28 TAC §3.3308(c)(2)(D)

PREMIUM INFORMATION (Boldface Type)

We (insert insurer's name) can only raise your premium if we raise the premium for all policies like yours in this state. (If the premium is based on the increasing age of the covered person for individual contracts or class of persons covered under group contracts, include information specifying when premiums will change.)

DISCLOSURES (Boldface Type)
Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY (Boldface Type)
This is only an outline describing your policy's most important features. The policy is your (insurance contract) (contract for coverage). You must read the policy itself to understand all of the rights and duties of both you and (name of issuer).

RIGHT TO RETURN POLICY (Boldface Type)

If you find that you are not satisfied with your policy, you may return it to (insert issuer's address). If you sent the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT (Boldface Type)

If you are replacing another health insurance policy or other health coverage, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE (Boldface Type)
This policy may not fully cover all of your medical costs.

(For agents)
Neither (insert company's name) nor its agents are connected with Medicare.

(For direct response business)
(insert company's name) is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "The Medicare Handbook" for more details.

LIMITATIONS AND EXCLUSIONS (Boldface Type)
(Include language regarding any limitations and/or exclusions including those related to pre-existing conditions as required by subsection (c) of this section.)

REFUND OF PREMIUM (Boldface Type)

(Include language regarding refund, or no refund, of premium upon death of the insured or policy cancellation) as required by subsection (c) of this section.

(For Medicare Select:
GRIEVANCE PROCEDURES (Boldface Type)

Include language regarding grievance procedures as required by subsection (c) of this section.)

COMPLETE ANSWERS ARE VERY IMPORTANT (Boldface Type)

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. (If the policy or certificate is guaranteed issue, this paragraph need not appear).

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

(Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts in subsection (c)(2) of this section. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to §3.3306 of this title (relating to Minimum Benefit Standards.)

(Include an explanation of any innovative benefits on the coverage page and in the chart, in a manner approved by the commissioner.)

[12 Point]

[COMPANY NAME]
Outline of Medicare Supplement Coverage - Cover Page:
Benefit Plan(s)_____[insert letter(s) of plan(s) being offered]

Medicare Supplement insurance can be sold in only ten standard plans plus two high deductible plans. This chart shows the benefits included in each plan. Every company must make available Plan "A". Some plans may not be available in your state.

BASIC BENEFITS: Included in All Plans.
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, in the case of hospital outpatient department services, applicable copayments.
Blood: First three pints of blood each year.

A	B	C	D	E	F	F*	G	H	I	J	J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits		Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	
		Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance		Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	
		Part B Deductible			Part B Deductible					Part B Deductible	
					Part B Excess (100%)		Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)	
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	
			At-Home Recovery				At-Home Recovery		At-Home Recovery	At-Home Recovery	
								Basic Drugs ($1,250 Limit)	Basic Drugs ($1,250 Limit)	Extended Drugs ($3,000 Limit)	
				Preventive Care						Preventive Care	

***Plans F and J also have an option called a high deductible Plan F and a high deductible Plan J. These high deductible plans pay the same or offer the same benefits as Plans F and J after one has paid a calendar year [$1500] deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses are [$1500]. 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 does not include, in Plan J, the plan's separate prescription drug deductible or, in Plans F and J, the plan's separate foreign travel emergency deductible.**

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.
**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**
(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION *			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but ($764)	$0	($764) (Part A Deductible)
61st through 90th day	All but ($191) a day	($191) a day	$0**
91st day and after:			
--While using 60 lifetime reserve days	All but ($382 a day	($382 a day	$0**
--Once lifetime reserve days are used:			
--Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
--Beyond the additional 365 days	$0	$0	All costs

PLAN A

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

* 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.
**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**
(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0**
21st through 100th day	All but ($95.50) a day	$0	Up to ($95.50) a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0**
Additional amounts	100%	$0	$0**
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

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

* Once you have been billed $100 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.
**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**
(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

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 test, durable medical equipment:			
First $100 of Medicare-Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0**
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0**
Next $100 of Medicare-Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0**
CLINICAL LABORATORY SERVICES-BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0**

PLAN A

PARTS A & B

* Once you have been billed $100 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.

**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

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 $100 of Medicare-Approved Amounts*	$0	$0	$100 (Part B Deductible)
--Remainder of Medicare-Approved Amounts	80%	20%	$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.

**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but ($764)	($764) (Part A Deductible)	$0**
61st through 90th day	All but ($191) a day	($191) a day	$0**
91st day and after:			
--While using 60 lifetime reserve days	All but ($382) a day	($382) a day	$0**
--Once lifetime reserve days are used:			
--Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
--Beyond the additional 365 days	$0	$0	All costs

PLAN B

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

*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.

**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0**
21st through 100th day	All but ($95.50) a day	$0	Up to ($95.50) a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0**
Additional amounts	100%	$0	$0**
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN B

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

*Once you have been billed $100 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.
**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**
(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

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 $100 of Medicare-Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generallly 20%	$0**
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0**
Next $100 of Medicare-Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0**
CLINICAL LABORATORY SERVICES-BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0**

PLAN B

PARTS A & B

*Once you have been billed $100 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.

**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

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 $100 of Medicare- Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$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.
**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**
(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but ($764)	($764) (Part A Deductible)	$0**
61st through 90th day	All but ($191) a day	($191) a day	$0**
91st day and after:			
--While using 60 lifetime reserve days	All but ($382 a day	($382 a day	$0**
--Once lifetime reserve days are used:			
--Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
--Beyond the Additional 365 days	$0	$0	All costs

PLAN C

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

*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.

**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0**
21st through 100th day	All but ($95.50) a day	Up to ($95.50) a day	$0**
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0**
Additional amounts	100%	$0	$0**
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN C

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

*Once you have been billed $100 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.
**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**
(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

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 $100 of Medicare-Approved Amounts*	$0	$100 (Part B Deductible)	$0**
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0**
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0**
Next $100 of Medicare-Approved Amounts*	$0	$100 (Part B Deductible)	$0**
Remainder of Medicare-Approved Amounts	80%	20%	$0**
CLINICAL LABORATORY SERVICES-BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0**

PLAN C

PARTS A & B

*Once you have been billed $100 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.
**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**
(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

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 $100 of Medicare-Approved Amounts*	$0	$100 (Part B Deductible)	$0**
--Remainder of Medicare-Approved Amounts	80%	20%	$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	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN D

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

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**
(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but ($764)	($764) (Part A Deductible)	$0**
61st through 90th day	All but ($191) a day	($191) a day	$0**
91st day and after:			
--While using 60 lifetime reserve days	All but ($382) a day	($382) a day	$0**
--Once lifetime reserve days are used:			
--Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
--Beyond the additional 365 days	$0	$0	All costs

PLAN D

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

*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.

**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0**
21st through 100th day	All but ($95.50) a day	Up to ($95.50) a day	$0**
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0**
Additional amounts	100%	$0	$0**
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN D

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

*Once you have been billed $100 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.
**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**
(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

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 $100 of Medicare-Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0**
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0**
Next $100 of Medicare-Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0**
CLINICAL LABORATORY SERVICES-BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0**

PLAN D
PARTS A & B

*Once you have been billed $100 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.

**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

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 $100 of Medicare-Approved Amounts*	$0	$0	$100 (Part B Deductible)
--Remainder of Medicare-Approved Amounts	80%	20%	$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	$0	Actual Charges to $40 a visit	Balance
Number of visits covered (must be received within 8 weeks of last Medicare-Approved visit)	$0	Up to the number of Medicare-Approved visits, not to exceed 7 each week	Balance
Calendar year maximum	$0	$ 1,600	Balance

PLAN D

OTHER BENEFITS - NOT COVERED BY MEDICARE

(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

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	$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 E

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.
**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**
(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but ($764)	($764) (Part A Deductible)	$0**
61st through 90th day	All but ($191) a day	($191) a day	$0**
91st day and after:			
--While using 60 lifetime reserve days	All but ($382) a day	($382) a day	$0**
--Once lifetime reserve days are used:			
--Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
--Beyond the additional 365 days	$0	$0	All costs

PLAN E

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

*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.

**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0**
21st through 100th day	All but ($95.50) a day	Up to ($95.50) a day	$0**
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0**
Additional amounts	100%	$0	$0**
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN E

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

*Once you have been billed $100 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.
**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**
(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

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 $100 of Medicare-Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0**
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0**
Next $100 of Medicare-Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0**
CLINICAL LABORATORY SERVICES-BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0**

PLAN E
PARTS A & B

*Once you have been billed $100 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.

**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

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 $100 of Medicare-Approved Amounts*	$0	$0	$100 (Part B Deductible)
--Remainder of Medicare-Approved Amounts	80%	20%	$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	$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 E
OTHER BENEFITS - NOT COVERED BY MEDICARE
CONTINUED

*Once you have been billed $100 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.
****$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**
(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**
†Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
† **PREVENTIVE MEDICAL CARE BENEFIT-NOT COVERED BY MEDICARE** Some annual physical and preventive tests and services such as: digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare:			
First $120 each calendar year	$0	$120	$0**
Additional charges	$0	$0	All costs

PLAN F or HIGH DEDUCTIBLE PLAN F

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

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

**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

‡This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year [$1500] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$1500]. 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 $1500 DEDUCTIBLE,‡ PLAN PAYS	IN ADDITION TO $1500 DEDUCTIBLE, ‡ YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but ($764)	($764) (Part A Deductible)	$0**
61st through 90th day	All but ($191) a day	($191) a day	$0**
91st day and after:			
--While using 60 lifetime reserve days	All but ($382) a day	($382) a day	$0**
--Once lifetime reserve days are used:			
--Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
--Beyond the additional 365 days	$0	$0	All costs

PLAN F OR HIGH DEDUCTIBLE PLAN F
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD
CONTINUED

*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.

**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

‡This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year [$1500] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$1500]. 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 $1500 DEDUCTIBLE, ‡ PLAN PAYS	IN ADDITION TO $1500 DEDUCTIBLE, ‡ YOU PAY
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0**
21st through 100th day	All but ($95.50) a day	Up to ($95.50) a day	$0**
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0**
Additional amounts	100%	$0	$0**
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

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

*Once you have been billed $100 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.

**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

‡This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year [$1500] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$1500]. 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 $1500 DEDUCTIBLE, ‡ PLAN PAYS	IN ADDITION TO $1500 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 $100 of Medicare-Approved Amounts*	$0	$100 (Part B Deductible)	$0**
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0**
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	100%	$0**
BLOOD			
First 3 pints	$0	All costs	$0**
Next $100 of Medicare-Approved Amounts*	$0	$100 (Part B Deductible)	$0**
Remainder of Medicare-Approved Amounts	80%	20%	$0**
CLINICAL LABORATORY SERVICES-BLOOD TESTS FOR DIAGNOSTIC SERVICE	100%	$0	$0**

PLAN F OR HIGH DEDUCTIBLE PLAN F
PARTS A & B

*Once you have been billed $100 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.

**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

‡This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year [$1500] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$1500]. 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 $1500 DEDUCTIBLE, ‡ PLAN PAYS	IN ADDITION TO $1500 DEDUCTIBLE, ‡ YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES:			
Medically necessary skilled care services and medical supplies	100%	$0	$0**
Durable medical equipment			
--First $100 of Medicare-Approved Amounts*	$0	$100 (Part B Deductible)	$0**
--Remainder of Medicare-Approved Amounts	80%	20%	$0**

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1500 DEDUCTIBLE, ‡ PLAN PAYS	IN ADDITION TO $1500 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.
**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**
(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but ($764)	($764) (Part A Deductible)	$0**
61st through 90th day	All but ($191) a day	($191) a day	$0**
91st day and after:			
--While using 60 lifetime reserve days	All but ($382 a day	($382 a day	$0**
--Once lifetime reserve days are used:			
--Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
--Beyond the Additional 365 days	$0	$0	All costs

PLAN G

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

*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.

**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0**
21st through 100th day	All but ($95.50) a day	Up to ($95.50) a day	$0**
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0**
Additional amounts	100%	$0	$0**
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services:	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN G

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

*Once you have been billed $100 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.
**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**
(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

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 $100 of Medicare-Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0**
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	80%	20%
BLOOD			
First 3 pints	$0	All costs	$0**
Next $100 of Medicare-Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0**
CLINICAL LABORATORY SERVICES-BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0**

PLAN G
PARTS A & B

*Once you have been billed $100 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.

**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

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 $100 of Medicare-Approved Amounts*	$0	$0	$100 (Part B Deductible)
--Remainder of Medicare-Approved Amounts	80%	20%	$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	$0	Actual charges to $40 a visit	Balance
Number of visits covered (must be received within 8 weeks of last Medicare-Approved visit)	$0	Up to the number of Medicare-Approved visits, not to exceed 7 each week	Balance
Calendar year maximum	$0	$ 1,600	Balance

PLAN G

OTHER BENEFITS - NOT COVERED BY MEDICARE

(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

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	$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 H

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

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**
(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but ($764)	($764) (Part A Deductible)	$0**
61st through 90th day	All but ($191) a day	($191) a day	$0**
91st day and after:			
--While using 60 lifetime reserve days	All but ($382) a day	($382 a day	$0**
--Once lifetime reserve days are used:			
--Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
--Beyond the Additional 365 days	$0	$0	All costs

PLAN H

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

*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.

**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0**
21st through 100th day	All but ($95.50) a day	Up to ($95.50) a day	$0**
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0**
Additional amounts	100%	$0	$0**
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN H

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

*Once you have been billed $100 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.
**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**
(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

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 $100 of Medicare-Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0**
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0**
Next $100 of Medicare-Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0**
CLINICAL LABORATORY SERVICES-BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0**

PLAN H

PARTS A & B

*Once you have been billed $100 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.

**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

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 $100 of Medicare-Approved Amounts*	$0	$0	$100 (Part B Deductible)
--Remainder of Medicare-Approved Amounts	80%	20%	$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	$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 H

OTHER BENEFITS - NOT COVERED BY MEDICARE
CONTINUED

(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

SERVICES	**MEDICARE PAYS**	**PLAN PAYS**	**YOU PAY**
BASIC OUTPATIENT PRESCRIPTION DRUGS-NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $2,500	$0	50% - $1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$0	$0	All costs

PLAN I

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

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**
(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but ($764)	($764 (Part A Deductible)	$0**
61st through 90th day	All but ($191) a day	($191) a day	$0**
91st day and after:			
--While using 60 lifetime reserve days	All but ($382 a day	($382 a day	$0**
--Once lifetime reserve days are used:			
--Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
--Beyond the Additional 365 days	$0	$0	All costs

PLAN I

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

*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.

**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0**
21st through 100th day	All but ($95.50) a day	Up to ($95.50) a day	$0**
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0**
Additional amounts	100%	$0	$0**
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN I

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

*Once you have been billed $100 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.
**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**
(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

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 $100 of Medicare-Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0**
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	100%	$0**
BLOOD			
First 3 pints	$0	All costs	$0**
Next $100 of Medicare-Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0**
CLINICAL LABORATORY SERVICES-BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0**

PLAN I

PARTS A & B

*Once you have been billed $100 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.

**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

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 $100 of Medicare-Approved Amounts*	$0	$0	$100 (Part B Deductible)
--Remainder of Medicare-Approved Amounts	80%	20%	$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	$0	Actual Charges to $40 a visit	Balance
Number of visits covered (must be received within 8 weeks of last Medicare-Approved visit)	$0	Up to the number of Medicare-Approved visits, not to exceed 7 each week	Balance
Calendar year maximum	$0	$ 1,600	Balance

PLAN I

OTHER BENEFITS - NOT COVERED BY MEDICARE

*Once you have been billed $100 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.

**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

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	$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
BASIC OUTPATIENT PRESCRIPTION DRUGS-NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$ 250
Next $2,500	$0	50% - $1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$0	$0	All costs

PLAN J or HIGH DEDUCTIBLE PLAN J

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

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

**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

‡This high deductible plan pays the same or offers the same benefits as Plan J after one has paid a calendar year [$1500] deductible. Benefits from the high deductible plan J will not begin until out-of-pocket expenses are [$1500]. 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 $1500 DEDUCTIBLE, ‡ PLAN PAYS**	**IN ADDITION TO $1500 DEDUCTIBLE, ‡ YOU PAY**
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but ($764)	($764) (Part A Deductible)	$0**
61st through 90th day	All but ($191) a day	($191) a day	$0**
91st day and after:			
--While using 60 lifetime reserve days	All but ($382) a day	($382) a day	$0**
--Once lifetime reserve days are used:			
--Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
--Beyond the Additional 365 days	$0	$0	All costs

PLAN J or HIGH DEDUCTIBLE PLAN J

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

*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.

**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

‡This high deductible plan pays the same or offers the same benefits as Plan J after one has paid a calendar year [$1500] deductible. Benefits from the high deductible plan J will not begin until out-of-pocket expenses are [$1500]. 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 $1500 DEDUCTIBLE, ‡ PLAN PAYS	IN ADDITION TO $1500 DEDUCTIBLE, ‡ YOU PAY
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0**
21st through 100th day	All but ($95.50) a day	Up to ($95.50) a day	$0**
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0**
Additional amounts	100%	$0	$0**
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN J or HIGH DEDUCTIBLE PLAN J

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

*Once you have been billed $100 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.

**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

‡This high deductible plan pays the same or offers the same benefits as Plan J after one has paid a calendar year [$1500] deductible. Benefits from the high deductible plan J will not begin until out-of-pocket expenses are [$1500]. 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 $1500 DEDUCTIBLE,‡ PLAN PAYS	IN ADDITION TO $1500 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 $100 of Medicare-Approved Amounts*	$0	$100 (Part B Deductible)	$0**
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0**
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	100%	$0**
BLOOD			
First 3 pints	$0	All costs	$0**
Next $100 of Medicare-Approved Amounts*	$0	$100 (Part B Deductible)	$0**
Remainder of Medicare-Approved Amounts	80%	20%	$0**
CLINICAL LABORATORY SERVICES-BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0**

PLAN J or HIGH DEDUCTIBLE PLAN J
PARTS A & B

*Once you have been billed $100 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.

**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

‡This high deductible plan pays the same or offers the same benefits as Plan J after one has paid a calendar year [$1500] deductible. Benefits from the high deductible plan J will not begin until out-of-pocket expenses are [$1500]. 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 $1500 DEDUCTIBLE,‡ PLAN PAYS	IN ADDITION TO $1500 DEDUCTIBLE,‡ YOU PAY
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES:			
Medically necessary skilled care services and medical supplies	100%	$0	$0**
Durable medical equipment			
--First $100 of Medicare-Approved Amounts*	$0	$100 (Part B Deductible)	$0**
--Remainder of Medicare-Approved Amounts	80%	20%	$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	$0	Actual charges to $40 a visit	Balance
Number of visits covered (must be received within 8 weeks of last Medicare-Approved visit)	$0	Up to the number of Medicare-Approved visits, not to exceed 7 each week	Balance
Calendar year maximum	$0	$1,600	Balance

PLAN J or HIGH DEDUCTIBLE PLAN J

OTHER BENEFITS - NOT COVERED BY MEDICARE

(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**

‡This high deductible plan pays the same or offers the same benefits as Plan J after one has paid a calendar year [$1500] deductible. Benefits from the high deductible plan J will not begin until out-of-pocket expenses are [$1500]. 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 $1500 DEDUCTIBLE,‡ PLAN PAYS	IN ADDITION TO $1500 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
EXTENDED OUTPATIENT PRESCRIPTION DRUGS-NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $6,000 each calendar year	$0	50% - $3,000 calendar year maximum benefit	50%
Over $6,000 each calendar year	$0	$0	All costs

PLAN J or HIGH DEDUCTIBLE PLAN J

OTHER BENEFITS - NOT COVERED BY MEDICARE
CONTINUED

**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**
(For Medicare Select Plans, add a triple asterisk "*" where appropriate, and language disclosing circumstances where covered person is responsible for some or all charges. For example: If you do not utilize a network provider, you are responsible for all charges.)**
‡This high deductible plan pays the same or offers the same benefits as Plan J after one has paid a calendar year [$1500] deductible. Benefits from the high deductible plan J will not begin until out-of-pocket expenses are [$1500]. 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.
†Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

SERVICES	**MEDICARE PAYS**	**AFTER YOU PAY $1500 DEDUCTIBLE, ‡ PLAN PAYS**	**IN ADDITION TO $1500 DEDUCTIBLE, ‡ YOU PAY**
† PREVENTIVE MEDICAL CARE BENEFIT-NOT COVERED BY MEDICARE Some annual physical and preventive tests and services such as: digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare:			
First $120 each calendar year	$0	$120	$0******
Additional charges	$0	$0	All costs