

**GPM HEALTH AND LIFE INSURANCE COMPANY**  
**OUTLINE OF MEDICARE SUPPLEMENT COVERAGE – COVER PAGE**  
**BENEFIT PLANS A, F, G AND N**

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan A available. Some plans may not be available in your state. Only applicants **first** eligible for Medicare before 2020 may purchase Plans C, F and High Deductible F.

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

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only			
	PLAN A	PLAN B	PLAN D	PLAN G	G <sup>1</sup>	PLAN K	PLAN L	PLAN M	PLAN N	PLAN C	PLAN F	F <sup>1</sup>
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	
Medicare Part B coinsurance or Copayment	✓	✓	✓	✓		50%	75%	✓	✓ copays apply <sup>3</sup>	✓	✓	
Blood (first three pints each year)	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓	
Part A hospice care coinsurance or copayment	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓	
Skilled nursing facility coinsurance			✓	✓		50%	75%	✓	✓	✓	✓	
Medicare Part A deductible		✓	✓	✓		50%	75%	50%	✓	✓	✓	
Medicare Part B deductible										✓	✓	
Medicare Part B excess charges				✓							✓	
Foreign travel emergency (up to plan limits)			✓	✓				✓	✓	✓	✓	
Out-of-pocket limit in 2019 <sup>2</sup>						\$5,560 <sup>2</sup>	\$2,780 <sup>2</sup>					

<sup>1</sup>Plans F and G also have a high deductible option which require first paying a plan deductible \$2,300 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

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

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

# MONTHLY NON-TOBACCO PREMIUMS\*

ZIP CODES: 460-461, 465-479

FEMALE				Attained Age	MALE			
Plan A MTM20	Plan F MTM24	Plan G MTM25	Plan N MTM31		Plan A MTM20	Plan F MTM24	Plan G MTM25	Plan N MTM31
96.94	135.16	97.94	79.81	65	111.48	155.43	112.64	91.79
96.94	135.16	97.94	79.81	66	111.48	155.43	112.64	91.79
96.94	135.16	97.94	79.81	67	111.48	155.43	112.64	91.79
99.02	138.05	99.87	81.58	68	113.88	158.76	114.85	93.82
102.96	143.55	103.85	84.83	69	118.41	165.08	119.43	97.55
107.11	149.34	108.04	88.24	70	123.18	171.73	124.24	101.49
111.46	155.40	112.42	91.84	71	128.19	178.71	129.28	105.61
115.82	161.46	116.81	95.42	72	133.20	185.68	134.33	109.73
120.31	167.73	121.33	99.12	73	138.36	192.89	139.55	113.99
124.32	173.32	125.38	102.43	74	142.97	199.33	144.19	117.79
128.19	178.72	129.29	105.62	75	147.43	205.54	148.69	121.46
133.26	185.78	134.39	109.79	76	153.25	213.65	154.56	126.25
136.99	190.99	138.16	112.86	77	157.54	219.62	158.89	129.79
140.62	196.03	141.83	115.85	78	161.72	225.45	163.10	133.23
144.28	201.14	145.52	118.86	79	165.91	231.30	167.34	136.69
147.88	206.16	149.14	121.84	80	170.06	237.09	171.52	140.11
151.42	211.11	152.73	124.76	81	174.15	242.78	175.64	143.47
154.90	215.97	156.23	127.63	82	178.15	248.37	179.67	146.77
158.32	220.73	159.68	130.44	83	182.07	253.84	183.63	150.00
161.65	225.37	163.03	133.18	84	185.88	259.16	187.49	153.15
164.72	229.64	166.13	135.70	85	189.42	264.08	191.04	156.06
167.69	233.78	169.11	138.15	86	192.84	268.85	194.48	158.87
170.36	237.52	171.83	140.37	87	195.92	273.14	197.60	161.41
172.42	240.36	173.88	142.05	88	198.26	276.42	199.97	163.35
174.13	242.77	175.63	143.46	89	200.26	279.18	201.97	164.98
175.87	245.19	177.38	144.90	90	202.26	281.97	203.99	166.63
177.28	247.16	178.80	146.06	91	203.88	284.24	205.62	167.97
178.53	248.88	180.05	147.07	92	205.30	286.21	207.06	169.15
179.42	250.13	180.95	147.81	93	206.33	287.64	208.10	169.98
180.29	251.34	181.83	148.54	94	207.33	289.05	209.10	170.81
180.93	252.26	182.48	149.07	95	208.09	290.10	209.86	171.43
181.60	253.18	183.15	149.61	96	208.84	291.15	210.62	172.05
182.32	254.18	183.88	150.21	97	209.67	292.31	211.47	172.75
182.99	255.10	184.55	150.75	98	210.43	293.36	212.23	173.36
183.27	255.50	184.85	151.00	99+	210.76	293.83	212.56	173.64

\*See PREMIUM INFORMATION regarding Household Premium Discount rating.

To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

**MONTHLY TOBACCO PREMIUMS\***

**ZIP CODES: 460-461, 465-479**

FEMALE				Attained Age	MALE			
Plan A MTM20	Plan F MTM24	Plan G MTM25	Plan N MTM31		Plan A MTM20	Plan F MTM24	Plan G MTM25	Plan N MTM31
111.43	155.36	112.57	91.74	65	128.14	178.65	129.47	105.50
111.43	155.36	112.57	91.74	66	128.14	178.65	129.47	105.50
111.43	155.36	112.57	91.74	67	128.14	178.65	129.47	105.50
113.82	158.68	114.79	93.77	68	130.90	182.48	132.01	107.84
118.35	165.00	119.37	97.51	69	136.10	189.75	137.27	112.13
123.12	171.65	124.18	101.43	70	141.58	197.39	142.80	116.65
128.12	178.62	129.22	105.56	71	147.34	205.41	148.60	121.39
133.13	185.59	134.26	109.68	72	153.10	213.43	154.40	126.13
138.29	192.79	139.46	113.93	73	159.03	221.71	160.40	131.02
142.90	199.22	144.12	117.73	74	164.33	229.11	165.74	135.39
147.35	205.43	148.61	121.40	75	169.46	236.25	170.91	139.61
153.17	213.54	154.47	126.19	76	176.15	245.57	177.66	145.12
157.46	219.53	158.80	129.72	77	181.08	252.44	182.63	149.18
161.63	225.32	163.02	133.16	78	185.88	259.14	187.47	153.14
165.84	231.19	167.26	136.62	79	190.70	265.86	192.35	157.11
169.98	236.97	171.43	140.04	80	195.47	272.52	197.15	161.04
174.05	242.66	175.55	143.40	81	200.17	279.06	201.88	164.91
178.05	248.24	179.57	146.70	82	204.77	285.48	206.52	168.70
181.98	253.71	183.54	149.93	83	209.28	291.77	211.07	172.41
185.80	259.04	187.39	153.08	84	213.66	297.89	215.51	176.03
189.33	263.95	190.95	155.98	85	217.72	303.54	219.59	179.38
192.75	268.71	194.38	158.79	86	221.65	309.02	223.54	182.61
195.82	273.01	197.50	161.34	87	225.20	313.95	227.13	185.53
198.18	276.28	199.86	163.27	88	227.89	317.72	229.85	187.76
200.15	279.05	201.87	164.90	89	230.18	320.90	232.15	189.63
202.15	281.83	203.88	166.55	90	232.48	324.10	234.47	191.53
203.77	284.09	205.52	167.88	91	234.34	326.71	236.35	193.07
205.21	286.07	206.95	169.05	92	235.98	328.98	238.00	194.42
206.23	287.51	207.99	169.90	93	237.16	330.62	239.19	195.38
207.23	288.90	209.00	170.73	94	238.31	332.24	240.34	196.33
207.97	289.95	209.75	171.35	95	239.18	333.45	241.22	197.05
208.74	291.01	210.52	171.96	96	240.05	334.65	242.09	197.76
209.56	292.16	211.36	172.65	97	241.00	335.99	243.07	198.56
210.33	293.22	212.13	173.27	98	241.87	337.20	243.94	199.26
210.65	293.68	212.47	173.56	99+	242.25	337.74	244.32	199.59

\*See PREMIUM INFORMATION regarding Household Premium Discount rating.

To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

# MONTHLY NON-TOBACCO PREMIUMS\*

ZIP CODES: 462 - 464

FEMALE					MALE			
Plan A MTM20	Plan F MTM24	Plan G MTM25	Plan N MTM31	Attained Age	Plan A MTM20	Plan F MTM24	Plan G MTM25	Plan N MTM31
118.27	164.90	119.48	97.37	65	136.01	189.62	137.42	111.98
118.27	164.90	119.48	97.37	66	136.01	189.62	137.42	111.98
118.27	164.90	119.48	97.37	67	136.01	189.62	137.42	111.98
120.81	168.42	121.84	99.53	68	138.94	193.68	140.12	114.46
125.62	175.13	126.70	103.50	69	144.46	201.40	145.70	119.01
130.68	182.19	131.81	107.66	70	150.27	209.51	151.57	123.81
135.99	189.59	137.15	112.04	71	156.39	218.02	157.72	128.84
141.30	196.99	142.50	116.42	72	162.50	226.54	163.88	133.87
146.78	204.63	148.02	120.93	73	168.79	235.32	170.25	139.06
151.67	211.45	152.97	124.96	74	174.42	243.18	175.92	143.70
156.40	218.04	157.74	128.85	75	179.86	250.76	181.40	148.18
162.58	226.65	163.95	133.94	76	186.97	260.65	188.57	154.03
167.13	233.01	168.55	137.69	77	192.20	267.94	193.84	158.34
171.55	239.15	173.03	141.34	78	197.29	275.05	198.98	162.54
176.02	245.39	177.53	145.01	79	202.41	282.18	204.16	166.76
180.42	251.52	181.96	148.64	80	207.47	289.25	209.26	170.93
184.74	257.56	186.33	152.21	81	212.46	296.19	214.28	175.04
188.98	263.48	190.60	155.71	82	217.34	303.01	219.20	179.06
193.15	269.29	194.81	159.14	83	222.13	309.68	224.03	183.00
197.21	274.95	198.90	162.48	84	226.78	316.18	228.74	186.84
200.96	280.16	202.67	165.56	85	231.09	322.18	233.07	190.39
204.59	285.21	206.32	168.54	86	235.26	327.99	237.27	193.82
207.84	289.77	209.63	171.25	87	239.03	333.23	241.08	196.92
210.35	293.24	212.13	173.29	88	241.88	337.23	243.96	199.29
212.44	296.18	214.27	175.03	89	244.31	340.60	246.40	201.27
214.56	299.13	216.40	176.78	90	246.75	344.00	248.87	203.29
216.28	301.53	218.14	178.19	91	248.73	346.77	250.86	204.92
217.81	303.63	219.66	179.43	92	250.47	349.18	252.61	206.36
218.89	305.16	220.76	180.33	93	251.72	350.92	253.88	207.38
219.95	306.64	221.83	181.21	94	252.94	352.64	255.10	208.38
220.74	307.75	222.63	181.87	95	253.87	353.92	256.03	209.15
221.56	308.88	223.45	182.52	96	254.79	355.20	256.95	209.90
222.43	310.10	224.34	183.25	97	255.80	356.62	257.99	210.75
223.24	311.22	225.15	183.91	98	256.72	357.90	258.92	211.50
223.58	311.71	225.52	184.22	99+	257.12	358.48	259.32	211.85

\*See PREMIUM INFORMATION regarding Household Premium Discount rating.

To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

# MONTHLY TOBACCO PREMIUMS\*

ZIP CODES: 462 - 464

FEMALE					MALE			
Plan A MTM20	Plan F MTM24	Plan G MTM25	Plan N MTM31	Attained Age	Plan A MTM20	Plan F MTM24	Plan G MTM25	Plan N MTM31
135.95	189.54	137.34	111.92	65	156.33	217.95	157.95	128.71
135.95	189.54	137.34	111.92	66	156.33	217.95	157.95	128.71
135.95	189.54	137.34	111.92	67	156.33	217.95	157.95	128.71
138.86	193.59	140.04	114.40	68	159.70	222.63	161.05	131.57
144.39	201.30	145.63	118.96	69	166.04	231.50	167.47	136.80
150.21	209.41	151.50	123.75	70	172.73	240.82	174.22	142.31
156.31	217.92	157.65	128.78	71	179.76	250.60	181.29	148.10
162.42	226.42	163.80	133.81	72	186.78	260.39	188.37	153.88
168.71	235.20	170.14	139.00	73	194.02	270.49	195.69	159.84
174.34	243.05	175.83	143.63	74	200.48	279.51	202.20	165.18
179.77	250.63	181.30	148.11	75	206.74	288.23	208.51	170.32
186.87	260.52	188.45	153.95	76	214.90	299.60	216.75	177.05
192.10	267.83	193.74	158.26	77	220.92	307.98	222.81	182.00
197.19	274.89	198.88	162.46	78	226.77	316.15	228.71	186.83
202.33	282.05	204.06	166.68	79	232.65	324.35	234.67	191.67
207.38	289.10	209.15	170.85	80	238.47	332.47	240.52	196.47
212.34	296.05	214.17	174.95	81	244.21	340.45	246.29	201.19
217.22	302.85	219.08	178.97	82	249.82	348.29	251.95	205.81
222.02	309.53	223.92	182.92	83	255.32	355.96	257.51	210.34
226.68	316.03	228.62	186.76	84	260.67	363.43	262.92	214.76
230.98	322.02	232.96	190.30	85	265.62	370.32	267.90	218.84
235.16	327.83	237.14	193.72	86	270.41	377.00	272.72	222.78
238.90	333.07	240.95	196.84	87	274.74	383.02	277.10	226.35
241.78	337.06	243.83	199.19	88	278.03	387.62	280.42	229.07
244.18	340.44	246.28	201.18	89	280.82	391.50	283.22	231.35
246.62	343.83	248.73	203.19	90	283.63	395.40	286.05	233.67
248.60	346.59	250.73	204.81	91	285.90	398.59	288.35	235.55
250.36	349.01	252.48	206.24	92	287.90	401.36	290.36	237.19
251.60	350.76	253.75	207.28	93	289.34	403.36	291.81	238.36
252.82	352.46	254.98	208.29	94	290.74	405.33	293.22	239.52
253.72	353.74	255.90	209.05	95	291.80	406.81	294.29	240.40
254.66	355.03	256.83	209.79	96	292.86	408.27	295.35	241.27
255.66	356.44	257.86	210.63	97	294.02	409.91	296.55	242.24
256.60	357.73	258.80	211.39	98	295.08	411.38	297.61	243.10
256.99	358.29	259.21	211.74	99+	295.55	412.04	298.07	243.50

\*See PREMIUM INFORMATION regarding Household Premium Discount rating.

To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

**Disclosures**

Use this outline to compare benefits and premiums among policies.

**Premium Information**

The premium for your policy will change. Because the premium rate is based on your attained age, the premium will increase each year as you age. This annual premium change will occur on the first policy renewal date which coincides with or follows the policy anniversary date.

A premium change for any other reason can occur on any policy renewal date. However, we cannot make such a change unless we make the same change to all policies using this form issued in the same state to persons of the same classification.

There will be a one-time policy fee of \$25.00 added to the first premium.

**Household Premium Discount**

You are eligible for a household premium discount if for the past year you have resided with at least one, but not more than three, other Medicare eligible adults who own or are issued a Medicare supplement policy underwritten by us or our affiliates. The residency requirement will be waived if you are married or in a civil union or domestic partnership with an individual that has an existing Medicare supplement plan with us or our affiliates. For the purposes of this discount, a civil union partner or domestic partner will be considered a legal spouse when such partnerships are valid and recognized in your state of residence. We may request additional documentation to determine eligibility. The discounted premium will be priced 7% lower than the rates illustrated.

**Read Your Policy Very Carefully**

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

**Right to Return Policy**

If you find that you are not satisfied with your policy, you may return it to GPM Health and Life Insurance Company at our administrative office, 3316 Farnam Street, Omaha, NE 68175. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

**Policy Replacement**

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

**Notice**

The policy may not fully cover all of your medical costs. Neither GPM Health and Life Insurance Company nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult "Medicare & You" for more details.

**Complete Answers Are Very Important**

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The Company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. Review the application carefully before you sign it. Be certain that all information has been properly recorded.

**Exclusions**

Exclusions apply to your coverage. Please be sure to review the exclusions in your policy.

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

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

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,364	\$0	\$1,364 (Part A deductible)
61 <sup>st</sup> through 90 <sup>th</sup> day	All but \$341 a day	\$341 a day	\$0
91 <sup>st</sup> day and after: While using 60 lifetime reserve days	All but \$682 a day	\$682 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
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21 <sup>st</sup> through 100 <sup>th</sup> day	All but \$170.50 a day	\$0	Up to \$170.50 a day
101 <sup>st</sup> day and after	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

\*\*NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid up to an additional 365 days as provided in the policy's/certificate'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 \$185 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 A PAYS	YOU PAY
<b>MEDICAL EXPENSES</b> – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$185 of Medicare-approved amounts*	\$0	\$0	\$185 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (above Medicare-approved amounts)	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next \$185 of Medicare-approved amounts*	\$0	\$0	\$185 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES</b> – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A AND B**

<b>HOME HEALTH CARE</b> – MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
<b>DURABLE MEDICAL EQUIPMENT</b>			
First \$185 of Medicare-approved amounts*	\$0	\$0	\$185 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0



**PLAN F**  
**MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**  
**Medicare first eligible before 2020 only**

\*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 F PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,364	\$1,364 (Part A deductible)	\$0
61 <sup>st</sup> through 90 <sup>th</sup> day	All but \$341 a day	\$341 a day	\$0
91 <sup>st</sup> day and after: While using 60 lifetime reserve days	All but \$682 a day	\$682 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
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 <sup>st</sup> through 100 <sup>th</sup> day	All but \$170.50 a day	Up to \$170.50 a day	\$0
101 <sup>st</sup> day and after	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

\*\*NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid up to an additional 365 days as provided in the policy's/certificate'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

### MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR – Medicare first eligible before 2020 only

\*Once you have been billed \$185 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 F PAYS	YOU PAY
<b>MEDICAL EXPENSES</b> – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$185 of Medicare-approved amounts*	\$0	\$185 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (above Medicare-approved amounts)	\$0	100%	\$0
<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next \$185 of Medicare-approved amounts*	\$0	\$185 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES</b> – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

### PARTS A AND B

<b>HOME HEALTH CARE</b> – MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	\$0	\$0
<b>DURABLE MEDICAL EQUIPMENT</b>			
First \$185 of Medicare-approved amounts*	\$0	\$185 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0

### OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
<b>FOREIGN TRAVEL</b> – 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 benefit

## PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,364	\$1,364 (Part A deductible)	\$0
61 <sup>st</sup> through 90 <sup>th</sup> day	All but \$341 a day	\$341 a day	\$0
91 <sup>st</sup> day and after: While using 60 lifetime reserve days	All but \$682 a day	\$682 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
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 <sup>st</sup> through 100 <sup>th</sup> day	All but \$170.50 a day	Up to \$170.50 a day	\$0
101 <sup>st</sup> day and after	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

\*\*NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid up to an additional 365 days as provided in the policy's/certificate'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 \$185 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 G PAYS	YOU PAY
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$185 of Medicare-approved amounts*	\$0	\$0	\$185 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (above Medicare-approved amounts)	\$0	100%	\$0
<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next \$185 of Medicare-approved amounts*	\$0	\$0	\$185 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A AND B**

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
<b>HOME HEALTH CARE – MEDICARE-APPROVED SERVICES</b> Medically necessary skilled care services and medical supplies	100%	\$0	\$0
<b>DURABLE MEDICAL EQUIPMENT</b> First \$185 of Medicare-approved amounts*	\$0	\$0	\$185 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

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

## PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,364	\$1,364 (Part A deductible)	\$0
61 <sup>st</sup> through 90 <sup>th</sup> day	All but \$341 a day	\$341 a day	\$0
91 <sup>st</sup> day and after: While using 60 lifetime reserve days	All but \$682 a day	\$682 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
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21 <sup>st</sup> through 100 <sup>th</sup> day	All but \$170.50 a day	Up to \$170.50 a day	\$0
101 <sup>st</sup> day and after	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

\*\*NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid up to an additional 365 days as provided in the policy's/certificate'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 N**  
**MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

\*Once you have been billed \$185 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 N PAYS	YOU PAY
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$185 of Medicare-approved amounts*	\$0	\$0	\$185 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense	Up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense
<b>Part B Excess Charges</b> (above Medicare-approved amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints	\$0	All costs	\$0
Next \$185 of Medicare-approved amounts*	\$0	\$0	\$185 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PLAN N**  
**MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

**PARTS A AND B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN N PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTH CARE – MEDICARE-APPROVED SERVICES</b> Medically necessary skilled care services and medical supplies	100%	\$0	\$0
<b>DURABLE MEDICAL EQUIPMENT</b> First \$185 of Medicare-approved amounts*	\$0	\$0	\$185 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

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