LOYAL AMERICAN LIFE INSURANCE COMPANY

P.O. Box 559004 ◆ Austin, Texas 78755-9004 ◆ 800-633-6752

Outline of Medicare Supplement Coverage - Cover Page 1 of 2

Benefit Plans A, H, I and J

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A". Some plans may not be available in your state.

See Outlines of Coverage sections for details about ALL plans

BASIC BENEFITS for Plans A – J:

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

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

Blood: First three pints of blood each year.

A	B	C	D	E	F	F*	G	H	I	J	J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits		Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	
		Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance		Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	
		Part B Deductible			Part B Deductible					Part B Deductible	
					Part B Excess (100%)		Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)	
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	
			At-Home Recovery				At-Home Recovery		At-Home Recovery	At-Home Recovery	
				Preventive Care NOT covered by Medicare						Preventive Care NOT covered by Medicare	

***Plans F and J also have an option called a high deductible Plan F and a high deductible Plan J. These high deductible plans pay the same or offer the same benefits as Plans F and J after one has paid a calendar year $2000 deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses are $2000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.**

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

J	K**	L**
Basic Benefits	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 50% Hospice cost-sharing 50% of Medicare-eligible expenses for the first three pints of blood 50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 75% Hospice cost-sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services
Skilled Nursing Co-Insurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT covered by Medicare		
	$4,620 Out of Pocket Annual Limit***	$2,310 Out of Pocket Annual Limit***

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

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

See Outline of Coverage for details and exceptions.

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MEDICARE SUPPLEMENT

GEORGIA

Issue Age Rates -- Effective 11/1/2009 -- Area 1 (304-312, 316-319, 398)

PREFERRED PLUS ANNUAL RATES

FEMALE RATES					MALE RATES			
Plan A	**Plan H**	**Plan I**	**Plan J**	**Issue Age**	**Plan A**	**Plan H**	**Plan I**	**Plan J**
				Under 65				
1415.23	1466.71	1569.67	1735.02	**65**	1574.64	1631.45	1762.49	1929.69
1415.23	1466.71	1569.67	1735.02	**66**	1574.64	1631.45	1762.49	1929.69
1415.23	1466.71	1569.67	1735.02	**67**	1574.64	1631.45	1762.49	1929.69
1415.23	1466.71	1569.67	1735.02	**68**	1574.64	1631.45	1762.49	1929.69
1436.13	1496.14	1611.97	1768.33	**69**	1616.56	1683.05	1830.47	1988.93
1458.00	1525.97	1645.31	1802.00	**70**	1658.48	1736.57	1890.14	2049.18
1483.52	1561.07	1683.92	1840.98	**71**	1706.77	1795.37	1956.83	2116.51
1509.94	1596.17	1723.41	1880.84	**72**	1755.07	1855.91	2026.15	2186.49
1531.81	1627.76	1757.63	1915.40	**73**	1799.72	1912.95	2090.21	2251.17
1549.13	1660.23	1796.24	1954.38	**74**	1839.81	1970.87	2158.65	2320.27
1566.44	1689.19	1826.08	1984.50	**75**	1879.91	2027.03	2219.20	2381.40
1583.76	1719.02	1858.55	2017.28	**76**	1920.00	2084.94	2283.26	2446.08
1594.69	1745.35	1887.50	2046.52	**77**	1953.72	2138.47	2343.80	2507.21
1605.63	1772.55	1916.46	2075.75	**78**	1987.44	2193.75	2404.35	2568.33
1616.56	1799.75	1946.30	2105.88	**79**	2020.24	2249.91	2467.53	2632.12
1626.58	1826.96	1975.25	2135.11	**80**	2033.91	2283.26	2503.51	2668.44
1642.98	1845.38	1995.44	2156.38	**81**	2053.96	2306.07	2528.96	2695.03
1659.39	1863.81	2015.62	2177.64	**82**	2074.92	2328.89	2554.40	2721.60
1675.79	1882.24	2035.80	2199.78	**83**	2095.88	2352.58	2579.85	2749.06
1692.19	1900.67	2055.98	2221.93	**84**	2116.83	2376.27	2605.30	2776.53
1709.51	1919.97	2076.17	2244.08	**85+**	2137.80	2399.96	2631.62	2803.99

Policies may be issued on an annual, semi-annual, quarterly or monthly mode. To obtain semi-annual premiums, multiply the above-quoted premium by 0.52, for quarterly premiums, multiply the above-quoted premium by 0.265 and for monthly premiums, multiply the above-quoted premium by 0.085.

Add one-time enrollment fee of $25.00 to the first premium.

MEDICARE SUPPLEMENT

GEORGIA

Issue Age Rates -- Effective 11/1/2009 -- Area 1 (304-312, 316-319, 398)

PREFERRED ANNUAL RATES

FEMALE RATES					MALE RATES			
Plan A	Plan H	Plan I	Plan J	Issue Age	Plan A	Plan H	Plan I	Plan J
				Under 65				
1415.23	1466.71	1569.67	1735.02	**65**	1574.64	1631.45	1762.49	1929.69
1446.63	1499.19	1608.05	1773.48	**66**	1609.63	1667.67	1804.61	1972.50
1478.02	1531.67	1646.42	1811.94	**67**	1644.62	1703.89	1847.66	2015.31
1509.52	1564.06	1683.86	1850.31	**68**	1679.62	1740.02	1889.78	2058.21
1531.87	1595.88	1719.43	1886.22	**69**	1724.33	1795.25	1952.50	2121.53
1555.20	1627.70	1755.00	1922.13	**70**	1769.04	1852.34	2016.14	2185.79
1582.42	1665.14	1796.18	1963.71	**71**	1820.56	1915.06	2087.28	2257.61
1610.60	1702.58	1838.30	2006.24	**72**	1872.07	1979.64	2161.22	2332.26
1633.93	1736.28	1874.81	2043.09	**73**	1919.70	2040.48	2229.55	2401.25
1652.40	1770.91	1915.99	2084.67	**74**	1962.47	2102.26	2302.56	2474.96
1670.87	1801.80	1947.82	2116.80	**75**	2005.24	2162.16	2367.14	2540.16
1689.34	1833.62	1982.45	2151.77	**76**	2048.00	2223.94	2435.47	2609.15
1701.00	1861.70	2013.34	2182.95	**77**	2083.97	2281.03	2500.06	2674.35
1712.66	1890.72	2044.22	2214.14	**78**	2119.93	2340.00	2564.64	2739.56
1724.33	1919.74	2076.05	2246.27	**79**	2154.92	2399.90	2632.03	2807.60
1735.02	1948.75	2106.94	2277.45	**80**	2169.50	2435.47	2670.41	2846.34
1752.52	1968.41	2128.46	2300.13	**81**	2190.89	2459.81	2697.55	2874.69
1770.01	1988.06	2149.99	2322.81	**82**	2213.24	2484.14	2724.70	2903.04
1787.51	2007.72	2171.52	2346.44	**83**	2235.60	2509.42	2751.84	2932.34
1805.00	2027.38	2193.05	2370.06	**84**	2257.96	2534.69	2778.98	2961.63
1823.47	2047.97	2214.58	2393.69	**85+**	2280.31	2559.96	2807.06	2990.93

Policies may be issued on an annual, semi-annual, quarterly or monthly mode. To obtain semi-annual premiums, multiply the above-quoted premium by 0.52, for quarterly premiums, multiply the above-quoted premium by 0.265 and for monthly premiums, multiply the above-quoted premium by 0.085.

Add one-time enrollment fee of $25.00 to the first premium.

MEDICARE SUPPLEMENT

GEORGIA

Issue Age Rates -- Effective 11/1/2009 -- Area 1 (304-312, 316-319, 398)

STANDARD ANNUAL RATES

FEMALE RATES					MALE RATES			
Plan A	Plan H	Plan I	Plan J	Issue Age	Plan A	Plan H	Plan I	Plan J
				Under 65				
1769.04	1833.39	1962.09	2168.78	**65**	1968.30	2039.31	2203.11	2412.11
1808.29	1873.99	2010.06	2216.86	**66**	2012.04	2084.59	2255.76	2465.63
1847.53	1914.59	2058.03	2264.93	**67**	2055.78	2129.87	2309.58	2519.13
1886.90	1955.07	2104.83	2312.89	**68**	2099.52	2175.03	2362.23	2572.76
1914.84	1994.85	2149.29	2357.78	**69**	2155.41	2244.06	2440.62	2651.91
1944.00	2034.63	2193.75	2402.66	**70**	2211.30	2315.43	2520.18	2732.23
1978.02	2081.43	2245.23	2454.64	**71**	2275.70	2393.82	2609.10	2822.01
2013.26	2128.23	2297.88	2507.79	**72**	2340.09	2474.55	2701.53	2915.33
2042.42	2170.35	2343.51	2553.86	**73**	2399.63	2550.60	2786.94	3001.56
2065.50	2213.64	2394.99	2605.84	**74**	2453.09	2627.82	2878.20	3093.69
2088.59	2252.25	2434.77	2646.00	**75**	2506.55	2702.70	2958.93	3175.20
2111.67	2292.03	2478.06	2689.71	**76**	2560.01	2779.92	3044.34	3261.43
2126.25	2327.13	2516.67	2728.69	**77**	2604.96	2851.29	3125.07	3342.94
2140.83	2363.40	2555.28	2767.67	**78**	2649.92	2925.00	3205.80	3424.44
2155.41	2399.67	2595.06	2807.83	**79**	2693.66	2999.88	3290.04	3509.49
2168.78	2435.94	2633.67	2846.81	**80**	2711.88	3044.34	3338.01	3557.93
2190.65	2460.51	2660.58	2875.16	**81**	2738.61	3074.76	3371.94	3593.36
2212.52	2485.08	2687.49	2903.51	**82**	2766.56	3105.18	3405.87	3628.80
2234.39	2509.65	2714.40	2933.04	**83**	2794.50	3136.77	3439.80	3665.42
2256.26	2534.22	2741.31	2962.58	**84**	2822.45	3168.36	3473.73	3702.04
2279.34	2559.96	2768.22	2992.11	**85+**	2850.39	3199.95	3508.83	3738.66

Policies may be issued on an annual, semi-annual, quarterly or monthly mode. To obtain semi-annual premiums, multiply the above-quoted premium by 0.52, for quarterly premiums, multiply the above-quoted premium by 0.265 and for monthly premiums, multiply the above-quoted premium by 0.085.

Add one-time enrollment fee of $25.00 to the first premium.

MEDICARE SUPPLEMENT

GEORGIA

Issue Age Rates -- Effective 11/1/2009 -- Area 2 (300-303, 313-315, 399)

PREFERRED PLUS ANNUAL RATES

FEMALE RATES					MALE RATES			
Plan A	Plan H	Plan I	Plan J	Issue Age	Plan A	Plan H	Plan I	Plan J
				Under 65				
1572.48	1629.68	1744.08	1927.80	65	1749.60	1812.72	1958.32	2144.10
1572.48	1629.68	1744.08	1927.80	66	1749.60	1812.72	1958.32	2144.10
1572.48	1629.68	1744.08	1927.80	67	1749.60	1812.72	1958.32	2144.10
1572.48	1629.68	1744.08	1927.80	68	1749.60	1812.72	1958.32	2144.10
1595.70	1662.38	1791.08	1964.81	69	1796.18	1870.06	2033.86	2209.92
1620.00	1695.52	1828.12	2002.22	70	1842.75	1929.52	2100.16	2276.86
1648.35	1734.52	1871.02	2045.54	71	1896.42	1994.86	2174.26	2351.67
1677.72	1773.52	1914.90	2089.83	72	1950.08	2062.12	2251.28	2429.44
1702.02	1808.62	1952.92	2128.22	73	1999.68	2125.50	2322.46	2501.30
1721.25	1844.70	1995.82	2171.54	74	2044.23	2189.86	2398.50	2578.08
1740.48	1876.88	2028.98	2205.00	75	2088.78	2252.26	2465.78	2646.00
1759.73	1910.02	2065.06	2241.42	76	2133.33	2316.60	2536.96	2717.86
1771.88	1939.28	2097.22	2273.91	77	2170.80	2376.08	2604.22	2785.79
1784.03	1969.50	2129.40	2306.39	78	2208.27	2437.50	2671.50	2853.70
1796.18	1999.72	2162.56	2339.86	79	2244.72	2499.90	2741.70	2924.58
1807.32	2029.96	2194.72	2372.35	80	2259.90	2536.96	2781.68	2964.94
1825.53	2050.42	2217.16	2395.97	81	2282.18	2562.30	2809.96	2994.47
1843.77	2070.90	2239.58	2419.60	82	2305.47	2587.66	2838.22	3024.00
1861.98	2091.38	2262.00	2444.20	83	2328.75	2613.98	2866.50	3054.51
1880.22	2111.86	2284.42	2468.81	84	2352.03	2640.30	2894.78	3085.04
1899.45	2133.30	2306.86	2493.42	85+	2375.33	2666.62	2924.02	3115.55

Policies may be issued on an annual, semi-annual, quarterly or monthly mode. To obtain semi-annual premiums, multiply the above-quoted premium by 0.52, for quarterly premiums, multiply the above-quoted premium by 0.265 and for monthly premiums, multiply the above-quoted premium by 0.085.

Add one-time enrollment fee of $25.00 to the first premium.

MEDICARE SUPPLEMENT

GEORGIA

Issue Age Rates -- Effective 11/1/2009 -- Area 2 (300-303, 313-315, 399)

PREFERRED ANNUAL RATES

FEMALE RATES					MALE RATES			
Plan A	Plan H	Plan I	Plan J	Issue Age	Plan A	Plan H	Plan I	Plan J
				Under 65				
1572.48	1629.68	1744.08	1927.80	65	1749.60	1812.72	1958.32	2144.10
1607.36	1665.77	1786.72	1970.54	66	1788.48	1852.97	2005.12	2191.67
1642.25	1701.86	1829.36	2013.27	67	1827.36	1893.22	2052.96	2239.23
1677.24	1737.84	1870.96	2055.90	68	1866.24	1933.36	2099.76	2286.90
1702.08	1773.20	1910.48	2095.80	69	1915.92	1994.72	2169.44	2357.25
1728.00	1808.56	1950.00	2135.70	70	1965.60	2058.16	2240.16	2428.65
1758.24	1850.16	1995.76	2181.90	71	2022.84	2127.84	2319.20	2508.45
1789.56	1891.76	2042.56	2229.15	72	2080.08	2199.60	2401.36	2591.40
1815.48	1929.20	2083.12	2270.10	73	2133.00	2267.20	2477.28	2668.05
1836.00	1967.68	2128.88	2316.30	74	2180.52	2335.84	2558.40	2749.95
1856.52	2002.00	2164.24	2352.00	75	2228.04	2402.40	2630.16	2822.40
1877.04	2037.36	2202.72	2390.85	76	2275.56	2471.04	2706.08	2899.05
1890.00	2068.56	2237.04	2425.50	77	2315.52	2534.48	2777.84	2971.50
1902.96	2100.80	2271.36	2460.15	78	2355.48	2600.00	2849.60	3043.95
1915.92	2133.04	2306.72	2495.85	79	2394.36	2666.56	2924.48	3119.55
1927.80	2165.28	2341.04	2530.50	80	2410.56	2706.08	2967.12	3162.60
1947.24	2187.12	2364.96	2555.70	81	2434.32	2733.12	2997.28	3194.10
1966.68	2208.96	2388.88	2580.90	82	2459.16	2760.16	3027.44	3225.60
1986.12	2230.80	2412.80	2607.15	83	2484.00	2788.24	3057.60	3258.15
2005.56	2252.64	2436.72	2633.40	84	2508.84	2816.32	3087.76	3290.70
2026.08	2275.52	2460.64	2659.65	85+	2533.68	2844.40	3118.96	3323.25

Policies may be issued on an annual, semi-annual, quarterly or monthly mode. To obtain semi-annual premiums, multiply the above-quoted premium by 0.52, for quarterly premiums, multiply the above-quoted premium by 0.265 and for monthly premiums, multiply the above-quoted premium by 0.085.

Add one-time enrollment fee of $25.00 to the first premium.

MEDICARE SUPPLEMENT

GEORGIA

Issue Age Rates -- Effective 11/1/2009 -- Area 2 (300-303, 313-315, 399)

STANDARD ANNUAL RATES

FEMALE RATES					MALE RATES			
Plan A	Plan H	Plan I	Plan J	Issue Age	Plan A	Plan H	Plan I	Plan J
				Under 65				
1965.60	2037.10	2180.10	2409.75	65	2187.00	2265.90	2447.90	2680.13
2009.21	2082.22	2233.40	2463.17	66	2235.60	2316.22	2506.40	2739.59
2052.81	2127.32	2286.70	2516.59	67	2284.20	2366.52	2566.20	2799.04
2096.55	2172.30	2338.70	2569.88	68	2332.80	2416.70	2624.70	2858.63
2127.60	2216.50	2388.10	2619.75	69	2394.90	2493.40	2711.80	2946.56
2160.00	2260.70	2437.50	2669.63	70	2457.00	2572.70	2800.20	3035.81
2197.80	2312.70	2494.70	2727.38	71	2528.55	2659.80	2899.00	3135.56
2236.95	2364.70	2553.20	2786.44	72	2600.10	2749.50	3001.70	3239.25
2269.35	2411.50	2603.90	2837.63	73	2666.25	2834.00	3096.60	3335.06
2295.00	2459.60	2661.10	2895.38	74	2725.65	2919.80	3198.00	3437.44
2320.65	2502.50	2705.30	2940.00	75	2785.05	3003.00	3287.70	3528.00
2346.30	2546.70	2753.40	2988.56	76	2844.45	3088.80	3382.60	3623.81
2362.50	2585.70	2796.30	3031.88	77	2894.40	3168.10	3472.30	3714.38
2378.70	2626.00	2839.20	3075.19	78	2944.35	3250.00	3562.00	3804.94
2394.90	2666.30	2883.40	3119.81	79	2992.95	3333.20	3655.60	3899.44
2409.75	2706.60	2926.30	3163.13	80	3013.20	3382.60	3708.90	3953.25
2434.05	2733.90	2956.20	3194.63	81	3042.90	3416.40	3746.60	3992.63
2458.35	2761.20	2986.10	3226.13	82	3073.95	3450.20	3784.30	4032.00
2482.65	2788.50	3016.00	3258.94	83	3105.00	3485.30	3822.00	4072.69
2506.95	2815.80	3045.90	3291.75	84	3136.05	3520.40	3859.70	4113.38
2532.60	2844.40	3075.80	3324.56	85+	3167.10	3555.50	3898.70	4154.06

Policies may be issued on an annual, semi-annual, quarterly or monthly mode. To obtain semi-annual premiums, multiply the above-quoted premium by 0.52, for quarterly premiums, multiply the above-quoted premium by 0.265 and for monthly premiums, multiply the above-quoted premium by 0.085.

Add one-time enrollment fee of $25.00 to the first premium.

Locate the appropriate Area according to the applicant's ZIP code in the ZIP code chart below.

GEORGIA	**ZIP CODES:**
Area	3 Digit ZIP Codes
Area 1	304-312, 316-319, 398
Area 2	300-303, 313-315, 399

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PREMIUM INFORMATION
We, Loyal American Life Insurance Company, can raise your premium if (a) we change the premium rates which apply to all policies of this form issued by Us and in-force in your state; (b) coverage under Medicare changes; or (c) you move to a different ZIP code location. We will send you a written notice at least 60 days in advance when we change the premium rates for all policies of this form issued by us and in-force in your state.

There will be a one-time enrollment fee of $25.00 added to the first premium.

DISCLOSURES
Use this Outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY
This is only an Outline, describing Your Policy's most important features. The Policy is Your insurance contract. You must read the Policy itself to understand all of the rights and duties of both You and Your insurance company.

30-DAY RIGHT TO RETURN POLICY
If You find that You are not satisfied with Your Policy, You may return it to Loyal American Life Insurance Company, P.O. Box 559004, Austin, Texas 78755-9004. 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 premiums.

POLICY REPLACEMENT
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
This Policy may not fully cover all of Your medical costs. Neither Loyal American Life Insurance Company nor its agents are connected with Medicare. This Outline of Coverage does not give all the details of Medicare coverage. Contact Your local Social Security Office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT
When You fill out the application for the new Policy, be sure to answer truthfully and completely all questions about Your medical and health history. The Company may cancel Your Policy and refuse to pay any claims if You leave out or falsify important medical information.

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

RENEWABILITY
This Policy is guaranteed renewable for life.

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 A PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1100	$0	$1100 (Part A Deductible)
61st thru 90th day	All but $275 a day	$275 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $550 a day	$550 a day	$0
• Once lifetime reserves days are used:			
- Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
- Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $137.50 a day	$0	Up to $137.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as Your doctor certifies You are terminally ill and You elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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 $155 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 A PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $155 of Medicare-approved amounts* (the Part B Deductible)	$0	$0	$155 (Part B Deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $155 of Medicare-approved amounts*	$0	$0	$155 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment			
First $155 of Medicare-approved amounts*	$0	$0	$155 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN H

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

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

SERVICES	MEDICARE PAYS	PLAN H PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1100	$1100 (Part A Deductible)	$0
61st thru 90th day	All but $275 a day	$275 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $550 a day	$550 a day	$0
• Once lifetime reserves days are used:			
- Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
- Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $137.50 a day	Up to $137.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as Your doctor certifies You are terminally ill and You elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

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

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

* Once you have been billed $155 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 H PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $155 of Medicare-approved amounts* (the Part B Deductible)	$0	$0	$155 (Part B Deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $155 of Medicare-approved amounts*	$0	$0	$155 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN H PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment			
First $155 of Medicare-approved amounts*	$0	$0	$155 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN H

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

* Once you have been billed $155 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.

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services 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 I
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN I PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1100	$1100 (Part A Deductible)	$0
61st thru 90th day	All but $275 a day	$275 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $550 a day	$550 a day	$0
• Once lifetime reserves days are used:			
- Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
- Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $137.50 a day	Up to $137.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as Your doctor certifies You are terminally ill and You elect to receive these services	All but very limited co-insurance for outpatient drugs and inpatient respite care	$0	Balance

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

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

* Once you have been billed $155 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 I PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $155 of Medicare-approved amounts* (the Part B Deductible)	$0	$0	$155 (Part B Deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $155 of Medicare-approved amounts*	$0	$0	$155 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN I PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment			
First $155 of Medicare-approved amounts*	$0	$0	$155 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN I

PARTS A & B

AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare-approved a home care treatment plan			
• Benefit for each visit	$0	Actual charges to $40 a visit	Balance
• Number of visits covered (must be received within 8 weeks of last Medicare-approved visit)	$0	Up to the number of Medicare-approved visits, not to exceed 7 each week	Balance
Calendar year maximum	$0	$1,600	Balance

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

PLAN J
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 J PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1100	$1100 (Part A Deductible)	$0
61st thru 90th day	All but $275 a day	$275 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $550 a day	$550 a day	$0
• Once lifetime reserves days are used:			
- Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
- Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $137.50 a day	Up to $137.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as Your doctor certifies You are terminally ill and You elect to receive these services	All but very limited co-insurance for outpatient drugs and inpatient respite care	$0	Balance

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

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

* Once you have been billed $155 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 J PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $155 of Medicare-approved amounts* (the Part B Deductible)	$0	$155 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $155 of Medicare-approved amounts*	$0	$155 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN J PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment			
First $155 of Medicare-approved amounts*	$0	$155 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN J

PARTS A & B

AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare-approved a home care treatment plan			
• Benefit for each visit	$0	Actual charges to $40 a visit	Balance
• Number of visits covered (must be received within 8 weeks of last Medicare-approved visit)	$0	Up to the number of Medicare-approved visits, not to exceed 7 each week	Balance
Calendar year maximum	$0	$1,600	Balance

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services 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
*******PREVENTIVE MEDICAL CARE BENEFIT – NOT COVERED BY MEDICARE** Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0*
Additional charges	$0	$0	All costs

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