

(COMPANY NAME)

Outline of Medicare Supplement Coverage - Cover Page:  
Benefit Plan(s) \_\_\_\_\_ (Insert letter(s) of plan(s) being offered)

This chart shows the benefits included in each plan of the standard Medicare supplement plans. Every company must make available Plan "A". Some plans may not be available in your state.

**See Outlines of Coverage sections for details about ALL plans**

**Basic Benefits for Plans A-J:**

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

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses), or, copayments for hospital outpatient services.

Blood: First three pints of blood each year.

**Basic Benefits for Plans K and L include similar services as Plans A-J, but cost-sharing for the basic benefits is at different levels.**

A	B	C	D	E	F*	G	H	I	J*	K**	L**
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits end 50% Hospice cost-sharing of Medicare-eligible expenses for the first three pints of blood 50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	100% of Part A Hospitalization Coinsurance plus coverage 365 Days after Medicare Benefits End 75% Hospice cost-sharing of Medicare-eligible expenses for the first three pints of blood 75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible		
					Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)		
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery		
				Preventive Care NOT covered by Medicare					Preventive Care NOT covered by Medicare		
										[\$4000] Out of Pocket Annual Limit***	[\$2000] Out of Pocket Annual Limit***

\* Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same benefits as plans F and J after one has paid a calendar year [\$1,730] deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses exceed [\$1,730]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include, the plan's separate foreign travel emergency deductible.

\*\*Plans K and L provide for different cost-sharing for items and services than Plans A-J. Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges". You will be responsible for paying excess charges.

\*\*\*The out-of-pocket annual limit will increase each year for inflation.

**PREMIUM INFORMATION** (Boldface Type)

We (insert issuer's name) can only raise your premium if we raise the premium for all policies like yours in this State. (If the premium is based on the increasing age of the insured, include information when premiums will change).

**DISCLOSURES** (Boldface Type)

Use this outline to compare benefits and premiums among policies.

**READ YOUR POLICY VERY CAREFULLY** (Boldface Type)

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 policy.

**RIGHT TO RETURN POLICY** (Boldface Type)

If you find that you are not satisfied with your policy, you may return it to (insert issuer's address). 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** (Boldface Type)

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** (Boldface Type)

This policy may not fully cover all of your medical costs.

(for agents:)

Neither (insert company's name) nor its agents are connected with Medicare.

(for direct response:)

(insert company's name) is not 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** (Boldface Type)

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. (If the policy or certificate is guaranteed issue, this paragraph need not appear.)

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

(Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to section 16-12-6(d) of this chapter.)

(Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the commissioner.)

**PLAN A**

**MEDICARE (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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies. First 60 days 61st thru 90th day 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve days are used: --Additional 365 days --Beyond the Additional 365 days	All but [\$912]† All but [\$228]† a day  All but [\$456]† a day  \$0  \$0	\$0 [\$228]†† a day  [\$456]†† a day  100% of Medicare Eligible Expenses  \$0	[\$912]†† (Part A Deductible) \$0  \$0  \$0**  All Costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21st thru 100th day 101st day and after	All approved amounts All but [\$114]† a day \$0	\$0 \$0 \$0	\$0 Up to [\$114]†† a day All Costs
<b>BLOOD</b> First 3 pints Additional Amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

† Medicare redetermines deductibles on an annual basis.

†† Plan Payments and your payments are adjusted annually based on medicare deductibles.

**\*\*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 (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

\*Once you have been billed [\$110] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES -</b> 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 [\$110] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	[\$110] (Part B Deductible) \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next [\$110] Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 [\$110] (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES --Medically necessary skilled care services and medical supplies --Durable medical equipment First [\$110] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 [\$110] (Part B Deductible) \$0
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**PLAN B**

**MEDICARE (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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies. First 60 days 61st thru 90th day 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve days are used: --Additional 365 days --Beyond the Additional 365 days	All but [\$912]† All but [\$228]† a day  All but [\$456]† a day  \$0  \$0	[\$912]†† (Part A Deductible) [\$228]†† a day  [\$456]†† a day  100% of Medicare Eligible Expenses  \$0	\$0 \$0  \$0  \$0**  All Costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21st thru 100th day 101st day and after	All approved amounts All but [\$114]† a day \$0	\$0 \$0 \$0	\$0 Up to [\$114]†† a day All Costs
<b>BLOOD</b> First 3 pints Additional Amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

† Medicare redetermines deductibles on an annual basis.

†† Plan payments and your payments are adjusted annually based on medicare deductibles.

**\*\*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 B**

**MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

\*Once you have been billed [\$110] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES -</b> 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 [\$110] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$0 Generally 20%	 [\$110] (Part B Deductible) \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All Costs
<b>BLOOD</b> First 3 pints Next [\$110] Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 \$0 80%	 All Costs \$0 20%	 \$0 [\$110] (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES --Medically necessary skilled care services and medical supplies --Durable medical equipment First [\$110] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100%  \$0 80%	  \$0 \$0 20%	  \$0 [\$110] (Part B Deductible) \$0
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**PLAN C**

**MEDICARE (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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies. First 60 days 61st thru 90th day 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve days are used: --Additional 365 days --Beyond the Additional 365 days	All but [\$912]† All but [\$228]† a day  All but [\$456]† a day  \$0  \$0	[\$912]†† (Part A Deductible) [\$228]†† a day  [\$456]†† a day  100% of Medicare Eligible Expenses  \$0	\$0 \$0  \$0  \$0**  All Costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21st thru 100th day 101st day and after	All approved amounts All but [\$114]† a day \$0	\$0 Up to [\$114]†† a day \$0	\$0 \$0 All Costs
<b>BLOOD</b> First 3 pints Additional Amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

† Medicare redetermines deductibles on an annual basis.

†† Plan payments and your payments are adjusted annually based on medicare deductibles.

**\*\*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 (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

\*Once you have been billed [\$110] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES -</b> 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 [\$110] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	[\$110] (Part B Deductible) Generally 20%	\$0 \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All Costs
<b>BLOOD</b> First 3 pints Next [\$110] Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs [\$110] (Part B Deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES --Medically necessary skilled care services and medical supplies --Durable medical equipment First [\$110] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 [\$110] (Part B Deductible) 20%	\$0 \$0 \$0
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**OTHER BENEFITS - NOT COVERED BY MEDICARE**

<b>FOREIGN TRAVEL -</b> 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 Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
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**PLAN D**

**MEDICARE (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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies. First 60 days 61st thru 90th day 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve days are used: --Additional 365 days --Beyond the Additional 365 days	All but [\$912]† All but [\$228]† a day  All but [\$456]† a day  \$0  \$0	[\$912]†† (Part A Deductible) [\$228]†† a day  [\$456]†† a day  100% of Medicare Eligible Expenses  \$0	\$0 \$0  \$0  \$0**  All Costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21st thru 100th day 101st day and after	All approved amounts All but [\$114]† a day \$0	\$0 Up to [\$114]†† a day \$0	\$0 \$0 All Costs
<b>BLOOD</b> First 3 pints Additional Amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

† Medicare redetermines deductibles on an annual basis.

†† Plan payments and your payments are adjusted annually based on medicare deductibles.

**\*\*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 D**

**MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

\*Once you have been billed [\$110] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES -</b> 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 [\$110] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts)	\$0  Generally 80%	\$0  Generally 20%	[\$110] (Part B Deductible)  \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All Costs
<b>BLOOD</b> First 3 pints Next [\$110] Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 [\$110] (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

(continued)

**PLAN D (continued)**

**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE - MEDICARE APPROVED SERVICES</b> --Medically necessary skilled care services and medical supplies --Durable medical equipment First [\$110] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100%  \$0  80%	\$0  \$0  20%	\$0  [\$110] (Part B Deductible)  \$0
<b>AT HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE</b> Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan --Benefit for each visit  --Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)  --Calendar year maximum	\$0  \$0  \$0	Actual Charges to \$40 a visit Up to the number of Medicare Approved visits, not to exceed 7 each week  \$1,600	Balance

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

<b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
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**PLAN E**

**MEDICARE (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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies. First 60 days 61st thru 90th day 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve days are used: --Additional 365 days --Beyond the Additional 365 days	All but [\$912]† All but [\$228]† a day  All but [\$456]† a day  \$0  \$0	[\$912]†† (Part A Deductible) [\$228]†† a day  [\$456]†† a day  100% of Medicare Eligible Expenses  \$0	\$0 \$0  \$0  \$0**  All Costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21st thru 100th day 101st day and after	All approved amounts All but [\$114]† a day \$0	\$0 Up to [\$114]†† a day \$0	\$0 \$0 All Costs
<b>BLOOD</b> First 3 pints Additional Amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

† Medicare redetermines deductibles on an annual basis.

†† Plan payments and your payments are adjusted annually based on medicare deductibles.

**\*\*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 E**

**MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

\*Once you have been billed [\$110] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES -</b> 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 [\$110] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	[\$110] (Part B Deductible) \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All Costs
<b>BLOOD</b> First 3 pints Next [\$110] Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 [\$110] (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

<b>•SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES --Medically necessary skilled care services and medical supplies --Durable medical equipment First [\$110] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 [\$110] (Part B Deductible) \$0

(continued)

**PLAN E (continued)**

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p><b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b>                      Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA                      First \$250 each calendar year                      Remainder of Charges</p>	<p>\$0                      \$0</p>	<p>\$0                      80% to a lifetime maximum benefit of \$50,000</p>	<p>\$250                      20% and amounts over the \$50,000 lifetime maximum</p>
<p><b>***PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE</b>                      Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare                      First \$120 each calendar year                      Additional Charges</p>	<p>\$0                      \$0</p>	<p>\$120                      \$0</p>	<p>\$0                      All Costs</p>

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

**PLAN F OR HIGH DEDUCTIBLE PLAN F**

**MEDICARE (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.

[\*\*This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$1,730] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [\$1,730]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>[AFTER YOU PAY [\$1,730] DEDUCTIBLE,**] PLAN PAYS</b>	<b>[IN ADDITION TO [\$1,730] DEDUCTIBLE,**] YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies. First 60 days 61st thru 90th day 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve days are used: --Additional 365 days  --Beyond the Additional 365 days	All but [\$912]† All but [\$228]† a day  All but [\$456]† a day  \$0  \$0	[\$912]†† (Part A Deductible) [\$228]†† a day  [\$456]†† a day  100% of Medicare Eligible Expenses  \$0	\$0 \$0  \$0  \$0***  All Costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21st thru 100th day 101st day and after	All approved amounts All but [\$114]† a day \$0	\$0 Up to [\$114]†† a day \$0	\$0 \$0 All Costs
<b>BLOOD</b> First 3 pints Additional Amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

(Continued)

† Medicare redetermines deductibles on an annual basis.

†† Plan payments and your payments are adjusted annually based on medicare deductibles.

\*\*\* **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 OR HIGH DEDUCTIBLE PLAN F**

**MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

\*Once you have been billed [\$110] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

[\*\*This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$1,730] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [\$1,730]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>[AFTER YOU PAY [\$1,730] DEDUCTIBLE,**] PLAN PAYS</b>	<b>[IN ADDITION TO [\$1,730] DEDUCTIBLE,**] YOU PAY</b>
<b>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.</b> First [\$110] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0  Generally 80%	[\$110] (Part B Deductible)  Generally 20%	\$0  \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next [\$110] Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs [\$110] (Part B Deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0



**PLAN F or HIGH DEDUCTIBLE PLAN F**

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>[AFTER YOU PAY [\$1,730] DEDUCTIBLE,**] PLAN PAYS</b>	<b>[IN ADDITION TO [\$1,730] DEDUCTIBLE,**] YOU PAY</b>
<b>HOME HEALTH CARE - MEDICARE APPROVED SERVICES</b>			
--Medically necessary skilled care services and medical supplies	100%	\$0	\$0
--Durable medical equipment First [\$110] of Medicare Approved Amounts*	\$0	[\$110] (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>[AFTER YOU PAY [\$1,730] DEDUCTIBLE,**] PLAN PAYS</b>	<b>[IN ADDITION TO [\$1,730] DEDUCTIBLE,**] YOU PAY</b>
<b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b>			
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

**PLAN G**

**MEDICARE (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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies. First 60 days 61st thru 90th day 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve days are used: --Additional 365 days --Beyond the Additional 365 days	All but [\$912]† All but [\$228]† a day All but [\$456]† a day \$0 \$0	[\$912]†† (Part A Deductible) [\$228]†† a day [\$456]†† a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0** All Costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21st thru 100th day 101st day and after	All approved amounts All but [\$114]† a day \$0	\$0 Up to [\$114]†† a day \$0	\$0 \$0 All Costs
<b>BLOOD</b> First 3 pints Additional Amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

† Medicare redetermines deductibles on an annual basis.

†† Plan payments and your payments are adjusted annually based on medicare deductibles.

\*\* **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 (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

\*Once you have been billed [\$110] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT,</b> such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First [\$110] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	[\$110] (Part B Deductible) \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	80%	20%
<b>BLOOD</b> First 3 pints Next [\$110] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 [\$110] (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

(continued)

**PLAN G (continued)**

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTH CARE - MEDICARE APPROVED SERVICES</b>			
--Medically necessary skilled care services and medical supplies	100%	\$0	\$0
--Durable medical equipment First [\$110] of Medicare Approved Amounts*	\$0	\$0	[\$110] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>AT HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE</b>			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
--Benefit for each visit	\$0	Actual Charges to \$40 a visit	Balance
--Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
--Calendar year maximum	\$0	\$1,600	

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b>			
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

**PLAN H**

**MEDICARE (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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies. First 60 days 61st thru 90th day 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve days are used: --Additional 365 days --Beyond the Additional 365 days	All but [\$912]† All but [\$228]† a day All but [\$456]† a day \$0 \$0	[\$912]†† (Part A Deductible) [\$228]†† a day [\$456]†† a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0** All Costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21st thru 100th day 101st day and after	All approved amounts All but [\$114]† a day \$0	\$0 Up to [\$114]†† a day \$0	\$0 \$0 All Costs
<b>BLOOD</b> First 3 pints Additional Amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

† Medicare redetermines deductibles on an annual basis.

†† Plan payments and your payments are adjusted annually based on medicare deductibles.

\*\* **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 H**

**MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

\*Once you have been billed [\$110] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES -</b> 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 [\$110] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	[\$110] (Part B Deductible) \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	0%	All Costs
<b>BLOOD</b> First 3 pints Next [\$110] Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 [\$110] (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES - TESTS FOR FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES --Medically necessary skilled care services and medical supplies --Durable medical equipment First [\$110] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 [\$110] (Part B Deductible) \$0

(continued)

**PLAN H (continued)**

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>FOREIGN TRAVEL -</b> 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 Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum

**PLAN I**

**MEDICARE (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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies. First 60 days 61st thru 90th day 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve days are used: --Additional 365 days --Beyond the Additional 365 days	All but [\$912]† All but [\$228]† a day All but [\$456]† a day \$0 \$0	[\$912]†† (Part A Deductible) [\$228]†† a day [\$456]†† a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0** All Costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21st thru 100th day 101st day and after	All approved amounts All but [\$114]† a day \$0	\$0 Up to [\$114]†† a day \$0	\$0 \$0 All Costs
<b>BLOOD</b> First 3 pints Additional Amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

† Medicare redetermines deductibles on an annual basis.

†† Plan payments and your payments are adjusted annually based on medicare deductibles.

\*\* **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 I**

**MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

\*Once you have been billed [\$110] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT,</b> such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First [\$110] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	[\$110] (Part B Deductible) \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next [\$110] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 [\$110] (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

(continued)

**PLAN I (continued)**

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTH CARE - MEDICARE APPROVED SERVICES</b>			
--Medically necessary skilled care services and medical supplies	100%	\$0	\$0
--Durable medical equipment First [\$110] of Medicare Approved Amounts*	\$0	\$0	[\$110] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>AT HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE</b>			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
--Benefit for each visit	\$0	Actual Charges to \$40 a visit	Balance
--Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
--Calendar year maximum	\$0	\$1,600	

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b>			
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

**PLAN J OR HIGH DEDUCTIBLE PLAN J**

**MEDICARE (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.

[\*\*This high deductible plan pays the same benefits as Plan J after one has paid a calendar year [\$1,730] deductible. Benefits from the high deductible Plan J will not begin until out-of-pocket expenses are [\$1,730]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>[AFTER YOU PAY [\$1,730] DEDUCTIBLE,**] PLAN PAYS</b>	<b>[IN ADDITION TO [\$1,730] DEDUCTIBLE,**] YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies. First 60 days 61st thru 90th day 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve days are used: --Additional 365 days --Beyond the Additional 365 days	All but [\$912]† All but [\$228]† a day All but [\$456]† a day \$0 \$0	[\$912]†† (Part A Deductible) [\$228]†† a day [\$456]†† a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0*** All Costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21st thru 100th day 101st day and after	All approved amounts All but [\$114]† a day \$0	\$0 Up to [\$114]†† a day \$0	\$0 \$0 All Costs
<b>BLOOD</b> First 3 pints Additional Amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

(continued)

† Medicare redetermines deductibles on an annual basis.

†† Plan payments and your payments are adjusted annually based on medicare deductibles.

\*\*\***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 J OR HIGH DEDUCTIBLE PLAN J**

**MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

\*Once you have been billed [\$110] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

[\*\*This high deductible plan pays the same benefits as Plan J after one has paid a calendar year [\$1,730] deductible. Benefits from the high deductible Plan J will not begin until out-of-pocket expenses are [\$1,730]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>[AFTER YOU PAY [\$1,730] DEDUCTIBLE,**] PLAN PAYS</b>	<b>[IN ADDITION TO [\$1,730] DEDUCTIBLE,**] YOU PAY</b>
<b>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.</b> First [\$110] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0  Generally 80%	[\$110] (Part B Deductible)  Generally 20%	\$0  \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next [\$110] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs  [\$110] (Part B Deductible)  20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE MEDICARE APPROVED SERVICES</b> --Medically necessary skilled care services and medical supplies --Durable medical equipment First [\$110] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100%  \$0 80%	\$0  [\$110] (Part B Deductible)  20%	\$0  \$0 \$0
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(continued)

**PLAN J OR HIGH DEDUCTIBLE PLAN J**

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>[AFTER YOU PAY [\$1,730] DEDUCTIBLE,**] PLAN PAYS</b>	<b>[IN ADDITION TO [\$1,730] DEDUCTIBLE,**] YOU PAY</b>
<b>HOME HEALTH CARE (cont'd) AT HOME RECOVERY SERVICES -- NOT COVERED BY MEDICARE</b> Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan --Benefit for each visit  --Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)  --Calendar year maximum	\$0  \$0  \$0	Actual Charges to \$40 a visit  Up to the number of Medicare Approved visits, not to exceed 7 each week  \$1,600	Balance

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>[AFTER YOU PAY [\$1,730] DEDUCTIBLE,**] PLAN PAYS</b>	<b>[IN ADDITION TO [\$1,730] DEDUCTIBLE,**] YOU PAY</b>
<b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
<b>***PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE</b> Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare First \$120 each calendar year Additional Charges	\$0 \$0	\$120 \$0	\$0 All Costs

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

## HCFA DEDUCTIBLES FOR PLANS F AND J

<u>Calendar Year Beginning</u>		<u>Federal Register</u>
January 1, 1999	\$1,500	
January 1, 2000	\$1,530	Monday, April 10, 2000
January 1, 2001	\$1,580	Thursday, December 21, 2000
January 1, 2002	\$1,620	Friday, December 28, 2001
January 1, 2003	\$1,650	
January 1, 2004	\$1,690	

**PLAN K**

\*You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket **limit** of [\$4000] each calendar year. The amounts **that count toward your annual limit** are noted with diamonds (♦) in the chart below. Once you reach the annual limit, 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.**

**MEDICARE (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*
<b>HOSPITALIZATION**</b> Semiprivate room and board, general nursing and miscellaneous services and supplies. First 60 days  61st thru 90th day 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve days are used: --Additional 365 days  --Beyond the Additional 365 days	All but [\$912]†  All but [\$228]† a day  All but [\$456]† a day  \$0  \$0	[\$456]†† (50% Part A Deductible)  [\$228]†† a day  [\$456]†† a day  100% of Medicare eligible expenses  \$0	[\$456]†† (50% of Part A Deductible)♦  \$0  \$0  \$0***  All Costs
<b>SKILLED NURSING FACILITY CARE**</b> 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 21st thru 100th day 101st day and after	All approved amounts All but [\$114]† a day \$0	\$0 Up to [\$57]†† a day \$0	\$0 Up to [\$57]†† a day♦ All Costs
<b>BLOOD</b> First 3 pints Additional Amounts	\$0 100%	50% \$0	50%♦ \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	Generally, most Medicare Eligible expenses for Out-patient drugs and Inpatient respite care	50% of coinsurance or copayments	50% of coinsurance or copayments♦

(continued)

† Medicare redetermines deductibles on an annual basis.

†† Plan payments and your payments are adjusted annually based on medicare deductibles.

\*\*\***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 (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

\*\*\*\*Once you have been billed [\$110] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY*</b>
<b>MEDICAL EXPENSES -</b> 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 [\$110] of Medicare Approved Amounts**** Preventive Benefits for Medicare covered services Remainder of Medicare Approved amounts	\$0 Generally 75% or more of Medicare approved amounts Generally 80%	\$0 Remainder of Medicare approved amounts Generally 10%	[\$110] (Part B Deductible)**** ♦ All costs above Medicare approved amounts Generally 10% ♦
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\$400]) *
<b>BLOOD</b> First 3 pints Next [\$110] of Medicare Approved Amounts**** Remainder of Medicare Approved Amounts	\$0 \$0 Generally 80%	50% \$0 Generally 10%	50% ♦ [\$110] (Part B Deductible)**** ♦ Generally 10% ♦
<b>CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

(continued)

\*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to [\$4000] 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.



**PLAN K**  
**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES --Medically necessary skilled care services and medical supplies --Durable medical equipment First [\$110] of Medicare Approved amounts*****  Remainder of Medicare approved amounts	100%  \$0  80%	\$0  \$0  10%	\$0  [\$110] (Part B Deductible)◆  10%◆

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

## PLAN L

\*You will pay one fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket **limit** of [\$2000] each calendar year. The amounts **that count toward your annual limit** are noted with diamonds (♦) in the chart below. Once you reach the annual limit, 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.**

### MEDICARE (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*
<b>HOSPITALIZATION**</b> Semiprivate room and board, general nursing and miscellaneous services and supplies. First 60 days  61st thru 90th day 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve days are used: --Additional 365 days  --Beyond the additional 365 days	All but [\$912]†  All but [\$228]† a day  All but [\$456]† a day  \$0  \$0	[\$684]†† (75% Part A Deductible)  [\$228]†† a day  [\$456]†† a day  100% OF Medicare eligible expenses  \$0	[\$228]†† (25% of Part A Deductible)♦ \$0  \$0  \$0***  All Costs
<b>SKILLED NURSING FACILITY CARE**</b> 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 21st thru 100th day  101st day and after	All approved amounts All but [\$114]† a day  \$0	\$0 Up to [\$85.50]†† a day  \$0	\$0 Up to [\$28.50]†† a day♦  All Costs
<b>BLOOD</b> First 3 pints Additional Amounts	\$0 100%	75% \$0	25%♦ \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	Generally, most Medicare Eligible expenses for Out-patient drugs and Inpatient respite care	75% of coinsurance or copayments	25% of coinsurance or copayments♦

(continued)

† Medicare redetermines deductibles on an annual basis.

†† Plan payments and your payments are adjusted annually based on medicare deductibles.

\*\*\***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 (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

\*\*\*\*Once you have been billed [\$110] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY*</b>
<b>MEDICAL EXPENSES -</b> 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 [\$110] of Medicare Approved Amounts****  Preventive Benefits for Medicare covered services  Remainder of Medicare Approved amounts	\$0  Generally 75% or more of Medicare approved amounts  Generally 80%	\$0  Remainder of Medicare approved amounts  Generally 15%	[\$110] (Part B Deductible)**** ♦  All costs above Medicare approved amounts  Generally 5% ♦
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\$2000])*
<b>BLOOD</b> First 3 pints Next [\$110] of Medicare Approved Amounts**** Remainder of Medicare Approved Amounts	\$0 \$0 Generally 80%	75% \$0 Generally 15%	25% ♦ [\$110] (Part B deductible) ♦ Generally 5% ♦
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

(continued)

\*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to [\$2000] 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.

**PLAN L**  
**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
<b>HOME HEALTH CARE</b>			
MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	\$0	\$0
--Durable medical equipment First [\$110] of Medicare Approved amounts*****	\$0	\$0	[\$110] (Part B Deductible)♦
Remainder of Medicare approved amounts	80%	15%	5%♦

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