rider. You may purchase this benefit by checking the box on the application and paying the premium.

Outline of Medicare Supplement Insurance

50% COST-SHARING PLAN

After Medicare pays its portion, you will pay one half of what remains of most covered services until you reach the annual out-of-pocket limit of $5,560 each calendar year. The amounts that count toward your annual limit are noted with diamonds (◊) in the chart below. Once you reach the annual limit, the policy pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, the annual out-of-pocket limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges"). You will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

Medicare Supplement Part A—Hospital Services—per benefit period

Your benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Per Benefit Period	Medicare Pays	Plan Pays	You Pay
Hospitalization Semiprivate room and board, general nursing, and miscellaneous hospital services and supplies.	First 60 days	All but the $1,364 deductible	$682 (50% of Part A deductible)	◊ $682 (50% of Part A deductible)
	61st to 90th days	All but $341 per day	$341 a day	$0
	91st day and after while using 60 lifetime reserve days	All but $682 per day	$682 a day	$0
	Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare eligible expenses[4]	$0
	Beyond the additional 365 days	$0	$0	100%
Skilled Nursing Facility Care You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.	First 20 days	All approved amounts	$0	$0
	21st through 100th day	All but $170.50 per day	Up to $85.25 per day	◊ Up to $85.25 per day
	101st day and after	$0	$0	100%
WPS Medicare supplement insurance also provides benefits for certain skilled nursing care and services that don't qualify for Medicare benefits. We'll pay benefits at the maximum daily rate established for the State of Wisconsin Medical Assistance Program, up to an additional 30 days for each confinement. You may request a policy for more details.				
Inpatient Psychiatric Care Inpatient psychiatric care in a participating psychiatric hospital.		190 days per lifetime	An additional 175 days per lifetime	Expenses beyond 365 days per lifetime
Blood	First 3 pints	$0	50%	◊ 50%
	Additional amounts	100%	$0	$0
Hospice Care Available as long as your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited coinsurance or co-payment for outpatient drugs and inpatient respite care	50% of Medicare copayment/ coinsurance	◊ 50% of Medicare copayment/ coinsurance

[4]NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid as provided in the policy's "Core Benefits."

50% COST-SHARING PLAN

Outline of Medicare Supplement Insurance

Medicare Supplement Policies—Part B Benefits

Medicare Part B Benefits	Per Calendar Year	Medicare Pays	Plan Pays	You Pay
Medical Expenses Eligible expense for physician's services, inpatient and outpatient medical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First $185 of Medicare-approved amounts[1]	$0	$0	◊ $185 (Part B deductible)
	Preventive Benefits for Medicare-covered services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
	Remainder of Medicare-approved amounts	Generally 80%	Generally 10%	◊ Generally 10%
Blood	First 3 pints	$0	50%	◊ 50%
	Next $185 of Medicare-approved amounts[1]	$0	$0	◊ $185 (Part B deductible)
	Remainder of Medicare-approved amounts	Generally 80%	Generally 10%	◊ Generally 10%
Clinical Laboratory Services Tests for diagnostic services.		100%	$0	$0
Home Health Care		100% of charges for visits considered medically necessary by Medicare	40 visits, **or**	All expenses beyond 40 visits per calendar year
			☐ Optional Additional Home Health Care Rider[2]	All expenses beyond 365 visits per calendar year

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "Medicare & You" for more details. The dollar benefits shown are based on the amounts payable by Medicare for 2019. They will change in future years as Medicare benefits are changed.

[1]Once you have been billed $185 of Medicare-approved amounts for covered services, your Medicare Part B Deductible will have been met for the calendar year.

[2]This is an optional rider. You may purchase this benefit by checking the box on the application and paying the premium.

LIMITATIONS AND EXCLUSIONS

No insurance policy covers everything. Here's a list of things WPS Medicare supplement insurance doesn't cover:

- Personal comfort items
- Routine physical exams and any related diagnostic, X-ray, and laboratory tests covered by Medicare
- Eye exams and hearing exams, except as stated in the policy; See page 6 for details
- Orthopedic shoes or other supporting devices for the feet
- Routine foot care not covered by Medicare
- Custodial care, including maintenance care or supportive care
- Cosmetic surgery, except as stated in the policy
- Outpatient prescription drugs
- Professional services not provided by a physician, except as required by law
- Routine immunizations, except if eligible under Medicare and except as stated in the policy
- Preparation, fitting, or purchase of eyeglasses or hearing aids, unless covered by Medicare
- Care, treatment, filling, removal, or replacement of teeth; dental X-rays, root canals, surgery for impacted teeth, or other surgical procedures to the teeth or supporting structures
- Nursing home care costs beyond what is covered by Medicare and the additional 30-day skilled nursing mandated by s. 632.895 (3), Stats
- If you terminate your Medicare coverage, expenses which would have been covered by Medicare
- Your Medicare Part A Deductible, unless you purchase the Medicare 100% Part A Deductible rider, the Medicare 50% Part A Deductible rider, or a cost-sharing plan
- Your Medicare Part B Deductible, unless you purchase the Medicare 100% Part B Deductible rider
- Physician charges above Medicare's approved charge, unless you purchase the Medicare 100% Part B Excess Charges rider
- Home health care beyond 40 visits, unless you purchase the Additional Home Health Care rider
- Any health care treatments, services, or supplies received outside the United States, unless you purchase the Foreign Travel Emergency rider
- Any health care treatments, services, or supplies:
  - Not covered by Medicare, unless specifically stated in the policy
  - You, or anyone on your behalf, aren't legally obligated to pay for
  - Paid for by Medicare or another government entity or program
  - For any injury, occurring on or after your effective date, caused by an act of war
  - Provided by immediate family members or by anyone else who lives with you
  - To the extent covered by worker's compensation or similar laws
  - Provided before the effective date of coverage or after coverage ends
  - Determined by Medicare to be unreasonable or unnecessary
  - For a military service-related condition treated at any military or veterans hospital, or at any hospital contracted by any national government or agency

IMPORTANT: If there's ever a discrepancy between the policy and this outline of coverage, the policy has final authority.

ANNUALIZED PREMIUM RATES

In U.S. $	Basic Plan Only			Basic Plan with Copayment/Coinsurance Rider**			25% Cost-Sharing Plan			
Area	**1**	**2**	**3**	**1**	**2**	**3**	**1**	**2**	**3**	**1**
Age 65	1568.76	1544.76	1471.20	1363.32	1342.44	1278.48				
66	1655.88	1630.56	1552.92	1439.04	1416.96	1349.52				
67	1743.24	1716.60	1634.88	1514.76	1491.60	1420.56	1346.88	1285.68	1224.48	1060.92
68	1830.84	1802.76	1716.96	1591.08	1566.60	1492.08				
69	1918.08	1888.80	1798.80	1666.92	1641.48	1563.24				
70	2005.68	1975.08	1881.00	1743.00	1716.36	1634.64				
71	2092.68	2060.76	1962.60	1818.72	1791.00	1705.68				
72	2180.16	2146.80	2044.56	1894.56	1865.52	1776.72	1654.92	1579.68	1504.44	1303.08
73	2267.52	2232.84	2126.52	1970.28	1940.16	1847.76				
74	2354.76	2318.76	2208.36	2046.24	2014.92	1919.04				
75	2442.12	2404.80	2290.32	2122.08	2089.68	1990.20				
76	2529.60	2490.84	2372.28	2197.92	2164.20	2061.24				
77	2617.08	2577.12	2454.36	2274.24	2239.56	2132.88	1977.72	1887.84	1797.96	1557.24
78	2704.20	2662.92	2536.08	2350.20	2314.32	2204.04				
79	2791.44	2748.84	2617.92	2425.56	2388.60	2274.84				
80	2879.04	2835.00	2700.00	2502.00	2463.72	2346.36				
81	2936.04	2891.16	2753.52	2551.44	2512.44	2392.80				
82	2994.00	2948.28	2807.88	2601.96	2562.24	2440.20	2279.16	2175.48	2071.92	1794.60
83	3053.16	3006.48	2863.32	2653.08	2612.52	2488.08				
84	3114.24	3066.60	2920.56	2706.36	2664.96	2538.00				
85+	3175.56	3127.08	2978.16	2759.76	2717.52	2588.16	2420.64	2310.60	2200.56	1906.08
Under 65	5286.36	5205.60	4957.68	4593.72	4523.52	4308.12	3636.96	3471.72	3306.36	2864.40

Optional Riders	
Part B Deductible**	$196.08
Additional Home Health Care	$24.48
Foreign Travel Emergency**	$18.36

Available Discounts:

1) A 7% premium discount will be applied for members who share the same household as another WPS Medicare supplement policy holder.*

2) A 2% premium discount will be applied for members who pay by automatic bank withdrawal.

TIP For monthly rates, shown with available discounts, please see the Medicare supplement booklet that accompanies this Outline of Coverage.

ANNUALIZED PREMIUM RATES

50% Cost-Sharing Plan		Optional Rider: 50% Part A Deductible**			Optional Rider: 100% Part A Deductible**			Optional Rider: Part B Excess Charges**		
2	3	1	2	3	1	2	3	1	2	3
		156.36	153.96	146.64	318.96	314.16	299.16	73.44	72.36	68.88
		166.44	163.92	156.12	339.24	334.08	318.12	76.32	75.12	71.52
1012.68	964.44	176.28	173.64	165.36	359.76	354.36	337.44	79.32	78.12	74.40
		186.36	183.48	174.72	380.28	374.52	356.64	82.20	80.88	77.04
		196.44	193.44	184.20	400.56	394.44	375.60	85.44	84.12	80.16
		206.28	203.16	193.44	421.20	414.84	395.04	88.44	87.12	82.92
		216.36	213.12	202.92	441.60	434.88	414.12	91.44	90.12	85.80
1243.92	1184.64	226.56	223.20	212.52	462.00	455.04	433.32	94.32	92.88	88.44
		236.28	232.68	221.64	482.16	474.72	452.16	97.68	96.12	91.56
		246.36	242.52	231.00	502.68	495.00	471.48	100.56	99.00	94.32
		256.44	252.48	240.48	523.08	515.04	490.56	103.56	101.88	97.08
		266.28	262.20	249.72	543.72	535.32	509.88	106.68	105.12	100.08
1486.44	1415.64	276.24	272.04	259.08	563.88	555.24	528.84	109.68	108.00	102.84
		286.08	281.76	268.32	584.40	575.40	548.04	112.80	111.12	105.84
		296.16	291.72	277.80	604.56	595.32	567.00	115.68	113.88	108.48
		306.48	301.80	287.40	625.32	615.72	586.44	118.80	116.88	111.36
		316.56	311.76	296.88	645.72	635.76	605.52	121.80	120.00	114.24
1713.00	1631.40	326.40	321.48	306.12	666.12	655.92	624.72	124.92	123.00	117.12
		336.48	331.44	315.60	686.52	675.96	643.80	127.80	125.88	119.88
		346.32	341.04	324.84	706.80	696.00	662.88	130.92	128.88	122.76
1819.44	1732.80	356.28	350.76	334.08	727.44	716.28	682.20	133.56	131.52	125.28
2734.20	2604.00	568.08	559.44	532.80	1159.80	1142.04	1087.68	213.36	210.00	200.04

Effective date: 1/1/2019

Area Definitions:

Area 1:

53101-13, 53116-19, 53122-24, 53126-27, 53129-36, 53139-46, 53149-55, 53158-75, 53177, 53179-83, 53185-89, 53192-94, 53196-99, All 530xx, 532xx - 534xx, and all out-of-state ZIP Codes.

Area 2:

All 546xx and 549xx

Area 3:

53114-15, 53120-21, 53125, 53128, 53137-38, 53147-48, 53156-57, 53176, 53178, 53184, 53190-91, 53195, All 535xx - 545xx, 547xx, 548xx.

*Household: Two or more individuals who reside together in the same dwelling. Dwelling is defined as a single home, condominium unit, or apartment unit within an apartment complex.

** Not available with Medicare supplement cost-sharing plans.

GRIEVANCE PROCEDURES

Your policy provides complete details on these procedures. 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 by contacting our WPS Customer Support department. Our toll-free telephone number is: 1-888-253-2694. Our Customer Support address is:

WPS Health Insurance
Attention: Customer Support
1717 W. Broadway ▪ P.O. Box 8190
Madison, WI 53708-8190

If your question or concern can't be resolved by our Customer Support department, you or an authorized representative can file a written grievance. You can designate a representative to act for you by sending us a signed letter of authorization with your written grievance. To file a grievance:

1. Write down your claim or benefit concern, including the reason you disagree with our payment or coverage decision.
2. 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:
3. WPS Health Insurance
   Attention: Grievance/Appeals Committee
   1717 W. Broadway ▪ P.O. Box 7062
   Madison, WI 53707-7062
   Fax: 1-608-977-9920

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 1-888-253-2694, and we can expedite the grievance process for you.

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 of our review 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.

DEFINITIONS

Grievance—Any dissatisfaction with our provision of services or our claims practices that is expressed in writing to us by, or on behalf of, you. **A charge**, as used in this outline of coverage, means the reasonable charge for an item or service established by Medicare.

Neither Medicare nor your WPS Medicare supplement insurance policy will pay for charges Medicare determines are "unreasonable or unnecessary."
A usual, customary, or reasonable charge, as used in this outline of coverage, is an amount we determine to be reasonable. In determining what is a reasonable charge, we consider such factors as the amount providers charge for similar treatments, services, and supplies provided in the same general area under similar circumstances. This definition applies only to state-mandated benefits for chiropractic care; diabetic equipment, supplies and self-management education programs; home health care; breast reconstruction; and hospital, ambulatory surgery center, and anesthesia charges for dental care.

GENERAL INFORMATION

This outline of coverage provides only a general description of WPS Medicare supplement insurance benefits, limitations, and exclusions. You can find a more detailed description of WPS Medicare supplement insurance in the policy. The policy will be issued to you upon approval for coverage under the WPS Medicare supplement insurance plan. Coverage is subject to all terms and conditions of the policy and all riders. We've added the subject headings in this outline of coverage for easier reading and quick reference. These headings aren't part of the description of coverage, and aren't to be used in determining applicable limitations and exclusions. This outline of coverage doesn't give all the details of Medicare coverage. Contact your local Social Security Office or consult "Medicare & You" for more details. To receive a copy of this handbook, call 1-800-633-4227.

RENEWAL TERMS

For your WPS Medicare supplement insurance coverage to continue, we must receive your premium as required by the policy. We'll only send one bill to notify you when your premium is due. (If you're paying by automatic bank withdrawal, no bills are sent.) Your grace period for paying the premium is 31 days after the premium due date.

Your premium is subject to change at our option. Any change in your WPS Medicare supplement insurance premium will apply to all policyholders with identical policies who live in the same ZIP code and who are the same age as you.

You can terminate your coverage at any time by writing to us prior to your requested termination date.

PREMIUM CALCULATION WORKSHEET

I live in: ☐ Area 1 ☐ Area 2 ☐ Area 3 (See page 13 for help determining your area.)

To view monthly premium discounted rates and to determine your rate area, please see the WPS Medicare supplement booklet that accompanies this Outline of Coverage. For annualized rates, with no discounts added, please see pages 12 and 13.

Important: Members who pay by automatic bank withdrawal pay a premium that is 2% less than those who pay by credit/debit card or by monthly direct bill. Please take into account this available discount when entering premium amounts below.

Choose your Medicare supplement coverage

$_____ ☐ **Basic Plan Only**
(Highest coverage option)

☐ **Basic Plan with Copayment/Coinsurance Rider***
(Second-highest coverage option)

☐ **25% Cost-Sharing Plan**
(Second-lowest coverage option)

☐ **50% Cost-Sharing Plan**
(Lowest coverage option)

* If you select this coverage, after you pay the Medicare Part B deductible, you pay a $20 copayment for office visits and up to a $50 copayment for emergency room visits, or pay the Medicare Part B coinsurance, whichever is less.

Optional benefit riders for Medicare supplement policy

Each of these riders may be purchased separately.

$_____ **Medicare Part A Deductible (available with either basic plan option)**
If you select this coverage, we will pay either 100% or 50% of your Medicare Part A deductible of $1,364 during the first 60 days of hospitalization.
☐100% **or** ☐ 50%

$_____ ☐ **Medicare Part B Deductible (available with the highest basic plan option)**
If you select this coverage, we will pay your Medicare Part B deductible of $185 each calendar year.

$_____ ☐ **Medicare Part B Excess Charges (available with either basic plan option)**
If you select this coverage, we will pay the difference between what Medicare approves for payment and the amount charged by the provider, if your provider does not accept Medicare assignment. The difference shall be no more than the actual charge or the limiting charge allowed by Medicare, whichever is less.

$_____ ☐ **Additional Home Health Care (available with any plan)**
If you select this coverage, we'll pay benefits for an additional 325 home health care visits each calendar year, up to a total of 365 visits per year, including those covered by Medicare.

$_____ ☐ **Foreign Travel Emergency (available with either basic plan option)**
If you select this coverage, we'll pay 80% of expenses associated with emergency medical care you receive outside the U.S. that begins in the first 60 days of a trip, after you satisfy a deductible of $250, up to a lifetime maximum benefit of $100,000.

\+ $_____ **Optional Rider Subtotal**

\+ $_____ **Optional Dental Coverage** If you are also enrolling in optional dental coverage, enter the dental rate here.

= $_____ **Subtotal**

x $_____ **Household Discount** If you are taking advantage of the 7% household discount, multiply your subtotal by 0.93

= $_____ **YOUR PREMIUM**

In addition to this Outline of Coverage, WPS Health Insurance will send an annual notice to you 30 days prior to the effective date of Medicare changes that will describe these changes and the changes in your Medicare supplement coverage.

NON-DISCRIMINATION POLICY

Wisconsin Physicians Service Insurance Corporation/ The EPIC Life Insurance Company (A WPS Company) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. WPS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

WPS: Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

WPS: Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, call us at the phone number on the attached correspondence, your ID card, or the number listed on wpshealth.com.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-731-0459 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-731-0459 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-731-0459 (телетайп: 711).

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-731-0459 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-731-0459 (ATS : 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-731-0459 (TTY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-731-0459 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-731-0459 (TTY: 711).

If you believe that WPS has failed to provide these services, or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

WPS Nondiscrimination Grievance Coordinator
P.O. Box 7458
Madison, WI 53707
Email: wpsnondiscrimination@wpsic.com

You can file a grievance in person or by mail, or email. If you need help filing a grievance, the Nondiscrimination Grievance Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf; by mail at U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201; or by phone at 1-800-368-1019 (TTY: 1-800-537-7697). Complaint forms are available at hhs.gov/ocr/office/file/index.html.

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-731-0459 (TTY: 711).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-731-0459 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-731-0459 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-731-0459 (رقم هاتف الصم والبكم: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-731-0459 (TTY: 711)。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-731-0459 (TTY: 711) 번으로 전화해 주십시오.

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິ ການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ ເສັ ຽຄ່າ, ແມ່ ນມ ພ້ ອມໃຫ້ ທ່ານ. ໂທຣ 1-800-731-0459 (TTY: 711).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-731-0459 (TTY: 711) पर कॉल करें।

WPS HEALTH INSURANCE
Local. Honest. Independent.