WPS HEALTH INSURANCE
Wisconsin Physicians Service Insurance Corporation
1717 W. Broadway | Madison, WI 53713

Outline of Medicare Supplement Coverage

Benefit Chart of Medicare Supplement Plans Sold On or After January 1, 2020

This chart shows the benefits included in each of the standardized Medicare supplement plans. 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

✓ indicates 100% of the benefit is paid.

Benefits	A	B	D	G[1]	K	L	M	N	Medicare first eligible before 2020 only: 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 2024[2]					$7,060[2]	$3,530[2]				

Plans shaded in gray are offered by WPS Health Insurance.

[1]Plans F and G also have high deductible options which require first paying the plans' deductibles of $2,800 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.

[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.

ANNUALIZED PREMIUM RATES

ZIP codes 436xx and 440xx - 445xx, and moving out of state **FEMALE**

Age	Plan A	Plan C	Plan F	Plan G	Plan N
Under 65	N/A	N/A	N/A	N/A	N/A
65	1,676.04	2,381.88	2,383.08	1,743.00	1,598.88
66	1,736.28	2,467.56	2,468.76	1,805.76	1,656.24
67	1,796.64	2,553.24	2,554.56	1,868.40	1,713.96
68	1,868.88	2,655.84	2,657.16	1,943.52	1,782.72
69	1,941.00	2,758.56	2,759.88	2,018.64	1,851.60
70	2,013.24	2,861.04	2,862.48	2,093.64	1,920.48
71	2,085.48	2,963.64	2,965.20	2,168.76	1,989.48
72	2,157.72	3,066.36	3,067.80	2,243.88	2,058.24
73	2,232.72	3,172.92	3,174.60	2,321.88	2,129.88
74	2,307.84	3,279.48	3,281.16	2,399.76	2,201.28
75	2,382.60	3,386.04	3,387.84	2,477.88	2,272.92
76	2,457.72	3,492.72	3,494.40	2,555.88	2,344.44
77	2,532.72	3,599.40	3,601.08	2,633.88	2,416.20
78	2,607.96	3,706.44	3,708.24	2,712.12	2,487.96
79	2,683.44	3,813.24	3,815.28	2,790.60	2,559.60
80	2,758.68	3,920.28	3,922.20	2,868.72	2,631.60
81	2,833.92	4,027.32	4,029.36	2,947.08	2,703.36
82	2,909.16	4,134.24	4,136.28	3,025.20	2,775.12
83	3,063.36	4,353.24	4,355.40	3,185.64	2,922.24
84	3,217.92	4,573.08	4,575.24	3,346.32	3,069.60
85+	3,372.00	4,791.96	4,794.24	3,506.52	3,216.60

MALE

Age	Plan A	Plan C	Plan F	Plan G	Plan N
Under 65	N/A	N/A	N/A	N/A	N/A
65	1,843.68	2,620.08	2,621.28	1,917.24	1,758.72
66	1,909.92	2,714.40	2,715.72	1,986.24	1,821.96
67	1,976.28	2,808.60	2,810.16	2,055.24	1,885.20
68	2,055.72	2,921.52	2,922.84	2,137.92	1,961.16
69	2,135.16	3,034.32	3,035.76	2,220.48	2,036.76
70	2,214.60	3,147.12	3,148.80	2,303.04	2,112.60
71	2,293.92	3,260.04	3,261.60	2,385.60	2,188.44
72	2,373.36	3,372.96	3,374.52	2,468.16	2,264.04
73	2,455.92	3,490.20	3,491.88	2,554.08	2,342.76
74	2,538.48	3,607.44	3,609.36	2,639.76	2,421.48
75	2,620.92	3,724.80	3,726.60	2,725.56	2,500.20
76	2,703.48	3,842.04	3,843.96	2,811.48	2,579.04
77	2,786.04	3,959.40	3,961.32	2,897.16	2,657.76
78	2,868.84	4,077.00	4,078.92	2,983.44	2,736.72
79	2,951.52	4,194.72	4,196.76	3,069.48	2,815.68
80	3,034.56	4,312.32	4,314.60	3,155.52	2,894.64
81	3,117.36	4,430.04	4,432.20	3,241.80	2,973.60
82	3,200.04	4,547.76	4,550.04	3,327.84	3,052.80
83	3,369.60	4,788.72	4,791.00	3,504.12	3,214.44
84	3,539.64	5,030.16	5,032.80	3,681.00	3,376.56
85+	3,709.08	5,271.24	5,273.76	3,857.16	3,538.20

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

Effective date: 7/1/2024

ANNUALIZED PREMIUM RATES

All other Ohio ZIP Codes **FEMALE**

Age	Plan A	Plan C	Plan F	Plan G	Plan N
Under 65	N/A	N/A	N/A	N/A	N/A
65	1,566.96	2,226.96	2,228.04	1,629.60	1,494.72
66	1,623.36	2,307.00	2,308.20	1,688.28	1,548.72
67	1,679.76	2,387.16	2,388.36	1,746.72	1,602.36
68	1,747.20	2,483.04	2,484.24	1,817.04	1,666.80
69	1,814.76	2,579.04	2,580.36	1,887.24	1,731.12
70	1,882.32	2,674.92	2,676.24	1,957.32	1,795.44
71	1,949.76	2,770.92	2,772.12	2,027.64	1,860.00
72	2,017.32	2,866.80	2,868.24	2,097.84	1,924.32
73	2,087.28	2,966.52	2,967.84	2,170.68	1,991.04
74	2,157.60	3,066.00	3,067.68	2,243.76	2,058.24
75	2,227.56	3,165.96	3,167.40	2,316.72	2,125.08
76	2,297.76	3,265.44	3,267.12	2,389.56	2,191.92
77	2,367.84	3,365.16	3,366.84	2,462.52	2,258.76
78	2,438.28	3,465.12	3,466.80	2,535.72	2,325.96
79	2,508.84	3,565.20	3,566.88	2,608.80	2,393.16
80	2,579.16	3,665.28	3,667.08	2,682.12	2,460.24
81	2,649.48	3,765.24	3,767.16	2,755.20	2,527.32
82	2,719.80	3,865.32	3,867.12	2,828.40	2,594.40
83	2,863.92	4,070.16	4,072.08	2,978.28	2,731.92
84	3,008.52	4,275.48	4,277.40	3,128.52	2,869.80
85+	3,152.52	4,480.08	4,482.36	3,278.28	3,007.32

MALE

Age	Plan A	Plan C	Plan F	Plan G	Plan N
Under 65	N/A	N/A	N/A	N/A	N/A
65	1,723.68	2,449.68	2,450.76	1,792.56	1,644.36
66	1,785.84	2,537.76	2,538.84	1,857.00	1,703.52
67	1,847.64	2,625.84	2,627.16	1,921.44	1,762.68
68	1,922.04	2,731.44	2,732.64	1,998.84	1,833.36
69	1,996.32	2,836.80	2,838.24	2,076.00	1,904.40
70	2,070.60	2,942.40	2,943.84	2,153.16	1,975.08
71	2,144.76	3,048.00	3,049.44	2,230.44	2,046.00
72	2,218.92	3,153.36	3,155.04	2,307.60	2,116.68
73	2,296.08	3,263.16	3,264.72	2,387.64	2,190.24
74	2,373.24	3,372.84	3,374.40	2,468.04	2,263.92
75	2,450.40	3,482.40	3,484.08	2,548.32	2,337.48
76	2,527.56	3,592.08	3,593.76	2,628.36	2,411.04
77	2,604.72	3,701.64	3,703.44	2,708.64	2,484.60
78	2,682.24	3,811.80	3,813.72	2,789.28	2,558.40
79	2,759.64	3,921.84	3,923.64	2,869.80	2,632.44
80	2,837.16	4,031.76	4,033.80	2,950.44	2,706.24
81	2,914.44	4,141.68	4,143.84	3,030.72	2,780.16
82	2,991.84	4,251.84	4,253.88	3,111.24	2,853.96
83	3,150.36	4,477.08	4,479.12	3,276.00	3,005.16
84	3,309.36	4,702.92	4,705.20	3,441.24	3,156.84
85+	3,467.76	4,928.16	4,930.56	3,606.24	3,307.92

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

Effective date: 7/1/2024

Premium Information

WPS Health Insurance can only raise your premium if we raise the premium for all policies like yours in this state or you enter a new age category. When entering a new age category, the premium increase will be effective on your anniversary date.

7% household discount

WPS offers a 7% discount when you and a second household member are enrolled in a WPS Medicare supplement plan. Household is defined as two or more individuals who reside together in the same dwelling. Dwelling is defined as a single home, condominium unit, or apartment unit within an apartment complex. This discount will be removed if you no longer meet the requirements.

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

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

Services		Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies.	First 60 days	All but $1,632	$0	$1,632 (Part A deductible)
	61st to 90th day	All but $408 per day	$408 a day	$0
	91st day and after while using 60 lifetime reserve days	All but $816 per day	$816 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 $204 per day	$0	Up to $204 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

** 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

***Once you have been billed $240 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the 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 $240 of Medicare-approved amounts***	$0	$0	$240 (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 $240 of Medicare-approved amounts***	$0	$0	$240 (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 $240 of Medicare-approved amounts***	$0	$0	$240 (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	$0

PLAN C

Medicare Supplement Part A—Hospital Services—per benefit period

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

Services		Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies.	First 60 days	All but $1,632	$1,632 (Part A deductible)	$0
	61st to 90th day	All but $408 per day	$408 a day	$0
	91st day and after while using 60 lifetime reserve days	All but $816 per day	$816 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 $204 per day	Up to $204 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

** 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 C

Medicare Supplement Part B—Medical Services—per calendar year

***Once you have been billed $240 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the 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 $240 of Medicare-approved amounts***	$0	$240 (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 $240 of Medicare-approved amounts***	$0	$240 (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 $240 of Medicare-approved amounts***	$0	$240 (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

PLAN F

Medicare Supplement Part A—Hospital Services—per benefit period

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

Services		Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies.	First 60 days	All but $1,632	$1,632 (Part A deductible)	$0
	61st to 90th day	All but $408 per day	$408 a day	$0
	91st day and after while using 60 lifetime reserve days	All but $816 per day	$816 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 $204 per day	Up to $204 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

** 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 F

Medicare Supplement Part B—Medical Services—per calendar year

***Once you have been billed $240 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the 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 $240 of Medicare-approved amounts***	$0	$240 (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 $240 of Medicare-approved amounts***	$0	$240 (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 $240 of Medicare-approved amounts***	$0	$240 (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

PLAN G

Medicare Supplement Part A—Hospital Services—per benefit period

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

Services		Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies.	First 60 days	All but $1,632	$1,632 (Part A deductible)	$0
	61st to 90th day	All but $408 per day	$408 a day	$0
	91st day and after while using 60 lifetime reserve days	All but $816 per day	$816 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 $204 per day	Up to $204 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

** 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

***Once you have been billed $240 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the 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 $240 of Medicare-approved amounts***	$0	$0	$240 (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 $240 of Medicare-approved amounts***	$0	$0	$240 (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 $240 of Medicare-approved amounts***	$0	$0	$240 (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	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

PLAN N

Medicare Supplement Part A—Hospital Services—per benefit period

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

Services		Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies.	First 60 days	All but $1,632	$1,632 (Part A deductible)	$0
	61st to 90th day	All but $408 per day	$408 a day	$0
	91st day and after while using 60 lifetime reserve days	All but $816 per day	$816 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 $204 per day	Up to $204 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

** 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

***Once you have been billed $240 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the 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 $240 of Medicare-approved amounts***	$0	$0	$240 (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 $240 of Medicare-approved amounts***	$0	$0	$240 (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 $240 of Medicare-approved amounts***	$0	$0	$240 (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

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.

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.

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

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

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

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

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

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

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

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

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

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

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

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິ ການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ ເສັ ຽຄ່າ, ແມ່ ນມ ີ ພ້ ອມໃຫ້ ທ່ ານ. 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।

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