



A Member of the American National Family of Companies

Standard Life and Accident Insurance Company

P.O. Box 1820, Galveston, TX 77553-1820, 888.350.1488

**Outline of Medicare Supplement Coverage — Cover Page: 1 of 2  
Benefit Plans A, B, C, D, E, F, F(HD) and G**

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	Basic Benefits
		Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	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	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	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
<b>Policy Form 125A-497</b>	<b>Policy Form 125B-497</b>	<b>Policy Form 125C-497</b>	<b>Policy Form 125D-299</b>	<b>Policy Form 125E-499</b>	<b>Policy Forms 125F-497 125F(HD)-499</b>		<b>Policy Form 125G-499</b>				

\*Plans F and J also have an option called a high deductible Plan F and a high deductible Plan J. These high deductible plans pay the same benefits as Plans F and J after one has paid a calendar year \$2000 deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses exceed \$2000. 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.

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**Outline of Medicare Supplement Coverage —  
Cover Page: 2 of 2**

**BASIC BENEFITS** (For Plans K and L) —  
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.

<b>K**</b>	<b>L**</b>	
100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End	
50% Hospice cost-sharing	75% Hospice cost-sharing	
50% of Medicare-eligible expenses for the first three pints of blood	75% of Medicare-eligible expenses for the first three pints of blood	
50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	
50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	
50% Part A Deductible	75% Part A Deductible	
\$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 Outlines of Coverage for details and exceptions.

## PREMIUMS FOR STANDARD LIFE MEDICARE SUPPLEMENT PLAN A, PLAN B, PLAN C AND PLAN D

PLAN A				
ATTAINED AGE	ANNUAL	SEMI-ANNUAL	QUARTERLY	PAC
65	\$1,448.47	\$ 753.20	\$391.09	\$126.74
66	1,499.29	779.63	404.81	131.19
67	1,552.65	807.38	419.22	135.86
68	1,608.55	836.45	434.31	140.75
69	1,661.94	864.21	448.72	145.42
70	1,712.76	890.64	462.45	149.87
71	1,766.12	918.38	476.85	154.54
72	1,816.95	944.81	490.58	158.98
73	1,862.68	968.59	502.92	162.98
74	1,910.96	993.70	515.96	167.21
75	1,956.71	1,017.49	528.31	171.21
76	2,007.54	1,043.92	542.04	175.66
77	2,048.18	1,065.05	553.01	179.22
78	2,088.86	1,086.21	563.99	182.78
79	2,129.50	1,107.34	574.97	186.33
80+	2,172.71	1,129.81	586.63	190.11

PLAN B					
ATTAINED AGE	ANNUAL	SEMI-ANNUAL	QUARTERLY	PAC	ATTAINED AGE
65	\$2,320.35	\$1,206.58	\$626.49	\$203.03	65
66	2,402.18	1,249.13	648.59	210.19	66
67	2,484.00	1,291.68	670.68	217.35	67
68	2,571.67	1,337.27	694.35	225.02	68
69	2,659.35	1,382.86	718.02	232.69	69
70	2,741.16	1,425.40	740.11	239.85	70
71	2,825.90	1,469.47	762.99	247.27	71
72	2,907.75	1,512.03	785.09	254.43	72
73	2,980.79	1,550.01	804.81	260.82	73
74	3,053.86	1,588.01	824.54	267.21	74
75	3,132.76	1,629.04	845.85	274.12	75
76	3,211.69	1,670.08	867.16	281.02	76
77	3,273.04	1,701.98	883.72	286.39	77
78	3,340.27	1,736.94	901.87	292.27	78
79	3,407.47	1,771.88	920.02	298.15	79
80+	3,474.69	1,806.84	938.17	304.04	80+

PLAN C				
ATTAINED AGE	ANNUAL	SEMI-ANNUAL	QUARTERLY	PAC
65	\$2,637.52	\$1,371.51	\$ 712.13	\$230.78
66	2,730.26	1,419.74	737.17	238.90
67	2,825.72	1,469.37	762.94	247.25
68	2,926.64	1,521.85	790.19	256.08
69	3,027.55	1,574.33	817.44	264.91
70	3,120.29	1,622.55	842.48	273.03
71	3,213.00	1,670.76	867.51	281.14
72	3,311.21	1,721.83	894.03	289.73
73	3,393.04	1,764.38	916.12	296.89
74	3,480.33	1,809.77	939.69	304.53
75	3,564.87	1,853.73	962.51	311.93
76	3,654.88	1,900.54	986.82	319.80
77	3,728.53	1,938.84	1,006.70	326.25
78	3,802.17	1,977.13	1,026.59	332.69
79	3,878.55	2,016.85	1,047.21	339.37
80+	3,954.91	2,056.55	1,067.83	346.05

PLAN D					
ATTAINED AGE	ANNUAL	SEMI-ANNUAL	QUARTERLY	PAC	ATTAINED AGE
65	\$2,098.72	\$1,091.33	\$ 566.65	\$183.64	65
66	2,152.10	1,119.09	581.07	188.31	66
67	2,227.37	1,158.23	601.39	194.89	67
68	2,305.95	1,199.09	622.61	201.77	68
69	2,398.77	1,247.36	647.67	209.89	69
70	2,491.25	1,295.45	672.64	217.98	70
71	2,590.01	1,346.81	699.30	226.63	71
72	2,695.00	1,401.40	727.65	235.81	72
73	2,811.85	1,462.16	759.20	246.04	73
74	2,943.30	1,530.52	794.69	257.54	74
75	3,074.42	1,598.70	830.09	269.01	75
76	3,212.45	1,670.47	867.36	281.09	76
77	3,362.05	1,748.27	907.75	294.18	77
78	3,517.26	1,828.98	949.66	307.76	78
79	3,678.74	1,912.94	993.26	321.89	79
80+	3,852.42	2,003.26	1,040.15	337.09	80+

PREMIUMS FOR STANDARD LIFE MEDICARE SUPPLEMENT PLAN E, PLAN F, PLAN F (HIGH DEDUCTIBLE) AND PLAN G

PLAN E				
ATTAINED AGE	ANNUAL	SEMI-ANNUAL	QUARTERLY	PAC
65	\$1,748.25	\$ 909.09	\$472.03	\$152.97
66	1,809.76	941.08	488.64	158.35
67	1,873.03	973.98	505.72	163.89
68	1,938.00	1,007.76	523.26	169.58
69	2,006.56	1,043.41	541.77	175.57
70	2,066.30	1,074.48	557.90	180.80
71	2,129.55	1,107.37	574.98	186.34
72	2,192.80	1,140.26	592.06	191.87
73	2,249.03	1,169.50	607.24	196.79
74	2,303.51	1,197.83	621.95	201.56
75	2,361.49	1,227.97	637.60	206.63
76	2,419.46	1,258.12	653.25	211.70
77	2,468.66	1,283.70	666.54	216.01
78	2,517.84	1,309.28	679.82	220.31
79	2,568.80	1,335.78	693.58	224.77
80+	2,621.52	1,363.19	707.81	229.38

PLAN F				
ANNUAL	SEMI-ANNUAL	QUARTERLY	PAC	ATTAINED AGE
\$2,680.16	\$1,393.68	\$ 723.64	\$234.51	65
2,774.46	1,442.72	749.10	242.77	66
2,871.41	1,493.13	775.28	251.25	67
2,971.10	1,544.97	802.20	259.97	68
3,076.14	1,599.59	830.56	269.16	69
3,167.72	1,647.21	855.28	277.18	70
3,264.70	1,697.64	881.47	285.66	71
3,361.66	1,748.06	907.65	294.15	72
3,447.86	1,792.89	930.92	301.69	73
3,531.38	1,836.32	953.47	309.00	74
3,620.24	1,882.52	977.46	316.77	75
3,709.15	1,928.76	1,001.47	324.55	76
3,784.57	1,967.98	1,021.83	331.15	77
3,860.00	2,007.20	1,042.20	337.75	78
3,938.10	2,047.81	1,063.29	344.58	79
4,018.91	2,089.83	1,085.11	351.65	80+

PLAN F (HIGH DEDUCTIBLE)				
ATTAINED AGE	ANNUAL	SEMI-ANNUAL	QUARTERLY	PAC
\$163.93	\$ 85.24	\$44.26	\$14.34	65
169.69	88.24	45.82	14.85	66
175.62	91.32	47.42	15.37	67
181.71	94.49	49.06	15.90	68
188.14	97.83	50.80	16.46	69
193.73	100.74	52.31	16.95	70
199.67	103.83	53.91	17.47	71
205.60	106.91	55.51	17.99	72
210.87	109.65	56.93	18.45	73
215.98	112.31	58.31	18.90	74
221.42	115.14	59.78	19.37	75
226.85	117.96	61.25	19.85	76
231.46	120.36	62.49	20.25	77
236.08	122.76	63.74	20.66	78
240.85	125.24	65.03	21.07	79
245.79	127.81	66.36	21.51	80+

PLAN G				
ANNUAL	SEMI-ANNUAL	QUARTERLY	PAC	ATTAINED AGE
\$1,875.12	\$ 975.06	\$506.28	\$164.07	65
1,941.08	1,009.36	524.09	169.84	66
2,008.91	1,044.63	542.41	175.78	67
2,077.17	1,080.13	560.84	181.75	68
2,145.65	1,115.74	579.33	187.74	69
2,215.04	1,151.82	598.06	193.82	70
2,290.13	1,190.87	618.34	200.39	71
2,372.22	1,233.55	640.50	207.57	72
2,458.38	1,278.36	663.76	215.11	73
2,555.54	1,328.88	690.00	223.61	74
2,657.17	1,381.73	717.44	232.50	75
2,761.90	1,436.19	745.71	241.67	76
2,874.55	1,494.77	776.13	251.52	77
2,993.81	1,556.78	808.33	261.96	78
3,123.22	1,624.07	843.27	273.28	79
3,260.15	1,695.28	880.24	285.26	80+

## **PREMIUM INFORMATION**

We, Standard Life and Accident Insurance Company, can only raise your premium if we raise the premium for all policies like yours in this state. The premiums of this policy are based on attained age rating. "Attained Age Rating" means that rates increase as you age or as you cross over into a different age group. Premiums for other Medicare Supplement policies that are issue age rated do not increase as the insured ages. Other Medicare Supplement policies that are issue age rated should be compared to policies that are attained age rated.

## **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.

## **RIGHT TO RETURN POLICY**

If you find that you are not satisfied with your policy, you may return it to Standard Life at the following address:

Standard Life and Accident  
Insurance Company  
P.O. Box 1820  
Galveston, TX 77553-1820

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**

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 Standard Life 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 *Guide to Health Insurance for People with Medicare* 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.

**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.

PLAN A			
SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p><b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous service and supplies:</p> <p>First 60 days</p> <p>61st thru 90th day</p> <p>91st day and after:</p> <ul style="list-style-type: none"> <li>— While using 60 lifetime reserve days</li> <li>— Once lifetime reserve days are used:                             <ul style="list-style-type: none"> <li>— Additional 365 days</li> </ul> </li> </ul>	<p>All but \$1,068</p> <p>All but \$267 a day</p> <p>All but \$534 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$267 a day</p> <p>\$534 a day</p> <p>100% of Medicare Eligible Expenses</p>	<p>\$1,068 (Part A Deductible)</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p>
<p><b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$133.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$133.50 a day</p> <p>All costs</p>
<p><b>BLOOD</b></p> <p>First 3 pints</p> <p>Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p><b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited co-insurance for outpatient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance</p>

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

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

\*Once you have been billed \$135 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.

**PLAN A**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES —</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment: First \$135 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$135 (Part B Deductible) \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare-Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next \$135 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$135 (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES —</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First \$135 of Medicare-Approved Amounts* — Remainder of Medicare-Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$135 (Part B Deductible) \$0
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**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.

**PLAN B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous service and supplies: First 60 days 61st thru 90th day 91st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the Additional 365 days	All but \$1,068 All but \$267 a day All but \$534 a day \$0 \$0	\$1,068 (Part A Deductible) \$267 a day \$534 a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0** All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$133.50 a day \$0	\$0 \$0 \$0	\$0 Up to \$133.50 a day All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited 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 the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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

\*Once you have been billed \$135 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.

**PLAN B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES —</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment: First \$135 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$135 (Part B Deductible) \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare-Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next \$135 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$135 (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES —</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First \$135 of Medicare-Approved Amounts* — Remainder of Medicare-Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$135 (Part B Deductible) \$0
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**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.

**PLAN C**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous service and supplies: First 60 days 61st thru 90th day 91st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the Additional 365 days	All but \$1,068 All but \$267 a day All but \$534 a day \$0 \$0	\$1,068 (Part A Deductible) \$267 a day \$534 a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0** All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$133.50 a day \$0	\$0 Up to \$133.50 a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited 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 the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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

\*Once you have been billed \$135 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.

**PLAN C**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES —</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment: First \$135 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$135 (Part B Deductible) Generally 20%	\$0 \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare-Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next \$135 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All costs \$135 (Part B Deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES —</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First \$135 of Medicare-Approved Amounts* — Remainder of Medicare-Approved Amounts	100% \$0 80%	\$0 \$135 (Part B Deductible) 20%	\$0 \$0 \$0
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**OTHER BENEFITS — NOT COVERED BY MEDICARE**

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

**PLAN D**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous service and supplies: First 60 days 61st thru 90th day 91st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the Additional 365 days	All but \$1,068 All but \$267 a day All but \$534 a day \$0 \$0	\$1,068 (Part A Deductible) \$267 a day \$534 a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0** All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$133.50 a day \$0	\$0 Up to \$133.50 a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited 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 the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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

\*Once you have been billed \$135 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.

**PLAN D**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES —</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment: First \$135 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$135 (Part B Deductible) \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare-Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next \$135 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$135 (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES —</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

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

\*Once you have been billed \$135 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.

**PARTS A & B****PLAN D**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES:			
— Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment			
First \$135 of Medicare-Approved Amounts*	\$0	\$0	\$135 (Part B Deductible)
— Remainder of Medicare-Approved Amounts	80%	20%	\$0
<b>AT-HOME RECOVERY SERVICES — NOT COVERED BY MEDICARE</b> Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan:			
— Benefit for each visit	\$0	Actual charges to \$40 a visit	Balance
— Number of visits covered (Must be received within 8 weeks of last Medicare-approved visit)	\$0	Up to the number of Medicare-approved visits, not to exceed 7 each week	
— Calendar year maximum	\$0	\$1,600	

**OTHER BENEFITS — NOT COVERED BY MEDICARE**

<b>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

**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.

**PLAN E**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous service and supplies: First 60 days 61st thru 90th day 91st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the Additional 365 days	All but \$1,068 All but \$267 a day All but \$534 a day \$0 \$0	\$1,068 (Part A Deductible) \$267 a day \$534 a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0** All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$133.50 a day \$0	\$0 Up to \$133.50 a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited 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 the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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

\*Once you have been billed \$135 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.

**PLAN E**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES —</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment: First \$135 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$135 (Part B Deductible) \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare-Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next \$135 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$135 (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES —</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First \$135 of Medicare-Approved Amounts* — Remainder of Medicare-Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$135 (Part B Deductible) \$0
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**MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR**

**OTHER BENEFITS — NOT COVERED BY MEDICARE**

**PLAN E**

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

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

**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.

**PLAN F**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous service and supplies: First 60 days 61st thru 90th day 91st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the Additional 365 days	All but \$1,068 All but \$267 a day All but \$534 a day \$0 \$0	\$1,068 (Part A Deductible) \$267 a day \$534 a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0** All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$133.50 a day \$0	\$0 Up to \$133.50 a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited 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 the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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

\*Once you have been billed \$135 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.

**PLAN F**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES —</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment: First \$135 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$135 (Part B Deductible) Generally 20%	\$0 \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare-Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$135 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All costs \$135 (Part B Deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES —</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First \$135 of Medicare-Approved Amounts* — Remainder of Medicare-Approved Amounts	100% \$0 80%	\$0 \$135 (Part B Deductible) 20%	\$0 \$0 \$0
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**OTHER BENEFITS — NOT COVERED BY MEDICARE**

<b>FOREIGN TRAVEL —</b> <b>NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
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**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 \$2,000 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$2,000. 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.

**PLAN F (HIGH DEDUCTIBLE)**

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,000 DEDUCTIBLE† PLAN PAYS	IN ADDITION TO \$2,000 DEDUCTIBLE† YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous service and supplies: First 60 days 61st thru 90th day 91st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the Additional 365 days	All but \$1,068 All but \$267 a day All but \$534 a day \$0 \$0	\$1,068 (Part A Deductible) \$267 a day \$534 a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0** All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$133.50 a day \$0	\$0 Up to \$133.50 a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited 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 the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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

\*Once you have been billed \$135 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

† This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2,000 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$2,000. 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.

**PLAN F (HIGH DEDUCTIBLE)**

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,000 DEDUCTIBLE† PLAN PAYS	IN ADDITION TO \$2,000 DEDUCTIBLE† YOU PAY
<b>MEDICAL EXPENSES —</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment: First \$135 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$135 (Part B Deductible) Generally 20%	\$0 \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare-Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$135 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All costs \$135 (Part B Deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES —</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

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

\*Once you have been billed \$135 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

† This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2,000 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$2,000. 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.

**PARTS A & B**

**PLAN F (HIGH DEDUCTIBLE)**

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,000 DEDUCTIBLE† PLAN PAYS	IN ADDITION TO \$2,000 DEDUCTIBLE† YOU PAY
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment			
First \$135 of Medicare-Approved Amounts*	\$0	\$135 (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

**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.

**PLAN G**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous service and supplies: First 60 days 61st thru 90th day 91st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the Additional 365 days	All but \$1,068 All but \$267 a day All but \$534 a day \$0 \$0	\$1,068 (Part A Deductible) \$267 a day \$534 a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0** All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$133.50 a day \$0	\$0 Up to \$133.50 a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited 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 the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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

\*Once you have been billed \$135 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.

**PLAN G**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES —</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment: First \$135 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$135 (Part B Deductible) \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare-Approved Amounts)	\$0	80%	20%
<b>BLOOD</b> First 3 pints Next \$135 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$135 (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES —</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

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

\*Once you have been billed \$135 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.

**PARTS A & B****PLAN G**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b>			
MEDICARE APPROVED SERVICES:			
— Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment First \$135 of Medicare-Approved Amounts*	\$0	\$0	\$135 (Part B Deductible)
— Remainder of Medicare-Approved Amounts	80%	20%	\$0
<b>AT-HOME RECOVERY SERVICES — NOT COVERED BY MEDICARE</b>			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan:			
— Benefit for each visit	\$0	Actual charges to \$40 a visit	Balance
— Number of visits covered (Must be received within 8 weeks of last Medicare-approved visit)	\$0	Up to the number of Medicare-approved visits, not to exceed 7 each week	
— Calendar year maximum	\$0	\$1,600	

**OTHER BENEFITS — NOT COVERED BY MEDICARE**

<b>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

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