Anthem
Underwritten by Community Insurance Company

Administrative Office: P.O. Box 659816, San Antonio, TX 78265–9116
Toll Free Telephone Number: 1-866-803-5169

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

This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available.
Only applicants' first eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F. We offer Plans A, F, G, N, Select F, Select G and Select N.

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

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G[1]	K	L	M	N	C	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply[3]	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2020[2]					$5,880[2]	$2,940[2]				

[1] Plans F and G also have a high deductible options which require first paying a plan deductible of $2,340 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.

[2] 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.

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

Monthly Premium

Plans A, F, G & N | Effective July 1, 2020

Premiums are subject to change.

FIND YOUR PREMIUM

Premium is based upon your age, gender, area and plan.

AREA 1

Age*	MALE				FEMALE			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
65	$124.25	$178.44	$119.25	$114.40	$113.25	$162.65	$108.70	$104.27
66	127.46	189.19	126.44	121.30	116.18	172.45	115.26	110.57
67	130.22	199.94	133.62	128.19	118.69	182.25	121.80	116.84
68	136.13	210.69	140.82	135.09	124.08	192.05	128.36	123.13
69	141.97	221.44	147.99	141.97	129.41	201.85	134.90	129.40
70	148.16	232.19	155.18	148.87	135.04	211.65	141.45	135.69
71	154.31	242.95	162.36	155.76	140.66	221.45	148.00	141.98
72	160.39	253.69	169.55	162.65	146.19	231.25	154.54	148.26
73	166.55	264.45	176.74	169.55	151.82	241.05	161.10	154.55
74	172.61	275.19	183.92	176.44	157.34	250.85	167.65	160.83
75	178.19	285.95	191.10	183.33	162.41	260.65	174.19	167.11
76	183.76	295.35	198.29	190.22	167.50	269.22	180.75	173.39
77	189.32	304.30	205.47	197.11	172.57	277.37	187.29	179.67
78	194.89	313.26	212.67	204.02	177.65	285.55	193.86	185.97
79	200.09	321.65	219.85	210.90	182.39	293.19	200.40	192.24
80	204.73	329.01	227.03	217.80	186.62	299.90	206.95	198.53
81+	208.58	335.26	227.03	217.80	190.13	305.59	206.95	198.53

- **Area 1:** Allen, Ashland, Athens, Auglaize, Belmont, Champaign, Clark, Clinton, Coshocton, Crawford, Defiance, Delaware, Fairfield, Fayette, Franklin, Gallia, Greene, Guernsey, Hancock, Hardin, Henry, Hocking, Holmes, Huron, Jefferson, Knox, Lawrence, Licking, Logan, Madison, Marion, Meigs, Mercer, Miami, Monroe, Morgan, Morrow, Muskingum, Noble, Paulding, Perry, Pickaway, Putnam, Richland, Ross, Seneca, Shelby, Union, Van Wert, Washington, Wayne, Williams, Wyandot

* Attained age at the time of enrollment.

(SEE NEXT PAGE FOR MORE AREAS)

Monthly Premium

Plans A, F, G & N | Effective July 1, 2020

Premiums are subject to change.

FIND YOUR PREMIUM *(continued)*

Premium is based upon your age, gender, area and plan.

AREA 2

Age*	MALE				FEMALE			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
65	$131.95	$189.51	$126.64	$121.49	$120.28	$172.74	$115.44	$110.74
66	135.36	200.92	134.28	128.82	123.39	183.14	122.41	117.43
67	138.30	212.34	141.91	136.14	126.05	193.55	129.36	124.09
68	144.56	223.75	149.54	143.46	131.78	203.96	136.31	130.76
69	150.77	235.18	157.16	150.77	137.43	214.37	143.26	137.43
70	157.34	246.59	164.80	158.10	143.42	224.77	150.22	144.11
71	163.88	258.01	172.43	165.42	149.38	235.18	157.18	150.79
72	170.33	269.42	180.06	172.74	155.25	245.59	164.13	157.45
73	176.88	280.85	187.70	180.05	161.23	256.00	171.09	164.13
74	183.32	292.26	195.33	187.38	167.10	266.40	178.05	170.80
75	189.23	303.68	202.96	194.69	172.48	276.81	185.00	177.47
76	195.15	313.67	210.59	202.01	177.89	285.92	191.95	184.14
77	201.05	323.16	218.21	209.33	183.27	294.57	198.90	190.81
78	206.98	332.69	225.86	216.66	188.66	303.25	205.87	197.50
79	212.49	341.59	233.48	223.98	193.69	311.37	212.83	204.17
80	217.42	349.41	241.11	231.30	198.19	318.50	219.78	210.83
81+	221.52	356.04	241.11	231.30	201.92	324.54	219.78	210.83

■ **Area 2:** Adams, Boone, Brown, Butler, Clermont, Darke, Hamilton, Highland, Jackson, Montgomery, Pike, Preble, Scioto, Vinton, Warren

* Attained age at the time of enrollment.

(SEE NEXT PAGE FOR MORE AREAS)

Monthly Premium

Plans A, F, G & N | Effective July 1, 2020

Premiums are subject to change.

FIND YOUR PREMIUM *(continued)*

Premium is based upon your age, gender, area and plan.

AREA 3

Age*	MALE				FEMALE			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
65	$140.60	$201.91	$134.93	$129.45	$128.15	$184.05	$122.99	$117.99
66	144.23	214.07	143.08	137.26	131.46	195.13	130.42	125.11
67	147.35	226.24	151.21	145.05	134.32	206.23	137.82	132.21
68	154.04	238.40	159.34	152.85	140.41	217.31	145.24	139.33
69	160.64	250.57	167.46	160.64	146.43	228.40	152.64	146.43
70	167.64	262.73	175.59	168.44	152.81	239.49	160.06	153.54
71	174.62	274.90	183.73	176.25	159.16	250.58	167.47	160.65
72	181.48	287.06	191.85	184.05	165.43	261.67	174.88	167.76
73	188.46	299.23	199.98	191.85	171.79	272.76	182.29	174.87
74	195.32	311.39	208.11	199.65	178.04	283.84	189.71	181.98
75	201.62	323.57	216.24	207.44	183.78	294.94	197.11	189.08
76	207.93	334.20	224.38	215.24	189.54	304.64	204.53	196.21
77	214.22	344.32	232.50	223.03	195.27	313.86	211.93	203.31
78	220.53	354.47	240.65	230.85	201.02	323.11	219.36	210.43
79	226.40	363.96	248.77	238.65	206.38	331.75	226.75	217.53
80	231.66	372.29	256.90	246.45	211.17	339.35	234.17	224.65
81+	236.02	379.36	256.90	246.45	215.13	345.79	234.17	224.65

- **Area 3:** Ashtabula, Carroll, Columbiana, Cuyahoga, Erie, Fulton, Geauga, Harrison, Lake, Lorain, Lucas, Mahoning, Medina, Ottawa, Portage, Sandusky, Stark, Summit, Trumbull, Tuscarawas, Wood

* Attained age at the time of enrollment.

(SEE NEXT PAGE FOR SELECT PLANS)

Monthly Premium

Plans F, G & N | Effective July 1, 2020

Premiums are subject to change.

FIND YOUR PREMIUM **SELECT PLANS** *(continued)*

Select Plans require use of a network hospital. Premium is based upon your age, gender, area and plan.

AREA 1

Age*	MALE			FEMALE		
	Plan F	Plan G	Plan N	Plan F	Plan G	Plan N
65	$167.64	$102.79	$94.64	$152.80	$93.70	$86.27
66	177.73	109.00	100.35	162.00	99.36	91.48
67	187.83	115.19	106.05	171.22	105.00	96.66
68	197.92	121.40	111.76	180.41	110.65	101.87
69	208.02	127.57	117.45	189.63	116.29	107.06
70	218.14	133.77	123.15	198.83	121.93	112.25
71	228.24	139.97	128.87	208.04	127.58	117.47
72	238.33	146.16	134.57	217.24	133.22	122.66
73	248.43	152.34	140.26	226.45	138.88	127.86
74	258.52	158.55	145.97	235.66	144.52	133.05
75	268.64	164.73	151.67	244.86	150.16	138.23
76	277.46	170.93	157.37	252.91	155.81	143.45
77	285.87	177.13	163.07	260.58	161.45	148.64
78	294.29	183.34	168.80	268.25	167.11	153.84
79	302.17	189.52	174.47	275.42	172.74	159.04
80	309.08	195.72	180.19	281.75	178.40	164.25
81+	314.96	195.72	180.19	287.09	178.40	164.25

- **Area 1:** Allen, Ashland, Athens, Auglaize, Belmont, Champaign, Clark, Clinton, Coshocton, Crawford, Defiance, Delaware, Fairfield, Fayette, Franklin, Gallia, Greene, Guernsey, Hancock, Hardin, Henry, Hocking, Holmes, Huron, Jefferson, Knox, Lawrence, Licking, Logan, Madison, Marion, Meigs, Mercer, Miami, Monroe, Morgan, Morrow, Muskingum, Noble, Paulding, Perry, Pickaway, Putnam, Richland, Ross, Seneca, Shelby, Union, Van Wert, Washington, Wayne, Williams, Wyandot

* Attained age at the time of enrollment.

(SEE NEXT PAGE FOR MORE AREAS)

Monthly Premium

Plans F, G & N | Effective July 1, 2020

Premiums are subject to change.

FIND YOUR PREMIUM **SELECT PLANS** *(continued)*

Select Plans require use of a network hospital. Premium is based upon your age, gender, area and plan.

AREA 2

Age*	MALE			FEMALE		
	Plan F	Plan G	Plan N	Plan F	Plan G	Plan N
65	$178.03	$109.16	$100.50	$162.29	$99.53	$91.62
66	188.75	115.76	106.58	172.06	105.51	97.14
67	199.49	122.33	112.62	181.84	111.50	102.66
68	210.21	128.92	118.69	191.60	117.51	108.19
69	220.93	135.48	124.73	201.38	123.51	113.69
70	231.65	142.07	130.80	211.16	129.51	119.23
71	242.40	148.65	136.86	220.94	135.50	124.74
72	253.11	155.21	142.90	230.71	141.49	130.27
73	263.84	161.81	148.96	240.49	147.49	135.79
74	274.56	168.38	155.03	250.26	153.48	141.30
75	285.29	174.96	161.08	260.05	159.48	146.82
76	294.67	181.53	167.12	268.60	165.47	152.34
77	303.60	188.09	173.17	276.74	171.45	157.84
78	312.56	194.70	179.25	284.88	177.47	163.39
79	320.91	201.26	185.30	292.52	183.46	168.90
80	328.25	207.85	191.36	299.21	189.46	174.43
81+	334.48	207.85	191.36	304.90	189.46	174.43

■ **Area 2:** Adams, Boone, Brown, Butler, Clermont, Darke, Hamilton, Highland, Jackson, Montgomery, Pike, Preble, Scioto, Vinton, Warren

* Attained age at the time of enrollment.

(SEE NEXT PAGE FOR MORE AREAS)

Monthly Premium

Plans F, G & N | Effective July 1, 2020

Premiums are subject to change.

FIND YOUR PREMIUM **SELECT PLANS** *(continued)*

Select Plans require use of a network hospital. Premium is based upon your age, gender, area and plan.

AREA 3

Age*	MALE			FEMALE		
	Plan F	Plan G	Plan N	Plan F	Plan G	Plan N
65	$189.70	$116.31	$107.08	$172.91	$106.03	$97.61
66	201.12	123.33	113.55	183.32	112.43	103.51
67	212.55	130.33	119.99	193.74	118.81	109.37
68	223.98	137.35	126.45	204.15	125.19	115.26
69	235.41	144.35	132.89	214.57	131.58	121.15
70	246.84	151.38	139.36	224.99	137.98	127.03
71	258.27	158.38	145.80	235.41	144.36	132.91
72	269.68	165.39	152.25	245.81	150.76	138.79
73	281.11	172.39	158.71	256.24	157.15	144.68
74	292.53	179.40	165.17	266.66	163.53	150.55
75	303.97	186.41	171.62	277.08	169.91	156.43
76	313.96	193.42	178.08	286.19	176.30	162.31
77	323.47	200.42	184.52	294.85	182.69	168.19
78	333.02	207.45	190.98	303.54	189.09	174.09
79	341.92	214.45	197.42	311.68	195.48	179.97
80	349.73	221.47	203.90	318.81	201.86	185.86
81+	356.39	221.47	203.90	324.86	201.86	185.86

- **Area 3:** Ashtabula, Carroll, Columbiana, Cuyahoga, Erie, Fulton, Geauga, Harrison, Lake, Lorain, Lucas, Mahoning, Medina, Ottawa, Portage, Sandusky, Stark, Summit, Trumbull, Tuscarawas, Wood

* Attained age at the time of enrollment.

PREMIUM INFORMATION

We, Anthem, can only raise your premium if we raise the premium for all policies like yours in this State. We will recalculate your age each year to determine your new attained age. Your premium may increase annually at your plan renewal based upon your new attained age.

TOBACCO

Anthem does not offer tobacco rates.

HOUSEHOLD DISCOUNT

A 5% multi-insured discount will apply to Insureds who reside with at least one other active Anthem Medicare supplement Insured within a household. The discount will apply only while this criterion is met. This discount will be offered to eligible Insureds and when the Insured is no longer eligible, the discount will be discontinued.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to us at our Administrative Office: P.O. Box 659816, San Antonio, TX 78265-9116. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

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

NOTICE

This policy may not fully cover all of your medical costs.

Neither Anthem 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.

GRIEVANCE PROCEDURES

The following terms when used in this procedure have the meanings shown below.

"Adverse Benefit Determination" is a denial, reduction, or failure to make payment (in whole or in part) of a claim due to lack of eligibility for coverage, policy limitations or exclusions, or a determination that an item or service otherwise covered is experimental or investigational or not Medically Necessary or appropriate. The application of copayments or deductibles is not considered a denial of a claim.

"Authorized Representative" is a person granted authority by You and us to act on Your behalf regarding a claim for benefit or a grievance of an Adverse Benefit Determination. An assignment of benefits is not a grant of authority to act on Your behalf in pursuing and appealing a benefit determination.

If You are dissatisfied with our benefit determination on a claim, You may appeal our decision by following the steps outlined in this procedure. We will resolve Your grievance in a thorough, appropriate, and timely manner to ensure that You are afforded a full and fair review of claims for benefits. Benefit determinations will be made in accordance with the Policy and consistently among claimants. Your Authorized Representative may submit written comments, documents, records and other information relating to claims or grievances. We will provide a review that takes into account all information submitted whether or not it was considered with its first determination on the claim. Any notifications by us required under these procedures will be supplied to Your Authorized Representative.

Your Authorized Representative may file a grievance with us within 180 days of receipt of an Adverse Benefit Determination. To file a grievance, telephone the toll-free number listed in this Policy.

We will review the claim and notify You of our decision within 60 days of the grievance. Any medical advisor involved in reviewing the grievance will be different from and not in a subordinate position to the medical advisor involved in the initial benefit determination.

Notice of the grievance decision will include the following in written or electronic form:

a) the specific reason for the grievance decision;

b) reference to the Policy provisions on which the decision was based;

c) a statement that You are entitled to receive upon request and free of charge, reasonable accessibility to and copies of all relevant documents, records, and criteria including an explanation of clinical judgment on which the decision was based and identification of the medical experts;

d) If You wish to dispute our decision on a claim, You may register a complaint by submitting the complaint to the following address. In reviewing, the complaint, we follow the complaint procedure described in this provision.

Community Insurance Company
4361 Irwin Simpson Rd, Mason OH, 45040

e) If Your claim has been denied on the basis that the services is not Medically Necessary, or You have been diagnosed with a terminal condition and the service has been denied on the basis that it is experimental or investigative, You may have a right to request an independent review by an outside medical practitioner. Submit such request in writing to the following address and arrangements will be made for You:

Community Insurance Company
4361 Irwin Simpson Rd, Mason OH, 45040

f) If Your claim has been denied on the basis that it is not a Covered Service, You have the right to file a complaint with the Ohio Department of Insurance at the address below or the complaint may also be filed via the Internet at **http://insurance.ohio.gov**.

FOR CONSUMERS:
Ohio Department of Insurance
Consumer Services Division
50 West Town Street
Third Floor – Suite 300
Columbus, OH 43215
(614) 644-2673
Toll free in Ohio 1-800-686-1526

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,408	$0	$1,408 (Part A deductible)
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $704 a day	$704 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 $176 a day	$0	Up to $176 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			
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, 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 $198 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES — IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $198 of Medicare Approved Amounts*	$0	$0	$198 (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 $198 of Medicare Approved Amounts*	$0	$0	$198 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES -TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE — MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment:			
First $198 of Medicare approved amounts*	$0	$0	$198 (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0

PLAN F

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,408	$1,408 (Part A deductible)	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $704 a day	$704 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 $176 a day	Up to $176 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			
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, 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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES — IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $198 of Medicare Approved Amounts*	$0	$198 (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 $198 of Medicare Approved Amounts*	$0	$198 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES -TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE — MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment:			
First $198 of Medicare approved amounts*	$0	$198 (Part B deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,408	$1,408 (Part A deductible)	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $704 a day	$704 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 $176 a day	Up to $176 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			
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, 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 $198 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES — IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $198 of Medicare Approved Amounts*	$0	$0	$198 (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 $198 of Medicare Approved Amounts*	$0	$0	$198 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES -TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE — MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment:			
First $198 of Medicare approved amounts*	$0	$0	$198 (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 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 PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,408	$1,408 (Part A deductible)	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $704 a day	$704 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 $176 a day	Up to $176 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			
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, 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 N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES — IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $198 of Medicare Approved Amounts*	$0	$0	$198 (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 co-payment 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 co-payment 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.
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $198 of Medicare Approved Amounts*	$0	$0	$198 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES -TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N (continued)

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 $198 of Medicare approved amounts*	$0	$0	$198 (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