The EPIC Life Insurance Company®
A WPS Company

Outline of Medicare Supplement Coverage

Benefit Chart of Medicare Supplement Plans Sold with Effective Dates On or After January 1, 2026

This chart shows the benefits included in each of the standardized Medicare supplement plans. Every company must make Plan A available. Some plans may not be available. Only applicants first eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

	Plans Available to All Applicants								Medicare first eligible before 2020 only	
Benefits	**A**	**B**	**D**	**G[1]**	**K**	**L**	**M**	**N**	**C**	**F[1]**
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓ Copays apply[3]	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2026[2]					$8,000[2]	$4,000[2]				

✓ indicates 100% of the benefit is paid.

Plans shaded in gray are offered by The EPIC Life Insurance Company®.

[1]Plans F and G also have high deductible options which require first paying the plans' deductibles of $2,950 before the plans begin to pay. Once the plans' deductibles are met, the plans pay 100% of covered services for the rest of the calendar year. High deductible Plans F and G do not cover the separate foreign travel emergency deductible. High deductible Plan G does not cover the Medicare Part B deductible. However, high deductible Plans F and G count your payments of the Medicare Part B deductible toward meeting the plan deductibles.

[2]Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limits.

[3]Plan N pays 100% of the Medicare Part B coinsurance, except for copayments of up to $20 for some office visits and up to $50 copayments for emergency room visits that do not result in inpatient admissions.

Notice to buyer: This policy may not cover all of the costs associated with medical care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.

FL_MSO_1908

ANNUALIZED PREMIUM RATES

ZIP codes 330xx - 334xx, and moving out of state

FEMALE

Age	Plan A	Plan G	Plan K	Plan L	Plan N	Plan C	Plan F
Under 65	$12,622.32	$15,075.72	$9,061.56	$11,871.24	$13,463.52	$16,425.00	$16,479.72
65	$3,606.48	$4,307.52	$2,589.12	$3,391.92	$3,846.72	$4,692.96	$4,708.56
66	$3,669.36	$4,382.64	$2,634.24	$3,450.96	$3,913.80	$4,775.04	$4,790.76
67	$3,732.48	$4,458.12	$2,679.60	$3,510.36	$3,981.24	$4,857.12	$4,872.96
68	$3,825.72	$4,569.24	$2,746.56	$3,598.08	$4,080.48	$4,978.32	$4,994.64
69	$3,918.72	$4,680.24	$2,813.16	$3,685.44	$4,179.72	$5,099.40	$5,116.32
70	$4,011.60	$4,791.48	$2,880.00	$3,772.92	$4,278.96	$5,220.36	$5,237.76
71	$4,104.72	$4,902.60	$2,946.72	$3,860.40	$4,378.44	$5,341.44	$5,359.08
72	$4,197.72	$5,013.60	$3,013.56	$3,948.24	$4,477.68	$5,462.64	$5,480.52
73	$4,285.80	$5,118.72	$3,076.68	$4,030.68	$4,571.52	$5,577.24	$5,595.48
74	$4,373.88	$5,224.08	$3,140.04	$4,113.48	$4,665.36	$5,691.72	$5,710.68
75	$4,461.96	$5,329.32	$3,203.28	$4,196.40	$4,759.44	$5,806.44	$5,825.64
76	$4,550.04	$5,434.44	$3,266.40	$4,279.08	$4,853.16	$5,920.92	$5,940.72
77	$4,638.00	$5,539.56	$3,329.52	$4,362.00	$4,947.12	$6,035.40	$6,055.56
78	$4,714.92	$5,631.48	$3,384.84	$4,434.60	$5,029.20	$6,135.36	$6,156.00
79	$4,791.96	$5,723.28	$3,440.04	$4,506.84	$5,111.04	$6,235.44	$6,256.20
80	$4,868.76	$5,815.08	$3,495.24	$4,578.96	$5,193.00	$6,335.40	$6,356.52
81	$4,945.56	$5,907.00	$3,550.32	$4,651.44	$5,275.08	$6,435.60	$6,456.96
82	$5,022.60	$5,998.68	$3,605.64	$4,723.56	$5,357.16	$6,535.56	$6,557.28
83	$5,132.52	$6,130.32	$3,684.96	$4,827.48	$5,474.52	$6,679.20	$6,701.16
84	$5,243.28	$6,262.44	$3,764.16	$4,931.28	$5,592.72	$6,822.84	$6,845.64
85+	$5,353.32	$6,394.20	$3,843.24	$5,034.84	$5,710.08	$6,966.36	$6,989.64

MALE

Age	Plan A	Plan G	Plan K	Plan L	Plan N	Plan C	Plan F
Under 65	$13,427.88	$16,038.12	$9,640.08	$12,628.92	$14,323.08	$17,473.56	$17,531.76
65	$3,836.52	$4,582.20	$2,754.24	$3,608.28	$4,092.12	$4,992.36	$5,009.04
66	$3,903.72	$4,662.48	$2,802.24	$3,671.28	$4,163.64	$5,079.60	$5,096.64
67	$3,970.56	$4,742.52	$2,850.72	$3,734.52	$4,235.40	$5,167.20	$5,184.24
68	$4,069.80	$4,860.72	$2,921.52	$3,827.64	$4,341.12	$5,295.72	$5,313.48
69	$4,168.68	$4,978.92	$2,992.80	$3,920.64	$4,446.60	$5,424.84	$5,442.72
70	$4,267.68	$5,097.24	$3,063.84	$4,013.64	$4,552.20	$5,553.60	$5,571.96
71	$4,366.80	$5,215.56	$3,134.88	$4,106.88	$4,657.80	$5,682.36	$5,701.20
72	$4,465.68	$5,333.64	$3,206.04	$4,200.00	$4,763.28	$5,811.24	$5,830.44
73	$4,559.40	$5,445.60	$3,273.24	$4,288.20	$4,863.12	$5,933.16	$5,952.84
74	$4,653.12	$5,557.56	$3,340.44	$4,376.28	$4,963.32	$6,054.84	$6,075.00
75	$4,746.96	$5,669.40	$3,407.64	$4,464.36	$5,063.16	$6,176.76	$6,197.52
76	$4,840.44	$5,781.24	$3,474.96	$4,552.32	$5,163.24	$6,298.68	$6,319.92
77	$4,934.28	$5,893.32	$3,542.16	$4,640.52	$5,263.08	$6,420.60	$6,441.96
78	$5,015.88	$5,991.00	$3,600.96	$4,717.44	$5,350.20	$6,527.16	$6,548.64
79	$5,097.72	$6,088.56	$3,659.64	$4,794.48	$5,437.44	$6,633.36	$6,655.68
80	$5,179.44	$6,186.24	$3,718.32	$4,871.28	$5,524.56	$6,739.92	$6,762.36
81	$5,261.40	$6,283.92	$3,777.00	$4,948.32	$5,611.80	$6,846.12	$6,868.92
82	$5,343.00	$6,381.60	$3,835.80	$5,025.12	$5,699.04	$6,952.80	$6,975.84
83	$5,460.48	$6,521.64	$3,920.04	$5,135.52	$5,824.08	$7,105.20	$7,128.96
84	$5,577.72	$6,662.16	$4,004.40	$5,246.16	$5,949.60	$7,258.44	$7,282.56
85+	$5,695.08	$6,802.20	$4,088.76	$5,356.32	$6,074.76	$7,410.96	$7,435.68

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

Effective date: 1/1/2026

ANNUALIZED PREMIUM RATES

ZIP codes 322xx, 327xx - 329xx, 335xx - 339xx, 341xx - 342xx, 346xx - 347xx, 349xx **FEMALE**

Age	Plan A	Plan G	Plan K	Plan L	Plan N	Plan C	Plan F
Under 65	$8,655.12	$10,337.76	$6,213.84	$8,140.44	$9,232.20	$11,262.96	$11,300.28
65	$2,473.08	$2,953.68	$1,775.28	$2,325.60	$2,637.84	$3,218.16	$3,228.72
66	$2,516.28	$3,005.28	$1,806.36	$2,366.52	$2,683.92	$3,274.20	$3,285.00
67	$2,559.36	$3,057.00	$1,837.20	$2,407.20	$2,730.00	$3,330.60	$3,341.64
68	$2,623.32	$3,133.20	$1,883.28	$2,467.20	$2,798.04	$3,413.52	$3,424.92
69	$2,687.04	$3,209.40	$1,928.88	$2,527.20	$2,866.20	$3,496.56	$3,508.20
70	$2,750.88	$3,285.48	$1,974.96	$2,587.32	$2,934.24	$3,579.60	$3,591.60
71	$2,814.72	$3,361.80	$2,020.80	$2,647.20	$3,002.16	$3,662.64	$3,674.88
72	$2,878.44	$3,438.12	$2,066.40	$2,707.20	$3,070.32	$3,745.68	$3,758.28
73	$2,938.92	$3,510.12	$2,109.84	$2,764.08	$3,134.64	$3,824.40	$3,837.12
74	$2,999.40	$3,582.24	$2,153.16	$2,820.84	$3,199.20	$3,902.76	$3,915.84
75	$3,059.64	$3,654.24	$2,196.72	$2,877.48	$3,263.52	$3,981.36	$3,994.68
76	$3,120.24	$3,726.48	$2,239.68	$2,934.36	$3,327.84	$4,060.08	$4,073.64
77	$3,180.48	$3,798.48	$2,283.24	$2,991.12	$3,392.28	$4,138.44	$4,152.36
78	$3,233.16	$3,861.60	$2,321.04	$3,040.68	$3,448.56	$4,207.32	$4,221.12
79	$3,285.96	$3,924.48	$2,358.84	$3,090.36	$3,504.96	$4,275.84	$4,290.24
80	$3,338.40	$3,987.48	$2,396.76	$3,140.04	$3,561.00	$4,344.48	$4,358.88
81	$3,391.08	$4,050.48	$2,434.56	$3,189.36	$3,617.28	$4,412.76	$4,427.52
82	$3,444.00	$4,113.36	$2,472.36	$3,239.04	$3,673.44	$4,481.52	$4,496.52
83	$3,519.48	$4,203.60	$2,526.60	$3,310.08	$3,754.08	$4,579.80	$4,595.04
84	$3,595.32	$4,294.32	$2,581.32	$3,381.60	$3,834.96	$4,678.68	$4,694.16
85+	$3,671.04	$4,384.44	$2,635.32	$3,452.52	$3,915.48	$4,776.96	$4,792.68

MALE

Age	Plan A	Plan G	Plan K	Plan L	Plan N	Plan C	Plan F
Under 65	$9,207.84	$10,997.64	$6,610.32	$8,660.04	$9,821.52	$11,981.88	$12,021.84
65	$2,630.76	$3,141.96	$1,888.68	$2,474.04	$2,806.08	$3,423.24	$3,434.88
66	$2,676.84	$3,197.04	$1,921.56	$2,517.48	$2,855.16	$3,483.36	$3,494.88
67	$2,722.80	$3,252.00	$1,954.68	$2,560.68	$2,904.24	$3,543.12	$3,554.64
68	$2,790.60	$3,333.12	$2,003.28	$2,624.64	$2,976.60	$3,631.32	$3,643.56
69	$2,858.64	$3,414.24	$2,052.00	$2,688.48	$3,049.08	$3,719.88	$3,732.12
70	$2,926.44	$3,495.24	$2,100.72	$2,752.44	$3,121.44	$3,808.20	$3,820.92
71	$2,994.36	$3,576.24	$2,149.68	$2,816.04	$3,194.04	$3,896.40	$3,909.36
72	$3,062.16	$3,657.60	$2,198.40	$2,880.00	$3,266.28	$3,984.84	$3,998.16
73	$3,126.36	$3,734.16	$2,244.48	$2,940.60	$3,334.92	$4,068.48	$4,081.80
74	$3,190.80	$3,810.96	$2,290.68	$3,000.84	$3,403.44	$4,152.12	$4,165.80
75	$3,255.00	$3,887.64	$2,336.76	$3,061.32	$3,471.84	$4,235.52	$4,249.80
76	$3,319.08	$3,964.32	$2,382.72	$3,121.56	$3,540.60	$4,319.16	$4,333.56
77	$3,383.40	$4,041.00	$2,429.04	$3,182.16	$3,608.76	$4,402.68	$4,417.56
78	$3,439.44	$4,108.08	$2,469.24	$3,234.84	$3,668.76	$4,475.64	$4,490.64
79	$3,495.36	$4,175.04	$2,509.56	$3,287.52	$3,728.52	$4,548.48	$4,563.96
80	$3,551.76	$4,242.12	$2,549.76	$3,340.20	$3,788.28	$4,621.68	$4,637.16
81	$3,607.68	$4,308.96	$2,590.08	$3,393.12	$3,848.04	$4,694.64	$4,710.24
82	$3,663.72	$4,376.04	$2,630.28	$3,445.80	$3,907.92	$4,767.48	$4,783.44
83	$3,744.12	$4,471.92	$2,687.88	$3,521.28	$3,993.72	$4,872.48	$4,888.20
84	$3,824.76	$4,568.40	$2,745.72	$3,597.24	$4,079.52	$4,977.12	$4,993.80
85+	$3,905.28	$4,664.28	$2,803.56	$3,672.96	$4,165.68	$5,081.76	$5,098.68

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

Effective date: 1/1/2026

ANNUALIZED PREMIUM RATES

All other Florida ZIP codes

FEMALE

Age	Plan A	Plan G	Plan K	Plan L	Plan N	Plan C	Plan F
Under 65	$8,294.88	$9,906.96	$5,954.88	$7,800.96	$8,847.48	$10,793.64	$10,829.64
65	$2,370.00	$2,830.56	$1,701.24	$2,229.00	$2,527.92	$3,083.88	$3,094.08
66	$2,411.52	$2,880.00	$1,731.12	$2,268.00	$2,571.96	$3,138.00	$3,148.20
67	$2,452.68	$2,929.56	$1,760.88	$2,306.76	$2,616.24	$3,191.76	$3,202.44
68	$2,513.88	$3,002.52	$1,804.68	$2,364.48	$2,681.40	$3,271.32	$3,282.36
69	$2,575.20	$3,075.72	$1,848.72	$2,421.84	$2,746.80	$3,350.88	$3,362.16
70	$2,636.16	$3,148.68	$1,892.52	$2,479.44	$2,811.84	$3,430.56	$3,441.96
71	$2,697.36	$3,221.88	$1,936.56	$2,536.80	$2,877.24	$3,510.12	$3,521.88
72	$2,758.68	$3,294.84	$1,980.36	$2,594.40	$2,942.52	$3,589.68	$3,601.68
73	$2,816.28	$3,363.84	$2,021.88	$2,648.88	$3,004.20	$3,665.04	$3,677.28
74	$2,874.48	$3,433.08	$2,063.64	$2,703.36	$3,065.76	$3,740.40	$3,752.64
75	$2,932.32	$3,501.96	$2,104.80	$2,757.72	$3,127.56	$3,815.76	$3,828.24
76	$2,989.92	$3,571.20	$2,146.44	$2,811.96	$3,189.24	$3,890.64	$3,903.96
77	$3,048.00	$3,640.08	$2,188.20	$2,866.44	$3,251.04	$3,966.12	$3,979.44
78	$3,098.40	$3,700.68	$2,224.32	$2,913.96	$3,305.04	$4,032.00	$4,045.20
79	$3,149.04	$3,761.04	$2,260.68	$2,961.72	$3,358.80	$4,097.64	$4,111.20
80	$3,199.44	$3,821.40	$2,296.92	$3,009.24	$3,412.56	$4,163.40	$4,177.20
81	$3,249.96	$3,881.64	$2,333.16	$3,056.64	$3,466.44	$4,229.04	$4,243.08
82	$3,300.24	$3,942.12	$2,369.28	$3,104.16	$3,520.44	$4,294.68	$4,309.20
83	$3,372.96	$4,028.52	$2,421.24	$3,172.20	$3,597.48	$4,389.00	$4,403.76
84	$3,445.68	$4,115.28	$2,473.68	$3,240.60	$3,675.24	$4,483.80	$4,498.44
85+	$3,517.92	$4,201.80	$2,525.64	$3,308.64	$3,752.40	$4,577.76	$4,593.12

MALE

Age	Plan A	Plan G	Plan K	Plan L	Plan N	Plan C	Plan F
Under 65	$8,824.20	$10,539.36	$6,334.92	$8,299.08	$9,412.32	$11,482.56	$11,520.96
65	$2,521.20	$3,011.16	$1,809.72	$2,371.32	$2,689.20	$3,280.56	$3,291.60
66	$2,565.36	$3,063.84	$1,841.64	$2,412.72	$2,736.36	$3,338.04	$3,349.08
67	$2,609.40	$3,116.52	$1,873.20	$2,454.24	$2,783.16	$3,395.52	$3,406.92
68	$2,674.56	$3,194.28	$1,919.88	$2,515.32	$2,852.76	$3,480.00	$3,491.52
69	$2,739.36	$3,272.04	$1,966.56	$2,576.40	$2,922.00	$3,564.72	$3,576.84
70	$2,804.52	$3,349.56	$2,013.24	$2,637.60	$2,991.60	$3,649.56	$3,661.68
71	$2,869.68	$3,427.32	$2,059.92	$2,698.80	$3,060.96	$3,734.16	$3,746.64
72	$2,934.60	$3,505.20	$2,106.60	$2,760.12	$3,130.32	$3,818.76	$3,831.48
73	$2,996.04	$3,578.52	$2,151.12	$2,817.96	$3,195.84	$3,898.92	$3,911.76
74	$3,057.72	$3,652.08	$2,195.16	$2,875.80	$3,261.36	$3,979.08	$3,992.16
75	$3,119.16	$3,725.64	$2,239.44	$2,933.88	$3,327.36	$4,059.12	$4,072.68
76	$3,180.84	$3,799.20	$2,283.60	$2,991.60	$3,393.00	$4,139.28	$4,153.08
77	$3,242.40	$3,872.64	$2,327.64	$3,049.56	$3,458.52	$4,219.20	$4,233.48
78	$3,296.16	$3,936.96	$2,366.52	$3,100.08	$3,515.88	$4,289.16	$4,303.44
79	$3,350.04	$4,001.04	$2,405.16	$3,150.48	$3,573.12	$4,359.12	$4,373.64
80	$3,403.68	$4,065.24	$2,443.44	$3,201.12	$3,630.36	$4,429.20	$4,443.84
81	$3,457.44	$4,129.44	$2,481.96	$3,251.52	$3,687.84	$4,499.04	$4,514.04
82	$3,511.20	$4,193.64	$2,520.60	$3,302.16	$3,745.20	$4,569.00	$4,584.00
83	$3,588.24	$4,285.56	$2,575.80	$3,374.52	$3,827.40	$4,669.20	$4,684.68
84	$3,665.40	$4,378.08	$2,631.36	$3,447.48	$3,909.48	$4,769.64	$4,785.72
85+	$3,742.56	$4,470.12	$2,686.68	$3,519.84	$3,991.80	$4,870.20	$4,886.28

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

Effective date: 1/1/2026

Basic Benefits:

Hospitalization—Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses—Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or copayments.

Blood—First three pints of blood each year.

Hospice—Part A coinsurance.

Premium Information

The EPIC Life Insurance Company can only raise your premium if we raise the premium for all policies like yours in this state, your residence changes such that you move to a new rating area, or if there is a change in Medicare benefits.

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 are not satisfied with your policy, you may return it to: The EPIC Life Insurance Company, 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.

Policy Replacement

If you are 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 The EPIC Life Insurance Company nor its agents are connected with Medicare. This Outline of Coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult *Medicare and You* for more details.

Complete Answers are Very Important

When you fill out the application for the new policy and it is NOT an "Open Enrollment or Guaranteed Issue status application," be sure to answer truthfully and completely all questions about your medical and health history. The policy is issued on the basis that the answers to all questions and all information shown in the application are correct and complete. The company may cancel your policy and refuse to pay any claims if you make misstatements, leave out, or falsify important information. Review the application carefully before you sign it and be certain that all information has been properly recorded. To review "Open Enrollment" timeframes please go to the following link on the Medicare.gov website: https://www.medicare.gov/supplement-other-insurance/when-can-i-buy-medigap/when-can-i-buy-medigap.html

PLAN A

Medicare Supplement Part A—Hospital Services—per benefit period				
Services		**Medicare Pays**	**Plan Pays**	**You Pay**
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies.	First 60 days	All but $1,736	$0	$1,736 (Part A deductible)
	61st to 90th day	All but $434 per day	$434 a day	$0
	91st day and after while using 60 lifetime reserve days	All but $868 per day	$868 a day	$0
	Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
	—Beyond the additional 365 days	$0	$0	All costs
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 to 100th day	All but $217 per day	$0	Up to $217 per day
	101st day and after	$0	$0	All costs
BLOOD	First 3 pints	$0	3 pints	$0
	Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.		All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

* 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.

** 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 for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

Medicare Supplement Part B—Medical Services—per calendar year				
Services		**Medicare Pays**	**Plan Pays**	**You Pay**
MEDICAL EXPENSES In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First $283 of Medicare-approved amounts***	$0	$0	$283 (Part B deductible)
	Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-approved amounts)		$0	$0	All costs
BLOOD	First 3 pints	$0	All costs	$0
	Next $283 of Medicare-approved amounts***	$0	$0	$283 (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES Tests for diagnostic services		100%	$0	$0
Medicare Parts A & B				
Services		**Medicare Pays**	**Plan Pays**	**You Pay**
HOME HEALTH CARE (Medicare-approved services) —Medically necessary skilled care services and medical supplies		100%	$0	$0
—Durable medical equipment	First $283 of Medicare-approved amounts***	$0	$0	$283 (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	$0

*** Once you have been billed $283 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN G

Medicare Supplement Part A—Hospital Services—per benefit period				
Services		**Medicare Pays**	**Plan Pays**	**You Pay**
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies.	First 60 days	All but $1,736	$1,736 (Part A deductible)	$0
	61st to 90th day	All but $434 per day	$434 a day	$0
	91st day and after while using 60 lifetime reserve days	All but $868 per day	$868 a day	$0
	Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
	—Beyond the additional 365 days	$0	$0	All costs
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 to 100th day	All but $217 per day	Up to $217 per day	$0
	101st day and after	$0	$0	All costs
BLOOD	First 3 pints	$0	3 pints	$0
	Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.		All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

* 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.

** 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 for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G

Medicare Supplement Part B—Medical Services—per calendar year				
Services		**Medicare Pays**	**Plan Pays**	**You Pay**
MEDICAL EXPENSES In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First $283 of Medicare-approved amounts***	$0	$0	$283 (Part B deductible)
	Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-approved amounts)		$0	100%	$0
BLOOD	First 3 pints	$0	All costs	$0
	Next $283 of Medicare-approved amounts***	$0	$0	$283 (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES Tests for diagnostic services		100%	$0	$0
Medicare Parts A & B				
Services		**Medicare Pays**	**Plan Pays**	**You Pay**
HOME HEALTH CARE (Medicare-approved services) —Medically necessary skilled care services and medical supplies		100%	$0	$0
—Durable medical equipment	First $283 of Medicare-approved amounts***	$0	$0	$283 (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	$0
Other Benefits—Not Covered by Medicare				
Services		**Medicare Pays**	**Plan Pays**	**You Pay**
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.	First $250 each calendar year	$0	$0	$250
	Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

*** Once you have been billed $283 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN K

Medicare Supplement Part A—Hospital Services—per benefit period				
Services		**Medicare Pays**	**Plan Pays**	**You Pay†**
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies.	First 60 days	All but $1,736	$868 (50% of Part A deductible)	$868 (50% of Part A deductible)◆
	61st to 90th day	All but $434 per day	$434 a day	$0
	91st day and after while using 60 lifetime reserve days	All but $868 per day	$868 a day	$0
	Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
	—Beyond the additional 365 days	$0	$0	All costs
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 to 100th day	All but $217 per day	Up to $108.50 a day (50% of Part A coinsurance)	Up to $108.50 a day (50% of Part A coinsurance)◆
	101st day and after	$0	$0	All costs
BLOOD	First 3 pints	$0	50%	50%◆
	Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.		All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	50% of copayment/ coinsurance	50% of copayment/ coinsurance◆

† You will pay half the cost sharing of some covered services until you reach the annual out-of-pocket maximum of $8,000 each calendar year. The amounts that count toward your annual limit are noted with diamonds (◆) in the chart above. Once you reach the annual maximum, the plan 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") and 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.

* 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.

** 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 for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN K

Medicare Supplement Part B—Medical Services—per calendar year				
Services		**Medicare Pays**	**Plan Pays**	**You Pay†**
MEDICAL EXPENSES In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First $283 of Medicare-approved amounts***	$0	$0	$283 (Part B deductible)***◆
	Preventive benefits for Medicare-covered services	Generally 80% 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%◆
PART B EXCESS CHARGES (Above Medicare-approved amounts)		$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $8,000)††
Blood	First 3 pints	$0	50%	50%◆
	Next $283 of Medicare-approved amounts***	$0	$0	$283 (Part B deductible)***◆
	Remainder of Medicare-approved amounts	Generally 80%	Generally 10%	Generally 10%◆
CLINICAL LABORATORY SERVICES Tests for diagnostic services		100%	$0	$0

Medicare Parts A & B				
Services		**Medicare Pays**	**Plan Pays**	**You Pay†**
HOME HEALTH CARE (Medicare-approved services) —Medically necessary skilled care services and medical supplies		100%	$0	$0
—Durable medical equipment	First $283 of Medicare-approved amounts***	$0	$0	$283 (Part B deductible)◆
	Remainder of Medicare-approved amounts	80%	10%	10%◆

† You will pay half the cost sharing of some covered services until you reach the annual out-of-pocket maximum of $8,000 each calendar year. The amounts that count toward your annual limit are noted with diamonds (◆) in the chart above. Once you reach the annual maximum, the plan 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") and 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.

†† This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $8,000 per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and 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.

*** Once you have been billed $283 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN L

Medicare Supplement Part A—Hospital Services—per benefit period				
Services		**Medicare Pays**	**Plan Pays**	**You Pay†**
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies.	First 60 days	All but $1,736	$1,302 (75% of Part A deductible)	$434 (25% of Part A deductible)◆
	61st to 90th day	All but $434 per day	$434 a day	$0
	91st day and after while using 60 lifetime reserve days	All but $868 per day	$868 a day	$0
	Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
	—Beyond the additional 365 days	$0	$0	All costs
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 to 100th day	All but $217 per day	Up to $162.75 a day (75% of Part A coinsurance)	Up to $54.25 a day (25% of Part A coinsurance)◆
	101st day and after	$0	$0	All costs
BLOOD	First 3 pints	$0	75%	25%◆
	Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.		All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	75% of copayment/ coinsurance	25% of copayment/ coinsurance◆

† You will pay one-fourth the cost sharing of some covered services until you reach the annual out-of-pocket maximum of $4,000 each calendar year. The amounts that count toward your annual limit are noted with diamonds (◆) in the chart above. Once you reach the annual maximum, the plan 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") and 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.

* 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.

** 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 for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN L

Medicare Supplement Part B—Medical Services—per calendar year				
Services		**Medicare Pays**	**Plan Pays**	**You Pay†**
MEDICAL EXPENSES In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First $283 of Medicare-approved amounts***	$0	$0	$283 (Part B deductible)***◆
	Preventive benefits for Medicare-covered services	Generally 80% 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%◆
PART B EXCESS CHARGES (Above Medicare-approved amounts)		$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $4,000)††
BLOOD	First 3 pints	$0	75%	25%◆
	Next $283 of Medicare-approved amounts***	$0	$0	$283 (Part B deductible)***◆
	Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5%◆
CLINICAL LABORATORY SERVICES Tests for diagnostic services		100%	$0	$0
Medicare Parts A & B				
Services		**Medicare Pays**	**Plan Pays**	**You Pay†**
HOME HEALTH CARE (Medicare-approved services) —Medically necessary skilled care services and medical supplies		100%	$0	$0
—Durable medical equipment	First $283 of Medicare-approved amounts***	$0	$0	$283 (Part B deductible)◆
	Remainder of Medicare-approved amounts	80%	15%	5%◆

† You will pay one-fourth the cost sharing of some covered services until you reach the annual out-of-pocket maximum of $4,000 each calendar year. The amounts that count toward your annual limit are noted with diamonds (◆) in the chart above. Once you reach the annual maximum, the plan 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") and 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.

†† This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $4,000 per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and 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.

*** Once you have been billed $283 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN N

Medicare Supplement Part A—Hospital Services—per benefit period				
Services		**Medicare Pays**	**Plan Pays**	**You Pay**
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies.	First 60 days	All but $1,736	$1,736 (Part A deductible)	$0
	61st to 90th day	All but $434 per day	$434 a day	$0
	91st day and after while using 60 lifetime reserve days	All but $868 per day	$868 a day	$0
	Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
	—Beyond the additional 365 days	$0	$0	All costs
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 to 100th day	All but $217 per day	Up to $217 per day	$0
	101st day and after	$0	$0	All costs
BLOOD	First 3 pints	$0	3 pints	$0
	Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.		All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

* 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.

** 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 for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

Medicare Supplement Part B—Medical Services—per calendar year				
Services		**Medicare Pays**	**Plan Pays**	**You Pay**
MEDICAL EXPENSES In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First $283 of Medicare-approved amounts***	$0	$0	$283 (Part B deductible)
	Remainder of Medicare-approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
PART B EXCESS CHARGES (Above Medicare-approved amounts)		$0	$0	All costs
BLOOD	First 3 pints	$0	All costs	$0
	Next $283 of Medicare-approved amounts***	$0	$0	$283 (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES Tests for diagnostic services		100%	$0	$0
Medicare Parts A & B				
Services		**Medicare Pays**	**Plan Pays**	**You Pay**
HOME HEALTH CARE (Medicare-approved services) —Medically necessary skilled care services and medical supplies		100%	$0	$0
—Durable medical equipment	First $283 of Medicare-approved amounts***	$0	$0	$283 (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	$0
Other Benefits—Not Covered by Medicare				
Services		**Medicare Pays**	**Plan Pays**	**You Pay**
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.	First $250 each calendar year	$0	$0	$250
	Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

*** Once you have been billed $283 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

This plan is only available to applicants who were eligible for Medicare prior to 1/1/2020.

PLAN C

Medicare Part A—Hospital Services—per benefit period				
Services		**Medicare Pays**	**Plan Pays**	**You Pay**
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies.	First 60 days	All but $1,736	$1,736 (Part A deductible)	$0
	61st to 90th day	All but $434 per day	$434 a day	$0
	91st day and after while using 60 lifetime reserve days	All but $868 per day	$868 a day	$0
	Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
	—Beyond the additional 365 days	$0	$0	All costs
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 to 100th day	All but $217 per day	Up to $217 per day	$0
	101st day and after	$0	$0	All costs
BLOOD	First 3 pints	$0	3 pints	$0
	Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.		All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

* 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.

** 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 for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

This plan is only available to applicants who were eligible for Medicare prior to 1/1/2020.

PLAN C

Medicare Part B—Medical Services—per calendar year				
Services		**Medicare Pays**	**Plan Pays**	**You Pay**
MEDICAL EXPENSES In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First $283 of Medicare-approved amounts***	$0	$283 (Part B deductible)	$0
	Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-approved amounts)		$0	$0	All costs
BLOOD	First 3 pints	$0	All costs	$0
	Next $283 of Medicare-approved amounts***	$0	$283 (Part B deductible)	$0
	Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES Tests for diagnostic services		100%	$0	$0
Medicare Parts A & B				
Services		**Medicare Pays**	**Plan Pays**	**You Pay**
HOME HEALTH CARE (Medicare-approved services) —Medically necessary skilled care services and medical supplies		100%	$0	$0
—Durable medical equipment	First $283 of Medicare-approved amounts***	$0	$283 (Part B deductible)	$0
	Remainder of Medicare-approved amounts	80%	20%	$0
Other Benefits—Not Covered by Medicare				
Services		**Medicare Pays**	**Plan Pays**	**You Pay**
FOREIGN TRAVEL—NOT COVERED BY MEDICARE	First $250 each calendar year	$0	$0	$250
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.	Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

*** Once you have been billed $283 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

This plan is only available to applicants who were eligible for Medicare prior to 1/1/2020.

PLAN F

Medicare Part A—Hospital Services—per benefit period				
Services		**Medicare Pays**	**Plan Pays**	**You Pay**
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies.	First 60 days	All but $1,736	$1,736 (Part A deductible)	$0
	61st to 90th day	All but $434 per day	$434 a day	$0
	91st day and after while using 60 lifetime reserve days	All but $868 per day	$868 a day	$0
	Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
	—Beyond the additional 365 days	$0	$0	All costs
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 to 100th day	All but $217 per day	Up to $217 per day	$0
	101st day and after	$0	$0	All costs
BLOOD	First 3 pints	$0	3 pints	$0
	Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.		All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

* 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.

** 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 for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

This plan is only available to applicants who were eligible for Medicare prior to 1/1/2020.

PLAN F

Medicare Part B—Medical Services—per calendar year				
Services		**Medicare Pays**	**Plan Pays**	**You Pay**
MEDICAL EXPENSES In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First $283 of Medicare-approved amounts***	$0	$283 (Part B deductible)	$0
	Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-approved amounts)		$0	100%	$0
BLOOD	First 3 pints	$0	All costs	$0
	Next $283 of Medicare-approved amounts***	$0	$283 (Part B deductible)	$0
	Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES Tests for diagnostic services		100%	$0	$0
Medicare Parts A & B				
Services		**Medicare Pays**	**Plan Pays**	**You Pay**
HOME HEALTH CARE (Medicare-approved services) —Medically necessary skilled care services and medical supplies		100%	$0	$0
—Durable medical equipment	First $283 of Medicare-approved amounts***	$0	$283 (Part B deductible)	$0
	Remainder of Medicare-approved amounts	80%	20%	$0
Other Benefits—Not Covered by Medicare				
Services		**Medicare Pays**	**Plan Pays**	**You Pay**
FOREIGN TRAVEL—NOT COVERED BY MEDICARE	First $250 each calendar year	$0	$0	$250
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.	Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

*** Once you have been billed $283 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

Notes

Notes

Nondiscrimination and Language Access Policy

Discrimination is Against the Law

Wisconsin Physicians Service Insurance Corporation (WPS)/The EPIC Life Insurance Company (collectively, WPS/EPIC) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)). WPS/EPIC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

WPS/EPIC:

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

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

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

- Qualified interpreters
- Information written in other languages

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

If you believe that WPS/EPIC 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/EPIC
Nondiscrimination Grievance Coordinator
P.O. Box 7458 Madison, WI 53707
Email: WPSNondiscrimination@wpsic.com

You can file a grievance in person, by mail, or by 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, D.C., 20201; or by phone at 800–368–1019, 800–537–7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

The EPIC Life Insurance Company®
A WPS Company
Medicare Supplement Insurance Plans

WPS
A HEALTH SOLUTIONS COMPANY

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Notice of Availability of Language Assistance Services and Auxiliary Aids

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call the number on your Member ID card or speak to your provider.

SPANISH: ATENCIÓN: Si habla español, los servicios de asistencia con el idioma están disponibles para usted sin cargo. También se encuentran disponibles de forma gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al número que figura en la tarjeta de identificación de miembro o hable con su proveedor.

HMONG: NCO NTSOOV: Yog hais tias koj hais lus Hmoob, peb yeej muaj kev pab txhais lus dawb rau koj. Peb los kuj tseem muaj cov khoom siv thiab cov kev pab los npaj lwm yam ntaub ntawv uas yuav muab tau coj los saib dawb. Hu xov tooj mus rau tus xov tooj nyob ntawm koj daim ID Ua Tswv Cuab los sis nrog koj tus kws kho mob tham.

TRADITIONAL CHINESE: 請注意：如果您說中文，您可以免費獲得語言協助服務。另免費提供適當的輔助工具和服務並以無障礙格式提供資訊。請致電您的會員 **ID** 卡上的電話號碼或聯絡您的提供者。

GERMAN: HINWEIS: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie die Nummer auf Ihrer Versichertenkarte an oder sprechen Sie mit Ihrem Dienstleister.

ARABIC: تنبيه: إذا كنت تتحدث العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. تتوفر أيضًا المساعدات والخدمات المساعدة المناسبة لتوفير المعلومات بتنسيقات يسهل الوصول إليها مجانًا. اتصل بالرقم الموجود على بطاقة **ID** هوية العضو الخاصة بك أو تحدث مع مقدم الخدمة الخاص بك.

RUSSIAN: ВНИМАНИЕ: если вы говорите на русском языке, вам могут предоставить бесплатные услуги перевода. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также можно получить бесплатно. Позвоните по номеру, указанному на вашей идентификационной карточке участника плана, или обратитесь к своему врачу.

KOREAN: 주의 사항: 한국어를 구사하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 액세스 가능한 형식으로 정보를 제공하기 위해 적절한 보조 도구 및 서비스도 무료로 제공됩니다. 가입자 **ID** 카드에 기재된 전화번호로 연락하시거나 귀하의 의료 제공자에게 문의하시길 바랍니다.

VIETNAMESE: CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí sẽ có sẵn cho quý vị. Các hỗ trợ và dịch vụ phụ trợ phù hợp để cung cấp thông tin ở định dạng dễ tiếp cận cũng được cung cấp miễn phí. Hãy gọi số trên thẻ ID Thành viên của quý vị hoặc nói chuyện với nhà cung cấp của quý vị.

PENNSYLVANIA DUTCH: WICHDICH: Wann du Deitsch schwetzscht un hoscht Druwwel fer Englisch verschtehe, kenne mer epper beigriege fer dich helfe unni as es dich ennich eppes koschte zeelt. Mir kenne dich helfe aa wann du Druwwel hoscht fer heere odder sehne. Mir kenne Schtofft lauder mache odder iesier fer lese un sell koscht dich aa nix. Ruf die Nummer uff dei Member ID Card uff odder schwetz mit dei Provider.

LAO: ຂ້ອນໃສ່ໃຈ: ຖ້າທ່ານເວົ້າພາສາລາວ, ຈະມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາຟຣີໃຫ້ແກ່ທ່ານ. ການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການເສີມທີ່ເໝາະສົມ ເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້ ແມ່ນມີໃຫ້ແບບບໍ່ໄດ້ເສຍຄ່າອີກດ້ວຍ. ໂທຫາເບີທີ່ຢູ່ໃນບັດປະຈຳຕົວສະມາຊິກຂອງທ່ານ ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

FRENCH: ATTENTION : Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et des services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le numéro figurant sur votre carte d'adhérent ou parlez à votre prestataire.

POLISH: UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Odpowiednie materiały pomocnicze i usługi zapewniające informacje w dostosowanych formatach są również dostępne bezpłatnie. Należy zadzwonić pod numer podany na karcie członkowskiej lub porozmawiać z lekarzem prowadzącym.

HINDI: ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएँ उपलब्ध हैं। सुलभ प्रारूप में सूचना उपलब्ध कराने के लिए उपयुक्त सहायक साधन और सेवाएं भी निःशुल्क उपलब्ध हैं। अपने सदस्य आईडी कार्ड पर दिए गए नंबर पर कॉल करें या अपने प्रदाता से बात करें।

ALBANIAN: KINI PARASYSH: Nëse flisni shqip, ofrohen shërbime falas të ndihmës gjuhësore. Ndihmat dhe shërbimet e përshtatshme ndihmëse për të ofruar informacion në formate të aksesueshme janë gjithashtu të disponueshme pa pagesë. Telefononi numrin në kartën tuaj të identitetit të Anëtarit ose flisni me ofruesin tuaj të shërbimit.

TAGALOG: BIGYANG-PANSIN: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyo sa tulong sa wika. Ang mga naaangkop na pantulong na suporta at serbisyo upang magbigay ng impormasyon sa mga naa-access na format ay makukuha rin nang libre. Tawagan ang numero sa iyong card ng Member ID o makipag-usap sa iyong provider.

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

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