



Thrivent Financial for Lutherans
4321 N. Ballard Road, Appleton, WI 54919-0001

Outline of Medicare Supplement Coverage

Benefit Chart of Medicare Supplement Plans sold on or after January 1, 2020

This chart shows the benefits included in each of the standardized Medicare supplement plans. Some plans may not be available. Only applicants first eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

Note: A ✓ means 100% of the benefit is paid.

Shaded plans represent those offered by Thrivent

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only			
	A	B	D	G	G ¹	K	L	M	N	C	F	F ¹
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓	✓
Blood (first three pints)	✓	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	✓	50%	75%	✓	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	✓	50%	75%	50%	✓	✓	✓	✓
Medicare Part B deductible										✓	✓	✓
Medicare Part B excess charges				✓	✓						✓	✓
Foreign travel emergency (up to plan limits)			✓	✓	✓			✓	✓	✓	✓	✓
Out-of-pocket limit in [2020] ²						\$[5880] ²	\$[2940] ²					

¹Plans F and G also have a high deductible option which require first paying a plan deductible of \$[2340] before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

²Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

³Plan N pays 100% of the Part B coinsurance, except for a copayment of up to \$20 for some office visits and up to a \$50 copayment for emergency room visits that do not result in an inpatient admission.

PREMIUMS

The following page(s) display the dollar amount of annual premiums. To determine the monthly or quarterly premium, complete the following calculations using the corresponding annual premium shown.

To calculate the monthly premium:

Multiply the annual premium amount shown on the chart by .0855.

Example:

$$\$1,500.00 \times .0855 = \$128.25$$

To calculate the quarterly premium:

Multiply the annual premium amount shown on the chart by .255, then add \$0.75.

Example:

$$(\$1,500.00 \times .255) + \$0.75 = \$383.25$$

ZIP 630-631, 633, 640-641, 649 – Non-Smoker – Issue Age

Chart shows \$ amount for annual premium.

Age	Plan A	Plan B	Plan C^	Plan D	Plan F^	Plan FH^	Plan G	Plan L	Plan M
<64	2,075.00	2,139.00	2,954.00	2,561.00	3,157.00	541.00	2,551.00	2,034.00	2,426.00
65	2,003.00	2,139.00	2,654.00	2,336.00	2,963.00	500.00	2,387.00	1,663.00	2,219.00
66	2,054.00	2,195.00	2,731.00	2,406.00	3,048.00	518.00	2,462.00	1,713.00	2,284.00
67	2,102.00	2,250.00	2,807.00	2,476.00	3,134.00	534.00	2,538.00	1,762.00	2,351.00
68	2,150.00	2,306.00	2,887.00	2,551.00	3,222.00	552.00	2,614.00	1,814.00	2,420.00
69	2,195.00	2,361.00	2,966.00	2,625.00	3,315.00	569.00	2,694.00	1,867.00	2,490.00
70	2,234.00	2,414.00	3,049.00	2,704.00	3,408.00	590.00	2,774.00	1,922.00	2,561.00
71	2,275.00	2,469.00	3,133.00	2,782.00	3,502.00	608.00	2,856.00	1,979.00	2,634.00
72	2,311.00	2,522.00	3,217.00	2,862.00	3,595.00	626.00	2,938.00	2,034.00	2,707.00
73	2,345.00	2,576.00	3,304.00	2,942.00	3,691.00	646.00	3,020.00	2,091.00	2,781.00
74	2,376.00	2,625.00	3,389.00	3,021.00	3,786.00	666.00	3,103.00	2,146.00	2,852.00
75	2,405.00	2,672.00	3,474.00	3,101.00	3,879.00	686.00	3,185.00	2,203.00	2,923.00
76	2,428.00	2,717.00	3,559.00	3,181.00	3,971.00	705.00	3,268.00	2,257.00	2,994.00
77	2,450.00	2,758.00	3,642.00	3,259.00	4,064.00	725.00	3,348.00	2,313.00	3,065.00
78	2,470.00	2,796.00	3,723.00	3,337.00	4,157.00	743.00	3,426.00	2,367.00	3,131.00
79	2,483.00	2,829.00	3,802.00	3,411.00	4,243.00	762.00	3,503.00	2,419.00	3,195.00
80	2,497.00	2,859.00	3,876.00	3,485.00	4,327.00	780.00	3,574.00	2,469.00	3,257.00
81	2,508.00	2,888.00	3,945.00	3,551.00	4,405.00	797.00	3,642.00	2,517.00	3,314.00
82	2,517.00	2,913.00	4,008.00	3,611.00	4,476.00	813.00	3,704.00	2,564.00	3,365.00
83	2,526.00	2,937.00	4,063.00	3,665.00	4,537.00	826.00	3,759.00	2,606.00	3,410.00
84	2,533.00	2,960.00	4,112.00	3,713.00	4,591.00	838.00	3,805.00	2,646.00	3,448.00
85	2,540.00	2,981.00	4,152.00	3,753.00	4,637.00	849.00	3,846.00	2,681.00	3,479.00
86	2,545.00	3,003.00	4,189.00	3,788.00	4,678.00	858.00	3,882.00	2,714.00	3,507.00
87	2,550.00	3,022.00	4,220.00	3,820.00	4,712.00	865.00	3,915.00	2,746.00	3,532.00
88	2,555.00	3,042.00	4,247.00	3,846.00	4,741.00	869.00	3,942.00	2,776.00	3,554.00
89	2,558.00	3,058.00	4,270.00	3,869.00	4,767.00	874.00	3,967.00	2,802.00	3,570.00
90	2,561.00	3,075.00	4,292.00	3,891.00	4,791.00	878.00	3,989.00	2,826.00	3,585.00
91	2,564.00	3,092.00	4,313.00	3,910.00	4,813.00	883.00	4,010.00	2,849.00	3,601.00
92	2,566.00	3,106.00	4,331.00	3,929.00	4,835.00	887.00	4,030.00	2,870.00	3,613.00
93	2,567.00	3,122.00	4,350.00	3,949.00	4,857.00	892.00	4,050.00	2,891.00	3,626.00
94	2,569.00	3,135.00	4,372.00	3,969.00	4,881.00	899.00	4,070.00	2,909.00	3,638.00
95	2,569.00	3,150.00	4,394.00	3,986.00	4,905.00	905.00	4,089.00	2,925.00	3,652.00
96	2,571.00	3,162.00	4,414.00	4,005.00	4,931.00	913.00	4,109.00	2,943.00	3,665.00
97	2,571.00	3,177.00	4,436.00	4,026.00	4,955.00	919.00	4,129.00	2,959.00	3,677.00
98	2,571.00	3,189.00	4,458.00	4,045.00	4,979.00	923.00	4,146.00	2,972.00	3,689.00
99	2,571.00	3,203.00	4,482.00	4,064.00	5,003.00	929.00	4,167.00	2,990.00	3,702.00

^Only applicants first eligible for Medicare before January 1, 2020, may purchase Plans C, F, and high deductible F (“Plan FH”).

ZIP 630-631, 633, 640-641, 649 – Smoker – Issue Age

Chart shows \$ amount for annual premium.

Age	Plan A	Plan B	Plan C^	Plan D	Plan F^	Plan FH^	Plan G	Plan L	Plan M
<64	2,283.00	2,353.00	3,249.00	2,817.00	3,473.00	595.00	2,806.00	2,237.00	2,669.00
65	2,203.00	2,353.00	2,919.00	2,570.00	3,259.00	550.00	2,626.00	1,829.00	2,441.00
66	2,259.00	2,415.00	3,004.00	2,647.00	3,353.00	570.00	2,708.00	1,884.00	2,512.00
67	2,312.00	2,475.00	3,088.00	2,724.00	3,447.00	587.00	2,792.00	1,938.00	2,586.00
68	2,365.00	2,537.00	3,176.00	2,806.00	3,544.00	607.00	2,875.00	1,995.00	2,662.00
69	2,415.00	2,597.00	3,263.00	2,888.00	3,647.00	626.00	2,963.00	2,054.00	2,739.00
70	2,457.00	2,655.00	3,354.00	2,974.00	3,749.00	649.00	3,051.00	2,114.00	2,817.00
71	2,503.00	2,716.00	3,446.00	3,060.00	3,852.00	669.00	3,142.00	2,177.00	2,897.00
72	2,542.00	2,774.00	3,539.00	3,148.00	3,955.00	689.00	3,232.00	2,237.00	2,978.00
73	2,580.00	2,834.00	3,634.00	3,236.00	4,060.00	711.00	3,322.00	2,300.00	3,059.00
74	2,614.00	2,888.00	3,728.00	3,323.00	4,165.00	733.00	3,413.00	2,361.00	3,137.00
75	2,646.00	2,939.00	3,821.00	3,411.00	4,267.00	755.00	3,504.00	2,423.00	3,215.00
76	2,671.00	2,989.00	3,915.00	3,499.00	4,368.00	776.00	3,595.00	2,483.00	3,293.00
77	2,695.00	3,034.00	4,006.00	3,585.00	4,470.00	798.00	3,683.00	2,544.00	3,372.00
78	2,717.00	3,076.00	4,095.00	3,671.00	4,573.00	817.00	3,769.00	2,604.00	3,444.00
79	2,731.00	3,112.00	4,182.00	3,752.00	4,667.00	838.00	3,853.00	2,661.00	3,515.00
80	2,747.00	3,145.00	4,264.00	3,834.00	4,760.00	858.00	3,931.00	2,716.00	3,583.00
81	2,759.00	3,177.00	4,340.00	3,906.00	4,846.00	877.00	4,006.00	2,769.00	3,645.00
82	2,769.00	3,204.00	4,409.00	3,972.00	4,924.00	894.00	4,074.00	2,820.00	3,702.00
83	2,779.00	3,231.00	4,469.00	4,032.00	4,991.00	909.00	4,135.00	2,867.00	3,751.00
84	2,786.00	3,256.00	4,523.00	4,084.00	5,050.00	922.00	4,186.00	2,911.00	3,793.00
85	2,794.00	3,279.00	4,567.00	4,128.00	5,101.00	934.00	4,231.00	2,949.00	3,827.00
86	2,800.00	3,303.00	4,608.00	4,167.00	5,146.00	944.00	4,270.00	2,985.00	3,858.00
87	2,805.00	3,324.00	4,642.00	4,202.00	5,183.00	952.00	4,307.00	3,021.00	3,885.00
88	2,811.00	3,346.00	4,672.00	4,231.00	5,215.00	956.00	4,336.00	3,054.00	3,909.00
89	2,814.00	3,364.00	4,697.00	4,256.00	5,244.00	961.00	4,364.00	3,082.00	3,927.00
90	2,817.00	3,383.00	4,721.00	4,280.00	5,270.00	966.00	4,388.00	3,109.00	3,944.00
91	2,820.00	3,401.00	4,744.00	4,301.00	5,294.00	971.00	4,411.00	3,134.00	3,961.00
92	2,823.00	3,417.00	4,764.00	4,322.00	5,319.00	976.00	4,433.00	3,157.00	3,974.00
93	2,824.00	3,434.00	4,785.00	4,344.00	5,343.00	981.00	4,455.00	3,180.00	3,989.00
94	2,826.00	3,449.00	4,809.00	4,366.00	5,369.00	989.00	4,477.00	3,200.00	4,002.00
95	2,826.00	3,465.00	4,833.00	4,385.00	5,396.00	996.00	4,498.00	3,218.00	4,017.00
96	2,828.00	3,478.00	4,855.00	4,406.00	5,424.00	1,004.00	4,520.00	3,237.00	4,032.00
97	2,828.00	3,495.00	4,880.00	4,429.00	5,451.00	1,011.00	4,542.00	3,255.00	4,045.00
98	2,828.00	3,508.00	4,904.00	4,450.00	5,477.00	1,015.00	4,561.00	3,269.00	4,058.00
99	2,828.00	3,523.00	4,930.00	4,470.00	5,503.00	1,022.00	4,584.00	3,289.00	4,072.00

^Only applicants first eligible for Medicare before January 1, 2020, may purchase Plans C, F, and high deductible F (“Plan FH”).

ZIP 634-639, 644-648, 650-658 – Non-Smoker – Issue Age

Chart shows \$ amount for annual premium.

Age	Plan A	Plan B	Plan C^	Plan D	Plan F^	Plan FH^	Plan G	Plan L	Plan M
<64	1,867.50	1,925.10	2,658.60	2,304.90	2,841.30	486.90	2,295.90	1,830.60	2,183.40
65	1,802.70	1,925.10	2,388.60	2,102.40	2,666.70	450.00	2,148.30	1,496.70	1,997.10
66	1,848.60	1,975.50	2,457.90	2,165.40	2,743.20	466.20	2,215.80	1,541.70	2,055.60
67	1,891.80	2,025.00	2,526.30	2,228.40	2,820.60	480.60	2,284.20	1,585.80	2,115.90
68	1,935.00	2,075.40	2,598.30	2,295.90	2,899.80	496.80	2,352.60	1,632.60	2,178.00
69	1,975.50	2,124.90	2,669.40	2,362.50	2,983.50	512.10	2,424.60	1,680.30	2,241.00
70	2,010.60	2,172.60	2,744.10	2,433.60	3,067.20	531.00	2,496.60	1,729.80	2,304.90
71	2,047.50	2,222.10	2,819.70	2,503.80	3,151.80	547.20	2,570.40	1,781.10	2,370.60
72	2,079.90	2,269.80	2,895.30	2,575.80	3,235.50	563.40	2,644.20	1,830.60	2,436.30
73	2,110.50	2,318.40	2,973.60	2,647.80	3,321.90	581.40	2,718.00	1,881.90	2,502.90
74	2,138.40	2,362.50	3,050.10	2,718.90	3,407.40	599.40	2,792.70	1,931.40	2,566.80
75	2,164.50	2,404.80	3,126.60	2,790.90	3,491.10	617.40	2,866.50	1,982.70	2,630.70
76	2,185.20	2,445.30	3,203.10	2,862.90	3,573.90	634.50	2,941.20	2,031.30	2,694.60
77	2,205.00	2,482.20	3,277.80	2,933.10	3,657.60	652.50	3,013.20	2,081.70	2,758.50
78	2,223.00	2,516.40	3,350.70	3,003.30	3,741.30	668.70	3,083.40	2,130.30	2,817.90
79	2,234.70	2,546.10	3,421.80	3,069.90	3,818.70	685.80	3,152.70	2,177.10	2,875.50
80	2,247.30	2,573.10	3,488.40	3,136.50	3,894.30	702.00	3,216.60	2,222.10	2,931.30
81	2,257.20	2,599.20	3,550.50	3,195.90	3,964.50	717.30	3,277.80	2,265.30	2,982.60
82	2,265.30	2,621.70	3,607.20	3,249.90	4,028.40	731.70	3,333.60	2,307.60	3,028.50
83	2,273.40	2,643.30	3,656.70	3,298.50	4,083.30	743.40	3,383.10	2,345.40	3,069.00
84	2,279.70	2,664.00	3,700.80	3,341.70	4,131.90	754.20	3,424.50	2,381.40	3,103.20
85	2,286.00	2,682.90	3,736.80	3,377.70	4,173.30	764.10	3,461.40	2,412.90	3,131.10
86	2,290.50	2,702.70	3,770.10	3,409.20	4,210.20	772.20	3,493.80	2,442.60	3,156.30
87	2,295.00	2,719.80	3,798.00	3,438.00	4,240.80	778.50	3,523.50	2,471.40	3,178.80
88	2,299.50	2,737.80	3,822.30	3,461.40	4,266.90	782.10	3,547.80	2,498.40	3,198.60
89	2,302.20	2,752.20	3,843.00	3,482.10	4,290.30	786.60	3,570.30	2,521.80	3,213.00
90	2,304.90	2,767.50	3,862.80	3,501.90	4,311.90	790.20	3,590.10	2,543.40	3,226.50
91	2,307.60	2,782.80	3,881.70	3,519.00	4,331.70	794.70	3,609.00	2,564.10	3,240.90
92	2,309.40	2,795.40	3,897.90	3,536.10	4,351.50	798.30	3,627.00	2,583.00	3,251.70
93	2,310.30	2,809.80	3,915.00	3,554.10	4,371.30	802.80	3,645.00	2,601.90	3,263.40
94	2,312.10	2,821.50	3,934.80	3,572.10	4,392.90	809.10	3,663.00	2,618.10	3,274.20
95	2,312.10	2,835.00	3,954.60	3,587.40	4,414.50	814.50	3,680.10	2,632.50	3,286.80
96	2,313.90	2,845.80	3,972.60	3,604.50	4,437.90	821.70	3,698.10	2,648.70	3,298.50
97	2,313.90	2,859.30	3,992.40	3,623.40	4,459.50	827.10	3,716.10	2,663.10	3,309.30
98	2,313.90	2,870.10	4,012.20	3,640.50	4,481.10	830.70	3,731.40	2,674.80	3,320.10
99	2,313.90	2,882.70	4,033.80	3,657.60	4,502.70	836.10	3,750.30	2,691.00	3,331.80

^Only applicants first eligible for Medicare before January 1, 2020, may purchase Plans C, F, and high deductible F (“Plan FH”).

ZIP 634-639, 644-648, 650-658 – Smoker – Issue Age

Chart shows \$ amount for annual premium.

Age	Plan A	Plan B	Plan C^	Plan D	Plan F^	Plan FH^	Plan G	Plan L	Plan M
<64	2,054.70	2,117.70	2,924.10	2,535.30	3,125.70	535.50	2,525.40	2,013.30	2,402.10
65	1,982.70	2,117.70	2,627.10	2,313.00	2,933.10	495.00	2,363.40	1,646.10	2,196.90
66	2,033.10	2,173.50	2,703.60	2,382.30	3,017.70	513.00	2,437.20	1,695.60	2,260.80
67	2,080.80	2,227.50	2,779.20	2,451.60	3,102.30	528.30	2,512.80	1,744.20	2,327.40
68	2,128.50	2,283.30	2,858.40	2,525.40	3,189.60	546.30	2,587.50	1,795.50	2,395.80
69	2,173.50	2,337.30	2,936.70	2,599.20	3,282.30	563.40	2,666.70	1,848.60	2,465.10
70	2,211.30	2,389.50	3,018.60	2,676.60	3,374.10	584.10	2,745.90	1,902.60	2,535.30
71	2,252.70	2,444.40	3,101.40	2,754.00	3,466.80	602.10	2,827.80	1,959.30	2,607.30
72	2,287.80	2,496.60	3,185.10	2,833.20	3,559.50	620.10	2,908.80	2,013.30	2,680.20
73	2,322.00	2,550.60	3,270.60	2,912.40	3,654.00	639.90	2,989.80	2,070.00	2,753.10
74	2,352.60	2,599.20	3,355.20	2,990.70	3,748.50	659.70	3,071.70	2,124.90	2,823.30
75	2,381.40	2,645.10	3,438.90	3,069.90	3,840.30	679.50	3,153.60	2,180.70	2,893.50
76	2,403.90	2,690.10	3,523.50	3,149.10	3,931.20	698.40	3,235.50	2,234.70	2,963.70
77	2,425.50	2,730.60	3,605.40	3,226.50	4,023.00	718.20	3,314.70	2,289.60	3,034.80
78	2,445.30	2,768.40	3,685.50	3,303.90	4,115.70	735.30	3,392.10	2,343.60	3,099.60
79	2,457.90	2,800.80	3,763.80	3,376.80	4,200.30	754.20	3,467.70	2,394.90	3,163.50
80	2,472.30	2,830.50	3,837.60	3,450.60	4,284.00	772.20	3,537.90	2,444.40	3,224.70
81	2,483.10	2,859.30	3,906.00	3,515.40	4,361.40	789.30	3,605.40	2,492.10	3,280.50
82	2,492.10	2,883.60	3,968.10	3,574.80	4,431.60	804.60	3,666.60	2,538.00	3,331.80
83	2,501.10	2,907.90	4,022.10	3,628.80	4,491.90	818.10	3,721.50	2,580.30	3,375.90
84	2,507.40	2,930.40	4,070.70	3,675.60	4,545.00	829.80	3,767.40	2,619.90	3,413.70
85	2,514.60	2,951.10	4,110.30	3,715.20	4,590.90	840.60	3,807.90	2,654.10	3,444.30
86	2,520.00	2,972.70	4,147.20	3,750.30	4,631.40	849.60	3,843.00	2,686.50	3,472.20
87	2,524.50	2,991.60	4,177.80	3,781.80	4,664.70	856.80	3,876.30	2,718.90	3,496.50
88	2,529.90	3,011.40	4,204.80	3,807.90	4,693.50	860.40	3,902.40	2,748.60	3,518.10
89	2,532.60	3,027.60	4,227.30	3,830.40	4,719.60	864.90	3,927.60	2,773.80	3,534.30
90	2,535.30	3,044.70	4,248.90	3,852.00	4,743.00	869.40	3,949.20	2,798.10	3,549.60
91	2,538.00	3,060.90	4,269.60	3,870.90	4,764.60	873.90	3,969.90	2,820.60	3,564.90
92	2,540.70	3,075.30	4,287.60	3,889.80	4,787.10	878.40	3,989.70	2,841.30	3,576.60
93	2,541.60	3,090.60	4,306.50	3,909.60	4,808.70	882.90	4,009.50	2,862.00	3,590.10
94	2,543.40	3,104.10	4,328.10	3,929.40	4,832.10	890.10	4,029.30	2,880.00	3,601.80
95	2,543.40	3,118.50	4,349.70	3,946.50	4,856.40	896.40	4,048.20	2,896.20	3,615.30
96	2,545.20	3,130.20	4,369.50	3,965.40	4,881.60	903.60	4,068.00	2,913.30	3,628.80
97	2,545.20	3,145.50	4,392.00	3,986.10	4,905.90	909.90	4,087.80	2,929.50	3,640.50
98	2,545.20	3,157.20	4,413.60	4,005.00	4,929.30	913.50	4,104.90	2,942.10	3,652.20
99	2,545.20	3,170.70	4,437.00	4,023.00	4,952.70	919.80	4,125.60	2,960.10	3,664.80

^Only applicants first eligible for Medicare before January 1, 2020, may purchase Plans C, F, and high deductible F (“Plan FH”).

PREMIUM INFORMATION

We, Thrivent Financial for Lutherans, 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 Thrivent Financial for Lutherans, 4321 N. Ballard Road, Appleton, WI 54919-0001. 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 Thrivent 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.

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

PLAN A
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days 61st through 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 \$[1408] All but \$[352] a day All but \$[704] a day \$0 \$0	\$0 \$[352] a day \$[704] a day 100% of Medicare eligible expenses \$0	\$[1408] (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 through 100th day 101st day and after	All approved amounts All but \$[176] a day \$0	\$0 \$0 \$0	\$0 Up to \$[176] a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

(continued)

****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 Basic 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 EXPENSES – PER CALENDAR YEAR

*Once you have been billed \$[198] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT 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 \$[198] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$[198] (Part B deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$[198] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[198] (Part B deductible) \$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

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 \$[198] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$[198] (Part B deductible) \$0

PLAN B
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days 61st through 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 \$[1408] All but \$[352] a day All but \$[704] a day \$0 \$0	\$[1408] (Part A deductible) \$[352] a day \$[704] 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 through 100th day 101st day and after	All approved amounts All but \$[176] a day \$0	\$0 \$0 \$0	\$0 Up to \$[176] a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

(continued)

****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 Basic Benefits. During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B
MEDICARE (PART B) – MEDICAL EXPENSES – PER CALENDAR YEAR

*Once you have been billed \$[198] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT 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 \$[198] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$[198] (Part B deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$[198] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[198] (Part B deductible) \$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

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 \$[198] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$[198] (Part B deductible) \$0

PLAN C
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days 61st through 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 \$[1408] All but \$[352] a day All but \$[704] a day \$0 \$0	\$[1408] (Part A deductible) \$[352] a day \$[704] 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 through 100th day 101st day and after	All approved amounts All but \$[176] a day \$0	\$0 Up to \$[176] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

(continued)

****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 Basic Benefits. During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN C
MEDICARE (PART B) – MEDICAL EXPENSES – PER CALENDAR YEAR

*Once you have been billed \$[198] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT 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 \$[198] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$[198] (Part B deductible) Generally 20%	\$0 \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$[198] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$[198] (Part B deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

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 \$[198] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$[198] (Part B deductible) 20%	\$0 \$0 \$0

(continued)

PLAN C
OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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

PLAN D
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days 61st through 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 \$[1408] All but \$[352] a day All but \$[704] a day \$0 \$0	\$[1408] (Part A deductible) \$[352] a day \$[704] 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 through 100th day 101st day and after	All approved amounts All but \$[176] a day \$0	\$0 Up to \$[176] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

(continued)

****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 Basic Benefits. During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN D
MEDICARE (PART B) – MEDICAL EXPENSES – PER CALENDAR YEAR

*Once you have been billed \$[198] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT 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 \$[198] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$[198] (Part B deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$[198] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[198] (Part B deductible) \$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

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 \$[198] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$[198] (Part B deductible) \$0

(continued)

**PLAN D
OTHER BENEFITS – NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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

PLAN F
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days 61st through 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 \$[1408] All but \$[352] a day All but \$[704] a day \$0 \$0	\$[1408] (Part A deductible) \$[352] a day \$[704] 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 through 100th day 101st day and after	All approved amounts All but \$[176] a day \$0	\$0 Up to \$[176] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

(continued)

****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 Basic Benefits. During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F
MEDICARE (PART B) – MEDICAL EXPENSES – PER CALENDAR YEAR

*Once you have been billed \$[198] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT 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 \$[198] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$[198] (Part B deductible) Generally 20%	\$0 \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$[198] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$[198] (Part B deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

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 \$[198] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$[198] (Part B deductible) 20%	\$0 \$0 \$0

(continued)

PLAN F
OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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

**HIGH DEDUCTIBLE PLAN F
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

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

^This high deductible plan pays the same benefits as Plan F after you have paid a calendar year \$[2340] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$[2340]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$[2340] DEDUCTIBLE^, PLAN PAYS	IN ADDITION TO \$[2340] DEDUCTIBLE^, YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days 61st through 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 \$[1408] All but \$[352] a day All but \$[704] a day \$0 \$0	\$[1408] (Part A deductible) \$[352] a day \$[704] 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 through 100th day 101st day and after	All approved amounts All but \$[176] a day \$0	\$0 Up to \$[176] a day \$0	\$0 \$0 All costs

(continued)

****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 Basic 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.

**HIGH DEDUCTIBLE PLAN F
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

^This high deductible plan pays the same benefits as Plan F after you have paid a calendar year \$[2340] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$[2340]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$[2340] DEDUCTIBLE^, PLAN PAYS	IN ADDITION TO \$[2340] DEDUCTIBLE^, YOU PAY
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

(continued)

**HIGH DEDUCTIBLE PLAN F
MEDICARE (PART B) – MEDICAL EXPENSES – PER CALENDAR YEAR**

*Once you have been billed \$[198] 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 you have paid a calendar year \$[2340] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$[2340]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$[2340] DEDUCTIBLE^, PLAN PAYS	IN ADDITION TO \$[2340] DEDUCTIBLE^, 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 \$[198] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$[198] (Part B deductible) Generally 20%	\$0 \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$[198] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$[198] (Part B deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

**HIGH DEDUCTIBLE PLAN F
PARTS A & B**

*Once you have been billed \$[198] 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 you have paid a calendar year \$[2340] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$[2340]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$[2340] DEDUCTIBLE^, PLAN PAYS	IN ADDITION TO \$[2340] DEDUCTIBLE^, YOU PAY
HOME HEALTH CARE— MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
First \$[198] of Medicare Approved Amounts*	\$0	\$[198] (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$[2340] DEDUCTIBLE^, PLAN PAYS	IN ADDITION TO \$[2340] DEDUCTIBLE^, YOU PAY
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	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days 61st through 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 \$[1408] All but \$[352] a day All but \$[704] a day \$0 \$0	\$[1408] (Part A deductible) \$[352] a day \$[704] 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 through 100th day 101st day and after	All approved amounts All but \$[176] a day \$0	\$0 Up to \$[176] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

(continued)

****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 Basic Benefits. During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G
MEDICARE (PART B) – MEDICAL EXPENSES – PER CALENDAR YEAR

*Once you have been billed \$[198] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT 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 \$[198] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$[198] (Unless Part B deductible has been met) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$[198] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[198] (Unless Part B deductible has been met) \$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

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 \$[198] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$[198] (Unless Part B deductible has been met) \$0

(continued)

PLAN G
OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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

PLAN L
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[2940] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days 61st through 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 \$[1408] All but \$[352] a day All but \$[704] a day \$0 \$0	\$[1056] (75% of Part A deductible) \$[352] a day \$[704] a day 100% of Medicare eligible expenses \$0	\$[352] (25% of 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 through 100th day 101st day and after	All approved amounts All but \$[176] a day \$0	\$0 Up to \$[132] a day \$0	\$0 \$Up to \$[44] a day (25% of Part A coinsurance)♦ All costs

(continued)

****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 Basic Benefits. During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN L
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD First 3 pints Additional amounts	\$0 100%	75% \$0	25%♦ \$0
HOSPICE CARE You must meet Medicare’s requirements, including a doctor’s certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	75% of copayment/coinsurance	25% of copayment/ coinsurance♦

(continued)

PLAN L
MEDICARE (PART B) – MEDICAL EXPENSES – PER CALENDAR YEAR

*Once you have been billed \$[198] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT 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 \$[198] of Medicare Approved Amounts* Preventive Benefits for Medicare Covered Services Remainder of Medicare Approved Amounts	\$0 Generally 80% or more of Medicare approved amounts Generally 80%	\$0 Remainder of Medicare approved amounts Generally 15%	\$[198] (Part B deductible)* ♦ All costs above Medicare approved amounts Generally 5% ♦
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of- pocket limit of \$[2940]^
BLOOD First 3 pints Next \$[198] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 Generally 80%	75% \$0 Generally 15%	25%♦ \$[198] (Part B deductible)* ♦ Generally 5%♦
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

^This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[2940] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

PLAN L
MEDICARE (PART B) – MEDICAL EXPENSES – PER CALENDAR YEAR

*Once you have been billed \$[198] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE— MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment First \$[198] of Medicare Approved Amounts*	\$0	\$0	\$[198] (Part B deductible)* ♦
Remainder of Medicare Approved Amounts	80%	15%	5%♦

PLAN M
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days 61st through 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 \$[1408] All but \$[352] a day All but \$[704] a day \$0 \$0	\$[704] (50% of Part A deductible) \$[352] a day \$[704] a day 100% of Medicare eligible expenses \$0	\$[704] (50% of 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 through 100th day 101st day and after	All approved amounts All but \$[176] a day \$0	\$0 Up to \$[176] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

(continued)

**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 Basic Benefits. During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN M
MEDICARE (PART B) – MEDICAL EXPENSES – PER CALENDAR YEAR

*Once you have been billed \$[198] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT 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 \$[198] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$[198] (Part B deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$[198] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[198] (Part B deductible) \$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

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 \$[198] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$[198] (Part B deductible) \$0

(continued)

PLAN M
OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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