

**Maximize cost Savings.** An HMO provides one of the most effective ways to manage health care costs. Members have access to the many services and programs available including 2,000 medical, hospital, and specialty providers throughout Wisconsin. Members will enjoy the outstanding reputation of Arise Health Plan while benefiting from the cost savings and stability of an HMO.



We care for Wisconsin.  
UNDERWRITTEN BY WPS HEALTH PLAN, INC.

Deductible	Coinsurance		Out-of-Pocket (Incl Deductible)
	In	In	In
Single/Family			Single/Family
250/750	80%	5,000	1,250/2,750
250/750	80%	10,000	2,250/4,750
500/1,500	80%	5,000	1,500/3,500
500/1,500	80%	10,000	2,500/5,500
1,000/3,000	100%	5,000	1,000/3,000
1,000/3,000	90%	10,000	2,000/5,000
1,000/3,000	80%	5,000	2,000/5,000
1,000/3,000	80%	10,000	3,000/7,000
1,500/4,500	100%	5,000	1,500/4,500
1,500/4,500	90%	10,000	2,500/6,500
1,500/4,500	80%	5,000	2,500/6,500
1,500/4,500	80%	10,000	3,500/8,500
2,500/7,500	100%	5,000	2,500/7,500
2,500/7,500	80%	10,000	4,500/11,500
5,000/15,000	100%	5,000	5,000/15,000

Individual Annual Maximum Benefit	\$5,000,000	
Summary of Services	Participating Providers (In-Network)	Non-Participating Providers (Out-of-Network)
<b>Wellness Care and Routine Physicals</b> Preventive services rated A or B by the U.S. Preventive Services Task Force (USPSTF) are covered at 100%, including recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women. Please see policy for a complete listing of services rated A or B.	100% Coverage + Waiver of Deductible	Not Covered
<ul style="list-style-type: none"> <li>Routine Mammograms (40+)</li> </ul>	100% Coverage + Waiver of Deductible	Not Covered
<b>Hospital Services</b> <ul style="list-style-type: none"> <li>Room and Board, Miscellaneous Hospital Expenses, and Intensive Care Unit (prior approval required*)</li> <li>Outpatient Facility Fees</li> <li>Outpatient Radiology, Pathology, and Lab Services</li> <li>Outpatient Practitioner Fees</li> </ul>	Deductible & Coinsurance	Not Covered
<b>Emergency and Urgent Care Services</b> <ul style="list-style-type: none"> <li>Emergency Room Facility Fees</li> <li>Emergency Room Care (including physician charges &amp; miscellaneous expenses)</li> </ul>	Participating Provider Deductible & Coinsurance	
<ul style="list-style-type: none"> <li>Ambulance (prior approval required for non-emergency transport*)</li> </ul>	Participating Provider Deductible & Coinsurance	
<b>Transplants</b> Covered expenses include, but are not limited to, hospital charges, practitioner charges, organ and tissue acquisition, tissue typing, and ancillary services at a Designated Transplant Facility that are Medically Necessary. (prior approval required*)	Deductible & Coinsurance	Not Covered
<b>Kidney Transplants and Dialysis Treatments</b> (prior approval required*)	Deductible & Coinsurance	Not Covered
<b>Professional Services</b> <ul style="list-style-type: none"> <li>Office Visits (including chiropractic care and occupational, physical, speech, and respiratory therapy)</li> <li>X-ray and Lab Services</li> </ul>	Deductible & Coinsurance	Not Covered
<ul style="list-style-type: none"> <li>Maternity Services</li> </ul>	Not Covered	Not Covered
<ul style="list-style-type: none"> <li>Medical and Surgical Services</li> </ul>	Deductible & Coinsurance	Not Covered

Summary of Services (Continued)	Participating Providers (In-Network)	Non-Participating Providers (Out-of-Network)
<b>Home Health Care</b> • Home Health Services (up to 40 visits per year; prior approval required*) • Home IV Therapy and Supplies (prior approval required*)	Deductible & Coinsurance	Not Covered
<b>Hearing Aids &amp; Cochlear Implants</b> • Covered expenses include the cost of hearing aids and cochlear implants that are prescribed by a physician or audiologist for a Dependent under the age of 18 who is certified as deaf or hearing impaired by a physician or audiologist • Coverage for hearing aids will be limited to the cost of one hearing aid every three years per ear per Dependent under 18 years of age	Deductible & Coinsurance	Not Covered
<b>Autism Spectrum Disorders</b> • Includes autism disorder, Asperger's syndrome, or any other pervasive development disorder • Covered expenses will be provided for services rendered that have a primary diagnosis code of Autism Spectrum Disorders • Covered expenses are payable for evidence-based behavioral intensive-level services up to a maximum benefit of \$50,000 per calendar year with a maximum of 35 hours of care per week for a maximum of 48 months • Covered expenses are payable for evidence-based nonintensive-level services up to a maximum benefit of \$25,000 per calendar year	Deductible & Coinsurance	Not Covered
<b>Other Health Care Services</b> • Breast Reconstruction (following a mastectomy) • Durable Medical Equipment (DME costing more than \$500 requires prior approval) • Diabetic Equipment and Self-Management Education Programs • Temporomandibular Joint (TMJ) Disorders (diagnosis and non-surgical treatment up to \$1,250 per year) • Skilled Nursing Care Facility (up to 30 days per confinement) • Contraceptive devices, implants, or injections	Deductible & Coinsurance	Not Covered
<b>Prescription Drugs</b> (subject to \$500 annual deductible) (including insulin, disposable diabetic supplies, and oral contraceptives; prior approval required for certain drugs*) <b>Retail</b> (30 day supply)** <ul style="list-style-type: none"> <li>• Generic</li> <li>• Brand</li> <li>• Non-Formulary</li> </ul>	30% Coinsurance After Deductible 30% Coinsurance After Deductible 60% Coinsurance After Deductible	Prescriptions covered only when provided by Express Scripts affiliated pharmacies
<b>Mail Order</b> (90 day supply)** <ul style="list-style-type: none"> <li>• Generic</li> <li>• Brand</li> <li>• Non-Formulary</li> </ul>	25% Coinsurance After Deductible 25% Coinsurance After Deductible 50% Coinsurance After Deductible	
*Prior approval required when receiving certain benefits; without prior approval, benefits may be denied or substantially limited. Note: All benefits are subject to the applicable limitations and exclusions as defined in the policy. Annual benefit limitations apply per calendar year.  **Maximum retail out-of-pocket is \$200 per prescription after prescription drug deductible has been met. Maximum mail order out-of-pocket is \$400 per prescription after prescription drug deductible has been met.		
IMPORTANT: This plan summary provides only a general description of benefits and limitations. You can find a detailed description of coverage in the applicable policy. Coverage is subject to all the terms and conditions of the policy and any endorsements or amendments. If there is ever a disagreement between the policy and this brochure, the policy has final authority. This plan summary must be used in conjunction with the additional plan information inserts which includes plan limitations and exclusions. In-network and out-of-network deductibles track separately.		

### 100% Wellness Benefit

Routine physicals, immunizations, mammograms, and other preventive services are covered 100%, with no annual dollar limit when received from a Participating Provider.

### Buy-Up Options

(available for POS and HMO plans only)

Choose our Buy-Up option to make your individual plan look and act more like a group insurance plan.

By choosing the Buy-Up option:

- Your drug deductible is waived (your prescription benefit remains 30%/30%/60% for retail and 25%/25%/50% for mail order)
- Any covered in-network office visits are paid at 100% after you pay a \$30 copayment (Applies to office visit charge only.)\*

\*See plan for details.