

3901-8-08

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**APPENDIX C****Benefit Chart of Medicare Supplement Plans Sold for Effective Dates on or After June 1, 2010**

This chart shows the benefits included in each of the standard Medicare supplement plans with an effective date for coverage on or after June 1, 2010. Every company must make Plan "A" available. Some plans may not be available in your state.

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  | K  | L  | M  | N   |
|--|--|--|--|--|----|--|--|--|--|---|
| 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 | 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 |
|  |  | Skilled Nursing Facility Co-insurance    | Skilled Nursing Facility Co-insurance    | Skilled Nursing Facility Co-insurance      |    | Skilled Nursing Facility Co-insurance    | 50% Skilled Nursing Facility Co-insurance  | 75% Skilled Nursing Facility Co-insurance  | Skilled Nursing Facility Co-insurance    | Skilled Nursing Facility Co-insurance   |
|  | Part A Deductible                        | Part A Deductible                        | Part A Deductible                        | Part A Deductible                          |    | Part A Deductible                        | 50% Part A Deductible  | 75% Part A Deductible  | 50% Part A Deductible                    | Part A Deductible   |
|  |  | Part B Deductible                        |  | Part B Deductible                          |    |  |  |  |  |   |
|  |  |  |  | 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  |
|  |  |  |  |  |    |  | Out-of-pocket limit \$[ ]; paid at 100% after limit reached                        | Out-of-pocket limit \$[ ]; 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 [\$ ] deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed [\$ ]. 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.]

**DISCLOSURES** [Boldface Type]

Use this outline to compare benefits and premiums among policies.

**READ YOUR POLICY VERY CAREFULLY** [Boldface Type]

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance 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 rule. An issuer may use additional benefit plan designations on these charts pursuant to paragraph (K)(4) of this rule.]

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

[Include an explanation of any smoker/non-smoker rates or household discounts in the premium information and disclosure pages, in a manner approved by the superintendent.]

\* \* \* \*

**PLAN A****MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

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

| SERVICES  | MEDICARE PAYS   | PLAN PAYS  | YOU PAY   |
|---|---|--|---|
| <b>HOSPITALIZATION*</b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies<br>First 60 days<br>61st thru 90th day<br>91st day and after:<br>---While using 60 lifetime reserve days<br>---Once lifetime reserve days are used:<br>---Additional 365 days<br>---Beyond the additional 365 days | All but \$[ ]<br>All but \$[ ] a day<br>All but \$[ ] a day<br>\$0<br>\$0                   | \$0<br>\$[ ] a day<br>\$[ ] a day<br>100% of Medicare eligible expenses<br>\$0 | \$[ ] (Part A deductible)<br>\$0<br>\$0<br>\$0**<br>All costs |
| <b>SKILLED NURSING FACILITY CARE*</b><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<br>First 20 days<br>21st thru 100th day<br>101st day and after   | All approved amounts<br>All but \$[ ] a day<br>\$0  | \$0<br>\$0<br>\$0  | \$0<br>Up to \$[ ] a day<br>All costs                         |
| <b>BLOOD</b><br>First 3 pints<br>Additional amounts   | \$0<br>100%   | 3 pints<br>\$0   | \$0<br>\$0  |
| <b>HOSPICE CARE</b><br>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 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 \$[ ] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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

**PARTS A & B**

|  |                            |                       |   |
|--|----------------------------|-----------------------|---|
| <b>HOME HEALTH CARE</b><br><b>MEDICARE APPROVED SERVICES</b><br>—Medically necessary skilled care services and medical supplies<br>—Durable medical equipment<br>First \$[ ] of Medicare Approved Amounts*<br>Remainder of Medicare Approved Amounts | 100%<br><br><br>\$0<br>80% | \$0<br><br>\$0<br>20% | \$0<br><br>\$[ ] (Part B deductible)<br>\$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           |
|--|---|------------------------------------|-------------------|
| <b>HOSPITALIZATION*</b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies   |   |                                    |                   |
| First 60 days  | All but \$[ ]   | \$[ ] (Part A deductible)          | \$0               |
| 61st thru 90th day   | All but \$[ ] a day   | \$[ ] a day                        | \$0               |
| 91st day and after:  |   |                                    |                   |
| ---While using 60 lifetime reserve days  | All but \$[ ] a day   | \$[ ] a day                        | \$0               |
| ---Once lifetime reserve days are used:  |   |                                    |                   |
| ---Additional 365 days   | \$0   | 100% of Medicare eligible expenses | \$0**             |
| ---Beyond the additional 365 days  | \$0   | \$0                                | All costs         |
| <b>SKILLED NURSING FACILITY CARE*</b><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 \$[ ] a day   | \$0                                | Up to \$[ ] a day |
| 101st day and after  | \$0   | \$0                                | All costs         |
| <b>BLOOD</b>   |   |                                    |                   |
| First 3 pints  | \$0   | 3 pints                            | \$0               |
| Additional amounts   | 100%  | \$0                                | \$0               |
| <b>HOSPICE CARE</b><br>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 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 \$[ ] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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

**PARTS A & B**

|   |                            |                       |   |
|---|----------------------------|-----------------------|---|
| <b>HOME HEALTH CARE</b><br>MEDICARE APPROVED SERVICES<br>—Medically necessary skilled care services and medical supplies<br>—Durable medical equipment<br>First \$[ ] of Medicare Approved Amounts*<br>Remainder of Medicare Approved Amounts | 100%<br><br><br>\$0<br>80% | \$0<br><br>\$0<br>20% | \$0<br><br>\$[ ] (Part B deductible)<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                                 |
|---|---|--|---|
| <b>HOSPITALIZATION*</b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies<br>First 60 days<br>61st thru 90th day<br>91st day and after:<br>---While using 60 lifetime reserve days<br>---Once lifetime reserve days are used:<br>---Additional 365 days<br>---Beyond the additional 365 days | All but \$[ ]<br>All but \$[ ] a day<br>All but \$[ ] a day<br>\$0<br>\$0                   | \$[ ] (Part A deductible)<br>\$[ ] a day<br>\$[ ] a day<br>100% of Medicare eligible expenses<br>\$0 | \$0<br>\$0<br>\$0<br>\$0**<br>All costs |
| <b>SKILLED NURSING FACILITY CARE*</b><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<br>First 20 days<br>21st thru 100th day<br>101st day and after   | All approved amounts<br>All but \$[ ] a day<br>\$0  | \$0<br>Up to \$[ ] a day<br>\$0  | \$0<br>\$0<br>All costs                 |
| <b>BLOOD</b><br>First 3 pints<br>Additional amounts   | \$0<br>100%   | 3 pints<br>\$0   | \$0<br>\$0                              |
| <b>HOSPICE CARE</b><br>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 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 \$[ ] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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

**PARTS A & B**

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

**OTHER BENEFITS—NOT COVERED BY MEDICARE**

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



**PLAN 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                                 |
|---|---|--|---|
| <b>HOSPITALIZATION*</b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies<br>First 60 days<br>61st thru 90th day<br>91st day and after:<br>---While using 60 lifetime reserve days<br>---Once lifetime reserve days are used:<br>---Additional 365 days<br>---Beyond the additional 365 days | All but \$[ ]<br>All but \$[ ] a day<br>All but \$[ ] a day<br>\$0<br>\$0                   | \$[ ] (Part A deductible)<br>\$[ ] a day<br>\$[ ] a day<br>100% of Medicare eligible expenses<br>\$0 | \$0<br>\$0<br>\$0<br>\$0**<br>All costs |
| <b>SKILLED NURSING FACILITY CARE*</b><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<br>First 20 days<br>21st thru 100th day<br>101st day and after   | All approved amounts<br>All but \$[ ] a day<br>\$0  | \$0<br>Up to \$[ ] a day<br>\$0  | \$0<br>\$0<br>All costs                 |
| <b>BLOOD</b><br>First 3 pints<br>Additional amounts   | \$0<br>100%   | 3 pints<br>\$0   | \$0<br>\$0                              |
| <b>HOSPICE CARE</b><br>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 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 \$[ ] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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

**PLAN D** (continued)**PARTS A & B**

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

**OTHER BENEFITS—NOT COVERED BY MEDICARE**

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

### PLAN F OR HIGH DEDUCTIBLE PLAN F

#### MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

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

[\*\* This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$ ] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [\$ ]. 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 [\$ ] DEDUCTIBLE, **]<br>PLAN PAYS  | [IN ADDITION TO [\$ ] DEDUCTIBLE, **]<br>YOU PAY         |
|---|---|--|--|
| <b>HOSPITALIZATION*</b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies<br>First 60 days<br><br>61st thru 90th day<br>91st day and after:<br>---While using 60 lifetime reserve days<br>---Once lifetime reserve days are used:<br>---Additional 365 days<br><br>---Beyond the additional 365 days | All but \$[ ]<br><br>All but \$[ ] a day<br><br>All but \$[ ] a day<br><br>\$0<br><br>\$0   | \$[ ] (Part A deductible)<br>\$[ ] a day<br><br>\$[ ] a day<br><br>100% of Medicare eligible expenses<br>\$0 | \$0<br><br>\$0<br><br>\$0<br><br>\$0***<br><br>All costs |
| <b>SKILLED NURSING FACILITY CARE*</b><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<br>First 20 days<br>21st thru 100th day<br>101st day and after   | All approved amounts<br>All but \$[ ] a day<br>\$0  | \$0<br>Up to \$[ ] a day<br>\$0  | \$0<br>\$0<br>All costs                                  |
| <b>BLOOD</b><br>First 3 pints<br>Additional amounts   | \$0<br>100%   | 3 pints<br>\$0   | \$0<br>\$0   |
| <b>HOSPICE CARE</b><br>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 based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN F OR HIGH DEDUCTIBLE PLAN F****MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

\* Once you have been billed \$[ ] 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 [\$ ] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [\$ ]. 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<br>[\$ ]<br>DEDUCTIBLE, **]<br>PLAN PAYS | [IN ADDITION TO<br>[\$ ] DEDUCTIBLE,<br>**]<br>YOU PAY |
|---|--------------------------|---|--|
| <b>MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,<br>First \$[ ] of Medicare Approved Amounts*<br>Remainder of Medicare Approved Amounts | \$0<br><br>Generally 80% | \$[ ] (Part B deductible)<br>Generally 20%              | \$0<br><br>\$0   |
| <b>Part B Excess Charges</b> (Above Medicare Approved Amounts)  | \$0                      | 100%  | \$0  |
| <b>BLOOD</b><br>First 3 pints<br>Next \$[ ] of Medicare Approved Amounts*<br>Remainder of Medicare Approved Amounts   | \$0<br>\$0<br>80%        | All costs<br>\$[ ] (Part B deductible)<br>20%           | \$0<br>\$0<br>\$0                                      |
| <b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>   | 100%                     | \$0   | \$0  |

**PLAN F OR HIGH DEDUCTIBLE PLAN F (continued)****PARTS A & B**

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

**OTHER BENEFITS—NOT COVERED BY MEDICARE**

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

**PLAN G****MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

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

| SERVICES   | MEDICARE PAYS   | PLAN PAYS                          | YOU PAY   |
|--|---|------------------------------------|-----------|
| <b>HOSPITALIZATION*</b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies   |   |                                    |           |
| First 60 days  | All but \$[ ]   | \$[ ] (Part A deductible)          | \$0       |
| 61st thru 90th day   | All but \$[ ] a day   | \$[ ] a day                        | \$0       |
| 91st day and after:  |   |                                    |           |
| ---While using 60 lifetime reserve days  | All but \$[ ] a day   | \$[ ] a day                        | \$0       |
| ---Once lifetime reserve days are used:  |   |                                    |           |
| ---Additional 365 days   | \$0   | 100% of Medicare eligible expenses | \$0**     |
| ---Beyond the additional 365 days  | \$0   | \$0                                | All costs |
| <b>SKILLED NURSING FACILITY CARE*</b><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 \$[ ] a day   | Up to \$[ ] a day                  | \$0       |
| 101st day and after  | \$0   | \$0                                | All costs |
| <b>BLOOD</b>   |   |                                    |           |
| First 3 pints  | \$0   | 3 pints                            | \$0       |
| Additional amounts   | 100%  | \$0                                | \$0       |
| <b>HOSPICE CARE</b><br>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 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 \$[ ] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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



**PLAN G (continued)****PARTS A & B**

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

**OTHER BENEFITS—NOT COVERED BY MEDICARE**

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

### PLAN K

\* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[ ] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

#### MEDICARE (PART A)-HOSPITAL SERVICES-PER BENEFIT PERIOD

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

| SERVICES   | MEDICARE PAYS  | PLAN PAYS   | YOU PAY*  |
|--|--|---|---|
| <b>HOSPITALIZATION**</b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies<br>First 60 days<br><br>61st thru 90th day<br>91st day and after:<br>---While using 60 lifetime reserve days<br>---Once lifetime reserve days are used:<br>---Additional 365 days<br><br>---Beyond the additional 365 days | All but \$[ ]<br><br>All but \$[ ] a day<br><br>All but \$[ ] a day<br><br>\$0<br><br>\$0  | \$[ ] (50% of Part A deductible)<br>\$[ ] a day<br><br>\$[ ] a day<br><br>100% of Medicare eligible expenses<br>\$0 | \$[ ] (50% of Part A deductible) ♦<br>\$0<br><br>\$0<br><br>\$0***<br>All costs |
| <b>SKILLED NURSING FACILITY CARE**</b><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<br>First 20 days<br>21st thru 100th day<br><br>101st day and after   | All approved amounts<br>All but \$[ ] a day<br><br>\$0                                     | \$0<br>Up to \$[ ] a day (50% of Part A Coinsurance)<br>\$0   | \$0<br>Up to \$[ ] a day (50% of Part A Coinsurance) ♦<br>All costs             |
| <b>BLOOD</b><br>First 3 pints<br>Additional amounts  | \$0<br>100%  | 50%<br>\$0  | 50% ♦<br>\$0  |
| <b>HOSPICE CARE</b><br>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 copayment/coinsurance  | 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 based on any difference between its billed charges and the amount Medicare would have paid.

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

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

| <b>SERVICES</b>   | <b>MEDICARE PAYS</b>   | <b>PLAN PAYS</b>   | <b>YOU PAY*</b>   |
|---|--|--|---|
| <b>MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,<br>First \$[ ] of Medicare Approved Amounts****<br>Preventive Benefits for Medicare Covered Services<br>Remainder of Medicare Approved Amounts | \$0<br>Generally 80% or more of Medicare approved amounts<br>Generally 80% | \$0<br>Remainder of Medicare approved amounts<br>Generally 10% | \$[ ] (Part B deductible) *** ♦<br>All costs above Medicare approved amounts<br>Generally 10% ♦ |
| <b>Part B Excess Charges</b> (Above Medicare Approved Amounts)  | \$0  | \$0  | All costs (and they do not count toward annual out-of-pocket limit of \$[ ])*                   |
| <b>BLOOD</b><br>First 3 pints<br>Next \$[ ] of Medicare Approved Amounts****<br>Remainder of Medicare Approved Amounts  | \$0<br>\$0<br>Generally 80%  | 50%<br>\$0<br>Generally 10%                                    | 50% ♦<br>\$[ ] (Part B deductible) **** ♦<br>Generally 10% ♦                                    |
| <b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>   | 100%   | \$0  | \$0   |

\* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[ ] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

**PLAN K** (continued)**PARTS A&B**

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

**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 \$[ ] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

**MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

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

| SERVICES   | MEDICARE PAYS  | PLAN PAYS   | YOU PAY*  |
|--|--|---|---|
| <b>HOSPITALIZATION**</b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies<br>First 60 days<br><br>61st thru 90th day<br>91st day and after:<br>---While using 60 lifetime reserve days<br>---Once lifetime reserve days are used:<br>---Additional 365 days<br><br>---Beyond the additional 365 days | All but \$[ ]<br><br>All but \$[ ] a day<br><br>All but \$[ ] a day<br><br>\$0<br><br>\$0  | \$[ ] (75% of Part A deductible)<br>\$[ ] a day<br><br>\$[ ] a day<br><br>100% of Medicare eligible expenses<br>\$0 | \$[ ] (25% of Part A deductible) ♦<br>\$0<br><br>\$0<br><br>\$0***<br>All costs |
| <b>SKILLED NURSING FACILITY CARE**</b><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<br>First 20 days<br>21st thru 100th day<br><br>101st day and after   | All approved amounts<br>All but \$[ ] a day<br><br>\$0                                     | \$0<br>Up to \$[ ] a day (75% of Part A Coinsurance)<br>\$0   | \$0<br>Up to \$[ ] a day (25% of Part A Coinsurance) ♦<br>All costs             |
| <b>BLOOD</b><br>First 3 pints<br>Additional amounts  | \$0<br>100%  | 75%<br>\$0  | 25% ♦<br>\$0  |
| <b>HOSPICE CARE</b><br>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 based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN L****MEDICARE (PART B)—MEDICAL SERVICES —PER CALENDAR YEAR**

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

| <b>SERVICES</b>   | <b>MEDICARE PAYS</b>   | <b>PLAN PAYS</b>   | <b>YOU PAY*</b>   |
|---|--|--|---|
| <b>MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,<br>First \$[ ] of Medicare Approved Amounts****<br>Preventive Benefits for Medicare Covered Services<br>Remainder of Medicare Approved Amounts | \$0<br>Generally 75% 80% or more of Medicare approved amounts<br>Generally 80% | \$0<br>Remainder of Medicare approved amounts<br>Generally 15% | \$[ ] (Part B deductible) **** ♦<br>All costs above Medicare approved amounts<br>Generally 5% ♦ |
| <b>Part B Excess Charges</b> (Above Medicare Approved Amounts)  | \$0  | \$0  | All costs (and they do not count toward annual out-of-pocket limit of \$[ ])*                   |
| <b>BLOOD</b><br>First 3 pints<br>Next \$[ ] of Medicare Approved Amounts****<br>Remainder of Medicare Approved Amounts  | \$0<br>\$0<br>Generally 80%  | 75%<br>\$0<br>Generally 15%                                    | 25% ♦<br>\$[ ] (Part B deductible) ♦<br>Generally 5% ♦  |
| <b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>   | 100%   | \$0  | \$0   |

\* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[ ] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

**PLAN L** (continued)**PARTS A&B**

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

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

**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  |
|---|---|---|--|
| <b>HOSPITALIZATION*</b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies<br>First 60 days<br>61st thru 90th day<br>91st day and after:<br>---While using 60 lifetime reserve days<br>---Once lifetime reserve days are used:<br>---Additional 365 days<br>---Beyond the additional 365 days | All but \$[ ]<br>All but \$[ ] a day<br>All but \$[ ] a day<br>\$0<br>\$0                   | \$[ ] (50% of Part A deductible)<br>\$[ ] a day<br>\$[ ] a day<br>100% of Medicare eligible expenses<br>\$0 | \$[ ] (50% of Part A deductible)<br>\$0<br>\$0<br>\$0**<br>All costs |
| <b>SKILLED NURSING FACILITY CARE*</b><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<br>First 20 days<br>21st thru 100th day<br>101st day and after   | All approved amounts<br>All but \$[ ] a day<br>\$0  | \$0<br>Up to \$[ ] a day<br>\$0   | \$0<br>\$0<br>All costs  |
| <b>BLOOD</b><br>First 3 pints<br>Additional amounts   | \$0<br>100%   | 3 pints<br>\$0  | \$0<br>\$0   |
| <b>HOSPICE CARE</b><br>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 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 \$[ ] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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

**PARTS A & B**

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

**OTHER BENEFITS—NOT COVERED BY MEDICARE**

|  |            |  |   |
|--|------------|--|---|
| <b>FOREIGN TRAVEL—NOT COVERED BY MEDICARE</b><br>Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA<br>First \$250 each calendar year<br>Remainder of charges | \$0<br>\$0 | \$0<br>80% to a lifetime maximum benefit of \$50,000 | \$250<br>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   |
|--|---|------------------------------------|-----------|
| <b>HOSPITALIZATION*</b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies   |   |                                    |           |
| First 60 days  | All but \$[ ]   | \$[ ] (Part A deductible)          | \$0       |
| 61st thru 90th day   | All but \$[ ] a day   | \$[ ] a day                        | \$0       |
| 91st day and after:  |   |                                    |           |
| ---While using 60 lifetime reserve days  | All but \$[ ] a day   | \$[ ] a day                        | \$0       |
| ---Once lifetime reserve days are used:  |   |                                    |           |
| ---Additional 365 days   | \$0   | 100% of Medicare eligible expenses | \$0**     |
| ---Beyond the additional 365 days  | \$0   | \$0                                | All costs |
| <b>SKILLED NURSING FACILITY CARE*</b><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 \$[ ] a day   | Up to \$[ ] a day                  | \$0       |
| 101st day and after  | \$0   | \$0                                | All costs |
| <b>BLOOD</b>   |   |                                    |           |
| First 3 pints  | \$0   | 3 pints                            | \$0       |
| Additional amounts   | 100%  | \$0                                | \$0       |
| <b>HOSPICE CARE</b><br>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 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 \$[ ] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| <b>SERVICES</b>  | <b>MEDICARE PAYS</b>     | <b>PLAN PAYS</b>   | <b>YOU PAY</b>   |
|--|--------------------------|--|--|
| <b>MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[ ] of Medicare Approved Amounts*<br>Remainder of Medicare Approved Amounts | \$0<br><br>Generally 80% | \$0<br><br>Balance, other than up to [\$ ] per office visit and up to [\$ ] per emergency room visit. The copayment of up to [\$ ] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense. | \$[ ] (Part B deductible)<br>Up to [\$ ] per office visit and up to [\$ ] per emergency room visit. The copayment of up to [\$ ] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense. |
| <b>Part B Excess Charges</b> (Above Medicare Approved Amounts)   | \$0                      | \$0  | All costs  |
| <b>BLOOD</b><br>First 3 pints<br>Next \$[ ] of Medicare Approved Amounts*<br>Remainder of Medicare Approved Amounts  | \$0<br>\$0<br>80%        | All costs<br>\$0<br>20%  | \$0<br>\$[ ] (Part B deductible)<br>\$0  |
| <b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>  | 100%                     | \$0  | \$0  |

**PLAN N (continued)****PARTS A & B**

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

**OTHER BENEFITS—NOT COVERED BY MEDICARE**

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

### 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 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* | K          | L          | M   | N                    | C  | F* |
| Medicare Part A coinsurance and hospice coverage (up to an additional 365 days after Medicare benefits are used up) | ✓                                 | ✓ | ✓ | ✓  | ✓          | ✓          | ✓   | ✓                    | ✓  | ✓  |
| Medicare Part B coinsurance or copayment  | ✓                                 | ✓ | ✓ | ✓  | 50%        | 75%        | ✓   | ✓<br>copays apply*** | ✓  | ✓  |
| 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)  |                                   |   | ✓ | ✓  |            |            | ✓   | ✓                    | ✓  | ✓  |
| Out-of-pocket limit in [2018]   |                                   |   |   |    | [\$5240]** | [\$2620]** |     |                      |  |    |

\* Plans F and G also have a high deductible options which require first paying a plan deductible of [\$2240] 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.

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

\*\*\* Plan 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.

**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.]

**DISCLOSURES [Boldface Type]**

Use this outline to compare benefits and premiums among policies.

**READ YOUR POLICY VERY CAREFULLY [Boldface Type]**

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance 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 rule. An issuer may use additional benefit plan designations on these charts pursuant to paragraph (K)(4) of this rule.]

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

[Include an explanation of any smoker/non-smoker rates or household discounts in the premium information and disclosure pages, in a manner approved by the superintendent.]

**PLAN A****MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

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

| SERVICES  | MEDICARE PAYS   | PLAN PAYS  | YOU PAY   |
|---|---|--|---|
| <b>HOSPITALIZATION*</b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies<br>First 60 days<br><br>61st thru 90th day<br>91st day and after:<br>---While using 60 lifetime reserve days<br>---Once lifetime reserve days are used:<br>---Additional 365 days<br><br>---Beyond the additional 365 days | All but \$[ ]<br><br>All but \$[ ] a day<br><br>All but \$[ ] a day<br><br>\$0<br><br>\$0   | \$0<br><br>\$[ ] a day<br><br>\$[ ] a day<br><br>100% of Medicare eligible expenses<br>\$0 | \$[ ] (Part A deductible)<br>\$0<br><br>\$0<br><br>\$0**<br><br>All costs |
| <b>SKILLED NURSING FACILITY CARE*</b><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<br>First 20 days<br>21st thru 100th day<br>101st day and after   | All approved amounts<br>All but \$[ ] a day<br>\$0  | \$0<br>\$0<br>\$0  | \$0<br>Up to \$[ ] a day<br>All costs                                     |
| <b>BLOOD</b><br>First 3 pints<br>Additional amounts   | \$0<br>100%   | 3 pints<br>\$0   | \$0<br>\$0  |
| <b>HOSPICE CARE</b><br>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 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 \$[ ] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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

**PARTS A & B**

|  |                        |                       |   |
|--|------------------------|-----------------------|---|
| <b>HOME HEALTH CARE</b><br><b>MEDICARE APPROVED SERVICES</b><br>—Medically necessary skilled care services and medical supplies<br>—Durable medical equipment<br>First \$[ ] of Medicare Approved Amounts*<br>Remainder of Medicare Approved Amounts | 100%<br><br>\$0<br>80% | \$0<br><br>\$0<br>20% | \$0<br><br>\$[ ] (Part B deductible)<br>\$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   |
|---|---|--|---|
| <b>HOSPITALIZATION*</b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies<br>First 60 days<br><br>61st thru 90th day<br>91st day and after:<br>---While using 60 lifetime reserve days<br>---Once lifetime reserve days are used:<br>---Additional 365 days<br><br>---Beyond the additional 365 days | All but \$[ ]<br><br>All but \$[ ] a day<br><br>All but \$[ ] a day<br><br>\$0<br><br>\$0   | \$[ ] (Part A deductible)<br>\$[ ] a day<br>\$[ ] a day<br><br>100% of Medicare eligible expenses<br>\$0 | \$0<br><br>\$0<br>\$0<br><br>\$0**<br>All costs |
| <b>SKILLED NURSING FACILITY CARE*</b><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<br>First 20 days<br>21st thru 100th day<br>101st day and after   | All approved amounts<br>All but \$[ ] a day<br>\$0  | \$0<br>\$0<br>\$0  | \$0<br>Up to \$[ ] a day<br>All costs           |
| <b>BLOOD</b><br>First 3 pints<br>Additional amounts   | \$0<br>100%   | 3 pints<br>\$0   | \$0<br>\$0                                      |
| <b>HOSPICE CARE</b><br>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 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 \$[ ] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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

**PARTS A & B**

|  |                        |                       |   |
|--|------------------------|-----------------------|---|
| <b>HOME HEALTH CARE</b><br><b>MEDICARE APPROVED SERVICES</b><br>—Medically necessary skilled care services and medical supplies<br>—Durable medical equipment<br>First \$[ ] of Medicare Approved Amounts*<br>Remainder of Medicare Approved Amounts | 100%<br><br>\$0<br>80% | \$0<br><br>\$0<br>20% | \$0<br><br>\$[ ] (Part B deductible)<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   |
|---|---|--|---|
| <b>HOSPITALIZATION*</b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies<br>First 60 days<br><br>61st thru 90th day<br>91st day and after:<br>---While using 60 lifetime reserve days<br>---Once lifetime reserve days are used:<br>---Additional 365 days<br><br>---Beyond the additional 365 days | All but \$[ ]<br><br>All but \$[ ] a day<br><br>All but \$[ ] a day<br><br>\$0<br><br>\$0   | \$[ ] (Part A deductible)<br>\$[ ] a day<br>\$[ ] a day<br><br>100% of Medicare eligible expenses<br>\$0 | \$0<br><br>\$0<br>\$0<br><br>\$0**<br>All costs |
| <b>SKILLED NURSING FACILITY CARE*</b><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<br>First 20 days<br>21st thru 100th day<br>101st day and after   | All approved amounts<br>All but \$[ ] a day<br>\$0  | \$0<br>Up to \$[ ] a day<br>\$0  | \$0<br>\$0<br>All costs                         |
| <b>BLOOD</b><br>First 3 pints<br>Additional amounts   | \$0<br>100%   | 3 pints<br>\$0   | \$0<br>\$0                                      |
| <b>HOSPICE CARE</b><br>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 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 \$[ ] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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

**PARTS A & B**

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

**OTHER BENEFITS—NOT COVERED BY MEDICARE**

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

**PLAN 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   |
|---|---|--|---|
| <b>HOSPITALIZATION*</b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies<br>First 60 days<br><br>61st thru 90th day<br>91st day and after:<br>---While using 60 lifetime reserve days<br>---Once lifetime reserve days are used:<br>---Additional 365 days<br><br>---Beyond the additional 365 days | All but \$[ ]<br><br>All but \$[ ] a day<br><br>All but \$[ ] a day<br><br>\$0<br><br>\$0   | \$[ ] (Part A deductible)<br>\$[ ] a day<br>\$[ ] a day<br><br>100% of Medicare eligible expenses<br>\$0 | \$0<br><br>\$0<br>\$0<br><br>\$0**<br>All costs |
| <b>SKILLED NURSING FACILITY CARE*</b><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<br>First 20 days<br>21st thru 100th day<br>101st day and after   | All approved amounts<br>All but \$[ ] a day<br>\$0  | \$0<br>Up to \$[ ] a day<br>\$0  | \$0<br>\$0<br>All costs                         |
| <b>BLOOD</b><br>First 3 pints<br>Additional amounts   | \$0<br>100%   | 3 pints<br>\$0   | \$0<br>\$0                                      |
| <b>HOSPICE CARE</b><br>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 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 \$[ ] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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

**PLAN D** (continued)**PARTS A & B**

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

**OTHER BENEFITS—NOT COVERED BY MEDICARE**

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

### PLAN F OR HIGH DEDUCTIBLE PLAN F

#### MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

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

**[\*\* This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$ ] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [\$ ]. 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 [\$ ] DEDUCTIBLE, **]<br>PLAN PAYS  | [IN ADDITION TO [\$ ] DEDUCTIBLE, **]<br>YOU PAY         |
|---|---|--|--|
| <b>HOSPITALIZATION*</b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies<br>First 60 days<br><br>61st thru 90th day<br>91st day and after:<br>---While using 60 lifetime reserve days<br>---Once lifetime reserve days are used:<br>---Additional 365 days<br><br>---Beyond the additional 365 days | All but \$[ ]<br><br>All but \$[ ] a day<br><br>All but \$[ ] a day<br><br>\$0<br><br>\$0   | \$[ ] (Part A deductible)<br>\$[ ] a day<br><br>\$[ ] a day<br><br>100% of Medicare eligible expenses<br>\$0 | \$0<br><br>\$0<br><br>\$0<br><br>\$0***<br><br>All costs |
| <b>SKILLED NURSING FACILITY CARE*</b><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<br>First 20 days<br>21st thru 100th day<br>101st day and after   | All approved amounts<br>All but \$[ ] a day<br>\$0  | \$0<br>Up to \$[ ] a day<br>\$0  | \$0<br>\$0<br>All costs                                  |
| <b>BLOOD</b><br>First 3 pints<br>Additional amounts   | \$0<br>100%   | 3 pints<br>\$0   | \$0<br>\$0   |
| <b>HOSPICE CARE</b><br>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 based on any difference between its billed charges and the amount Medicare would have paid.



**PLAN F OR HIGH DEDUCTIBLE PLAN F****MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

\* Once you have been billed \$[ ] 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 [\$ ] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [\$ ]. 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<br>[\$ ]<br>DEDUCTIBLE, **]<br>PLAN PAYS | [IN ADDITION TO<br>[\$ ] DEDUCTIBLE,<br>**]<br>YOU PAY |
|---|--------------------------|---|--|
| <b>MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,<br>First \$[ ] of Medicare Approved Amounts*<br>Remainder of Medicare Approved Amounts | \$0<br><br>Generally 80% | \$[ ] (Part B deductible)<br>Generally 20%              | \$0<br><br>\$0   |
| <b>Part B Excess Charges</b> (Above Medicare Approved Amounts)  | \$0                      | \$100   | \$0  |
| <b>BLOOD</b><br>First 3 pints<br>Next \$[ ] of Medicare Approved Amounts*<br>Remainder of Medicare Approved Amounts   | \$0<br>\$0<br>80%        | All costs<br>\$[ ] (Part B deductible)<br>20%           | \$0<br>\$0<br>\$0                                      |
| <b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>   | 100%                     | \$0   | \$0  |

**PLAN F OR HIGH DEDUCTIBLE PLAN F (continued)****PARTS A & B**

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

**OTHER BENEFITS—NOT COVERED BY MEDICARE**

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

**PLAN G 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 [\$2240] deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are [\$2240]. 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<br>\$[2240]<br>DEDUCTIBLE,**]<br>PLAN PAYS | [IN ADDITION TO<br>\$[2240]<br>DEDUCTIBLE, **]<br>YOU PAY |
|--|----------------------|---|---|
| <b>HOSPITALIZATION*</b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies   |                      |   |   |
| First 60 days  | All but \$[ ]        | \$[ ] (Part A deductible)                                 | \$0   |
| 61st thru 90th day   | All but \$[ ] a day  | \$[ ] a day   | \$0   |
| 91st day and after:  |                      |   |   |
| ---While using 60 lifetime reserve days  | All but \$[ ] a day  | \$[ ] a day   | \$0   |
| ---Once lifetime reserve days are used:  |                      |   |   |
| ---Additional 365 days   | \$0                  | 100% of Medicare eligible expenses                        | \$0***  |
| ---Beyond the additional 365 days  | \$0                  | \$0   | All costs   |
| <b>SKILLED NURSING FACILITY CARE*</b><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 \$[ ] a day  | Up to \$[ ] a day   | \$0   |
| 101st day and after  | \$0                  | \$0   | All costs   |
| <b>BLOOD</b>   |                      |   |   |
| First 3 pints  | \$0                  | 3 pints   | \$0   |
| Additional amounts   | 100%                 | \$0   | \$0   |

|   |   |                                |     |
|---|---|--------------------------------|-----|
| <b>HOSPICE CARE</b><br>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 based 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 \$[ ] 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 [\$2240] deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are [\$2240]. 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.]

| <b>SERVICES</b>   | <b>MEDICARE PAYS</b>          | <b>[AFTER YOU PAY<br/>\$[2240]<br/>DEDUCTIBLE,**]<br/>PLAN PAYS</b> | <b>[IN ADDITION TO<br/>\$[2240]<br/>DEDUCTIBLE, **]<br/>YOU PAY</b> |
|---|-------------------------------|---|---|
| <b>MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,<br><br>First \$[ ] of Medicare Approved Amounts*<br><br>Remainder of Medicare Approved Amounts | <br>\$0<br><br>Generally 80%  | <br>\$0<br><br>Generally 20%  | <br>\$[ ] (Unless Part B deductible has been met)<br>\$0            |
| <b>Part B Excess Charges</b> (Above Medicare Approved Amounts)  | \$0                           | 100%  | \$0   |
| <b>BLOOD</b><br><br>First 3 pints<br><br>Next \$[ ] of Medicare Approved Amounts*<br><br>Remainder of Medicare Approved Amounts   | <br>\$0<br><br>\$0<br><br>80% | <br>All costs<br><br>\$0<br><br>20%                                 | <br>\$0<br><br>\$[ ] (Unless Part B deductible has been met)<br>\$0 |
| <b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>   | 100%                          | \$0   | \$0   |

**PLAN G or HIGH DEDUCTIBLE PLAN G****PARTS A & B**

| <b>SERVICES</b>  | <b>MEDICARE PAYS</b> | <b>[AFTER YOU PAY<br/>\$[2240]<br/>DEDUCTIBLE,**]<br/>PLAN PAYS</b> | <b>[IN ADDITION TO<br/>\$[2240]<br/>DEDUCTIBLE, **]<br/>YOU PAY</b> |
|--|----------------------|---|---|
| <b>HOME HEALTH CARE</b><br><b>MEDICARE APPROVED SERVICES</b><br>—Medically necessary skilled care<br>services and medical supplies<br>—Durable medical equipment | 100%                 | \$0   | \$0   |
| First \$[ ] of Medicare Approved<br>Amounts*   | \$0                  | \$0   | \$[ ] (Unless Part B<br>deductible has been<br>met)                 |
| Remainder of Medicare Approved<br>Amounts  | 80%                  | 20%   | \$0   |

**OTHER BENEFITS—NOT COVERED BY MEDICARE**

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

### PLAN K

\* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[ ] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

#### MEDICARE (PART A)-HOSPITAL SERVICES-PER BENEFIT PERIOD

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

| SERVICES   | MEDICARE PAYS  | PLAN PAYS   | YOU PAY*  |
|--|--|---|---|
| <b>HOSPITALIZATION**</b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies<br>First 60 days<br><br>61st thru 90th day<br>91st day and after:<br>---While using 60 lifetime reserve days<br>---Once lifetime reserve days are used:<br>---Additional 365 days<br><br>---Beyond the additional 365 days | All but \$[ ]<br><br>All but \$[ ] a day<br><br>All but \$[ ] a day<br><br>\$0<br><br>\$0  | \$[ ] (50% of Part A deductible)<br>\$[ ] a day<br><br>\$[ ] a day<br><br>100% of Medicare eligible expenses<br>\$0 | \$[ ] (50% of Part A deductible) ♦<br>\$0<br><br>\$0<br><br>\$0***<br>All costs |
| <b>SKILLED NURSING FACILITY CARE**</b><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<br>First 20 days<br>21st thru 100th day<br><br>101st day and after   | All approved amounts<br>All but \$[ ] a day<br><br>\$0                                     | \$0<br>Up to \$[ ] a day (50% of Part A Coinsurance)<br>\$0   | \$0<br>Up to \$[ ] a day (50% of Part A Coinsurance) ♦<br>All costs             |
| <b>BLOOD</b><br>First 3 pints<br>Additional amounts  | \$0<br>100%  | 50%<br>\$0  | 50% ♦<br>\$0  |
| <b>HOSPICE CARE</b><br>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 respice care | 50% of copayment/coinsurance  | 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 based on any difference between its billed charges and the amount Medicare would have paid.

# PLAN K

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

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

| SERVICES  | MEDICARE PAYS  | PLAN PAYS  | YOU PAY*  |
|---|--|--|---|
| <b>MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,<br>First \$[ ] of Medicare Approved Amounts****<br>Preventive Benefits for Medicare Covered Services<br>Remainder of Medicare Approved Amounts | \$0<br>Generally 80% or more of Medicare approved amounts<br>Generally 80% | \$0<br>Remainder of Medicare approved amounts<br>Generally 10% | \$[ ] (Part B deductible) *** ♦<br>All costs above Medicare approved amounts<br>Generally 10% ♦ |
| <b>Part B Excess Charges</b> (Above Medicare Approved Amounts)  | \$0  | \$0  | All costs (and they do not count toward annual out-of-pocket limit of \$[ ])*                   |
| <b>BLOOD</b><br>First 3 pints<br>Next \$[ ] of Medicare Approved Amounts****<br>Remainder of Medicare Approved Amounts  | \$0<br>\$0<br>Generally 80%  | 50%<br>\$0<br>Generally 10%                                    | 50% ♦<br>\$[ ] (Part B deductible) **** ♦<br>Generally 10% ♦                                    |
| <b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>   | 100%   | \$0  | \$0   |

\* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[ ] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**



**PLAN K** (continued)

| <b>PARTS A&amp;B</b>  |                      |                  |                             |
|---|----------------------|------------------|-----------------------------|
| <b>SERVICES</b>   | <b>MEDICARE PAYS</b> | <b>PLAN PAYS</b> | <b>YOU PAY*</b>             |
| <b>HOME HEALTH CARE</b>   |                      |                  |                             |
| <b>MEDICARE APPROVED SERVICES</b>                               |                      |                  |                             |
| —Medically necessary skilled care services and medical supplies | 100%                 | \$0              | \$0                         |
| —Durable medical equipment                                      |                      |                  |                             |
| First \$[ ] of Medicare Approved Amounts*****                   | \$0                  | \$0              | \$[ ] (Part B deductible) ♦ |
| 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*.

**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 \$[ ] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

**MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

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

| SERVICES   | MEDICARE PAYS  | PLAN PAYS   | YOU PAY*  |
|--|--|---|---|
| <b>HOSPITALIZATION**</b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies<br>First 60 days<br><br>61st thru 90th day<br>91st day and after:<br>---While using 60 lifetime reserve days<br>---Once lifetime reserve days are used:<br>---Additional 365 days<br><br>---Beyond the additional 365 days | All but \$[ ]<br><br>All but \$[ ] a day<br><br>All but \$[ ] a day<br><br>\$0<br><br>\$0  | \$[ ] (75% of Part A deductible)<br>\$[ ] a day<br><br>\$[ ] a day<br><br>100% of Medicare eligible expenses<br>\$0 | \$[ ] (25% of Part A deductible) ♦<br>\$0<br><br>\$0<br><br>\$0***<br>All costs |
| <b>SKILLED NURSING FACILITY CARE**</b><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<br>First 20 days<br>21st thru 100th day<br><br>101st day and after   | All approved amounts<br>All but \$[ ] a day<br><br>\$0                                     | \$0<br>Up to \$[ ] a day (75% of Part A Coinsurance)<br>\$0   | \$0<br>Up to \$[ ] a day (25% of Part A Coinsurance) ♦<br>All costs             |
| <b>BLOOD</b><br>First 3 pints<br>Additional amounts  | \$0<br>100%  | 75%<br>\$0  | 25% ♦<br>\$0  |
| <b>HOSPICE CARE</b><br>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 based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN L****MEDICARE (PART B)—MEDICAL SERVICES —PER CALENDAR YEAR**

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

| SERVICES  | MEDICARE PAYS  | PLAN PAYS  | YOU PAY*  |
|---|--|--|---|
| <b>MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,<br>First \$[ ] of Medicare Approved Amounts****<br>Preventive Benefits for Medicare Covered Services<br>Remainder of Medicare Approved Amounts | \$0<br><br>Generally 80% or more of Medicare approved amounts<br>Generally 80% | \$0<br><br>Remainder of Medicare approved amounts<br>Generally 15% | \$[ ] (Part B deductible) **** ♦<br>All costs above Medicare approved amounts<br>Generally 5% ♦ |
| <b>Part B Excess Charges</b> (Above Medicare Approved Amounts)  | \$0  | \$0  | All costs (and they do not count toward annual out-of-pocket limit of \$[ ])*                   |
| <b>BLOOD</b><br>First 3 pints<br>Next \$[ ] of Medicare Approved Amounts****<br>Remainder of Medicare Approved Amounts  | \$0<br>\$0<br>Generally 80%  | 75%<br>\$0<br>Generally 15%  | 25% ♦<br>\$[ ] (Part B deductible) ♦<br>Generally 5% ♦  |
| <b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>   | 100%   | \$0  | \$0   |

\* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[ ] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

**PLAN L** (continued)

| <b>PARTS A&amp;B</b>  |                      |                  |                             |
|---|----------------------|------------------|-----------------------------|
| <b>SERVICES</b>   | <b>MEDICARE PAYS</b> | <b>PLAN PAYS</b> | <b>YOU PAY*</b>             |
| <b>HOME HEALTH CARE</b>   |                      |                  |                             |
| MEDICARE APPROVED SERVICES                                      |                      |                  |                             |
| —Medically necessary skilled care services and medical supplies | 100%                 | \$0              | \$0                         |
| —Durable medical equipment                                      |                      |                  |                             |
| First \$[ ] of Medicare Approved Amounts*****                   | \$0                  | \$0              | \$[ ] (Part B deductible) ♦ |
| Remainder of Medicare Approved Amounts                          | 80%                  | 15%              | 5% ♦                        |

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

**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  |
|---|---|---|--|
| <b>HOSPITALIZATION*</b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies<br>First 60 days<br><br>61st thru 90th day<br>91st day and after:<br>---While using 60 lifetime reserve days<br>---Once lifetime reserve days are used:<br>---Additional 365 days<br><br>---Beyond the additional 365 days | All but \$[ ]<br><br>All but \$[ ] a day<br><br>All but \$[ ] a day<br><br>\$0<br><br>\$0   | \$[ ] (50% of Part A deductible)<br>\$[ ] a day<br><br>\$[ ] a day<br><br>100% of Medicare eligible expenses<br>\$0 | \$[ ] (50% of Part A deductible)<br>\$0<br><br>\$0<br><br>\$0**<br><br>All costs |
| <b>SKILLED NURSING FACILITY CARE*</b><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<br>First 20 days<br>21st thru 100th day<br>101st day and after   | All approved amounts<br>All but \$[ ] a day<br>\$0  | \$0<br>Up to \$[ ] a day<br>\$0   | \$0<br>\$0<br>All costs  |
| <b>BLOOD</b><br>First 3 pints<br>Additional amounts   | \$0<br>100%   | 3 pints<br>\$0  | \$0<br>\$0   |
| <b>HOSPICE CARE</b><br>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 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 \$[ ] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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

**PARTS A & B**

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

**OTHER BENEFITS—NOT COVERED BY MEDICARE**

|  |            |  |   |
|--|------------|--|---|
| <b>FOREIGN TRAVEL—NOT COVERED BY MEDICARE</b><br>Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA<br>First \$250 each calendar year<br>Remainder of charges | \$0<br>\$0 | \$0<br>80% to a lifetime maximum benefit of \$50,000 | \$250<br>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   |
|---|---|--|---|
| <b>HOSPITALIZATION*</b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies<br>First 60 days<br><br>61st thru 90th day<br>91st day and after:<br>---While using 60 lifetime reserve days<br>---Once lifetime reserve days are used:<br>---Additional 365 days<br><br>---Beyond the additional 365 days | All but \$[ ]<br><br>All but \$[ ] a day<br><br>All but \$[ ] a day<br><br>\$0<br><br>\$0   | \$[ ] (Part A deductible)<br>\$[ ] a day<br>\$[ ] a day<br><br>100% of Medicare eligible expenses<br>\$0 | \$0<br><br>\$0<br><br>\$0<br><br>\$0**<br><br>All costs |
| <b>SKILLED NURSING FACILITY CARE*</b><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<br>First 20 days<br>21st thru 100th day<br>101st day and after   | All approved amounts<br>All but \$[ ] a day<br>\$0  | \$0<br>Up to \$[ ] a day<br>\$0  | \$0<br>\$0<br>All costs                                 |
| <b>BLOOD</b><br>First 3 pints<br>Additional amounts   | \$0<br>100%   | 3 pints<br>\$0   | \$0<br>\$0  |
| <b>HOSPICE CARE</b><br>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 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 \$[ ] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| <b>SERVICES</b>  | <b>MEDICARE PAYS</b>     | <b>PLAN PAYS</b>   | <b>YOU PAY</b>   |
|--|--------------------------|--|--|
| <b>MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[ ] of Medicare Approved Amounts*<br>Remainder of Medicare Approved Amounts | \$0<br><br>Generally 80% | \$0<br><br>Balance, other than up to \$[ ] per office visit and up to \$[ ] per emergency room visit. The copayment of up to \$[ ] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense. | \$[ ] (Part B deductible)<br>Up to \$[ ] per office visit and up to \$[ ] per emergency room visit. The copayment of up to \$[ ] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense. |
| <b>Part B Excess Charges</b> (Above Medicare Approved Amounts)   | \$0                      | \$0  | All costs  |
| <b>BLOOD</b><br>First 3 pints<br>Next \$[ ] of Medicare Approved Amounts*<br>Remainder of Medicare Approved Amounts  | \$0<br>\$0<br>80%        | All costs<br>\$0<br>20%  | \$0<br>\$[ ] (Part B deductible)<br>\$0  |
| <b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>  | 100%                     | \$0  | \$0  |



**PLAN N** (continued)**PARTS A & B**

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

**OTHER BENEFITS—NOT COVERED BY MEDICARE**

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