

DEPARTMENT OF LABOR AND REGULATION

DIVISION OF INSURANCE

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE POLICIES
PLANS A THROUGH N

Chapter 20:06:13

APPENDIX D

SEE: § 20:06:13:36

Source: 18 SDR 225, effective July 17, 1992; 23 SDR 236, effective July 13, 1997; 25 SDR 44, effective September 30, 1998; 26 SDR 26, effective September 1, 1999; 27 SDR 53, effective December 4, 2000; 31 SDR 214, effective July 6, 2005; 35 SDR 83, effective February 2, 2009; 36 SDR 209, effective July 1, 2010; 37 SDR 241, effective July 1, 2011; 39 SDR 10, effective August 1, 2012; 41 SDR 41, effective September 17, 2014; 42 SDR 52, effective October 13, 2015; 42 SDR 177, effective June 28, 2016; 43 SDR 181, effective July 7, 2017; 44 SDR 184, effective June 25, 2018; 46 SDR 147, effective July 2, 2020; 47 SDR 137, effective June 28, 2021.

APPENDIX D
[COMPANY NAME]

Outline of Medicare Supplement Coverage-Cover Page:

Benefit Plan(s)	[insert letter(s) of plan(s) being offered]
-----------------	---

These charts show the benefits included in each 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:

- **Hospitalization** -- Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses** -- Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or copayments.
- **Blood** -- First three pints of blood each year.
- **Hospice** -- Part A coinsurance.

A	B	C	D	F	F*	G
Basic, including 100% Part B coinsurance	Basic, Including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance*	Basic, including 100% Part B coinsurance*	Basic, including 100% Part B coinsurance
		Skilled Nursing Facility Coinsurance Part A Deductible	Skilled Nursing Facility Coinsurance Part A Deductible	Skilled Nursing Facility Coinsurance Part A Deductible	Skilled Nursing Facility Coinsurance Part A Deductible Part B Deductible	Skilled Nursing Facility Coinsurance Part A Deductible Part B Deductible
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency

K	L	M	N
Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance except up to \$20 copayment for office visit, and up to \$50 copayment for ER
50% Skilled Nursing Facility Coinsurance 50% Part A Deductible	75% Skilled Nursing Facility Coinsurance 75% Part A Deductible	Skilled Nursing Facility Coinsurance 50% Part A Deductible	Skilled Nursing Facility Coinsurance Part A Deductible
		Foreign Travel Emergency	Foreign Travel Emergency
Out-of-pocket limit \$[6,220 6,620]; paid at 100% after limit reached	Out-of-pocket limit \$[3,110 3,310]; paid at 100% after limit reached		

* Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year ~~\$2,370~~ \$2,490 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed ~~\$2,370~~ \$2,490. 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.

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 specifying when premiums will change.]

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 company.

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 & 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 chapter. An issuer may use additional benefit plan designations on these charts pursuant to § 20:06:13:17.05.]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the director.]

Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020

This chart shows the benefits included in each of the standard ~~Medicare~~ Medicare supplement plans. Some plans may not be available. Only applicants first eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

Note: A ✓ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G ¹	K	L	M	N	C	F ¹
Medicare Part A coinsurance <u>coinsurance</u> and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B Coinsurance or Copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply ³	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓ <u>80</u> %	✓ <u>80</u> %			✓ <u>80</u> %	✓ <u>80</u> %	✓ <u>80</u> %	✓ <u>80</u> %
Out-of-pocket limit in [2021 2022] ²					[\$ 6,220 \$6,620] ²	[\$ 3,110 \$3,310] ²				

¹Plans F and G also have a high deductible option which require first paying a plan deductible of [~~\$2,370~~ \$2,490] before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare part B deductible toward meeting the plan deductible.

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

³Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to \$20 for some office visits and up to a \$50 co-payment for emergency room visits that do not result in an inpatient admission.

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
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st 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 \$[1,484-1,556] All but \$[371-389] a day All but \$[742-778] a day \$0	\$0 \$[371-389] a day \$[742-778] a day 100% of Medicare eligible expenses \$0	\$[1,484-1,556] (Part A deductible) \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$[185.50-194.50] a day \$0	\$0 \$0 \$0	\$0 Up to \$[185.50-194.50] a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's Core Benefits. During this time the hospital is prohibited from billing you for the balance 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 \$[203-233] 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
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[203-233] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$[203-233] (Part B deductible) \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$[203-233] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[203-233] (Part B deductible) \$0
CLINICAL LABORATORY SERVICES --TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies ---Durable medical equipment First \$[203-233] of Medicare approved amounts* Remainder of Medicare approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$[203-233] (Part B deductible) \$0

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
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st 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 \$[1,484 <u>1,556</u>] All but \$[371-389] a day All but \$[742-778] a day \$0 \$0	\$[1,484 <u>1,556</u>](Part A deductible) \$[371-389] a day \$[742-778] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$[185.50-194.50] a day \$0	\$0 \$0 \$0	\$0 Up to \$[185.50-194.50] a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's Core Benefits. During this time the hospital is prohibited from billing you for the balance 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 \$[203-233] 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
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[203-233] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$[203-233] (Part B deductible) \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$[203-233] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[203-233] (Part B deductible) \$0
CLINICAL LABORATORY SERVICES --TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies ---Durable medical equipment First \$[203-233] of Medicare approved amounts* Remainder of Medicare approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$[203-233] (Part B deductible) \$0

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
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st 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 \$[1,484-1,556] All but \$[371-389] a day All but \$[742-778] a day \$0 \$0	\$[1,484-1,556](Part A deductible) \$[371-389] a day \$[742-778] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$[185.50-194.50] a day \$0	\$0 Up to \$ [185.50-194.50] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's Core Benefits. During this time the hospital is prohibited from billing you for the balance 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 \$[203-233] 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
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment; First \$[203-233] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 Generally 80%	\$[203-233] (Part B deductible) Generally 20%	\$0 \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$[203-233] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All costs \$[203-233] (Part B deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES --TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies ---Durable medical equipment First \$[203-233] of Medicare approved - amounts* Remainder of Medicare approved amounts	100% \$0 80%	\$0 \$[203-233] (Part B deductible) 20%	\$0 \$0 \$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 life-time maximum

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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st 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 \$[1,484-1,556] All but \$[371-389] a day All but \$[742-778] a day \$0 \$0	\$[1,484-1,556](Part A deductible) \$[371-389] a day \$[742-778] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$[185.50-194.50] a day \$0	\$0 Up to \$ [185.50-194.50] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's Core Benefits. During this time the hospital is prohibited from billing you for the balance 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 \$[203-233] 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
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment; First \$[203-233] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$[203-233] (Part B deductible) \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$[203-233] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[203-233] (Part B deductible) \$0
CLINICAL LABORATORY SERVICES --TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies ---Durable medical equipment First \$[203-233] of Medicare approved amounts* Remainder of Medicare approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$[203-233] (Part B deductible) \$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 life-time maximum

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 you have paid a calendar year \$[2,370-2,490] deductible. Benefits from the high deductible ~~plan-Plan F~~ will not begin until out-of-pocket expenses are \$[2,370-2,490]. 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.

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[2,370-2,490] DEDUCTIBLE,** PLAN PAYS]	[IN ADDITION TO \$[2,370-2,490] DEDUCTIBLE,** YOU PAY]
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st 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 \$[1,484-1,556] All but \$[371-389] a day All but \$[742-778] a day \$0 \$0	\$[1,484-1,556](Part A deductible) \$[371-389] a day \$[742-778] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0*** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$[185.50-194.50] a day \$0	\$0 Up to \$[185.50-194.50] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's Core Benefits. During this time the hospital is prohibited from billing you for the balance 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 \$[203-233] 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 \$[2,370-2,490] deductible. Benefits from the high deductible ~~plan-Plan F~~ will not begin until out-of-pocket expenses are \$[2,370-2,490]. 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.

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[2,370-2,490] DEDUCTIBLE,** PLAN PAYS]	[IN ADDITION TO \$[2,370-2,490] DEDUCTIBLE,** YOU PAY]
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment; First \$[203-233] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 Generally 80%	\$[203-233] (Part B deductible) Generally 20%	\$0 \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$[203-233] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All costs \$[203-233] (Part B deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES --TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[2,370-2,490] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[2,370-2,490] DEDUCTIBLE,**] YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES --Medically necessary skilled care services and medical supplies ---Durable medical equipment ---First \$[203-233] of Medicare approved -- amounts* Remainder of Medicare approved amounts	100% \$0 80%	\$0 \$[203-233] (Part B deductible) 20%	\$0 \$0 \$0

(continued)

PLAN F or HIGH DEDUCTIBLE PLAN F (continued)

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[2,370-2,490] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[2,370-2,490] DEDUCTIBLE,**] YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 life-time maximum

PLAN G or HIGH DEDUCTIBLE 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.

[**This high deductible plan pays the same benefits as Plan G after you have paid a calendar year [~~\$2,370-2,490~~] deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are [~~\$2,370-2,490~~]. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY [\$2,370-2,490] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO [\$2,370-2,490] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90 th day 91 st 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 [\$1,484-1,556] All but [\$371-389] a day All but [\$742-778] a day \$0 \$0	 [\$1,484-1,556] (Part A deductible) [\$371-389] a day [\$742-778] a day 100% of Medicare eligible expenses \$0	 \$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101th day and after	All approved amounts All but [\$185.50-194.50] a day \$0	\$0 Up to [\$185.50-194.50] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's Core Benefits. During this time the hospital is prohibited from billing you for the balance on any difference between its billed charges and the amount Medicare would have paid.

PLAN G or HIGH DEDUCTIBLE PLAN G

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

*Once you have been billed \$[203-233] 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 G after you have paid a calendar year [\$2,370-2,490] deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are [\$2,370-2,490]. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[2,370-2,490] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[2,370-2,490] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment; First \$[203-233] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$[203-233] (Unless Part B deductible has been met) \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	100%	0%
BLOOD First 3 pints Next \$[203-233] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[203-233] (Unless Part B deductible has been met) \$0
CLINICAL LABORATORY SERVICES --TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[2,370-2,490] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[2,370-2,490] DEDUCTIBLE,**] YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies ---Durable medical equipment First \$[203-233] of Medicare approved amounts* Remainder of Medicare approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$[203-233] (Unless Part B deductible has been met) \$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[2,370 2,490] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[2,370 2,490] DEDUCTIBLE,**] YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 life-time maximum

PLAN K

*You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[~~6,220~~ 6,620] 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 that 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*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st 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 \$[1,484-1,556] All but \$[371-389] a day All but \$[742-778] a day \$0 \$0	\$[742-778] (50% of Part A deductible) \$[371-389] a day \$[742-778] a day 100% of Medicare eligible expenses \$0	\$[742-778] (50% of Part A deductible)♦ \$0 \$0 \$0*** All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$[185.50-194.50] a day \$0	\$0 Up to \$[92.75-97.25] a day (50% of Part A coinsurance) \$0	\$0 Up to \$[92.75-97.25] a day (50% of Part A coinsurance)♦ All costs
BLOOD First 3 pints Additional amounts	\$0 100%	50% \$0	50%♦ \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	50% of coinsurance/copayment	50% of Medicare copayment/coinsurance♦

*****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 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 \$[203-233] 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*
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$[203-233] of Medicare approved amounts**** Preventative Benefits for Medicare covered services Remainder of Medicare approved amounts	\$0 Generally 80% or more of Medicare approved amounts Generally 80%	\$0 Remainder of Medicare approved amounts Generally 10%	\$[203-233] (Part B deductible)**** All costs above Medicare approved amounts Generally 10%
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	0%	All costs (and they do not count toward annual out-of-pocket limit of \$[6,220-6,620])*
BLOOD First 3 pints Next \$[203-233] of Medicare approved amounts**** Remainder of Medicare approved amounts	\$0 \$0 Generally 80%	50% \$0 Generally 10%	\$50% \$[203-233] (Part B deductible)**** Generally 10%
CLINICAL LABORATORY SERVICES --TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[6,220-6,620] 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.**

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES --Medically necessary skilled care services and medical supplies --Durable medical equipment First \$[203-233] of Medicare approved amounts **** Remainder of Medicare approved amounts	100% \$0 80%	\$0 \$0 10%	\$0 \$[203-233] (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 \$[3,110-3,310] 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 that 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*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st 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 \$[1,484-1,556] All but \$[371-389] a day All but \$[742-778] a day \$0 \$0	\$[1,113-1,167] (75% of Part A deductible) \$[371-389] a day \$[742-778] a day 100% of Medicare eligible expenses \$0	\$[371-389] (25% of Part A deductible)♦ \$0 \$0 \$0*** All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$[185.50-194.50] a day \$0	\$0 Up to \$[139.13-145.88] a day (75% of Part A Coinsurance) \$0	\$0 Up to \$[46.38-48.63] a day (25% of Part A Coinsurance)♦ All costs
BLOOD First 3 pints Additional amounts	\$0 100%	75% \$0	25%♦ \$0
HOSPICE CARE You must meet Medicare's requirements including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	75% of copayment/coinsurance	25% of copayment/coinsurance ♦

*****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 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 \$[203-233] 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*
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$[203-233] of Medicare approved amounts**** Preventative Benefits for Medicare covered services Remainder of Medicare approved amounts	\$0 Generally 80% or more of Medicare approved amounts Generally 80%	\$0 Remainder of Medicare approved amounts Generally 15%	\$[203-233] (Part B deductible)**** All costs above Medicare approved amounts Generally 5%♦
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of \$[3,110-3,310])*
BLOOD First 3 pints Next \$[203-233] of Medicare approved amounts**** Remainder of Medicare approved amounts	\$0 \$0 Generally 80%	75% \$0 Generally 15%	\$25% \$[203-233] (Part B deductible)**** Generally 5%♦
CLINICAL LABORATORY SERVICES --TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[3,110-3,310] 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.**

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES --Medically necessary skilled care services and medical supplies --Durable medical equipment First \$[203-233] of Medicare approved amounts **** Remainder of Medicare approved amounts	100% \$0 80%	\$0 \$0 15%	\$0 \$[203-233] (Part B deductible)♦ 5%♦

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

PLAN M

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
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st 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 \$[1,484 1,556] All but \$[371 389] a day All but \$[742 778] a day \$0 \$0	\$[742 778] (50% of Part A deductible) \$[371 389] a day \$[742 778] a day 100% of Medicare eligible expenses \$0	\$[742 778] (50% of Part A deductible) \$0 \$0 \$0*** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$[185.50 194.50] a day \$0	\$0 Up to \$[185.50 194.50] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's Core Benefits. During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN M

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

*Once you have been billed \$[203-233] 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
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$[203-233] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$[203-233] (Part B deductible) \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$[203-233] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0% \$[203-233] (Part B deductible) 0%
CLINICAL LABORATORY SERVICES --TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES --Medically necessary skilled care services and medical supplies --Durable medical equipment First \$[203-233] of Medicare approved amounts * Remainder of Medicare approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$[203-233] (Part B deductible) \$0

OTHER BENEFITS -- NOT COVERED BY MEDICARE

FOREIGN TRAVEL NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year 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 N

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
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st 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 \$[1,484-1,556] All but \$[371-389] a day All but \$[742-778] a day \$0 \$0	\$[1,484-1,556] (Part A deductible) \$[371-389] a day \$[742-778] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$[185.50-194.50] a day \$0	\$0 Up to \$[185.50-194.50] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including, a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's Core Benefits. During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

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

*Once you have been billed \$[203-233] 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
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$[203-233] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 Generally 80%	\$0 Balance, other than up to [\$20] per office visit and up to [\$50] per emergency room visit. The copayment of up to [\$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense	\$[203-233] (Part B deductible) Up to [\$20] per office visit and up to [\$50] per emergency room visit. The copayment of up to [\$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$[203-233] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0% \$[203-233] (Part B deductible) 0%
CLINICAL LABORATORY SERVICES --TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES --Medically necessary skilled care services and medical supplies --Durable medical equipment First \$[203-233] of Medicare approved amounts* Remainder of Medicare approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$[203-233] (Part B deductible) \$0

OTHER BENEFITS -- NOT COVERED BY MEDICARE

<p>FOREIGN TRAVEL NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year 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>
--	---------------------	---	--