

## Outline of Medicare Supplement Plan Benefits

### Available Plans: A, F, HdF<sup>1</sup>, G, HdG<sup>1</sup>, 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.**

A ✓ means 100% of the benefit is paid.

Highlighted plans are available from Medico Insurance Company.

| Benefits   | Plans Available to All Applicants |   |   |                |         |         |     |                                | Medicare first eligible before 2020 only |
|--|-----------------------------------|---|---|----------------|---------|---------|-----|--------------------------------|--|
|  | A                                 | B | D | G <sup>1</sup> | K       | L       | M   | N                              |  |
| 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%     | ✓   | ✓<br>copays apply <sup>3</sup> |  |
| 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 2026 <sup>2</sup>   |                                   |   |   |                | \$8,000 | \$4,000 |     |                                |  |

<sup>1</sup>Plans F and G also have a high deductible option which require first paying a plan deductible of \$2,950 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.

## **Premium Information**

We, Medico Insurance Company, guarantee to renew your policy for life as long as the premium is paid when due.

We can only raise your premium if we raise the premium for all policies like yours in this state. If it is necessary to change the premium for your policy, we will notify you 30 days in advance of the change in premium. Premiums are based on your attained age.

## **Spousal or Domestic Partnership Discount**

When the applicant is married or in a domestic partnership registered with the state of Washington a discount is applied to the premium rates.

## **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**

When you receive your policy, please review it along with the attached application. If you find that you are not satisfied with your policy, you may return it to us at P.O. Box 10386, Des Moines, IA 50306. 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, less any claims paid.

## **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 Medico Insurance Company nor its producers are connected with Medicare.

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

## **Complete Answers Are Very Important**

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The Company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. Medical and health history questions are not required to be answered on the application if you apply during Open Enrollment or if you are eligible for a Guaranteed Issue.

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

## PLAN A

### MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD\*

| SERVICES  | MEDICARE PAYS  | PLAN PAYS                             | YOU PAY                        |
|---|--|---------------------------------------|--------------------------------|
| <b>HOSPITALIZATION*</b>   |  |                                       |                                |
| Semiprivate room and board, general nursing and miscellaneous services and supplies   |  |                                       |                                |
| First 60 days   | All but \$1,736  | \$0                                   | \$1,736<br>(Part A deductible) |
| 61st thru 90th day  | All but \$434 a day  | \$434 a day                           | \$0                            |
| 91st day and after:   |  |                                       |                                |
| • While using 60 lifetime reserve days  | All but \$868 a day  | \$868 a day                           | \$0                            |
| • Once lifetime reserve days are used:  |  |                                       |                                |
| • Additional 365 days   | \$0  | 100% of Medicare<br>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                            |
| 21st thru 100th day   | All but \$217 a day  | \$0                                   | Up to \$217 a day              |
| 101st 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 physician's certification of terminal illness.   | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance        | \$0                            |

\* 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.

\*\* **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** (continued)  
**MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

| SERVICES  | MEDICARE PAYS | PLAN PAYS     | YOU PAY                      |
|---|---------------|---------------|------------------------------|
| <b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT,</b><br>such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment |               |               |                              |
| First \$283 of Medicare Approved Amounts*<br>(Part B deductible)  | \$0           | \$0           | \$283<br>(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 \$283 of Medicare Approved Amounts* (Part B deductible)  | \$0           | \$0           | \$283<br>(Part B deductible) |
| Remainder of Medicare Approved Amounts  | 80%           | 20%           | \$0                          |
| <b>CLINICAL LABORATORY SERVICES</b>   |               |               |                              |
| Tests for Diagnostic Services   | 100%          | \$0           | \$0                          |

**MEDICARE (PARTS A AND B) - HOME HEALTH CARE**

| SERVICES   | MEDICARE PAYS | PLAN PAYS | YOU PAY                      |
|--|---------------|-----------|------------------------------|
| <b>HOME HEALTH CARE - MEDICARE APPROVED SERVICES</b>           |               |           |                              |
| Medically necessary skilled care services and medical supplies | 100%          | \$0       | \$0                          |
| Durable medical equipment                                      |               |           |                              |
| • First \$283 of Medicare Approved Amounts*                    | \$0           | \$0       | \$283<br>(Part B deductible) |
| • Remainder of Medicare Approved Amounts                       | 80%           | 20%       | \$0                          |

\* Once you have been billed for \$283 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.

**PLAN F**  
**MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD\***

| SERVICES   | MEDICARE PAYS  | PLAN PAYS                             | YOU PAY   |
|--|--|---------------------------------------|-----------|
| <b>HOSPITALIZATION*</b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies   |  |                                       |           |
| First 60 days  | All but \$1,736  | \$1,736<br>(Part A deductible)        | \$0       |
| 61st thru 90th day   | All but \$434 a day  | \$434 a day                           | \$0       |
| 91st day and after:  |  |                                       |           |
| • While using 60 lifetime reserve days   | All but \$868 a day  | \$868 a day                           | \$0       |
| • Once lifetime reserve days are used:   |  |                                       |           |
| • Additional 365 days  | \$0  | 100% of Medicare<br>Eligible expenses | \$0**     |
| • Beyond the additional 365 days   | \$0  | \$0                                   | All costs |
| <b>SKILLED NURSING FACILITY CARE*</b><br>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 \$217 a day  | Up to \$217 a day                     | \$0       |
| 101st 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 physician's certification of terminal illness.  | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance        | \$0       |

\* 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.

\*\* **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** (continued)  
**MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

| SERVICES  | MEDICARE PAYS | PLAN 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 \$283 of Medicare Approved Amounts*<br>(Part B deductible)  | \$0           | \$283<br>(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 \$283 of Medicare Approved Amounts* (Part B deductible)  | \$0           | \$283<br>(Part B deductible) | \$0     |
| Remainder of Medicare Approved Amounts  | 80%           | 20%                          | \$0     |
| <b>CLINICAL LABORATORY SERVICES</b>   |               |                              |         |
| Tests for Diagnostic Services   | 100%          | \$0                          | \$0     |

**MEDICARE (PARTS A AND B) - HOME HEALTH CARE**

| SERVICES   | MEDICARE PAYS | PLAN PAYS                    | YOU PAY |
|--|---------------|------------------------------|---------|
| <b>HOME HEALTH CARE - MEDICARE APPROVED SERVICES</b>           |               |                              |         |
| Medically necessary skilled care services and medical supplies |               |                              |         |
| Durable medical equipment                                      |               |                              |         |
| • First \$283 of Medicare Approved Amounts*                    | \$0           | \$283<br>(Part B deductible) | \$0     |
| • Remainder of Medicare Approved Amounts                       | 80%           | 20%                          | \$0     |

\* Once you have been billed for \$283 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.

**PLAN F** (continued)  
**OTHER BENEFITS - NOT COVERED BY MEDICARE**

| SERVICES  | MEDICARE PAYS | PLAN 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<br>Maximum Benefit of<br>\$50,000 | 20% and amounts over<br>the \$50,000 lifetime<br>maximum |

## HIGH DEDUCTIBLE PLAN F

### MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD\*

| SERVICES  | MEDICARE PAYS  | AFTER YOU PAY<br>\$2,950 DEDUCTIBLE**<br>PLAN PAYS | IN ADDITION TO<br>\$2,950 DEDUCTIBLE**<br>YOU PAY |
|---|--|--|---|
| <b>HOSPITALIZATION*</b>   |  |  |   |
| Semiprivate room and board, general nursing and miscellaneous services and supplies   |  |  |   |
| First 60 days   | All but \$1,736  | \$1,736<br>(Part A deductible)                     | \$0   |
| 61st thru 90th day  | All but \$434 a day  | \$434 a day  | \$0   |
| 91st day and after:   |  |  |   |
| • While using 60 lifetime reserve days  | All but \$868 a day  | \$868 a day  | \$0   |
| • Once lifetime reserve days are used:  |  |  |   |
| • Additional 365 days   | \$0  | 100% of Medicare<br>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   |
| 21st thru 100th day   | All but \$217 a day  | Up to \$217 a day                                  | \$0   |
| 101st 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 physician's certification of terminal illness.   | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance                     | \$0   |

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

\*\* This high deductible plan pays the same benefits as Plan F after you have paid a calendar year \$2,950 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$2,950. 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.

\*\*\* **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.

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

| SERVICES  | MEDICARE PAYS | AFTER YOU PAY<br>\$2,950 DEDUCTIBLE**<br>PLAN PAYS | IN ADDITION TO<br>\$2,950 DEDUCTIBLE**<br>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 \$283 of Medicare Approved Amounts*<br>(Part B deductible)  | \$0           | \$283<br>(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 \$283 of Medicare Approved Amounts* (Part B deductible)  | \$0           | \$283<br>(Part B deductible)                       | \$0   |
| Remainder of Medicare Approved Amounts  | 80%           | 20%  | \$0   |
| <b>CLINICAL LABORATORY SERVICES</b>   |               |  |   |
| Tests for Diagnostic Services   | 100%          | \$0  | \$0   |

**MEDICARE (PARTS A AND B) - HOME HEALTH CARE**

| SERVICES   | MEDICARE PAYS | AFTER YOU PAY<br>\$2,950 DEDUCTIBLE**<br>PLAN PAYS | IN ADDITION TO<br>\$2,950 DEDUCTIBLE**<br>YOU PAY |
|--|---------------|--|---|
| <b>HOME HEALTH CARE - MEDICARE APPROVED SERVICES</b>           |               |  |   |
| Medically necessary skilled care services and medical supplies |               |  |   |
| Durable medical equipment                                      |               |  |   |
| • First \$283 of Medicare Approved Amounts*                    | \$0           | \$283<br>(Part B deductible)                       | \$0   |
| • Remainder of Medicare Approved Amounts                       | 80%           | 20%  | \$0   |

\* Once you have been billed for \$283 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

\*\* This high deductible plan pays the same benefits as Plan F after you have paid a calendar year \$2,950 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$2,950. 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.

## HIGH DEDUCTIBLE PLAN F (continued)

### OTHER BENEFITS - NOT COVERED BY MEDICARE

| SERVICES  | MEDICARE PAYS | AFTER YOU PAY<br>\$2,950 DEDUCTIBLE**<br>PLAN PAYS  | IN ADDITION TO<br>\$2,950 DEDUCTIBLE**<br>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<br>Maximum Benefit of<br>\$50,000 | 20% and amounts over<br>the \$50,000 lifetime<br>maximum |

\*\* This high deductible plan pays the same benefits as Plan F after you have paid a calendar year \$2,950 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$2,950. 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.

## PLAN G

### MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD\*

| SERVICES  | MEDICARE PAYS  | PLAN PAYS                             | YOU PAY   |
|---|--|---------------------------------------|-----------|
| <b>HOSPITALIZATION*</b>   |  |                                       |           |
| Semiprivate room and board, general nursing and miscellaneous services and supplies   |  |                                       |           |
| First 60 days   | All but \$1,736  | \$1,736<br>(Part A deductible)        | \$0       |
| 61st thru 90th day  | All but \$434 a day  | \$434 a day                           | \$0       |
| 91st day and after:   |  |                                       |           |
| • While using 60 lifetime reserve days  | All but \$868 a day  | \$868 a day                           | \$0       |
| • Once lifetime reserve days are used:  |  |                                       |           |
| • Additional 365 days   | \$0  | 100% of Medicare<br>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       |
| 21st thru 100th day   | All but \$217 a day  | Up to \$217 a day                     | \$0       |
| 101st 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 physician's certification of terminal illness.   | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance        | \$0       |

\* 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.

\*\* **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** (continued)  
**MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

| SERVICES  | MEDICARE PAYS | PLAN 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 \$283 of Medicare Approved Amounts*<br>(Part B deductible)  | \$0           | \$0           | \$283 (Unless Part B deductible has been met) |
| 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 \$283 of Medicare Approved Amounts* (Part B deductible)  | \$0           | \$0           | \$283 (Unless Part B deductible has been met) |
| Remainder of Medicare Approved Amounts  | 80%           | 20%           | \$0   |
| <b>CLINICAL LABORATORY SERVICES</b>   |               |               |   |
| Tests for Diagnostic Services   | 100%          | \$0           | \$0   |

**MEDICARE (PARTS A AND B) - HOME HEALTH CARE**

| SERVICES   | MEDICARE PAYS | PLAN PAYS | YOU PAY                                       |
|--|---------------|-----------|---|
| <b>HOME HEALTH CARE - MEDICARE APPROVED SERVICES</b>           |               |           |   |
| Medically necessary skilled care services and medical supplies | 100%          | \$0       | \$0   |
| Durable medical equipment                                      |               |           |   |
| • First \$283 of Medicare Approved Amounts*                    | \$0           | \$0       | \$283 (Unless Part B deductible has been met) |
| • Remainder of Medicare Approved Amounts                       | 80%           | 20%       | \$0   |

\* Once you have been billed for \$283 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.

**PLAN G** (continued)  
**OTHER BENEFITS - NOT COVERED BY MEDICARE**

| <b>SERVICES</b>   | <b>MEDICARE PAYS</b> | <b>PLAN 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<br>Maximum Benefit of<br>\$50,000 | 20% and amounts over<br>the \$50,000 lifetime<br>maximum |

## HIGH DEDUCTIBLE PLAN G

### MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD\*

| SERVICES  | MEDICARE PAYS  | AFTER YOU PAY<br>\$2,950 DEDUCTIBLE**<br>PLAN PAYS | IN ADDITION TO<br>\$2,950 DEDUCTIBLE**<br>YOU PAY |
|---|--|--|---|
| <b>HOSPITALIZATION*</b>   |  |  |   |
| Semiprivate room and board, general nursing and miscellaneous services and supplies   |  |  |   |
| First 60 days   | All but \$1,736  | \$1,736<br>(Part A deductible)                     | \$0   |
| 61st thru 90th day  | All but \$434 a day  | \$434 a day  | \$0   |
| 91st day and after:   |  |  |   |
| • While using 60 lifetime reserve days  | All but \$868 a day  | \$868 a day  | \$0   |
| • Once lifetime reserve days are used:  |  |  |   |
| • Additional 365 days   | \$0  | 100% of Medicare<br>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   |
| 21st thru 100th day   | All but \$217 a day  | Up to \$217 a day                                  | \$0   |
| 101st 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 physician's certification of terminal illness.   | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance                     | \$0   |

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

\*\* This high deductible plan pays the same benefits as Plan G after you have paid a calendar year \$2,950 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are \$2,950. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

\*\*\* **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.

**HIGH DEDUCTIBLE PLAN G** (continued)  
**MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

| SERVICES  | MEDICARE PAYS | AFTER YOU PAY<br>\$2,950 DEDUCTIBLE**<br>PLAN PAYS | IN ADDITION TO<br>\$2,950 DEDUCTIBLE**<br>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 \$283 of Medicare Approved Amounts*<br>(Part B deductible)  | \$0           | \$0  | \$283 (Unless Part B deductible has been met)     |
| 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 \$283 of Medicare Approved Amounts* (Part B deductible)  | \$0           | \$0  | \$283 (Unless Part B deductible has been met)     |
| Remainder of Medicare Approved Amounts  | 80%           | 20%  | \$0   |
| <b>CLINICAL LABORATORY SERVICES</b>   |               |  |   |
| Tests for Diagnostic Services   | 100%          | \$0  | \$0   |

\* Once you have been billed for \$283 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

\*\* This high deductible plan pays the same benefits as Plan G after you have paid a calendar year \$2,950 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are \$2,950. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

**HIGH DEDUCTIBLE PLAN G** (continued)  
**MEDICARE (PARTS A AND B) - HOME HEALTH CARE**

| SERVICES   | MEDICARE PAYS | AFTER YOU PAY<br>\$2,950 DEDUCTIBLE**<br>PLAN PAYS | IN ADDITION TO<br>\$2,950 DEDUCTIBLE**<br>YOU PAY |
|--|---------------|--|---|
| <b>HOME HEALTH CARE - MEDICARE APPROVED SERVICES</b>           |               |  |   |
| Medically necessary skilled care services and medical supplies | 100%          | \$0  | \$0   |
| Durable medical equipment                                      |               |  |   |
| • First \$283 of Medicare Approved Amounts*                    | \$0           | \$0  | \$283 (Unless Part B deductible has been met)     |
| • Remainder of Medicare Approved Amounts                       | 80%           | 20%  | \$0   |

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

| SERVICES  | MEDICARE PAYS | AFTER YOU PAY<br>\$2,950 DEDUCTIBLE**<br>PLAN PAYS | IN ADDITION TO<br>\$2,950 DEDUCTIBLE**<br>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 |

\* Once you have been billed for \$283 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

\*\* This high deductible plan pays the same benefits as Plan G after you have paid a calendar year \$2,950 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are \$2,950. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

**PLAN N**  
**MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD\***

| SERVICES   | MEDICARE PAYS  | PLAN PAYS                             | YOU PAY   |
|--|--|---------------------------------------|-----------|
| <b>HOSPITALIZATION*</b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies   |  |                                       |           |
| First 60 days  | All but \$1,736  | \$1,736<br>(Part A deductible)        | \$0       |
| 61st thru 90th day   | All but \$434 a day  | \$434 a day                           | \$0       |
| 91st day and after:  |  |                                       |           |
| • While using 60 lifetime reserve days   | All but \$868 a day  | \$868 a day                           | \$0       |
| • Once lifetime reserve days are used:   |  |                                       |           |
| • Additional 365 days  | \$0  | 100% of Medicare<br>Eligible expenses | \$0**     |
| • Beyond the additional 365 days   | \$0  | \$0                                   | All costs |
| <b>SKILLED NURSING FACILITY CARE*</b><br>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 \$217 a day  | Up to \$217 a day                     | \$0       |
| 101st 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 physician's certification of terminal illness.  | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance        | \$0       |

\* 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.

\*\* **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** (continued)  
**MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

| SERVICES  | MEDICARE PAYS | PLAN PAYS   | YOU PAY   |
|---|---------------|---|---|
| <b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT,</b><br>such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment |               |   |   |
| First \$283 of Medicare Approved Amounts*<br>(Part B deductible)  | \$0           | \$0   | \$283<br>(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 you are 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 you are 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 \$283 of Medicare Approved Amounts* (Part B deductible)  | \$0           | \$0   | \$283<br>(Part B deductible)  |
| Remainder of Medicare Approved Amounts  | 80%           | 20%   | \$0   |
| <b>CLINICAL LABORATORY SERVICES</b>   |               |   |   |
| Tests for Diagnostic Services   | 100%          | \$0   | \$0   |

\* Once you have been billed for \$283 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.

**PLAN N** (continued)  
**MEDICARE (PARTS A AND B) - HOME HEALTH CARE**

| SERVICES   | MEDICARE PAYS | PLAN PAYS | YOU PAY                      |
|--|---------------|-----------|------------------------------|
| <b>HOME HEALTH CARE - MEDICARE APPROVED SERVICES</b>           |               |           |                              |
| Medically necessary skilled care services and medical supplies | 100%          | \$0       | \$0                          |
| Durable medical equipment                                      |               |           |                              |
| • First \$283 of Medicare Approved Amounts*                    | \$0           | \$0       | \$283<br>(Part B deductible) |
| • Remainder of Medicare Approved Amounts                       | 80%           | 20%       | \$0                          |

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

| SERVICES  | MEDICARE PAYS | PLAN 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<br>Maximum Benefit of<br>\$50,000 | 20% and amounts over<br>the \$50,000 lifetime<br>maximum |

\* Once you have been billed for \$283 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.