



MEDICARE SUPPLEMENT INSURANCE

Base Plan with Plan Riders and High-Deductible Plan Options

Rates effective 1/1/2027



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

WPS Medicare Supplement Plan Quick Comparison¹

	Medicare Supplement Benefits	Base Plan	High-Deductible Plan After the Annual Policy Deductible \$2,950
Medicare Part A	Hospitalization	Optional riders to pay 100% or 50% of deductible	100% of Part A Deductible
	Skilled Nursing Facility Care	Up to \$217 per day for 21st through 100th day	Up to \$217 per day for 21st through 100th day
	Hospice Care	Plan pays 100% of Medicare copayments/coinsurance	Plan pays 100% of Medicare copayments/coinsurance
	Blood (first three pints)	Plan pays 100% of Medicare copayments/coinsurance	Plan pays 100% of Medicare copayments/coinsurance
Medicare Part B	Medicare Part B Excess Charges	Optional rider	Included
	Home Health Care	Plan pays for 40 visits (up to 365 with optional rider)	Plan pays for up to 365 visits per policy year
	Foreign Travel Emergency Medical Care (up to plan limits)	Optional rider	Included*
	Out-of-Pocket Limits	–	–
	Additional Preventive Care	Included	Included
	Medicare Part B Deductible	Optional rider only available to applicants first eligible for Medicare prior to 1/1/2020	Not included in plan payments, but will apply towards the Policy deductible if not already met

*Subject to a separate \$250 deductible then 80% of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country; care that would have been covered by Medicare if provided in the United States; and when the care began during the first 60 consecutive days of each trip outside the United States for up to a lifetime maximum benefit of at least \$100,000.

¹IMPORTANT: This chart provides a Base overview. Limits may apply. Please see plan summaries on the following pages for details. If there is ever a discrepancy between the policy and this outline of coverage, the policy has final authority.

Outline of Medicare Supplement Coverage

The Wisconsin Insurance Commissioner has set standards for Medicare supplement insurance. The WPS Medicare supplement policy meets these standards. You should carefully review all policy limitations. For an explanation of these standards and other important information, see the “Wisconsin Guide to Health Insurance for People with Medicare” provided to you with this outline of coverage. Do not buy a policy if you did not get this guide.

Premium Information

We can only raise your premium if we raise the premium for all policies like yours in this state, 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, unless you reapply at age 65.

Disclosures

Use this outline to compare benefits and premiums among policies.

Read Your Policy Very Carefully

This is only an outline describing the policy’s most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

Right to Return Policy

If you find that you’re not satisfied with your policy, you may return it to: WPS, 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 your payments directly to you.

Policy Replacement

If you’re replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

Notice

Your policy may not fully cover all of your medical costs. **Neither WPS nor its agents are connected with the federal Medicare program.** Review the application carefully before you sign it and be certain that all information has been properly recorded. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

BASE PLAN

Outline of Medicare Supplement Insurance

Medicare Supplement Part A—Hospital Services—per benefit period

Services	Per Benefit Period	Medicare Pays	Plan Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing, and miscellaneous hospital services and supplies.	First 60 days	All but the \$1,736 deductible	\$0, or	\$1,736 deductible, or
			☐ Part A 100% Rider ¹ or,	\$0
			☐ Part A 50% Rider ²	\$868
	61st to 90th days	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 ³	\$0
	Beyond the additional 365 days	\$0	\$0	100%
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 through 100th day	All but \$217 per day	Up to \$217 per day	\$0
	101st day and after	\$0	\$0	100%
WPS Medicare supplement insurance also provides benefits for certain skilled nursing care and services that don't qualify for Medicare benefits. We'll pay benefits at the maximum daily rate established for the State of Wisconsin Medical Assistance Program, up to an additional 30 days for each confinement. You may request a policy for more details.				
Inpatient Psychiatric Care Inpatient psychiatric care in a participating psychiatric hospital.		190 days per lifetime	An additional 175 days per lifetime	Expenses beyond 365 days per lifetime
Blood	First 3 pints	\$0	First 3 pints	\$0
	Additional amounts	100%	\$0	\$0
Hospice Care Available as long as your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited coinsurance or copayment for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

*Your 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.

¹This is an optional rider. You may purchase this benefit by checking the box on the application and paying the premium.

²This optional rider may reduce your premium when you pay 50% of Medicare Part A deductible.

³NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid as provided in the policy's "Core Benefits."

Outline of Medicare Supplement Insurance

BASE PLAN

Medicare Supplement Policies—Part B Benefits

Medicare Part B Benefits	Per Calendar Year	Medicare Pays	Plan Pays	You Pay
Medical Expenses Eligible expense for physician's services, inpatient and outpatient medical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First \$283 of Medicare-approved amounts ⁴	\$0	\$0, or	\$283, or
			☐ Optional Part B Deductible Rider ⁵	\$0
	Remainder of Medicare-approved amounts	Generally 80%	Generally 20%, or	Charges exceeding eligible charges, or
			☐ Optional Part B Copayment or Coinsurance rider ⁶ , or	No more than \$20 per office visit and \$50 per emergency room visit, or
			☐ Optional Medicare Part B Excess Charges Rider ¹	\$0
Blood	First 3 pints	\$0	All costs	\$0
	Next \$283 of Medicare-approved amounts ⁴	\$0	\$0, or	\$283, or
			☐ Optional Part B Deductible Rider ⁵	\$0
	Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services Tests for diagnostic services		100%	\$0	\$0
Home Health Care		100% of charges for visits considered medically necessary by Medicare	40 visits, or	All expenses beyond 40 visits per year, or
			☐ Optional Additional Home Health Care Rider ¹	All expenses beyond 365 visits per year

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "Medicare & You" for more details. The dollar benefits shown are based on the amounts payable by Medicare for 2026. They will change in future years as Medicare benefits are changed.

⁴Once you have been billed \$283 of Medicare-approved amounts for covered services, your Medicare Part B Deductible will have been met for the calendar year.

⁵This is an optional rider only available to applicants first eligible for Medicare prior to 1/1/2020. You may purchase this benefit by checking the box on the application and paying the premium.

⁶This is an optional rider that may decrease your premium when you pay copayments for medical and emergency room visits.

BASE PLAN

Outline of Medicare Supplement Insurance

Foreign Travel Emergency Medical Care Benefits¹

Services	Medicare Pays	Plan Pays	You Pay
Foreign Travel Emergency Medical Care This benefit rider can be added at any time without answering medical questions.	\$0	\$0	All charges while traveling outside the U.S., or
		☐ Optional Foreign Travel Emergency Rider ¹	\$250 deductible and 20% of emergency medical charges that begin in the first 60 days of your trip up to the \$100,000 lifetime maximum

Other Wisconsin-Mandated Benefits²

Services	
- Kidney Transplants - Dialysis Treatments - Kidney Disease Care - Diabetic Equipment - Certain Diabetic Supplies - Diabetes Self-Management Education Programs - Chiropractic Care - Breast Reconstruction after a Mastectomy - Hospital, Ambulatory Surgery Center, and Anesthesia Charges for Dental Care (limited to specific conditions and circumstances)	Wisconsin-mandated benefits may apply to services denied by Medicare. Mandated benefits for kidney transplants, dialysis treatments, and kidney disease care are subject to a \$30,000 maximum per calendar year. All other benefits are paid for services that are medically necessary, as determined by us, and are payable at 100% of usual and customary charges.

Preventive Health Care Benefits

Services	Medicare Pays	Plan Pays	You Pay
Preventive Care Services Health care services to prevent or detect illness at an early stage, prior to the development of any symptoms. They can include exams, immunizations, lab tests, screenings, health monitoring programs, counseling and education to help you take care of your health. Visit medicare.gov for a complete list of Medicare covered services.	100% of the Medicare-approved charges (no Part B deductible)	\$0, or	Charges billed by the provider that exceed Medicare-approved amounts, or
		☐ Optional Medicare Part B Excess Charges Rider ¹	\$0
Preventive Services (not covered by Medicare)² Coverage for preventive health care services not covered by Medicare and as determined to be medically appropriate	\$0	The actual charges up to 100% of the Medicare approved amount for each service, as if Medicare were to cover the service. This benefit does not include payment for any procedure covered by Medicare.	Charges billed by the provider that exceed the Medicare approved amount.

¹This is an optional rider. You may purchase this benefit by checking the box on the application and paying the premium.

²These benefits are required under Wisconsin law and are payable under the policy when the services are not covered by Medicare. Medicare benefits will not be duplicated..

HIGH-DEDUCTIBLE PLAN

Outline of Medicare Supplement Insurance

Medicare Supplement Part A—Hospital Services—per benefit period

Services	Per Benefit Period	Medicare Pays	After you pay a \$2,950 deductible Policy Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing, and miscellaneous hospital services and supplies.	First 60 days	All but the \$1,736 deductible	\$1,736 (Part A deductible)	\$0
	61st to 90th days	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 ³	\$0
	Beyond the additional 365 days	\$0	\$0	100%
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 through 100th day	All but \$217 per day	Up to \$217 per day	\$0
	101st day and after	\$0	\$0	100%
WPS Medicare supplement insurance also provides benefits for certain skilled nursing care and services that don't qualify for Medicare benefits. We'll pay benefits at the maximum daily rate established for the State of Wisconsin Medical Assistance Program, up to an additional 30 days for each confinement. You may request a policy for more details.				
Inpatient Psychiatric Care Inpatient psychiatric care in a participating psychiatric hospital.		190 days per lifetime	An additional 175 days per lifetime	Expenses beyond 365 days per lifetime
Blood	First 3 pints	\$0	First 3 pints	\$0
	Additional amounts	100%	\$0	\$0
Hospice Care Available as long as your doctor certifies you are terminally ill and you elect to receive these services.		All but very limited coinsurance or copayment for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

*Your 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.

Note: This includes the Medicare deductibles for Part A and Part B

Note: The Policy deductible includes the Medicare deductibles for Part A and Part B. The Policy does not pay benefits for any amounts applied to the Part B deductible even if the Policy deductible is met. This high-deductible plan offers benefits after one has paid the Policy's calendar year \$2,950 deductible. This deductible consists of expenses that would ordinarily be paid by the policy. This also includes the Medicare deductible for Part A but does not include payment for amounts applied to the Part B deductible or the plan's separate foreign travel emergency deductible.

³NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid as provided in the policy's "Core Benefits."

Medicare Supplement Policies—Part B Benefits

Medicare Part B Benefits	Per Calendar Year	Medicare Pays	After you pay a \$2,950 deductible Plan Pays	You Pay
Medical Expenses Eligible expense for physician's services, inpatient and outpatient medical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.	First \$283 of Medicare-approved amounts ⁴	\$0	\$0	\$283
	Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Blood	First 3 pints	\$0	All costs	\$0
	Next \$283 of Medicare-approved amounts ⁴	\$0	\$0, or	\$283
	Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services Tests for diagnostic services		100%	\$0	\$0
Home Health Care – Medicare-approved services		100% of charges for visits considered medically necessary by Medicare	365 visits	All expenses beyond 365 visits per year

Note: This includes the Medicare deductibles for Part A and Part B

Note: The Policy deductible includes the Medicare deductibles for Part A and Part B. The Policy does not pay benefits for any amounts applied to the Part B deductible even if the Policy deductible is met. This high-deductible plan offers benefits after one has paid the Policy's calendar year \$2,950 deductible. This deductible consists of expenses that would ordinarily be paid by the policy. This also includes the Medicare deductible for Part A but does not include payment for amounts applied to the Part B deductible or the plan's separate foreign travel emergency deductible.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "Medicare & You" for more details. The dollar benefits shown are based on the amounts payable by Medicare for 2026. They will change in future years as Medicare benefits are changed.

⁴Once you have been billed \$283 of Medicare-approved amounts for covered services, your Medicare Part B Deductible will have been met for the calendar year.

Foreign Travel Emergency Medical Care Benefits

Services	Medicare Pays	Plans Pays	You Pay
Foreign Travel Emergency Medical Care	\$0	80% of emergency medical charges that begin in the first 60 days of your trip up to a lifetime maximum of \$100,000	\$250 deductible and 20% of emergency medical charges that begin in the first 60 days of your trip up to the \$100,000 lifetime maximum

Other Wisconsin-Mandated Benefits¹

Services	
• Kidney Transplants • Dialysis Treatments • Kidney Disease Care • Diabetic Equipment • Certain Diabetic Supplies • Diabetes Self-Management Education Programs • Chiropractic Care • Breast Reconstruction after a Mastectomy • Hospital, Ambulatory Surgery Center, and Anesthesia Charges for Dental Care (limited to specific conditions and circumstances)	Wisconsin-mandated benefits may apply to services denied by Medicare. Mandated benefits for kidney transplants, dialysis treatments, and kidney disease care are subject to a \$30,000 maximum per calendar year. All other benefits are paid for services that are medically necessary, as determined by us, and are payable at 100% of usual and customary charges.

Preventive Health Care Benefits

Services	Medicare Pays	Plans Pays	You Pay
Preventive Services (Preventive services prevent illness or detect illness at an early stage. They include exams, shots, lab tests, and screenings. They also include programs for health monitoring, and counseling and education to help you take care of your own health. Visit medicare.gov for complete list of Medicare covered services.)	100% of the Medicare-approved charges (no Part B deductible)	\$0	\$0
Preventive Services (not covered by Medicare)¹ Coverage for preventive health care services not covered by Medicare and as determined to be medically appropriate	\$0	The actual charges up to 100% of the Medicare approved amount for each service, as if Medicare were to cover the service. This benefit does not include payment for any procedure covered by Medicare.	Charges billed by the provider that exceed the Medicare approved amount.

¹These benefits are required under Wisconsin law and are payable under the policy when the services are not covered by Medicare. Medicare benefits will not be duplicated.

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

- Health care services Medicare does not cover unless this policy specifically provides coverage for them.
- Health care services which neither you nor a party on your behalf has a legal obligation to pay in the absence of insurance.
- Health care services to the extent that they are paid for by Medicare, or would have been paid for by Medicare if you were enrolled in both Medicare Parts A and B.
- Health care services to the extent that they are paid for by another government entity or program This doesn't apply to health benefits or insurance plans for employees of such entities.
- Health care services to the extent that a worker's compensation law or other U.S. or state plan covers them.
- Health care services you need because of war, or an act of war, occurring on or after the effective date of this policy.
- Custodial care.
- Maintenance care and supportive care.
- Services provided by members of your immediate family or anyone else living in your household.
- Teeth-related services, including:
 1. Care, treatment, filling, removal, or replacement
 2. Dental x-rays
 3. Root canal therapy
 4. Surgery for impacted teeth
 5. Any other surgical procedures involving the teeth or structures directly supporting them.
- Drugs and medicines you buy with or without a physician's prescription except for Equipment and Supplies for Treatment of Diabetes as noted in the policy.
- Health care services before your insurance becomes effective, or after coverage ends, except as allowed under Extension of Benefits.
- Health care services which are not medically necessary as determined by us, except for such health care services covered by Medicare.
- Medicare Part B copayment or coinsurance, except when you have purchased the Medicare Part B Copayment or Coinsurance Rider or the High-Deductible plan has been purchased.
- Medicare Part A deductible, except when one of the Medicare Part A Deductible Riders or the High-Deductible plan has been purchased.
- Medicare Part B deductible, except when the Medicare Part B Deductible Rider has been purchased. Note if the High-Deductible plan was purchased, the Medicare Part B deductible amounts can be used to help satisfy the Annual Policy Deductible, but is otherwise not covered.
- Charges exceeding the Medicare allowed amount for health care services, except when the Medicare Part B Excess Charges Rider or the High-Deductible plan has been purchased.
- Home health care above forty (40) visits as required by Wisconsin insurance statutes, except when the Additional Home Health Care Rider or the High-Deductible plan has been purchased.
- Health care services received outside the United States, except when the Foreign Travel Emergency Rider or the High-Deductible plan has been purchased.

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

ANNUALIZED BASE PLAN MALE PREMIUM RATES

	Base Plan Only			Base Plan with Copayment/Coinsurance Rider		
Area	1	2	3	1	2	3
<65	\$9,498.36	\$8,736.00	\$7,518.72	\$8,254.20	\$7,591.68	\$6,533.88
65	\$2,374.56	\$2,184.00	\$1,879.68	\$2,063.52	\$1,897.92	\$1,633.44
66	\$2,472.12	\$2,273.64	\$1,956.84	\$2,148.36	\$1,975.80	\$1,700.52
67	\$2,572.08	\$2,365.68	\$2,036.04	\$2,235.12	\$2,055.72	\$1,769.28
68	\$2,675.04	\$2,460.36	\$2,117.52	\$2,324.76	\$2,138.16	\$1,840.20
69	\$2,780.52	\$2,557.44	\$2,201.04	\$2,416.20	\$2,222.40	\$1,912.68
70	\$2,889.00	\$2,657.04	\$2,286.84	\$2,510.64	\$2,309.04	\$1,987.32
71	\$3,000.36	\$2,759.52	\$2,375.04	\$2,607.24	\$2,397.96	\$2,063.88
72	\$3,114.24	\$2,864.28	\$2,465.16	\$2,706.12	\$2,488.92	\$2,142.12
73	\$3,231.12	\$2,971.80	\$2,557.68	\$2,807.76	\$2,582.40	\$2,222.52
74	\$3,350.52	\$3,081.60	\$2,652.24	\$2,911.44	\$2,677.80	\$2,304.72
75	\$3,472.92	\$3,194.16	\$2,749.08	\$3,018.00	\$2,775.72	\$2,388.96
76	\$3,597.96	\$3,309.24	\$2,848.08	\$3,126.60	\$2,875.80	\$2,475.00
77	\$3,725.64	\$3,426.60	\$2,949.12	\$3,237.60	\$2,977.80	\$2,562.84
78	\$3,856.20	\$3,546.60	\$3,052.44	\$3,351.12	\$3,082.08	\$2,652.60
79	\$3,989.04	\$3,668.88	\$3,157.68	\$3,466.44	\$3,188.28	\$2,744.04
80	\$4,124.76	\$3,793.68	\$3,265.08	\$3,584.52	\$3,296.76	\$2,837.40
81	\$4,262.88	\$3,920.76	\$3,374.40	\$3,704.40	\$3,407.16	\$2,932.32
82	\$4,403.52	\$4,050.12	\$3,485.76	\$3,826.56	\$3,519.48	\$3,029.04
83	\$4,546.68	\$4,181.76	\$3,599.04	\$3,951.00	\$3,633.96	\$3,127.56
84	\$4,692.24	\$4,315.56	\$3,714.24	\$4,077.48	\$3,750.12	\$3,227.64
85+	\$4,839.96	\$4,451.52	\$3,831.24	\$4,206.00	\$3,868.44	\$3,329.40

Amounts shown are in U.S. \$

Available Discounts:

1) A 7% premium discount will be applied for customers who share the same household* with someone other than yourself who meets either of the following conditions:

1. They are age 60 or older, and you have continuously lived with them for the last 12 months; OR
2. They are currently enrolled in or applying for a WPS Medicare Supplement plan

2) A 2% premium discount will be applied for customers who pay by automatic bank withdrawal.

*Household: 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.

¹This is an optional rider only available to applicants first eligible for Medicare prior to 1/1/2020. You may purchase this benefit by checking the box on the application and paying the premium.

ANNUALIZED BASE PLAN MALE PREMIUM RATES

	Optional Rider: 50% Part A Deductible			Optional Rider: 100% Part A Deductible			Optional Rider: Part B Excess Charges		
Area	1	2	3	1	2	3	1	2	3
<65	\$965.40	\$887.88	\$764.16	\$1,969.80	\$1,811.76	\$1,559.28	\$401.88	\$369.60	\$318.12
65	\$241.32	\$222.00	\$191.04	\$492.36	\$452.88	\$389.76	\$100.32	\$92.28	\$79.44
66	\$251.16	\$231.00	\$198.84	\$512.64	\$471.60	\$405.84	\$104.64	\$96.24	\$82.80
67	\$261.36	\$240.36	\$206.88	\$533.28	\$490.56	\$422.16	\$108.84	\$100.08	\$86.16
68	\$271.80	\$249.96	\$215.16	\$554.88	\$510.36	\$439.20	\$113.28	\$104.16	\$89.64
69	\$282.60	\$259.92	\$223.68	\$576.72	\$530.40	\$456.48	\$117.60	\$108.24	\$93.12
70	\$293.52	\$269.88	\$232.32	\$599.16	\$551.04	\$474.24	\$122.16	\$112.32	\$96.72
71	\$304.80	\$280.44	\$241.32	\$622.20	\$572.16	\$492.48	\$126.84	\$116.76	\$100.44
72	\$316.56	\$291.12	\$250.56	\$645.84	\$594.00	\$511.20	\$131.76	\$121.20	\$104.28
73	\$328.32	\$302.04	\$259.92	\$670.08	\$616.32	\$530.40	\$136.68	\$125.76	\$108.24
74	\$340.44	\$313.20	\$269.52	\$694.80	\$639.00	\$549.96	\$141.72	\$130.32	\$112.20
75	\$353.04	\$324.72	\$279.48	\$720.24	\$662.40	\$570.12	\$146.88	\$135.12	\$116.28
76	\$365.64	\$336.36	\$289.44	\$746.16	\$686.28	\$590.64	\$152.40	\$140.16	\$120.60
77	\$378.72	\$348.24	\$299.76	\$772.68	\$710.64	\$611.64	\$157.68	\$144.96	\$124.80
78	\$391.92	\$360.48	\$310.20	\$799.68	\$735.48	\$633.00	\$163.08	\$150.00	\$129.12
79	\$405.36	\$372.84	\$320.88	\$827.28	\$760.80	\$654.84	\$168.84	\$155.28	\$133.68
80	\$419.16	\$385.56	\$331.80	\$855.48	\$786.84	\$677.16	\$174.48	\$160.44	\$138.12
81	\$433.32	\$398.52	\$342.96	\$883.92	\$813.00	\$699.72	\$180.36	\$165.96	\$142.80
82	\$447.72	\$411.72	\$354.36	\$913.20	\$839.88	\$722.88	\$186.36	\$171.36	\$147.48
83	\$462.12	\$424.92	\$365.76	\$942.96	\$867.24	\$746.40	\$192.36	\$176.88	\$152.28
84	\$476.88	\$438.60	\$377.52	\$973.08	\$894.96	\$770.28	\$198.48	\$182.52	\$157.08
85+	\$491.88	\$452.40	\$389.40	\$1,003.68	\$923.16	\$794.52	\$204.84	\$188.40	\$162.12

Effective date: 1/1/2027

Area Definitions:

Area 1:

All 538xx, 540xx, 548xx, and all out-of-state ZIP Codes.

Area 2:

All 531xx - 534xx, 539xx, 541xx, 542xx, 546xx, and 549xx.

Area 3:

All 530xx, 535xx, 537xx, 543xx - 545xx, and 547xx.

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

ANNUALIZED BASE PLAN FEMALE PREMIUM RATES

	Base Plan Only			Base Plan with Copayment/Coinsurance Rider		
Area	1	2	3	1	2	3
<65	\$8,690.40	\$7,992.84	\$6,879.12	\$7,551.96	\$6,945.72	\$5,977.92
65	\$2,172.72	\$1,998.24	\$1,719.84	\$1,888.20	\$1,736.52	\$1,494.60
66	\$2,261.64	\$2,080.08	\$1,790.28	\$1,965.24	\$1,807.44	\$1,555.68
67	\$2,353.32	\$2,164.44	\$1,862.88	\$2,044.92	\$1,880.88	\$1,618.80
68	\$2,447.52	\$2,251.08	\$1,937.40	\$2,126.88	\$1,956.24	\$1,683.60
69	\$2,544.12	\$2,339.88	\$2,013.84	\$2,210.76	\$2,033.28	\$1,749.96
70	\$2,643.24	\$2,431.08	\$2,092.32	\$2,297.04	\$2,112.60	\$1,818.24
71	\$2,745.12	\$2,524.80	\$2,172.96	\$2,385.48	\$2,194.08	\$1,888.32
72	\$2,849.28	\$2,620.56	\$2,255.40	\$2,475.84	\$2,277.12	\$1,959.84
73	\$2,956.32	\$2,718.96	\$2,340.12	\$2,568.96	\$2,362.68	\$2,033.52
74	\$3,065.76	\$2,819.64	\$2,426.76	\$2,664.00	\$2,450.16	\$2,108.76
75	\$3,177.60	\$2,922.60	\$2,515.32	\$2,761.32	\$2,539.68	\$2,185.80
76	\$3,291.96	\$3,027.72	\$2,605.80	\$2,860.68	\$2,631.00	\$2,264.40
77	\$3,408.84	\$3,135.12	\$2,698.32	\$2,962.20	\$2,724.36	\$2,344.80
78	\$3,528.12	\$3,244.92	\$2,792.76	\$3,065.88	\$2,819.76	\$2,426.88
79	\$3,649.80	\$3,356.88	\$2,889.12	\$3,171.72	\$2,917.08	\$2,510.64
80	\$3,774.00	\$3,471.12	\$2,987.40	\$3,279.60	\$3,016.44	\$2,596.08
81	\$3,900.24	\$3,587.16	\$3,087.36	\$3,389.16	\$3,117.12	\$2,682.84
82	\$4,029.00	\$3,705.60	\$3,189.24	\$3,501.12	\$3,220.08	\$2,771.40
83	\$4,159.92	\$3,826.08	\$3,292.92	\$3,614.88	\$3,324.84	\$2,861.52
84	\$4,293.00	\$3,948.48	\$3,398.28	\$3,730.56	\$3,431.16	\$2,953.08
85+	\$4,428.24	\$4,072.80	\$3,505.32	\$3,848.04	\$3,539.16	\$3,046.08

Amounts shown are in U.S. \$

Available Discounts:

1) A 7% premium discount will be applied for customers who share the same household* with someone other than yourself who meets either of the following conditions:

1. They are age 60 or older, and you have continuously lived with them for the last 12 months; OR
2. They are currently enrolled in or applying for a WPS Medicare Supplement plan

2) A 2% premium discount will be applied for customers who pay by automatic bank withdrawal.

*Household: 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.

¹This is an optional rider only available to applicants first eligible for Medicare prior to 1/1/2020. You may purchase this benefit by checking the box on the application and paying the premium.

ANNUALIZED BASE PLAN FEMALE PREMIUM RATES

	Optional Rider: 50% Part A Deductible			Optional Rider: 100% Part A Deductible			Optional Rider: Part B Excess Charges		
Area	1	2	3	1	2	3	1	2	3
<65	\$883.20	\$812.28	\$699.12	\$1,802.16	\$1,657.56	\$1,426.56	\$367.68	\$338.16	\$291.00
65	\$220.68	\$203.04	\$174.72	\$450.60	\$414.36	\$356.64	\$91.92	\$84.48	\$72.72
66	\$229.80	\$211.32	\$181.92	\$469.08	\$431.40	\$371.28	\$95.64	\$87.96	\$75.72
67	\$239.16	\$219.96	\$189.36	\$488.04	\$448.80	\$386.28	\$99.60	\$91.56	\$78.84
68	\$248.76	\$228.84	\$196.92	\$507.60	\$466.80	\$401.76	\$103.56	\$95.28	\$81.96
69	\$258.60	\$237.84	\$204.72	\$527.52	\$485.16	\$417.60	\$107.64	\$99.00	\$85.20
70	\$268.68	\$247.08	\$212.64	\$548.16	\$504.12	\$433.92	\$111.72	\$102.72	\$88.44
71	\$279.12	\$256.68	\$220.92	\$569.28	\$523.56	\$450.60	\$116.16	\$106.80	\$91.92
72	\$289.56	\$266.28	\$229.20	\$590.88	\$543.48	\$467.76	\$120.72	\$111.00	\$95.52
73	\$300.48	\$276.36	\$237.84	\$613.20	\$564.00	\$485.40	\$125.04	\$115.08	\$99.00
74	\$311.52	\$286.56	\$246.60	\$635.64	\$584.64	\$503.16	\$129.72	\$119.40	\$102.72
75	\$322.92	\$297.00	\$255.60	\$659.04	\$606.12	\$521.64	\$134.52	\$123.72	\$106.44
76	\$334.56	\$307.68	\$264.84	\$682.68	\$627.84	\$540.36	\$139.20	\$128.04	\$110.16
77	\$346.44	\$318.60	\$274.20	\$706.92	\$650.16	\$559.56	\$144.36	\$132.72	\$114.24
78	\$358.56	\$329.76	\$283.80	\$731.76	\$672.96	\$579.24	\$149.28	\$137.28	\$118.20
79	\$370.92	\$341.16	\$293.64	\$756.96	\$696.12	\$599.16	\$154.32	\$141.96	\$122.16
80	\$383.52	\$352.80	\$303.60	\$782.64	\$719.88	\$619.56	\$159.84	\$147.00	\$126.48
81	\$396.48	\$364.56	\$313.80	\$808.80	\$743.88	\$640.20	\$165.12	\$151.80	\$130.68
82	\$409.44	\$376.56	\$324.12	\$835.56	\$768.48	\$661.44	\$170.40	\$156.72	\$134.88
83	\$422.76	\$388.92	\$334.68	\$862.68	\$793.44	\$682.92	\$176.04	\$161.88	\$139.32
84	\$436.32	\$401.28	\$345.36	\$890.28	\$818.88	\$704.76	\$181.56	\$167.04	\$143.76
85+	\$450.12	\$414.00	\$356.28	\$918.36	\$844.68	\$726.96	\$187.32	\$172.32	\$148.32

Effective date: 1/1/2027

Area Definitions:

Area 1:

All 538xx, 540xx, 548xx, and all out-of-state ZIP Codes.

Area 2:

All 531xx - 534xx, 539xx, 541xx, 542xx, 546xx, and 549xx.

Area 3:

All 530xx, 535xx, 537xx, 543xx - 545xx, and 547xx.

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

ANNUALIZED HIGH-DEDUCTIBLE PLAN PREMIUM RATES

	High Deductible - Male			High Deductible - Female		
Area	1	2	3	1	2	3
<65	\$4,769.64	\$4,386.84	\$3,775.56	\$4,365.72	\$4,015.20	\$3,455.76
65	\$1,208.52	\$1,111.56	\$956.64	\$1,107.72	\$1,018.80	\$876.84
66	\$1,257.36	\$1,156.44	\$995.28	\$1,152.12	\$1,059.60	\$912.00
67	\$1,307.40	\$1,202.40	\$1,034.88	\$1,198.08	\$1,101.84	\$948.36
68	\$1,358.88	\$1,249.80	\$1,075.68	\$1,245.00	\$1,145.16	\$985.56
69	\$1,411.68	\$1,298.40	\$1,117.44	\$1,293.36	\$1,189.56	\$1,023.84
70	\$1,465.80	\$1,348.08	\$1,160.28	\$1,342.80	\$1,235.04	\$1,062.96
71	\$1,521.36	\$1,399.32	\$1,204.32	\$1,393.80	\$1,281.96	\$1,103.28
72	\$1,578.36	\$1,451.76	\$1,249.44	\$1,445.88	\$1,329.84	\$1,144.56
73	\$1,636.80	\$1,505.40	\$1,295.64	\$1,499.40	\$1,379.04	\$1,186.92
74	\$1,696.56	\$1,560.36	\$1,342.92	\$1,554.12	\$1,429.44	\$1,230.24
75	\$1,757.64	\$1,616.52	\$1,391.28	\$1,610.16	\$1,480.92	\$1,274.52
76	\$1,820.16	\$1,674.12	\$1,440.84	\$1,667.16	\$1,533.24	\$1,319.64
77	\$1,884.00	\$1,732.80	\$1,491.36	\$1,725.60	\$1,587.12	\$1,365.96
78	\$1,949.28	\$1,792.80	\$1,542.96	\$1,785.36	\$1,642.08	\$1,413.24
79	\$2,015.76	\$1,854.00	\$1,595.64	\$1,846.08	\$1,698.00	\$1,461.36
80	\$2,083.56	\$1,916.28	\$1,649.28	\$1,908.24	\$1,755.12	\$1,510.56
81	\$2,152.56	\$1,979.76	\$1,703.88	\$1,971.36	\$1,813.08	\$1,560.48
82	\$2,222.88	\$2,044.44	\$1,759.56	\$2,035.68	\$1,872.24	\$1,611.36
83	\$2,294.40	\$2,110.20	\$1,816.20	\$2,101.08	\$1,932.48	\$1,663.20
84	\$2,367.12	\$2,177.16	\$1,873.80	\$2,167.68	\$1,993.68	\$1,715.88
85+	\$2,441.04	\$2,245.08	\$1,932.24	\$2,235.24	\$2,055.84	\$1,769.40

Area Definitions:

Area 1:

All 538xx, 540xx, 548xx, and all out-of-state ZIP Codes.

Area 2:

All 531xx - 534xx, 539xx, 541xx, 542xx, 546xx, and 549xx.

Area 3:

All 530xx, 535xx, 537xx, 543xx - 545xx, and 547xx.

Available Discounts:

1) A 7% premium discount will be applied for customers who share the same household* with someone other than yourself who meets either of the following conditions:

1. They are age 60 or older, and you have continuously lived with them for the last 12 months; OR
2. They are currently enrolled in or applying for a WPS Medicare Supplement plan

2) A 2% premium discount will be applied for customers who pay by automatic bank withdrawal.

*Household: 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.

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

GRIEVANCE PROCEDURES

Your policy provides complete details on these procedures. Situations might arise when you have a question or concern about your benefits or our claim payment decisions. Most benefit and claim questions or concerns can be resolved by contacting our WPS Customer Support department. Our toll-free telephone number is: 1-888-253-2694. Our Customer Support address is:

WPS
Attention: Customer Support
1717 W. Broadway • P.O. Box 8190
Madison, WI 53708-8190

If your question or concern can't be resolved by our Customer Support department, you or an authorized representative can file a written grievance. You can designate a representative to act for you by sending us a signed letter of authorization with your written grievance. To file a grievance:

1. Write down your claim or benefit concern, including the reason you disagree with our payment or coverage decision.
2. Mail, deliver, or fax your written grievance, along with copies of any related materials (such as letters or other supporting documents), to us at the following address:

WPS
Attention: Grievance/Appeals Department
1717 W. Broadway • P.O. Box 7062
Madison, WI 53707-7062
Fax: 1-608-327-6319

If your life, health, or ability to regain maximum function is in serious jeopardy, or your pain can't be managed without the care or treatment being grieved, call us toll-free at 1-877-897-4123, and we can expedite the grievance process for you.

We'll provide a prompt, complete, and unbiased review of your request and our decision. If you designate a representative, we'll send the results of our review to him or her instead of to you. The results will include our claim or benefit decision, the reason for our decision, and identify the policy provisions on which we based our decision.

DEFINITIONS

Grievance—Any dissatisfaction with our provision of services or our claims practices that is expressed in writing to us by, or on behalf of, you. **A charge**, as used in this outline of coverage, means the amounts billed by a health care provider for a health care service. These charges are incurred on the date you receive the health care service.

Neither Medicare nor your WPS Medicare supplement insurance policy will pay for charges Medicare determines are "unreasonable or unnecessary."

A usual and customary charge, as used in this outline of coverage, is a fee for a service or item that does not exceed the general level of billed amounts, as determined by us, for such a service or item when provided in the same geographic area under similar or comparable circumstances. In some cases, the amount we determine may be less than the amount billed. This definition applies only to state-mandated benefits for chiropractic care; diabetic equipment, supplies and self-management education programs; home health care; breast reconstruction; and hospital, ambulatory surgery center, and anesthesia charges for dental care.

GENERAL INFORMATION

This outline of coverage provides only a general description of WPS Medicare supplement insurance benefits, limitations, and exclusions. You can find a more detailed description of WPS Medicare supplement insurance in the policy. The policy will be issued to you upon approval for coverage and your payment of premium. Coverage is subject to all terms and conditions of the policy and all riders. We've added the subject headings in this outline of coverage for easier reading and quick reference. These headings aren't part of the description of coverage, and aren't to be used in determining applicable limitations and exclusions. This outline of coverage doesn't give all the details of Medicare coverage. Contact your local Social Security Office or consult "Medicare & You" for more details. To receive a copy of this handbook, call 1-800-633-4227.

RENEWAL TERMS

The WPS Medicare supplement insurance policy has a renewal term of one (1) year. For your WPS Medicare supplement insurance coverage to continue, we must receive your premium payment as required by the policy. We'll only send one bill to notify you when your premium is due. (If you're paying by automatic bank withdrawal, no bills are sent.) Your grace period for paying the premium is 31 days after the premium due date.

Your premium is subject to change at our option. Any change in your WPS Medicare supplement insurance premium will apply to all participants in the same rating class as determined by us.

You can terminate your coverage at any time by contacting us.

PREMIUM CALCULATION WORKSHEET

I live in: ☐ Area 1 ☐ Area 2 ☐ Area 3 (See page 12, 14 and 15 for help determining your area.)

To view monthly premium discounted rates and to determine your rate area, please see the WPS Medicare Supplement booklet that accompanies this Outline of Coverage. For annualized rates, with no discounts added, please see pages 11-15.

Important: Members who pay by automatic bank withdrawal pay a premium that is 2% less than those who pay by credit/debit card or by monthly direct bill. Please take into account this available discount when entering premium amounts below.

Choose your Medicare supplement coverage

\$ _____ ☐ **Base Plan Only** ☐ **Base Plan with Copayment/Coinsurance Rider***
\$ _____ ☐ **High-Deductible Plan**

*If you select this coverage, after you pay the Medicare Part B deductible, you pay a \$20 copayment for office visits and up to a \$50 copayment for emergency room visits, or pay the Medicare Part B coinsurance, whichever is less.

Optional benefit riders for Base Plans Medicare supplement policy

Each of these riders may be purchased separately.

- \$ _____ **Medicare Part A Deductible**
If you select this coverage, we will pay either 100% or 50% of your Medicare Part A deductible of \$1,736 during the first 60 days of hospitalization.
☐ 100% **or** ☐ 50%
- \$ _____ ☐ **Medicare Part B Deductible (available with the Base plan only)**
If you select this coverage, we will pay your Medicare Part B deductible of \$283 each calendar year. This optional rider is only available to applicants first eligible for Medicare prior to 1/1/2020.
- \$ _____ ☐ **Medicare Part B Excess Charges**
If you select this coverage, we will pay the difference between what Medicare approves for payment and the amount charged by the provider, if your provider does not accept Medicare assignment. The difference shall be no more than the actual charge or the limiting charge allowed by Medicare, whichever is less.
- \$ _____ ☐ **Additional Home Health Care**
If you select this coverage, we'll pay benefits for an additional 325 home health care visits each calendar year, up to a total of 365 visits per year, including those covered by Medicare.
- \$ _____ ☐ **Foreign Travel Emergency**
If you select this coverage, we'll pay 80% of expenses associated with emergency medical care you receive outside the U.S. that begins in the first 60 days of a trip, after you satisfy a deductible of \$250, up to a lifetime maximum benefit of \$100,000.

+ \$ _____ **Optional Rider Subtotal**

+ \$ _____ **Optional Dental Coverage** If you are also enrolling in optional dental coverage, enter the dental rate here. Refer to the Sales Booklet for more information.

= \$ _____ **Subtotal**

x \$ _____ **Household Discount¹** If you are taking advantage of the 7% household discount, multiply your subtotal by 0.93.

= \$ _____ **YOUR PREMIUM**

¹Discounts are approximate; actual discount amount will be determined when your application is approved. In addition to this Outline of Coverage, WPS will send an annual notice to you 30 days prior to the effective date of Medicare changes that will describe these changes and the changes in your Medicare supplement coverage.

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



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 koj 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 Sprachassistenzen 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، فستوفر 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: ຂໍຄວນໃສ່ໃຈ: 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.

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