



# **WPS Medicare Companion**

**25% Cost-Sharing Plan / 50% Cost-Sharing Plan**

Medicare Supplement Rates and Plan Information

***Effective August 1, 2009***

**WPS**  
HEALTH INSURANCE®

# WPS Health Insurance

## Outline of Medicare Supplement Coverage

### 25% COST-SHARING PLAN

### 50% COST-SHARING PLAN

### Medicare Supplement Insurance

The Wisconsin Insurance Commissioner has set standards for Medicare supplement insurance. This policy meets these standards. It, 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. Rate changes that reflect an increase in your age will be effective on the first renewal after your birthday.

### 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.*

# Outline of Medicare Supplement Coverage - 25% Cost-Sharing Plan

You will pay one quarter the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$2,310 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 COST-SHARING PLAN PART A — HOSPITAL SERVICES-PER BENEFIT PERIOD

A 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	THIS POLICY PAYS	YOU PAY
<b>• HOSPITALIZATION</b> Semiprivate room and board, general nursing, and miscellaneous hospital services and supplies.	First 60 days	All but \$1,068	\$801 (75% of Part A deductible)	♦\$267 (25% of Part A deductible)
	61st to 90th day	All but \$267 per day	\$267 per day	\$0
	91st to 150th day	All but \$534 per day	\$534 per day	\$0
	Beyond 150 days	\$0	100% Medicare-eligible expenses**	\$0
<b>• SKILLED NURSING FACILITY CARE</b> 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 \$133.50 per day	Up to \$100.12 per day	♦Up to \$33.38 per day
	101st day and after	\$0	\$0	All costs
<b>• INPATIENT PSYCHIATRIC CARE</b> Inpatient psychiatric care in a participating psychiatric hospital.		190 days per lifetime	175 days per lifetime	Expenses beyond 365 days per lifetime
<b>• BLOOD</b>	First 3 pints	\$0	75%	♦25%
	Additional amounts	100%	\$0	\$0
<b>• HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services.		Generally, most Medicare eligible expenses for outpatient drugs and inpatient respite care	75% of coinsurance or copayments	♦25% of coinsurance or copayments

✶✶ 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 COST-SHARING PLAN — PART B BENEFITS**

<b>MEDICARE PART B BENEFITS</b>	<b>PER CALENDAR YEAR</b>	<b>MEDICARE PAYS</b>	<b>THIS POLICY PAYS</b>	<b>YOU PAY</b>
<b>• MEDICAL EXPENSES</b> Eligible expense for physician’s services, inpatient and outpatient medical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First \$135 of Medicare approved amounts*	\$0	\$0	◆\$135 (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%
<b>• BLOOD</b>	First 3 pints	\$0	75%	◆25%
	Next \$135 of Medicare-approved amounts*	\$0	\$0	◆\$135 (Part B Deductible)
	Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	◆Generally 5%
<b>• CLINICAL LABORATORY SERVICES</b> Tests for diagnostic services.		100%	\$0	\$0
<b>• HOME HEALTH CARE</b>		100% of charges for visits considered medically necessary by Medicare	40 visits <input type="checkbox"/> Optional Additional Home Health Care Rider**	Beyond 40 visits per calendar year or beyond 365 visits

- **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 2009. They will change in future years as Medicare benefits are changed.
- ★ Once you have been billed \$135 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Medicare Part B Deductible will have been met for the calendar year.
- ★★ This is an optional rider. You purchased this benefit if the box is checked and you paid the premium.

# Outline of Medicare Supplement Coverage - 50% Cost-Sharing Plan

You will pay one half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$4,620 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, this 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 COST-SHARING PLAN PART A — HOSPITAL SERVICES-PER BENEFIT PERIOD

A 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	THIS POLICY PAYS	YOU PAY
<b>• HOSPITALIZATION</b> Semiprivate room and board, general nursing, and miscellaneous hospital services and supplies.	First 60 days	All but \$1,068	\$534 (50% of Part A deductible)	◆\$534 (50% of Part A deductible)
	61st to 90th day	All but \$267 per day	\$267 a day	\$0
	91st to 150th day	All but \$534 per day	\$534 a day	\$0
	Beyond 150 days	\$0	100% of Medicare eligible expenses**	\$0
<b>• SKILLED NURSING FACILITY CARE</b> 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 \$133.50 per day	Up to \$66.75 per day	◆Up to \$66.75 per day
	101st day and after	\$0	\$0	All costs
<b>• INPATIENT PSYCHIATRIC CARE</b> Inpatient psychiatric care in a participating psychiatric hospital.		190 days per lifetime	175 days per lifetime	Expenses beyond 365 days per lifetime
<b>• BLOOD</b>	First 3 pints	\$0	50% of coinsurance or copayments	◆50% of coinsurance or copayments
	Additional amounts	100%	\$0	\$0
<b>• HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services.		Generally, most Medicare eligible expenses for outpatient drugs and inpatient respite care	50% of coinsurance or copayments	◆50% of coinsurance or copayments

\*\* 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 COST-SHARING PLAN — PART B BENEFITS

MEDICARE PART B BENEFITS	PER CALENDAR YEAR	MEDICARE PAYS	THIS POLICY PAYS	YOU PAY
<p><b>• MEDICAL EXPENSES</b> Eligible expenses for physician’s services, inpatient and outpatient medical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.</p>	<p>First \$135 of Medicare approved amounts*</p> <p>Preventive Benefits for Medicare covered services</p> <p>Remainder of Medicare approved amounts</p>	<p>\$0</p> <p>Generally 75% or more of Medicare approved amounts</p> <p>Generally 80%</p>	<p>\$0</p> <p>Remainder of Medicare approved amounts</p> <p>Generally 10%</p>	<p>◆\$135 (Part B Deductible)</p> <p>All costs above Medicare approved amounts</p> <p>◆Generally 10%</p>
<p><b>• BLOOD</b></p>	<p>First 3 pints</p> <p>Next \$135 of Medicare-approved amounts*</p> <p>Remainder of Medicare-approved amounts</p>	<p>\$0</p> <p>\$0</p> <p>Generally 80%</p>	<p>50%</p> <p>\$0</p> <p>Generally 10%</p>	<p>◆50%</p> <p>◆\$135 (Part B Deductible)</p> <p>◆Generally 10%</p>
<p><b>• CLINICAL LABORATORY SERVICES</b> Tests for diagnostic services.</p>		100%	\$0	\$0
<p><b>• HOME HEALTH CARE</b></p>		100% of charges for visits considered medically necessary by Medicare	40 visits <input type="checkbox"/> Optional Additional Home Health Care Rider**	Beyond 40 visits per calendar year or beyond 365 visits

- **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 2009. They will change in future years as Medicare benefits are changed.
- ★ Once you have been billed \$135 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Medicare Part B Deductible will have been met for the calendar year.
- ★★ This is an optional rider. You purchased this benefit if the box is checked and you paid the premium.

# Premium Rates

## Effective August 1, 2009

# AREA 1

(The Milwaukee area and Southeastern Wisconsin)

Rates for applicants living in Area 1, including the following ZIP codes:

530\_\_\_: 02, 04, 05, 07, 08, 12, 17, 18, 21, 22, 24, 25, 27-30, 33, 37, 40, 41, 45, 46,  
51-56, 58, 60, 64, 66-69, 71, 72, 74, 76, 77, 80, 86, 87, 89, 90, 92, 95-97

531\_\_\_: 01-13, 16-19, 22-24, 26, 27, 29-36, 39-46, 49-55, 58-75, 77, 79-83, 85-89, 92-94, 96-99

532\_\_\_ thru 534\_\_\_: All ZIP Codes

MONTHLY PREMIUM				
	25% COST-SHARING PLAN		50% COST-SHARING PLAN	
Age	PREMIUM	HOME HEALTH CARE RIDER	PREMIUM	HOME HEALTH CARE RIDER
65-67	\$99.06	\$2.00	\$78.01	\$2.00
68-69	\$110.88	\$2.00	\$87.32	\$2.00
70-74	\$137.81	\$2.00	\$108.52	\$2.00
75+	\$153.97	\$2.00	\$121.23	\$2.00
Under 65	\$160.46	\$2.00	\$126.37	\$2.00

ANNUAL PREMIUM				
	25% COST-SHARING PLAN		50% COST-SHARING PLAN	
Age	PREMIUM	HOME HEALTH CARE RIDER	PREMIUM	HOME HEALTH CARE RIDER
65-67	\$1,188.72	\$24.00	\$936.12	\$24.00
68-69	\$1,330.56	\$24.00	\$1,047.84	\$24.00
70-74	\$1,653.72	\$24.00	\$1,302.24	\$24.00
75+	\$1,847.64	\$24.00	\$1,454.76	\$24.00
Under 65	\$1,925.52	\$24.00	\$1,516.44	\$24.00

## Renewal Terms.

For your WPS Medicare supplement 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 through our Automatic Cash Handling program, no bills are sent.)

Your grace period for paying the premium is:

- 31 days after the premium due date when you pay quarterly, semiannually, or annually
- 10 days after the premium due date when you pay monthly

### To calculate rates:

- Quarterly: Divide annual rate by 4
- Semiannually: Divide annual rate by 2
- Rates include a discount for using one of our automated payment options (payment by debit card, credit card, automated bank draft, or annual billing by mail). If you prefer to receive a bill in the mail on a monthly, quarterly, or semiannual basis, the cost will be \$5.00 higher for each bill.

**Additional Notes:** These rates also apply if you move outside Wisconsin. If, in the future, you permanently relocate to another state, Area 1 rates will apply. If you relocate to another Wisconsin ZIP code, Area 1 or 2 rates will apply as appropriate.

This brochure contains rates and plan information for coverage effective August 1, 2009. If you need to enroll for 2010, please contact your agent or your WPS sales representative for updated information.

### Spousal Discount:

- WPS offers a 2% spousal discount when both you and your spouse are enrolled in a current WPS Medicare supplement plan. To calculate, multiply your final rate by 0.98.

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

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

# Premium Rates

## Effective August 1, 2009

# AREA 2

(All other Wisconsin locations not included in Area 1)

Rates for applicants living in Area 2, including the following ZIP codes:

530\_\_\_: 01, 03, 06, 09-11, 13-16, 19, 20, 23, 26, 31, 32, 34-36, 38, 39, 42-44, 47-50,  
57, 59, 61-63, 65, 70, 73, 75, 78, 79, 81-85, 88, 91, 93, 94, 98, 99

531\_\_\_: 14, 15, 20, 21, 25, 28, 37, 38, 47, 48, 56, 57, 76, 78, 84, 90, 91, 95

535\_\_\_ thru 549\_\_\_: All ZIP Codes

MONTHLY PREMIUM				
Age	25% COST-SHARING PLAN		50% COST-SHARING PLAN	
	PREMIUM	HOME HEALTH CARE RIDER	PREMIUM	HOME HEALTH CARE RIDER
65-67	\$90.05	\$2.00	\$70.92	\$2.00
68-69	\$100.80	\$2.00	\$79.38	\$2.00
70-74	\$125.28	\$2.00	\$98.65	\$2.00
75+	\$139.97	\$2.00	\$110.21	\$2.00
Under 65	145.87	\$2.00	\$114.88	\$2.00

ANNUAL PREMIUM				
Age	25% COST-SHARING PLAN		50% COST-SHARING PLAN	
	PREMIUM	HOME HEALTH CARE RIDER	PREMIUM	HOME HEALTH CARE RIDER
65-67	\$1,080.60	\$24.00	\$851.04	\$24.00
68-69	\$1,209.60	\$24.00	\$952.56	\$24.00
70-74	\$1,503.36	\$24.00	\$1,183.80	\$24.00
75+	\$1,679.64	\$24.00	\$1,322.52	\$24.00
Under 65	\$1,750.44	\$24.00	\$1,378.56	\$24.00

## Renewal Terms.

For your WPS Medicare supplement 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 through our Automatic Cash Handling program, no bills are sent.) Your grace period for paying the premium is:

- 31 days after the premium due date when you pay quarterly, semiannually, or annually
- 10 days after the premium due date when you pay monthly

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

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

### To calculate rates:

- Quarterly: Divide annual rate by 4
- Semiannually: Divide annual rate by 2
- Rates include a discount for using one of our automated payment options (payment by debit card, credit card, automated bank draft, or annual billing by mail). If you prefer to receive a bill in the mail on a monthly, quarterly, or semiannual basis, the cost will be \$5.00 higher for each bill.

**Additional Notes:** These rates also apply if you move outside Wisconsin. If, in the future, you permanently relocate to another state, Area 1 rates will apply. If you relocate to another Wisconsin ZIP code, Area 1 or 2 rates will apply as appropriate.

This brochure contains rates and plan information for coverage effective August 1, 2009. If you need to enroll for 2010, please contact your agent or your WPS sales representative for updated information.

### Spousal Discount:

- WPS offers a 2% spousal discount when both you and your spouse are enrolled in a current WPS Medicare supplement plan. To calculate, multiply your final rate by 0.98.

# No Waiting Periods for Pre-existing Conditions if You Have a Prior Health Insurance Plan.

You **WILL NOT** have a waiting period for pre-existing conditions as long as, immediately prior to your effective date of coverage under WPS Medicare Companion, you were continuously covered by another health insurance plan (including Medicare, TRICARE, or other state or federal health benefits program) for at least six months.

You **WILL** have a waiting period for pre-existing conditions if you weren't continuously covered by another health insurance plan for at least six months immediately prior to your effective date of coverage under WPS Medicare Companion. If so, WPS Medicare Companion won't provide benefits for pre-existing conditions for six months following your effective date.

## 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 Member Services department. Our toll-free telephone number is:

**1-888-253-2694.**

Our Member Services address is:

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

If your question or concern can't be resolved by our Member Services 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:

**WPS Health Insurance**  
**Attention: Grievance/Appeal Committee**  
1717 West Broadway  
P.O. Box 7062  
Madison, WI 53707-7062  
Fax: 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 at one of the following telephone numbers and we can expedite the grievance process for you:

Toll Free **1-888-253-2694** or  
**608-221-1600** (Local to Madison)

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.

### **DEFINITION:**

**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.

## Limitations and Exclusions.

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


- Personal comfort items
- Routine physical exams, eye exams, hearing exams, and directly related tests, eye glasses or for the preparation or fitting of such things as eye glasses or hearing aids, except for those services covered by Medicare
- 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
- 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
- Your Medicare Part B Deductible
- Physician charges above Medicare's approved charge
- Home health care beyond 40 visits, unless you purchase the Additional Home Health Care Rider
- Any treatments, services, or supplies received outside the United States
- **Any 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
  - For any pre-existing condition provided during the applicable waiting period
  - 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


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## General Information.

This outline of coverage provides only a general description of the WPS Medicare supplement benefits, limitations, and exclusions. You can find a more detailed description of the WPS Medicare supplement coverage in the policy. The policy will be issued to you upon approval for coverage under the WPS Medicare supplement plan. Coverage is subject to all terms and conditions of the policy and the Home Health Care Rider.

**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.**

## IMPORTANT:

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



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[www.wpsic.com](http://www.wpsic.com)