



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 and F**

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 | 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%) | 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 | At-Home Recovery |
| | | | | Preventive Care NOT Covered By Medicare | | | | | | | Preventive Care NOT Covered By Medicare |
| Policy Form 126A-597 | Policy Form 126B-597 | Policy Form 126C-597 | Policy Form 126D-299 | | Policy Forms 126F-597 | | | | | | |

*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.

| K** | L** | |
|---|---|--|
| 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, PLAN D AND PLAN F

| PLAN A | | | | |
|-----------|------------|-------------|-----------|----------|
| ISSUE AGE | ANNUAL | SEMI-ANNUAL | QUARTERLY | PAC |
| Under 65 | \$1,335.84 | \$694.64 | \$360.68 | \$116.89 |
| 65 | 1,207.21 | 627.75 | 325.95 | 105.63 |
| 66-69 | 1,261.26 | 655.86 | 340.54 | 110.36 |
| 70-74 | 1,372.97 | 713.94 | 370.70 | 120.13 |
| 75-79 | 1,398.20 | 727.06 | 377.51 | 122.34 |
| 80+ | 1,398.20 | 727.06 | 377.51 | 122.34 |

| PLAN B | | | | |
|------------|-------------|-----------|----------|-----------|
| ANNUAL | SEMI-ANNUAL | QUARTERLY | PAC | ISSUE AGE |
| \$2,319.38 | \$1,206.08 | \$626.23 | \$202.95 | Under 65 |
| 1,957.15 | 1,017.72 | 528.43 | 171.25 | 65 |
| 2,063.40 | 1,072.97 | 557.12 | 180.55 | 66-69 |
| 2,275.91 | 1,183.47 | 614.50 | 199.14 | 70-74 |
| 2,375.75 | 1,235.39 | 641.45 | 207.88 | 75-79 |
| 2,397.01 | 1,246.45 | 647.19 | 209.74 | 80+ |

| PLAN C | | | | |
|-----------|------------|-------------|------------|----------|
| ISSUE AGE | ANNUAL | SEMI-ANNUAL | QUARTERLY | PAC |
| Under 65 | \$3,810.05 | \$1,981.23 | \$1,028.71 | \$333.38 |
| 65 | 3,191.96 | 1,659.82 | 861.83 | 279.30 |
| 66-69 | 3,358.64 | 1,746.49 | 906.83 | 293.88 |
| 70-74 | 3,678.08 | 1,912.60 | 993.08 | 321.83 |
| 75-79 | 3,886.46 | 2,020.96 | 1,049.34 | 340.07 |
| 80+ | 3,966.98 | 2,062.83 | 1,071.08 | 347.11 |

| PLAN D | | | | |
|------------|-------------|-----------|----------|-----------|
| ANNUAL | SEMI-ANNUAL | QUARTERLY | PAC | ISSUE AGE |
| \$2,737.62 | \$1,423.56 | \$ 739.16 | \$239.54 | Under 65 |
| 2,276.09 | 1,183.57 | 614.54 | 199.16 | 65 |
| 2,496.99 | 1,298.43 | 674.19 | 218.49 | 66-69 |
| 2,998.65 | 1,559.30 | 809.64 | 262.38 | 70-74 |
| 3,613.24 | 1,878.88 | 975.57 | 316.16 | 75-79 |
| 3,868.81 | 2,011.78 | 1,044.58 | 338.52 | 80+ |

| PLAN F | | | | |
|-----------|------------|-------------|------------|----------|
| ISSUE AGE | ANNUAL | SEMI-ANNUAL | QUARTERLY | PAC |
| Under 65 | \$3,814.44 | \$1,983.51 | \$1,029.90 | \$333.76 |
| 65 | 3,324.91 | 1,728.95 | 897.73 | 290.93 |
| 66-69 | 3,499.45 | 1,819.71 | 944.85 | 306.20 |
| 70-74 | 3,834.45 | 1,993.91 | 1,035.30 | 335.51 |
| 75-79 | 4,045.63 | 2,103.73 | 1,092.32 | 353.99 |
| 80+ | 4,132.88 | 2,149.10 | 1,115.88 | 361.63 |

THIS SPACE IS LEFT INTENTIONALLY BLANK.

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.

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 |
|---|---|--|---|
| HOSPITALIZATION* 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 | \$0 \$267 a day \$534 a day 100% of Medicare Eligible Expenses \$0 | \$1,068 (Part A Deductible) \$0 \$0 \$0** All costs |
| SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 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 |
| BLOOD First 3 pints Additional amounts | \$0 100% | 3 pints \$0 | \$0 \$0 |
| HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services | All but very limited 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 A

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

PARTS A & B

| | | | |
|---|--------------------|-------------------|---|
| HOME HEALTH CARE 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 |
|---|--------------------|-------------------|---|

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 |
|---|---|--|--|
| HOSPITALIZATION* 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 |
| 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 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 |
| BLOOD First 3 pints Additional amounts | \$0 100% | 3 pints \$0 | \$0 \$0 |
| HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services | All but very limited 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 |
|---|----------------------|-------------------------|---|
| 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 \$135 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts | \$0 Generally 80% | \$0 Generally 20% | \$135 (Part B Deductible) \$0 |
| PART B EXCESS CHARGES (Above Medicare-Approved Amounts) | \$0 | \$0 | All costs |
| BLOOD 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 |
| CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES | 100% | \$0 | \$0 |

PARTS A & B

| | | | |
|---|--------------------|-------------------|---|
| HOME HEALTH CARE 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 |
|---|--------------------|-------------------|---|

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 |
|---|---|--|---|
| HOSPITALIZATION* 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 |
| 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 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 |
| BLOOD First 3 pints Additional amounts | \$0 100% | 3 pints \$0 | \$0 \$0 |
| HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services | All but very limited 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 |
|---|----------------------|---|-------------------|
| 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 \$135 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts | \$0 Generally 80% | \$135 (Part B Deductible) Generally 20% | \$0 \$0 |
| PART B EXCESS CHARGES (Above Medicare-Approved Amounts) | \$0 | \$0 | All costs |
| BLOOD 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 |
| CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES | 100% | \$0 | \$0 |

PARTS A & B

| | | | |
|---|--------------------|---|-------------------|
| HOME HEALTH CARE 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 |
|---|--------------------|---|-------------------|

OTHER BENEFITS — NOT COVERED BY MEDICARE

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

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 |
|---|---|--|---|
| HOSPITALIZATION* 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 |
| 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 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 |
| BLOOD First 3 pints Additional amounts | \$0 100% | 3 pints \$0 | \$0 \$0 |
| HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services | All but very limited 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 |
|---|----------------------|-------------------------|---|
| 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 \$135 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts | \$0 Generally 80% | \$0 Generally 20% | \$135 (Part B Deductible) \$0 |
| PART B EXCESS CHARGES (Above Medicare-Approved Amounts) | \$0 | \$0 | All costs |
| BLOOD 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 |
| CLINICAL LABORATORY SERVICES — 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 |
|---|---------------------------|--|---|
| HOME HEALTH CARE 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 |
| 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 — Number of visits covered (Must be received within 8 weeks of last Medicare-approved visit) — Calendar year maximum | \$0 \$0 \$0 | Actual charges to \$40 a visit Up to the number of Medicare-approved visits, not to exceed 7 each week \$1,600 | Balance |

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

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 |
|---|---|--|---|
| HOSPITALIZATION* 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 |
| 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 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 |
| BLOOD First 3 pints Additional amounts | \$0 100% | 3 pints \$0 | \$0 \$0 |
| HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services | All but very limited 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 |
|---|----------------------|---|-------------------|
| 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 \$135 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts | \$0 Generally 80% | \$135 (Part B Deductible) Generally 20% | \$0 \$0 |
| PART B EXCESS CHARGES (Above Medicare-Approved Amounts) | \$0 | 100% | \$0 |
| BLOOD 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 |
| CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES | 100% | \$0 | \$0 |

PARTS A & B

| | | | |
|---|--------------------|---|-------------------|
| HOME HEALTH CARE 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 |
|---|--------------------|---|-------------------|

OTHER BENEFITS — NOT COVERED BY MEDICARE

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