N [12 Point]

[COMPANY NAME]

**Outline of Medicare Supplement Coverage** - Cover Page:1 of 2

Benefit Plan(s)_____[insert letter(s) of plans(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 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.

| A | B | C | D | E | F | F* | G | H | I | J | J* |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Basic Benefits | Basic Benefits | Basic Benefits | Basic Benefits | Basic Benefits | Basic Benefits | | Basic Benefits | Basic Benefits | Basic Benefits | Basic Benefits | |
| | | 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 Coinsurance. | 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 | |
| | | 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 | |

* 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 [$1730] deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses are [$1730]. 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.

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.

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

**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.

See Outlines of Coverage for details and exceptions.

## Premium Information

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this State.

## Disclosures

Use this outline to compare benefits and premiums among policies.

## Read Your Certificate Very Carefully

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

## Right To Return Policy

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy

## Policy Replacement

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

## Notice

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

Neither [insert company's name] nor its agents are connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult Medicare & You for more details.

## Complete Answers Are Very Important

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your certificate and refuse to pay any claims if you leave out or falsify important medical information.

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

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*<br>Semiprivate room and board, general nursing and miscellaneous services and supplies. | | | |
| First 60 days | All but [XXX] | $0 | [XXX} (Part A Ded.) |
| 61st thru 90th day | All but [XXX] | [XXX] a day | $0 |
| 91st day and after:<br>-While using 60 lifetime reserve days | All but [XXX] a day | [XXX] a day | $0 |
| -Once lifetime reserve days are used: | | | |
| -Additional 365 days | $0 | 100% of Medicare Eligible Expense | $0** |
| -Beyond the additional 365 days | $0 | $0 | All Costs |
| SKILLED NURSING FACILITY CARE*<br>You must meet Medicare's requirements including Having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st thru 100th day | All but [XXX] a day | $0 | [Up to [XXX] a day |
| 101st day and after | $0 | $0 | All Costs |
| BLOOD<br>First 3 pints<br>Additional amounts | $0<br>100% | 3 Pints<br>$0 | $0<br>$0 |
| HOSPICE CARE<br>Available as long as your doctor certifies you are terminally ill and you elect to receive these services. | All but very limited coinsurance for out-<br>patient drugs and inpatient respite care | $0 | Balance |

** 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 $[100] 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 TREATMENT, such as Physician's services, inpatient and out-patient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.<br><br>First $[100] of Medicare Approved Amounts*<br><br>Remainder of Medicare Approved Amounts | $0<br><br>Generally 80% | $0<br><br>Generally 20% | $[100] (Part B Ded.)<br><br>$0 |
| PART B Excess Charges<br>Above Medicare Approved Amounts | $0 | $0 | All Costs |
| **BLOOD**<br>First 3 pints<br><br>Next $[100] of Medicare Approved Amounts*<br><br>Remainder of Medicare Approved Amounts | $0<br><br>$0<br><br>80% | All Costs<br><br>$0<br><br>20% | $0<br><br>$[100] (Part B Ded.)<br><br>$0 |
| **CLINICAL LABORATORY SERVICES**<br>TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

PARTS A & B

| | | | |
|---|---|---|---|
| **HOME HEALTH CARE** MEDICARE APPROVED SERVICES<br>-Medically necessary skilled care service and medical supplies<br><br>-Durable medical equipment<br><br>First $[100] of Medicare Approved Amounts*<br><br>Remainder of Medicare Approved Amounts | 100%<br><br>$0<br><br>80% | $0<br><br>$0<br><br>20% | $0<br><br>$[100] (Part B Ded.)<br><br>$0 |

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 | All but [XXX] | [XXX] (Part A Ded.) | $0 |
| 61st thru 90th day | All but [XXX] a day | [XXX] a day | $0 |
| 91st day and after: | | | |
| -While using 60 lifetime reserve days | [XXX] a day | [XXX] a day | $0 |
| -Once Life time reserve days are used: | Generally 80% | | |
| -Additional 365 days | 100% of Medicare Eligible Expense | 100% of Medicare Eligible Expense | $0** |
| -Beyond the additional 365 days | $0 | $0 | All Costs |
| **SKILLED NURSING FACILITY CARE*** | | | |
| You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st thru 100th day | All but [XXX] a day | $0 | Up to [XXX] a day |
| 101st day and after | $0 | $0 | All Costs |
| BLOOD | | | |
| First 3 pints | $0 | 3 Pints | $0 |
| Additional Amounts | $0 | $0 | $0 |
| HOSPICE CARE | | | |
| Available as long as your doctor certifies you are terminally ill and you elect to receive these services. | All but very limited coinsurance for out-patient drugs and inpatient respite care | $0 | Balance |

** **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 $[100] 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 TREATMENT, such as Physician's services, inpatient and out-patient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.<br><br>First $[100] of Medicare Approved Amounts*<br><br>Remainder of Medicare Approved Amounts | $0<br><br>Generally 80% | $0<br><br>Generally 20% | $[100] (Part B Ded.)<br><br>$0 |
| PART B Excess Charges<br>Above Medicare Approved Amounts | $0 | $0 | All Costs |
| **BLOOD**<br>First 3 pints<br><br>Next $[100] of Medicare Approved Amounts*<br><br>Remainder of Medicare Approved Amounts | $0<br><br>$0<br><br>80% | All Costs<br><br>$0<br><br>20% | $0<br><br>$[100] (Part B Ded.)<br><br>$0 |
| **CLINICAL LABORATORY SERVICES**<br>TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

PARTS A & B

| | | | |
|---|---|---|---|
| **HOME HEALTH CARE** MEDICARE APPROVED SERVICES<br>-Medically necessary skilled care service and medical supplies<br><br>-Durable medical equipment<br><br>First $[100] of Medicare Approved Amounts*<br><br>Remainder of Medicare Approved Amounts | 100%<br><br>$0<br><br>80% | $0<br><br>$0<br><br>20% | $0<br><br>$[100] (Part B Ded.)<br><br>$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*<br>Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but [XXX] | [XXX] (Part A Ded.) | $0 |
| 61st thru 90th day | All but [XXX] a day | [XXX] a day | $0 |
| 91st day and after:<br>-While using 60 lifetime reserve days | All but [XXX] a day | [XXX] a day | $0 |
| -Once lifetime reserve days are used: | | | |
| -Additional 365 days | $0 | 100% of Medicare Eligible Expense | $0** |
| -Beyond the additional 365 days | $0 | $0 | All Costs |
| SKILLED NURSING FACILITY CARE*<br>You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st thru 100th day | All but [XXX] a day | Up to [XXX] a day | $0 |
| 101st day and after | $0 | $0 | All Costs |
| BLOOD<br>First 3 pints<br>Additional Amounts | $0<br>100% | 3 Pints<br>$0 | $0<br>$0 |
| HOSPICE CARE<br>Available as long as your doctor certifies you are terminally ill and you elect to receive these services. | All but very limited coinsurance for out-patient drugs and inpatient respite care | $0 | Balance |

** 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 $[100] 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 TREATMENT, such as Physician's services, inpatient and out-patient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.<br><br>First $[100] of Medicare Approved Amounts*<br><br>Remainder of Medicare Approved Amounts | $0<br><br>Generally 80% | $[100] (Part B Ded.)<br><br>Generally 20% | $0<br><br>$0 |
| Part B Excess Charges<br>(Above Medicare Approved Amounts) | $0 | $0 | All Costs |
| BLOOD<br>First 3 pints<br><br>Next $[100] of Medicare Approved Amounts*<br><br>Remainder of Medicare Approved Amounts | $0<br><br>$0<br><br>80% | All Costs<br><br>$0<br><br>20% | $0<br><br>$[100] (Part B. Ded.)<br><br>$0 |
| CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

PARTS A & B

| | | | |
|---|---|---|---|
| HOME HEALTH CARE MEDICARE APPROVED SERVICES<br>-Medically necessary skilled care service and medical supplies<br><br>-Durable medical equipment<br><br>First $[100] of Medicare Approved Amounts*<br><br>Remainder of Medicare Approved Amounts | 100%<br><br>$0<br><br>80% | $0<br><br>$[100] (Part B Ded.)<br><br>20% | $0<br><br>$0<br><br>$0 |

OTHER BENEFITS - NOT COVERED BY MEDICARE

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| FOREIGN TRAVEL-NOT COVERED BY MEDICARE<br><br>Medically necessary emergency care service beginning during the first 60 days of each trip outside of the USA.<br><br>First $250 each calendar year<br><br>Remainder of Charges | $0<br><br>$0 | $0<br><br>80% to a lifetime maximum benefit of $50,000. | $250<br><br>20% and amounts over the $50,000 lifetime 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*<br>Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but [XXX] | [XXX] (Part A Ded.) | $0 |
| 61st thru 90th day | All but [XXX] a day | [XXX] a day | $0 |
| 91st day and after:<br>-While using 60 lifetime reserve days | All but [XXX] a day | [XXX] a day | $0 |
| -Once lifetime reserve days are used: | | | |
| -Additional 365 days | $0 | 100% of Medicare Eligible Expense | $0** |
| -Beyond the additional 365 days | $0 | $0 | All Costs |
| SKILLED NURSING FACILITY CARE*<br>You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st thru 100th day | All but [XXX] a day | Up to [XXX] a day | $0 |
| 101st day and after | $0 | $0 | All Costs |
| BLOOD | | | |
| First 3 pints | $0 | 3 Pints | $0 |
| Additional Amounts | 100% | $0 | $0 |
| HOSPICE CARE<br>Available as long as your doctor certifies you are terminally ill and you elect to receive these services. | All but very limited coinsurance for out-<br>patient drugs and inpatient respite care | $0 | Balance |

** 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 $[100] 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 TREATMENT, such as Physician's services, inpatient and out-patient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.<br><br>First $[100] of Medicare Approved Amounts*<br><br>Remainder of Medicare Approved Amounts | $0<br><br>Generally 80% | $0<br><br>Generally 20% | $[100] (Part B Ded.)<br><br>$0 |
| PART B Excess Charges<br>Above Medicare Approved Amounts | $0 | $0 | All Costs |
| **BLOOD**<br>First 3 pints<br><br>Next $[100] of Medicare Approved Amounts*<br><br>Remainder of Medicare Approved Amounts | $0<br><br>$0<br><br>80% | All Costs<br><br>$0<br><br>20% | $0<br><br>$[100] (Part B Ded.)<br><br>$0 |
| **CLINICAL LABORATORY SERVICES**<br>TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

PARTS A & B

| | | | |
|---|---|---|---|
| **HOME HEALTH CARE** MEDICARE APPROVED SERVICES<br>-Medically necessary skilled care service and medical supplies<br><br>-Durable medical equipment<br><br>First $[100] of Medicare Approved Amounts*<br><br>Remainder of Medicare Approved Amounts | 100%<br><br>$0<br><br>80% | $0<br><br>$0<br><br>20% | $0<br><br>$[100] (Part B Ded.)<br><br>$0 |

MEDICARE (PART A & B) - (CONTINUED)

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

OTHER BENEFITS - NOT COVERED BY MEDICARE

| | | | |
|---|---|---|---|
| FOREIGN TRAVEL - NOT COVERED BY MEDICARE<br>Medically necessary emergency care service beginning during the first 60 days of each trip outside of the USA.<br><br>First $250 each calendar year<br><br>Remainder of charges | $0<br><br>$0 | $0<br><br>80% to a lifetime maximum benefit of $50,000. | $250<br><br>20% and amounts over the $50,000 lifetime maximum. |

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 |
|---|---|---|---|
| HOSPITALIZATION*<br>Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but [XXX] | [XXX] (Part A Ded.) | $0 |
| 61st thru 90th day | All but [XXX] a day | [XXX] a day | $0 |
| 91st day and after:<br>-While using 60 lifetime reserve days | All but [XXX] a day | [XXX] a day | $0 |
| -Once lifetime reserve days are used: | | | |
| -Additional 365 days | $0 | 100% of Medicare Eligible Expense | $0** |
| -Beyond the additional 365 days | $0 | $0 | All Costs |
| SKILLED NURSING FACILITY CARE*<br>You must meet Medicare's requirements including<br>having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days<br>after leaving the hospital. | All approved amounts | $0 | $0 |
| First 20 days | All but [XXX] a day | Up to [XXX] a day | $0 |
| 21st thru 100th day | $0 | $0 | All Costs |
| 101st day and after | | | |
| BLOOD<br>First 3 pints<br>Additional Amounts | <br>$0<br>100% | <br>3 Pints<br>$0 | <br>$0<br>$0 |
| HOSPICE CARE<br>Available as long as your doctor certifies you are terminally ill and you elect to receive these services. | All but very limited coinsurance for out-<br>patient drugs and inpatient respite care | $0 | Balance |

** 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.

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

*Once you have been billed $[100] 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 TREATMENT, such as Physician's services, inpatient and out-patient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.<br><br>First $[100] of Medicare Approved Amounts*<br><br>Remainder of Medicare Approved Amounts | $0<br><br>Generally 80% | $0<br><br>Generally 20% | $[100] (Part B Ded.)<br><br>$0 |
| PART B Excess Charges<br>Above Medicare Approved Amounts | $0 | $0 | All Costs |
| **BLOOD**<br>First 3 pints<br><br>Next $[100] of Medicare Approved Amounts*<br><br>Remainder of Medicare Approved Amounts | $0<br><br>$0<br><br>80% | All Costs<br><br>$0<br><br>20% | $0<br><br>$[100] (Part B. Ded.)<br><br>$0 |
| **CLINICAL LABORATORY SERVICES**<br>TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

PARTS A & B

| | | | |
|---|---|---|---|
| HOME HEALTH CARE MEDICARE APPROVED SERVICES<br>-Medically necessary skilled care service and medical supplies<br><br>-Durable medical equipment<br><br>First $[100] of Medicare Approved Amounts*<br><br>Remainder of Medicare Approved Amounts | 100%<br><br>$0<br><br>80% | $0<br><br>$0<br><br>20% | $0<br><br>$[100] (Part B Ded.)<br><br>$0 |

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

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

PLAN F or HIGH DEDUCTABLE 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 [$1730] 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.]

| SERVICES | MEDICARE PAYS | AFTER YOU PAY $[1,730] DEDUCTIBLE1 , PLAN PAYS | IN ADDITION TO $[1,730] DEDUCTIBLE YOU PAY |
|---|---|---|---|
| HOSPITALIZATION*<br>Semiprivate room and board, general nursing and miscellaneous services and supplies. | | | |
| First 60 days | All but [XXX] | [XXX] (Part A. Ded.) | $0 |
| 61st thru 90th day | All but [XXX] a day | [XXX] a day | $0 |
| 91st day and after:<br>-While using 60 lifetime reserve days | All but [XXX] a day | [XXX] a day | $0 |
| -Once lifetime reserve days are used: | | | |
| -Additional 365 days | $0 | 100% of Medicare Eligible Expense | $0*** |
| -Beyond the additional 365 days | $0 | $0 | All Costs |
| SKILLED NURSING FACILITY CARE*<br>You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st thru 100th day | All but [XXX] a day | Up to [XXX] a day | $0 |
| 101st day and after | $0 | $0 | All Costs |
| BLOOD<br>First 3 pints | $0 | 3 Pints | $0 |

| | | | |
|---|---|---|---|
| Additional amounts | 100% | $0 | $0 |
| HOSPICE CARE<br>Available as long as your doctor certifies you are terminally ill and you elect to receive these services. | All but very limited coinsurance for out-patient drugs and in-patient respite care. | $0 | Balance |

*** **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 DEDUCTABLE PLAN F

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

*Once you have been billed $[100] 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 [$1730] 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.]

| SERVICES | MEDICARE PAYS | AFTER YOU PAY $[1,730] DEDUCTIBLE , PLAN PAYS | IN ADDITION TO $[1,730] DEDUCTIBLE YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES** - IN OR OUT OF THE HOSPITAL AND OUTPATIENT TREATMENT, such as Physician's services, inpatient and out-patient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.<br><br>First $[100] of Medicare Approved Amounts*<br><br>Remainder of Medicare Approved Amounts | <br><br>$0<br><br>Generally 80% | <br><br>$[100] (Part B Ded.)<br><br>Generally 20% | <br><br>$0<br><br>$0 |
| PART B Excess Charges<br>Above Medicare Approved Amounts | $0 | 100% | $0 |
| **BLOOD**<br>First 3 pints<br><br>Next $[100] of Medicare Approved Amounts*<br><br>Remainder of Medicare Approved Amounts | <br>$0<br><br>$0<br><br>80% | <br>All Costs<br><br>$[100] (Part B Ded.)<br><br>20% | <br>$0<br><br>$0<br><br>$0 |
| **CLINICAL LABORATORY SERVICES**<br>TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

PARTS A & B

| | | | |
|---|---|---|---|
| HOME HEALTH CARE MEDICARE APPROVED SERVICES<br>-Medically necessary skilled care service and medical supplies<br><br>-Durable medical equipment<br><br>First $[100] of Medicare Approved Amounts*<br><br>Remainder of Medicare Approved Amounts | 100%<br><br>$0<br><br>80% | $0<br><br>$[100] (Part B Ded.)<br><br>20% | $0<br><br>$0<br><br>$0 |

PLAN F or HIGH DEDUCTABLE PLAN F

OTHER BENEFITS - NOT COVERED BY MEDICARE

| SERVICES | MEDICARE PAYS | AFTER YOU PAY $[1,730] DEDUCTIBLE , PLAN PAYS | IN ADDITION TO $[1,730] DEDUCTIBLE YOU PAY |
|---|---|---|---|
| FOREIGN TRAVEL - NOT COVERED BY MEDICARE<br>Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.<br><br>First $250 each calendar year<br><br>Remainder of charges | $0<br><br>$0 | $0<br><br>80% to a lifetime maximum benefit of $50,000 | $250<br><br>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 |
|---|---|---|---|
| HOSPITALIZATION*<br>Semiprivate room and board, general nursing and miscellaneous services and supplies. | | | |
| First 60 days | All but [XXX] | [XXX] (Part A. Ded.) | $0 |
| 61st thru 90th day | All but [XXX] a day | [XXX] a day | $0 |
| 91st day and after: | | | |
| -While using 60 lifetime reserve days | All but [XXX] a day | [XXX] a day | $0 |
| -Once lifetime reserve days are used: | | | |
| -Additional 365 days | $0 | 100% of Medicare Eligible | $0** |
| -Beyond the additional 365 days | $0 | Expense<br>$0 | All Costs |
| SKILLED NURSING FACILITY CARE*<br>You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st thru 100th day | All but [XXX] a day | Up to [XXX] a day | $0 |
| 101st day and after | $0 | $0 | All Costs |
| BLOOD | | | |
| First 3 pints | $0 | 3 Pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| HOSPICE CARE<br>Available as long as your doctor certifies you are terminally ill and you elect to receive these services. | All but very limited coinsurance for out-patient drugs and in-patient respite care. | $0 | Balance |

** **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 $[100] 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 TREATMENT, such as Physician's services, inpatient and out-patient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.<br><br>First $[100] of Medicare Approved Amounts*<br><br>Remainder of Medicare Approved Amounts | $0<br><br>Generally 80% | $0<br><br>Generally 20% | $[100] (Part B Ded.)<br><br>$0 |
| PART B Excess Charges<br>Above Medicare Approved Amounts | $0 | 80% | 20% |
| **BLOOD**<br>First 3 pints<br><br>Next $[100] of Medicare Approved Amounts*<br><br>Remainder of Medicare Approved Amounts | $0<br><br>$0<br><br>80% | All Costs<br><br>$0<br><br>20% | $0<br><br>$[100] (Part B Ded.)<br><br>$0 |
| **CLINICAL LABORATORY SERVICES**<br>TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

PARTS A & B

| | | | |
|---|---|---|---|
| HOME HEALTH CARE MEDICARE APPROVED SERVICES<br>-Medically necessary skilled care service and medical supplies<br><br>-Durable medical equipment<br><br>First $[100] of Medicare Approved Amounts*<br><br>Remainder of Medicare Approved Amounts | 100%<br><br>$0<br><br>80% | $0<br><br>$0<br><br>20% | $0<br><br>$[100] (Part B Ded.)<br><br>$0 |

MEDICARE (PART A & B) - (CONTINUED)

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

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

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*<br>Semiprivate room and board, general nursing and miscellaneous services and supplies. | | | |
| First 60 days | All but [XXX] | [XXX] (Part A. Ded.) | $0 |
| 61st thru 90th day | All but [XXX] a day | [XXX] a day | $0 |
| 91st day and after:<br>-While using 60 lifetime reserve days | All but [XXX] a day | [XXX] a day | $0 |
| -Once lifetime reserve days are used: | | | |
| -Additional 365 days | $0 | 100% of Medicare Eligible | $0** |
| -Beyond the additional 365 days | $0 | Expense<br>$0 | All Costs |
| SKILLED NURSING FACILITY CARE*<br>You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st thru 100th day | All but [XXX] a day | Up to [XXX] a day | $0 |
| 101st day and after | $0 | $0 | All Costs |
| BLOOD<br>First 3 pints<br>Additional amounts | <br>$0<br>100% | <br>3 Pints<br>$0 | <br>$0<br>$0 |
| HOSPICE CARE<br>Available as long as your doctor certifies you are terminally ill and you elect to receive these services. | All but very limited coinsurance for out-patient drugs and in-patient respite care. | $0 | Balance |

** **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 $[100] 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 TREATMENT, such as Physician's services, inpatient and out-patient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.<br><br>First $[100] of Medicare Approved Amounts*<br><br>Remainder of Medicare Approved Amounts | $0<br><br>Generally 80% | $0<br><br>Generally 20% | $[100] (Part B Ded.)<br><br>$0 |
| PART B Excess Charges<br>Above Medicare Approved Amounts | $0 | $0 | All Costs |
| **BLOOD**<br>First 3 pints<br><br>Next $[100] of Medicare Approved Amounts*<br><br>Remainder of Medicare Approved Amounts | $0<br><br>$0<br><br>80% | All Costs<br><br>$0<br><br>20% | $0<br><br>$[100] (Part B Ded.)<br><br>$0 |
| **CLINICAL LABORATORY SERVICES**<br>TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

PARTS A & B

| | | | |
|---|---|---|---|
| HOME HEALTH CARE MEDICARE APPROVED SERVICES<br>-Medically necessary skilled care service and medical supplies<br><br>-Durable medical equipment<br><br>First $[100] of Medicare Approved Amounts*<br><br>Remainder of Medicare Approved Amounts | 100%<br><br>$0<br><br>80% | $0<br><br>$0<br><br>20% | $0<br><br>$[100] (Part B Ded.)<br><br>$0 |

PLAN H

OTHER BENEFITS - NOT COVERED BY MEDICARE

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| FOREIGN TRAVEL - NOT COVERED BY MEDICARE<br>Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA. | $0 | $0 | $250 |
| First $250 each calendar year | $0 | 80% to a lifetime maximum benefit of $50,000 | 20% and amounts over the $50,000 lifetime maximum. |
| Remainder of charges | | | |
| BASIC OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE+ | | | |
| First $250 each calendar year | $0 | $0 | $250 |
| Next $2,500 each calendar year | $0 | 50% - $1,250 calendar year maximum benefit. | 50% |
| Over $2,500 each calendar year | $0 | $0 | All Costs |

+ This benefit section may be included only for policies issued before January 1, 2006.

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.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| HOSPITALIZATION*<br>Semiprivate room and board, general nursing and miscellaneous services and supplies. | | | |
| First 60 days | All but [XXX] | [XXX] (Part A. Ded.) | $0 |
| 61st thru 90th day | All but [XXX] a day | [XXX] a day | $0 |
| 91st day and after:<br>-While using 60 lifetime reserve days | All but [XXX] a day | [XXX] a day | $0 |
| -Once lifetime reserve days are used: | | | |
| -Additional 365 days | $0 | 100% of Medicare Eligible | $0** |
| -Beyond the additional 365 days | $0 | Expense<br>$0 | All Costs |
| SKILLED NURSING FACILITY CARE*<br>You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st thru 100th day | All but [XXX] a day | Up to [XXX] a day | $0 |
| 101st day and after | $0 | $0 | All Costs |
| BLOOD<br>First 3 pints<br>Additional amounts | <br>$0<br>100% | <br>3 Pints<br>$0 | <br>$0<br>$0 |
| HOSPICE CARE<br>Available as long as your doctor certifies you are terminally ill and you elect to receive these services. | All but very limited coinsurance for out-patient drugs and in-patient respite care. | $0 | Balance |

** 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.

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

*Once you have been billed $[100] 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 TREATMENT, such as Physician's services, inpatient and out-patient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.<br><br>First $[100] of Medicare Approved Amounts*<br><br>Remainder of Medicare Approved Amounts | $0<br><br>Generally 80% | $0<br><br>Generally 20% | $[100] (Part B Ded.)<br><br>$0 |
| PART B Excess Charges<br>Above Medicare Approved Amounts | $0 | $0 | All Costs |
| **BLOOD**<br>First 3 pints<br><br>Next $[100] of Medicare Approved Amounts*<br><br>Remainder of Medicare Approved Amounts | $0<br><br>$0<br><br>80% | All Costs<br><br>$0<br><br>20% | $0<br><br>$[100] (Part B Ded.)<br><br>$0 |
| **CLINICAL LABORATORY SERVICES**<br>TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

PARTS A & B

| | | | |
|---|---|---|---|
| HOME HEALTH CARE MEDICARE APPROVED SERVICES<br>-Medically necessary skilled care service and medical supplies<br><br>-Durable medical equipment<br><br>First $[100] of Medicare Approved Amounts*<br><br>Remainder of Medicare Approved Amounts | 100%<br><br>$0<br><br>80% | $0<br><br>$0<br><br>20% | $0<br><br>$[100] (Part B Ded.)<br><br>$0 |

MEDICARE (PART A & B) - (CONTINUED)

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

OTHER BENEFITS

| | | | |
|---|---|---|---|
| FOREIGN TRAVEL - NOT COVERED BY MEDICARE<br>Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.<br><br>First $250 each calendar year<br><br>Remainder of charges | $0<br><br>$0 | $0<br><br>80% to a lifetime maximum benefit of $50,000. | $250<br><br>20% and amounts over the $50,000 lifetime maximum. |
| BASIC OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY-MEDICARE+<br>First $250 each calendar year<br><br>Next $2,500 each calendar year<br><br>Over $2,500 each calendar year | $0<br><br>$0<br><br>$0 | $0<br><br>50% - $1,250 calendar year maximum benefit.<br>$0 | $250<br><br>50%<br><br>All Costs |

+ This benefit section may be included only for policies issued before January 1, 2006.

PLAN J or HIGH DEDUCTABLE 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 [$1730] 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 outpatient prescription drug deductible or the plan's separate foreign travel emergency deductible.]

| SERVICES | MEDICARE PAYS | AFTER YOU PAY $[1,730] DEDUCTIBLE ***, PLAN PAYS | IN ADDITION TO $[1,730] DEDUCTIBLE*** YOU PAY |
|---|---|---|---|
| HOSPITALIZATION*<br>Semiprivate room and board, general nursing and miscellaneous services and supplies. | | | |
| First 60 days | All but [XXX] | [XXX] (Part A. Ded.) | $0 |
| 61st thru 90th day | All but [XXX] a day | [XXX] a day | $0 |
| 91st day and after: | | | |
| -While using 60 lifetime reserve days | All but [XXX] a day | [XXX] a day | $0 |
| -Once lifetime reserve days are used: | | | |
| -Additional 365 days | $0 | 100% of Medicare Eligible | $0** |
| -Beyond the additional 365 days | $0 | Expense $0 | All Costs |
| SKILLED NURSING FACILITY CARE*<br>You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st thru 100th day | All but [XXX] a day | Up to [XXX] a day | $0 |
| 101st day and after | $0 | $0 | All Costs |
| BLOOD<br>First 3 pints | $0 | 3 Pints | $0 |

| | | | |
|---|---|---|---|
| Additional amounts | 100% | $0 | $0 |
| HOSPICE CARE<br>Available as long as your doctor certifies you are terminally ill and you elect to receive these services. | All but very limited coinsurance for out-patient drugs and in-patient respite care. | $0 | Balance |

** 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 DEDUCTABLE PLAN J

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

*Once you have been billed $100 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 [$1730] 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 outpatient prescription drug deductible or the plan's separate foreign travel emergency deductible.]

| SERVICES | MEDICARE PAYS | AFTER YOU PAY $[1,730] DEDUCTIBLE*** , PLAN PAYS | IN ADDITION TO $[1,730] DEDUCTIBLE*** YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES** - IN OR OUT OF THE HOSPITAL AND OUTPATIENT TREATMENT, such as Physician's services, inpatient and out-patient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.<br><br>First $[100] of Medicare Approved Amounts*<br><br>Remainder of Medicare Approved Amounts | <br><br>$0<br><br>Generally 80% | <br><br>$[100] (Part B Ded.)<br><br>Generally 20% | <br><br>$0<br><br>$0 |
| PART B Excess Charges<br>Above Medicare Approved Amounts | $0 | 100% | $0 |
| **BLOOD**<br>First 3 pints<br><br>Next $[100] of Medicare Approved Amounts*<br><br>Remainder of Medicare Approved Amounts | <br>$0<br><br>$0<br><br>80% | <br>All Costs<br><br>$[100] (Part B Ded.)<br><br>20% | <br>$0<br><br>$0<br><br>$0 |
| CLINICAL LABORATORY SERVICES<br>TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

PARTS A & B

| | | | |
|---|---|---|---|
| HOME HEALTH CARE MEDICARE APPROVED SERVICES<br>-Medically necessary skilled care service and medical supplies | 100% | $0 | $0 |

| | | | |
|---|---|---|---|
| -Durable medical equipment | $0 | $[100] (Part B Ded.) | $0 |
| First $[100] of Medicare Approved Amounts* | 80% | 20% | $0 |
| Remainder of Medicare Approved Amounts | | | |

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

OTHER BENEFITS

| | | | |
|---|---|---|---|
| FOREIGN TRAVEL - NOT COVERED BY MEDICARE<br>Medically necessary emergency care services beginning<br>during the first 60 days of each trip outside the USA.<br><br>First $250 each calendar year<br><br>Remainder of charges | $0<br><br>$0 | $0<br><br>80% to a lifetime maximum benefit of $50,000. | $250<br><br>20% and amounts over the $50,000 lifetime maximum. |
| EXTENDED OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE+<br>First $250 each calendar year<br><br>Next $6,000 each calendar year<br><br>Over $6,000 each calendar year | $0<br><br>$0<br><br>$0 | $0<br><br>50% - $3,000 calendar year maximum benefit. | $250<br><br>50%<br><br>All Costs |

| | | | |
|---|---|---|---|
| | | $0 | |

+ This benefit section may be included only for policies issued before January 1, 2006.

PLAN J or HIGH DEDUCTABLE PLAN J

OTHER BENEFITS - (CONTINUED)

| SERVICES | MEDICARE PAYS | AFTER YOU PAY $1,730 DEDUCTIBLE***, PLAN PAYS | IN ADDITION TO $[1,730] DEDUCTIBLE ***YOU PAY |
|---|---|---|---|
| PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE**<br>Annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare.<br><br>First $120 each calendar year<br><br>Additional charges | <br><br><br><br>$0<br><br>$0 | <br><br><br><br>$120<br><br>$0 | <br><br><br><br>$0<br><br>All Costs |

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

* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[4,000] each calendar year. The amount 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 our provider that exceed Medicare-approved amount (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* |
|---|---|---|---|
| HOSPITALIZATION**<br>Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but [XXX] | [XXX] (50% of the Part A Ded.) | $[XXX] (50% of Part A deductible)♦ |
| 61st thru 90th day | All but [XXX] a day | [XXX] a day | $0 |
| 91st day and after:<br>-While using 60 lifetime reserve days | All but [XXX] a day | [XXX] a day | $0 |
| -Once lifetime reserve days are used: | | | |
| -Additional 365 days | $0 | 100% of Medicare Eligible Expense | $0*** |
| -Beyond the additional 365 days | $0 | $0 | All Costs |
| SKILLED NURSING FACILITY CARE**<br>You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st thru 100th day | All but [XXX] a day | Up to [XXX] a day | Up to [XXX] a day♦ |
| 101st day and after | $0 | $0 | All Costs |
| BLOOD<br>First 3 pints<br>Additional Amounts | $0<br>100% | 50%<br>$0 | 50%♦<br>$0 |
| HOSPICE CARE<br>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♦ |

*** **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.

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

****Once you have been billed $[100] 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 TREATMENT, such as Physician's services, inpatient and out-patient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.<br><br>First $[100] of Medicare Approved Amounts****<br><br>Preventive Benefits for Medicare covered services<br><br>Remainder of Medicare Approved Amounts | $0<br><br>Generally 75% or more of Medicare approved amounts Generally 80% | $0<br><br>Remainder of Medicare approved amounts Generally 10% | $[100] (Part B Ded.)**** ♦<br><br>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 [$4,000])* |
| **BLOOD**<br>First 3 pints<br><br>Next $[100] of Medicare Approved Amounts****<br><br>Remainder of Medicare Approved Amounts | $0<br><br>$0<br><br>Generally 80% | 50%<br><br>$0<br><br>Generally 10% | 50%♦<br><br>$[100] (Part B Ded.) ♦<br><br>Generally 10%♦ |
| **CLINICAL LABORATORY SERVICES**<br>TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

* This plan limits your annual out-of-pocket payment for Medicare-approved amount to $[4,000] per year. However, this **limit** does NOT include charges from your provider that exceed Medicare-approved amount (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.

| | | | |
|---|---|---|---|
| **HOME HEALTH CARE** MEDICARE APPROVED SERVICES<br>-Medically necessary skilled care service and medical supplies | 100% | $0 | $0 |
| -Durable medical equipment First $[100] of Medicare Approved Amounts***** | $0 | $0 | $[100] (Part B Ded.) ♦ |
| Remainder of Medicare Approved Amounts | 80% | 10% | 10%♦ |

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

* You will pay one-fourth the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[2,000] each calendar year. The amount 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 our provider that exceed Medicare-approved amount (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* |
|---|---|---|---|
| HOSPITALIZATION**<br>Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but [XXX] | [XXX] (75% of the Part A Ded.) | $[XXX] (25% of Part A deductible)♦ |
| 61st thru 90th day | All but [XXX] a day | [XXX] a day | $0 |
| 91st day and after:<br>-While using 60 lifetime reserve days | All but [XXX] a day | [XXX] a day | $0 |
| -Once lifetime reserve days are used: | | | |
| -Additional 365 days | $0 | 100% of Medicare Eligible Expense | $0*** |
| -Beyond the additional 365 days | $0 | $0 | All Costs |
| SKILLED NURSING FACILITY CARE**<br>You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st thru 100th day | All but [XXX] a day | Up to [XXX] a day | Up to [XXX] a day♦ |
| 101st day and after | $0 | $0 | All Costs |
| BLOOD<br>First 3 pints<br>Additional Amounts | $0<br>100% | 75%<br>$0 | 25%♦<br>$0 |
| HOSPICE CARE<br>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♦ |

*** **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.

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

****Once you have been billed $[100] 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 TREATMENT, such as Physician's services, inpatient and out-patient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.<br><br>First $[100] of Medicare Approved Amounts****<br><br>Preventive Benefits for Medicare covered services<br><br>Remainder of Medicare Approved Amounts | $0<br><br>Generally 75% or more of Medicare approved amounts Generally 80% | $0<br><br>Remainder of Medicare approved amounts Generally 15% | $[100] (Part B Ded.)**** ♦<br><br>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 [$2,000])* |
| **BLOOD**<br>First 3 pints<br><br>Next $[100] of Medicare Approved Amounts****<br><br>Remainder of Medicare Approved Amounts | $0<br><br>$0<br><br>Generally 80% | 75%<br><br>$0<br><br>Generally 15% | 25%♦<br><br>$[100] (Part B Ded.) ♦<br><br>Generally 5%♦ |
| **CLINICAL LABORATORY SERVICES**<br>TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

* This plan limits your annual out-of-pocket payment for Medicare-approved amount to $[2,000] per year. However, this **limit** does NOT include charges from your provider that exceed Medicare-approved amount (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.

| | | | |
|---|---|---|---|
| **HOME HEALTH CARE** MEDICARE APPROVED SERVICES<br>-Medically necessary skilled care service and medical supplies | 100% | $0 | $0 |
| -Durable medical equipment First $[100] of Medicare Approved Amounts***** | $0 | $0 | $[100] (Part B Ded.) ♦ |
| 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*.