Figure: 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: 1 of 2
Benefit Plan(s)_____[insert letter(s) of plan(s) being offered]

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

BASIC BENEFITS for Plans A - J:[~~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 paid under a prospective payment system, 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 not covered by Medicare					Preventive Care not covered by Medicare

***Plans F and J also have an option called a high deductible Plan F and a high deductible Plan J. These high deductible plans pay the same or offer the same benefits as Plans F and J after one has paid a calendar year$[1690] [~~$1500~~] deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses are $[1690] [~~$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 do [~~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.**

[COMPANY NAME]
Outline of Medicare Supplement Coverage-Cover Page: 2 of 2

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

J	K**	L**
Basic Benefits	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 50% Hospice cost-sharing 50% of Medicare-eligible expenses for the first three pints of blood 50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 75% Hospice cost-sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services
Skilled Nursing Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		

At-Home Recovery		
Preventive Care NOT covered by Medicare		
	$[4000] Out of Pocket Annual Limit***	$[2000] Out of Pocket Annual Limit***

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

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

See Outlines of Coverage for details and exceptions.

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 $[876][~~($764)~~]	$0	$[876][~~($764)~~] (Part A Deductible)

61st through 90th day	All but $[219][($191)] a day	$[219][($191)] a day	$0**
91st day and after:			
--While using 60 lifetime reserve days	All but $[438][($382] a day	$[438][($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 $[109.50][($95.50)] a day	$0	Up to $[109.50][($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

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

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] [~~$100~~] of Medicare-Approved Amounts*	$0	$0	$[100] [~~$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] [~~$100~~] of Medicare-Approved Amounts*	$0	$0	$[100] [~~$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] [~~$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	100%	$0	$0**

medical supplies			
Durable medical equipment			
--First $[100] [~~$100~~] of Medicare-Approved Amounts*	$0	$0	$[100] [~~$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 $[876][(~~$764)~~]	$[876] [(~~$764)~~] (Part A Deductible)	$0**
61st through 90th day	All but $[219][(~~$191)~~] a day	$[219][(~~$191)~~] a day	$0**
91st day and after:			
--While using 60 lifetime reserve days	All but $[438][(~~$382~~] a day	$[438][(~~$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 $[109.50][~~($95.50)~~] a day	$0	Up to $[109.50][~~($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

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

PLAN B

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

*Once you have been billed $[100] [~~$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] [~~$100~~] of Medicare-Approved Amounts*	$0	$0	$[100] [~~$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] [~~$100~~] of Medicare-Approved Amounts*	$0	$0	$[100] [~~$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] [~~$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] [~~$100~~] of Medicare- Approved Amounts*	$0	$0	$[100] [~~$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 $[876][($764)]	$[876][($764)] (Part A Deductible)	$0**
61st through 90th day	All but $[219][($191)] a day	$[219][($191)] a day	$0**
91st day and after:			
--While using 60 lifetime reserve days	All but $[438][($382] a day	$[438][($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 $[109.50][~~($95.50)~~] a day	Up to $[109.50][~~($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

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

PLAN C

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

*Once you have been billed $[100] [~~$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] [~~$100~~] of Medicare-Approved Amounts*	$0	$[100] [~~$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] [~~$100~~] of Medicare-Approved Amounts*	$0	$[100] [~~$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] [~~$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] [~~$100~~] of Medicare-Approved Amounts*	$0	$[100] [~~$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 $[876][($764)]	$[876][($764)] (Part A Deductible)	$0**
61st through 90th day	All but $[219][($191)] a day	$[219][($191)] a day	$0**
91st day and after:			
--While using 60 lifetime reserve days	All but $[438][($382] a day	$[438][($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 $[109.50][($95.50)] a day	Up to $[109.50][($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

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

PLAN D

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

*Once you have been billed $[100] [~~$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] [~~$100~~] of Medicare-Approved Amounts*	$0	$0	$[100] [~~$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] [~~$100~~] of Medicare-Approved Amounts*	$0	$0	$[100] [~~$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] [~~$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] [~~$100~~] of Medicare-Approved Amounts*	$0	$0	$[100] [~~$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 $[876][($764)]	$[876][($764)] (Part A Deductible)	$0**
61st through 90th day	All but $[219][($191)] a day	$[219][($191)] a day	$0**
91st day and after:			
--While using 60 lifetime reserve days	All but $[438][($382] a day	$[438][($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 $[109.50][~~($95.50)~~] a day	Up to $[109.50][~~($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

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

PLAN E

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

*Once you have been billed $[100] [~~$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] [~~$100~~] of Medicare-Approved Amounts*	$0	$0	$[100] [~~$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] [~~$100~~] of Medicare-Approved Amounts*	$0	$0	$[100] [~~$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] [~~$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] [~~$100~~] of Medicare-Approved Amounts*	$0	$0	$[100] [~~$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] [~~$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 $[1690] [~~[$1500]~~] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $[1690] [~~[$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 $[1690] [~~$1500~~] DEDUCTIBLE,‡] PLAN PAYS	[IN ADDITION TO $[1690] [~~$1500~~] DEDUCTIBLE, ‡] YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but $[876][~~($764)~~]	$[876][~~($764)~~] (Part A Deductible)	$0**
61st through 90th day	All but $[219][~~($191)~~]) a day	$[219][~~($191)~~] a day	$0**
91st day and after:			
--While using 60 lifetime reserve days	All but $[438][~~($382~~] a day	$[438][~~($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 $[1690][$1500] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $[1690] [$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 $[1690] [$1500] DEDUCTIBLE,‡] PLAN PAYS**	**[IN ADDITION TO $[1690] [$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 $[109.50][($95.50)] a day	Up to $[109.50][($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

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

PLAN F OR HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed $[100] [~~$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 $[1690] [~~[$1500]~~] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $[1690] [~~[$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 $[1690] [~~$1500~~] DEDUCTIBLE,‡] PLAN PAYS**	**[IN ADDITION TO $[1690] [~~$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] [~~$100~~] of Medicare-Approved Amounts*	$0	$[100] [~~$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] [~~$100~~] of Medicare-Approved Amounts*	$0	$[100] [~~$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] [~~$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 $[1690] [~~[$1500]~~] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $[1690] [~~[$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 $[1690] [~~$1500~~] DEDUCTIBLE,‡] PLAN PAYS**	**[IN ADDITION TO $[1690] [~~$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] [~~$100~~] of Medicare-Approved Amounts*	$0	$[100] [~~$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 $[1690] [~~$1500~~] DEDUCTIBLE,‡]**	**[IN ADDITION TO $[1690] [~~$1500~~] DEDUCTIBLE, ‡]**

		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 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 $[876][~~($764)~~]	$[876][~~($764)~~] (Part A Deductible)	$0**
61st through 90th day	All but $[219][~~($191)~~] a day	$[219][~~($191)~~] a day	$0**
91st day and after:			

--While using 60 lifetime reserve days	All but $[438][($382] a day	$[438][($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 $[109.50][($95.50)] a day	Up to $[109.50][($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

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

PLAN G

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

*Once you have been billed $[100] [~~$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] [~~$100~~] of Medicare-Approved Amounts*	$0	$0	$[100] [~~$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] [~~$100~~] of Medicare-Approved Amounts*	$0	$0	$[100] [~~$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] [~~$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] [~~$100~~] of Medicare-Approved Amounts*	$0	$0	$[100] [~~$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 $[876][~~($764)~~]	$[876][~~($764)~~] (Part A Deductible)	$0**
61st through 90th day	All but $[219][~~($191)~~] a day	$[219][~~($191)~~] a day	$0**
91st day and after:			
--While using 60 lifetime reserve days	All but $[438][~~($382~~] a day	$[438][~~($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 $[109.50][~~($95.50)~~] a day	Up to $[109.50][~~($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

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

PLAN H

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

*Once you have been billed $[100] [~~$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] [~~$100~~] of Medicare-Approved Amounts*	$0	$0	$[100] [~~$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] [~~$100~~] of Medicare-Approved Amounts*	$0	$0	$[100] [~~$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] [~~$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] [~~$100~~] of Medicare-Approved Amounts*	$0	$0	$[100] [~~$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 $[876][~~($764)~~]	$[876][~~($764~~] (Part A Deductible)	$0**
61st through 90th day	All but $[219][~~($191)~~] a day	$[219][~~($191)~~] a day	$0**
91st day and after:			
--While using 60 lifetime reserve days	All but $[438][~~($382~~] a day	$[438][~~($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 $[109.50][($95.50)] a day	Up to $[109.50][($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

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

PLAN I

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

*Once you have been billed $[100] [$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] [~~$100~~] of Medicare-Approved Amounts*	$0	$0	$[100] [~~$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] [~~$100~~] of Medicare-Approved Amounts*	$0	$0	$[100] [~~$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] [~~$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] [~~$100~~] of Medicare-Approved Amounts*	$0	$0	$[100] [~~$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] [~~$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 $[1690] [~~$1500~~] deductible. Benefits

from the high deductible plan J will not begin until out-of-pocket expenses are $[1690] [[$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 $[1690] [$1500] DEDUCTIBLE,‡] PLAN PAYS	[IN ADDITION TO $[1690] [$1500] DEDUCTIBLE, ‡] YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but $[876][($764)]	$[876][($764)] (Part A Deductible)	$0**
61st through 90th day	All but $[219][($191)] a day	$[219][($191)] a day	$0**
91st day and after:			
--While using 60 lifetime reserve days	All but $[438][($382] a day	$[438][($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 $[1690] [~~[$1500]~~] deductible. Benefits from the high deductible plan J will not begin until out-of-pocket expenses are $[1690] [~~[$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 $[1690] [~~$1500~~] DEDUCTIBLE, ‡] PLAN PAYS	[IN ADDITION TO $[1690] [~~$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 $[109.50][~~($95.50)~~] a day	Up to $[109.50][~~($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	All but very limited coinsurance for outpatient	$0	Balance

you elect to receive these services	drugs and inpatient respite care		

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

PLAN J or HIGH DEDUCTIBLE PLAN J

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

*Once you have been billed $[100] [$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 $[1690] [[$1500]] deductible. Benefits from the high deductible plan J will not begin until out-of-pocket expenses are $[1690] [[$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 $[1690] [$1500] DEDUCTIBLE,‡] PLAN PAYS**	**[IN ADDITION TO $[1690] [$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] [$100] of Medicare-Approved Amounts*	$0	$[100] [$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] [~~$100~~] of Medicare-Approved Amounts*	$0	$[100] [~~$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] [~~$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 $[1690] [~~[$1500]~~] deductible. Benefits from the high deductible plan J will not begin until out-of-pocket expenses are $[1690] [~~[$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 $[1690] [~~$1500~~] DEDUCTIBLE,‡] PLAN PAYS**	**[IN ADDITION TO $[1690] [~~$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] [$100] of Medicare-Approved Amounts*	$0	$[100] [$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 $[1690] [[$1500]] deductible. Benefits from the high deductible plan J will not begin until out-of-pocket expenses are $[1690] [[$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 $[1690] [$1500] DEDUCTIBLE,‡] PLAN PAYS	[IN ADDITION TO $[1690] [$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 $[1690] [[$1500]] deductible. Benefits from the high deductible plan J will not begin until out-of-pocket expenses are $[1690] [[$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 $[1690] [~~$1500~~] DEDUCTIBLE,‡] PLAN PAYS**	**[IN ADDITION TO $[1690] [~~$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

PLAN K

* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[4000] 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.**

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

***** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**
** 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	All but $[876]	$[438](50% of Part A deductible)	$[438](50% of Part A deductible)♦
61st thru 90th day	All but $[219] a day	$[219] a day	$0***
91st day and after: —While using 60 lifetime reserve days	All but $[438] a day	$[438] 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
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0***
21st thru 100th day	All but $(109.50) a day	Up to $(54.75) a day	Up to $(54.75) a day ♦
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	50%	50%♦
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	Generally, most Medicare eligible expenses for out-patient drugs and inpatient respite care	50% of coinsurance or copayments	50% of coinsurance or copayments♦

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

PLAN K

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

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

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)**** ♦
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $[4000])*
BLOOD			
First 3 pints	$0	50%	50%♦
Next $[100] of Medicare Approved Amounts****	$0	$0	$[100] (Part B deductible)**** ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0***

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[4000] 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 K

PARTS A & B

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%	10%	10%♦

PLAN L

* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[2000] 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.**

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

***** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**
** 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	All but $[876]	$[657] (75% of Part A deductible)	$[219] (25% of Part A deductible)♦
61st thru 90th day	All but $[219] a day	$[219] a day	$0***
91st day and after: —While using 60 lifetime reserve days	All but $[438] a day	$[438] 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
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0***
21st thru 100th day	All but $[109.50] a day	Up to $[82.13] a day	Up to $[27.37] a day♦
101st day and after	$0	$0	All costs
BLOOD First 3 pints Additional amounts	 $0 100%	 75% $0	 25%♦ $0***
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	Generally, most Medicare eligible expenses for out-patient drugs and inpatient respite care	75% of coinsurance or copayments	25% of coinsurance or copayments ♦

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

PLAN L

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physi-cian'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)**** ♦
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	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 $[2000])*
BLOOD First 3 pints	$0	75%	25%♦
Next $[100] of Medicare Approved Amounts****	$0	$0	$[100] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5%♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0***

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[2000] 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

PARTS A & B

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%	15%	5% ♦