



MEDICARE SUPPLEMENT INSURANCE

Medicare Supplement Plans A, C, F, G, K, L, and N

Rates effective January 1, 2021

Outline of Medicare Supplement Coverage

Benefit Chart of Medicare Supplement Plans Sold with Effective Dates On or After Jan. 1, 2020

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 2021 ²					\$6,220 ²	\$3,110 ²				

✓ indicates 100% of the benefit is paid.

Plans shaded in gray are offered by WPS Health Insurance.

¹Plans F and G also have high deductible options which require first paying the plans' deductibles of \$2,370 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 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.

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

³Plan 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.

ANNUALIZED PREMIUM RATES

ZIP codes 600xx - 608xx, and moving out of state

FEMALE

Age	Plan A	Plan G	Plan K	Plan L	Plan N	Plan C	Plan F
Under 65	2,453.40	2,960.28	1,784.16	2,335.68	2,561.16	3,419.52	3,425.64
65	1,241.88	1,498.44	903.12	1,182.24	1,296.36	1,730.88	1,733.88
66	1,286.28	1,551.84	935.40	1,224.36	1,342.68	1,792.68	1,795.92
67	1,330.56	1,605.24	967.56	1,266.60	1,389.00	1,854.48	1,857.72
68	1,383.48	1,669.20	1,006.08	1,317.12	1,444.20	1,928.16	1,931.76
69	1,436.40	1,733.16	1,044.48	1,367.40	1,499.52	2,001.96	2,005.68
70	1,489.44	1,797.00	1,083.12	1,417.92	1,554.72	2,075.76	2,079.60
71	1,542.36	1,860.96	1,121.52	1,468.20	1,610.04	2,149.68	2,153.52
72	1,595.28	1,924.80	1,160.16	1,518.72	1,665.36	2,223.36	2,227.44
73	1,649.64	1,990.32	1,199.52	1,570.32	1,722.00	2,299.20	2,303.28
74	1,703.88	2,055.84	1,239.12	1,622.04	1,778.76	2,374.80	2,379.12
75	1,758.24	2,121.48	1,278.60	1,673.88	1,835.52	2,450.52	2,454.96
76	1,812.60	2,186.88	1,318.08	1,725.48	1,892.16	2,526.24	2,530.92
77	1,866.84	2,252.40	1,357.68	1,777.20	1,948.80	2,601.96	2,606.76
78	1,920.48	2,317.08	1,396.56	1,828.20	2,004.72	2,676.60	2,681.52
79	1,974.00	2,381.76	1,435.56	1,879.20	2,060.64	2,751.24	2,756.28
80	2,027.52	2,446.32	1,474.44	1,930.20	2,116.56	2,826.00	2,831.04
81	2,081.16	2,511.00	1,513.32	1,981.20	2,172.48	2,900.64	2,905.92
82	2,134.80	2,575.68	1,552.32	2,032.20	2,228.40	2,975.40	2,980.68
83	2,240.88	2,703.72	1,629.60	2,133.36	2,339.16	3,123.24	3,128.88
84	2,347.32	2,832.12	1,707.00	2,234.52	2,450.28	3,271.56	3,277.44
85+	2,453.40	2,960.28	1,784.16	2,335.68	2,561.16	3,419.52	3,425.64

MALE

Age	Plan A	Plan G	Plan K	Plan L	Plan N	Plan C	Plan F
Under 65	2,698.80	3,256.32	1,962.60	2,569.20	2,817.24	3,761.40	3,768.36
65	1,366.08	1,648.08	993.48	1,300.32	1,425.96	1,903.92	1,907.40
66	1,414.80	1,707.00	1,028.88	1,346.88	1,476.96	1,971.96	1,975.44
67	1,463.52	1,765.80	1,064.40	1,393.32	1,527.96	2,039.88	2,043.48
68	1,521.84	1,836.12	1,106.64	1,448.76	1,588.68	2,121.12	2,124.84
69	1,580.04	1,906.44	1,149.12	1,504.20	1,649.52	2,202.24	2,206.20
70	1,638.36	1,976.64	1,191.36	1,559.64	1,710.24	2,283.36	2,287.44
71	1,696.68	2,046.96	1,233.72	1,615.08	1,770.96	2,364.48	2,368.80
72	1,754.76	2,117.28	1,276.20	1,670.52	1,831.80	2,445.72	2,450.16
73	1,814.64	2,189.40	1,319.52	1,727.40	1,894.20	2,529.00	2,533.68
74	1,874.40	2,261.40	1,363.08	1,784.28	1,956.60	2,612.28	2,617.08
75	1,934.04	2,333.52	1,406.52	1,841.16	2,019.00	2,695.68	2,700.48
76	1,993.80	2,405.64	1,449.96	1,898.16	2,081.40	2,778.84	2,783.88
77	2,053.56	2,477.76	1,493.40	1,954.92	2,143.80	2,862.12	2,867.40
78	2,112.48	2,548.92	1,536.24	2,010.96	2,205.24	2,944.32	2,949.60
79	2,171.40	2,619.96	1,578.96	2,067.12	2,266.68	3,026.40	3,031.80
80	2,230.32	2,691.00	1,621.92	2,123.28	2,328.24	3,108.60	3,114.24
81	2,289.24	2,762.16	1,664.76	2,179.32	2,389.80	3,190.68	3,196.44
82	2,348.16	2,833.20	1,707.60	2,235.48	2,451.36	3,272.88	3,278.76
83	2,464.92	2,974.08	1,792.56	2,346.60	2,573.16	3,435.60	3,441.72
84	2,581.92	3,115.44	1,877.64	2,458.08	2,695.44	3,598.68	3,605.28
85+	2,698.80	3,256.32	1,962.60	2,569.20	2,817.24	3,761.40	3,768.36

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

Effective date: Jan. 1, 2021

ANNUALIZED PREMIUM RATES

All other Illinois ZIP Codes

FEMALE

Age	Plan A	Plan G	Plan K	Plan L	Plan N	Plan C	Plan F
Under 65	2,190.48	2,642.88	1,592.88	2,085.24	2,286.60	3,052.92	3,058.56
65	1,108.68	1,337.64	806.28	1,055.40	1,157.40	1,545.24	1,548.12
66	1,148.28	1,385.52	835.08	1,093.32	1,198.80	1,600.44	1,603.44
67	1,187.88	1,433.16	863.88	1,130.88	1,239.96	1,655.64	1,658.64
68	1,235.16	1,490.28	898.32	1,175.88	1,289.40	1,721.52	1,724.76
69	1,282.56	1,547.28	932.64	1,220.88	1,338.72	1,787.40	1,790.76
70	1,329.72	1,604.28	967.08	1,265.88	1,388.04	1,853.40	1,856.64
71	1,377.00	1,661.40	1,001.40	1,310.88	1,437.48	1,919.16	1,922.76
72	1,424.28	1,718.40	1,035.84	1,355.88	1,486.80	1,985.04	1,988.76
73	1,472.88	1,777.08	1,071.00	1,402.08	1,537.56	2,052.72	2,056.44
74	1,521.24	1,835.52	1,106.40	1,448.28	1,588.08	2,120.28	2,124.12
75	1,569.84	1,893.96	1,141.44	1,494.48	1,638.72	2,187.84	2,191.92
76	1,618.32	1,952.52	1,176.84	1,540.56	1,689.36	2,255.52	2,259.60
77	1,666.80	2,011.08	1,212.12	1,586.76	1,740.00	2,323.08	2,327.28
78	1,714.68	2,068.80	1,246.92	1,632.24	1,789.92	2,389.80	2,394.12
79	1,762.44	2,126.40	1,281.72	1,677.84	1,839.84	2,456.40	2,460.96
80	1,810.32	2,184.12	1,316.52	1,723.20	1,889.64	2,523.00	2,527.56
81	1,858.08	2,241.96	1,351.20	1,768.80	1,939.68	2,589.72	2,594.40
82	1,905.84	2,299.56	1,386.00	1,814.40	1,989.60	2,656.32	2,661.12
83	2,000.76	2,413.80	1,454.88	1,904.64	2,088.48	2,788.44	2,793.48
84	2,095.68	2,528.64	1,524.12	1,995.12	2,187.72	2,920.92	2,926.32
85+	2,190.48	2,642.88	1,592.88	2,085.24	2,286.60	3,052.92	3,058.56

MALE

Age	Plan A	Plan G	Plan K	Plan L	Plan N	Plan C	Plan F
Under 65	2,409.60	2,907.24	1,752.24	2,293.80	2,515.32	3,358.32	3,364.32
65	1,219.56	1,471.56	886.92	1,161.00	1,273.20	1,699.80	1,702.92
66	1,263.24	1,524.12	918.60	1,202.52	1,318.68	1,760.52	1,763.64
67	1,306.68	1,576.56	950.28	1,243.92	1,364.16	1,821.24	1,824.60
68	1,358.76	1,639.32	988.08	1,293.48	1,418.40	1,893.60	1,897.20
69	1,410.72	1,702.08	1,025.88	1,342.92	1,472.64	1,966.20	1,969.68
70	1,462.68	1,764.84	1,063.68	1,392.48	1,526.88	2,038.68	2,042.28
71	1,514.76	1,827.60	1,101.48	1,442.04	1,581.24	2,111.04	2,115.00
72	1,566.72	1,890.36	1,139.40	1,491.48	1,635.60	2,183.64	2,187.60
73	1,620.00	1,954.68	1,178.16	1,542.36	1,691.16	2,257.92	2,262.00
74	1,673.40	2,019.00	1,216.92	1,593.00	1,746.84	2,332.32	2,336.52
75	1,726.80	2,083.32	1,255.68	1,643.88	1,802.52	2,406.60	2,411.04
76	1,780.08	2,147.76	1,294.44	1,694.64	1,858.32	2,481.00	2,485.56
77	1,833.48	2,212.20	1,333.32	1,745.40	1,914.00	2,555.28	2,559.96
78	1,886.16	2,275.68	1,371.48	1,795.56	1,968.84	2,628.72	2,633.40
79	1,938.72	2,339.04	1,409.88	1,845.60	2,023.80	2,702.04	2,706.96
80	1,991.28	2,402.52	1,448.16	1,895.64	2,078.64	2,775.36	2,780.40
81	2,043.96	2,466.00	1,486.32	1,945.80	2,133.60	2,848.80	2,853.84
82	2,096.52	2,529.60	1,524.60	1,995.84	2,188.56	2,922.00	2,927.28
83	2,200.80	2,655.24	1,600.32	2,095.08	2,297.28	3,067.32	3,072.84
84	2,305.32	2,781.48	1,676.40	2,194.56	2,406.60	3,213.00	3,218.88
85+	2,409.60	2,907.24	1,752.24	2,293.80	2,515.32	3,358.32	3,364.32

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

Effective date: Jan. 1, 2021

Premium Information

WPS Health Insurance 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 are 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.

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 WPS Health Insurance 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, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. Review the application carefully before you sign it and be certain that all information has been properly recorded.

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 \$1,484	\$0	\$1,484 (Part A deductible)
	61st to 90th day	All but \$371 per day	\$371 a day	\$0
	91st day and after while using 60 lifetime reserve days	All but \$742 per day	\$742 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 \$185.50 per day	\$0	Up to \$185.50 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 \$203 of Medicare-approved amounts***	\$0	\$0	\$203 (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 \$203 of Medicare-approved amounts***	\$0	\$0	\$203 (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 \$203 of Medicare-approved amounts***	\$0	\$0	\$203 (Part B deductible)
		Remainder of Medicare-approved amounts	80%	20%	\$0

*** Once you have been billed \$203 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 \$1,484	\$1,484 (Part A deductible)	\$0
	61st to 90th day	All but \$371 per day	\$371 a day	\$0
	91st day and after while using 60 lifetime reserve days	All but \$742 per day	\$742 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 \$185.50 per day	Up to \$185.50 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 \$203 of Medicare-approved amounts***	\$0	\$0	\$203 (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 \$203 of Medicare-approved amounts***		\$0	\$0	\$203 (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 \$203 of Medicare-approved amounts***		\$0	\$0	\$203 (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 \$203 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 \$1,484	\$742 (50% of Part A deductible)	\$742 (50% of Part A deductible)♦
	61st to 90th day	All but \$371 per day	\$371 a day	\$0
	91st day and after while using 60 lifetime reserve days	All but \$742 per day	\$742 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 \$185.50 per day	Up to \$92.75 a day (50% of Part A coinsurance)	Up to \$92.75 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 \$6,220 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 \$203 of Medicare-approved amounts ^{***}	\$0	\$0	\$203 (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 \$6,220) ^{††}
Blood	First 3 pints	\$0	50%	50%♦
	Next \$203 of Medicare-approved amounts ^{***}	\$0	\$0	\$203 (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 \$203 of Medicare-approved amounts ^{***}	\$0	\$0	\$203 (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 \$6,220 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 \$6,220 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 \$203 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 \$1,484	\$1,113 (75% of Part A deductible)	\$371 (25% of Part A deductible)♦
	61st to 90th day	All but \$371 per day	\$371 a day	\$0
	91st day and after while using 60 lifetime reserve days	All but \$742 per day	\$742 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 \$185.50 per day	Up to \$139.12 a day (75% of Part A coinsurance)	Up to \$46.38 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 \$3,110 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 \$203 of Medicare-approved amounts ^{***}	\$0	\$0	\$203 (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 \$3,110) ^{††}
BLOOD	First 3 pints	\$0	75%	25%♦
	Next \$203 of Medicare-approved amounts ^{***}	\$0	\$0	\$203 (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 \$203 of Medicare-approved amounts ^{***}	\$0	\$0	\$203 (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 \$3,110 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 \$3,110 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 \$203 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 \$1,484	\$1,484 (Part A deductible)	\$0
	61st to 90th day	All but \$371 per day	\$371 a day	\$0
	91st day and after while using 60 lifetime reserve days	All but \$742 per day	\$742 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 \$185.50 per day	Up to \$185.50 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 \$203 of Medicare-approved amounts***	\$0	\$0	\$203 (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 \$203 of Medicare-approved amounts***	\$0	\$0	\$203 (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 \$203 of Medicare-approved amounts***	\$0	\$0	\$203 (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 \$203 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 \$1,484	\$1,484 (Part A deductible)	\$0
	61st to 90th day	All but \$371 per day	\$371 a day	\$0
	91st day and after while using 60 lifetime reserve days	All but \$742 per day	\$742 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 \$185.50 per day	Up to \$185.50 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 \$203 of Medicare-approved amounts***	\$0	\$203 (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 \$203 of Medicare-approved amounts***	\$0	\$203 (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 \$203 of Medicare-approved amounts***	\$0	\$203 (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 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 \$203 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 \$1,484	\$1,484 (Part A deductible)	\$0
	61st to 90th day	All but \$371 per day	\$371 a day	\$0
	91st day and after while using 60 lifetime reserve days	All but \$742 per day	\$742 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 \$185.50 per day	Up to \$185.50 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 \$203 of Medicare-approved amounts***	\$0	\$203 (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 \$203 of Medicare-approved amounts***	\$0	\$203 (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 \$203 of Medicare-approved amounts***	\$0	\$203 (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 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 \$203 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*.

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. We do not exclude people
or treat them differently because of race, color, national
origin, age, disability, or sex.

We provide 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)

We provide 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 do not 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 [Deutsch (Pennsylvania German / Dutch)]
schwetzsch, kannsch 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).

In AZ, CO, FL, IA, KS, MO, NE, OK, PA, SC, TN, and TX, Medicare supplement insurance plans are underwritten by The EPIC Life Insurance Company. Neither Wisconsin Physicians Service Insurance Corporation, nor The EPIC Life Insurance Company, nor their products, nor agents are connected with or endorsed by the United States government or the federal Medicare program.

If you believe that we have 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:

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 ທ່ານເວົ້າພາສາລາວ, ການບໍລິ
ການຊ່ວຍເຫຼືອ ສູດ ານພາສາ, ໂດຍບໍ່ ເສັຽຄ່າ, ແມ່
ນັ້ນ ພ້ອມໂຕ້ ທ່ານ. ໂທ 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।

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

