

**MEDMUTUAL LIFE INSURANCE COMPANY**  
**Outline of Medicare Supplement Coverage**  
**Benefit Plans A, D, F, G, N and High Deductible Plan G**

**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 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		
	A	B	D	G	G <sup>1</sup>	K	L	M	N	C	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)	✓	✓	✓	✓		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 2025 <sup>2</sup>						\$7220 <sup>2</sup>	\$3610 <sup>2</sup>					

<sup>1</sup>Plans F and G also have a high deductible option which requires first paying a plan deductible of \$2870 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 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.

**MedMutual Life Insurance Company**  
South Dakota Monthly Premiums

For Use in Zip Codes: All of State  
Female Rates

Attained Age	Preferred						Standard					
	A	D	F	G	GHD	N	A	D	F	G	GHD	N
Under 65	\$167.99	\$272.81	\$158.60	\$141.10	\$47.84	\$98.95	\$188.15	\$305.55	\$177.63	\$158.04	\$53.58	\$110.82
65	\$133.33	\$216.52	\$125.87	\$111.99	\$37.97	\$78.53	\$149.33	\$242.50	\$140.98	\$125.43	\$42.52	\$87.95
66	\$133.33	\$216.52	\$125.87	\$111.99	\$37.97	\$78.53	\$149.33	\$242.50	\$140.98	\$125.43	\$42.52	\$87.95
67	\$133.33	\$216.52	\$125.87	\$111.99	\$37.97	\$78.53	\$149.33	\$242.50	\$140.98	\$125.43	\$42.52	\$87.95
68	\$133.33	\$216.52	\$125.87	\$111.99	\$37.97	\$78.53	\$149.33	\$242.50	\$140.98	\$125.43	\$42.52	\$87.95
69	\$137.66	\$223.56	\$129.96	\$115.63	\$39.20	\$81.08	\$154.18	\$250.38	\$145.56	\$129.50	\$43.90	\$90.81
70	\$142.14	\$230.82	\$134.19	\$119.39	\$40.47	\$83.72	\$159.19	\$258.52	\$150.29	\$133.71	\$45.33	\$93.76
71	\$146.75	\$238.32	\$138.55	\$123.27	\$41.79	\$86.44	\$164.37	\$266.92	\$155.17	\$138.06	\$46.80	\$96.81
72	\$151.52	\$246.07	\$143.05	\$127.27	\$43.15	\$89.25	\$169.71	\$275.60	\$160.21	\$142.54	\$48.32	\$99.95
73	\$156.45	\$254.07	\$147.70	\$131.41	\$44.55	\$92.15	\$175.22	\$284.55	\$165.42	\$147.18	\$49.90	\$103.20
74	\$161.53	\$262.32	\$152.50	\$135.68	\$46.00	\$95.14	\$180.92	\$293.80	\$170.80	\$151.96	\$51.52	\$106.56
75	\$166.78	\$270.85	\$157.45	\$140.09	\$47.49	\$98.23	\$186.80	\$303.35	\$176.35	\$156.90	\$53.19	\$110.02
76	\$172.20	\$279.65	\$162.57	\$144.64	\$49.04	\$101.43	\$192.87	\$313.21	\$182.08	\$162.00	\$54.92	\$113.60
77	\$177.80	\$288.74	\$167.86	\$149.34	\$50.63	\$104.72	\$199.14	\$323.39	\$188.00	\$167.26	\$56.70	\$117.29
78	\$183.58	\$298.12	\$173.31	\$154.20	\$52.27	\$108.13	\$205.61	\$333.90	\$194.11	\$172.70	\$58.55	\$121.10
79	\$189.54	\$307.81	\$178.94	\$159.21	\$53.97	\$111.64	\$212.29	\$344.75	\$200.42	\$178.31	\$60.45	\$125.04
80	\$195.71	\$317.82	\$184.76	\$164.38	\$55.73	\$115.27	\$219.19	\$355.95	\$206.93	\$184.11	\$62.41	\$129.10
81	\$202.07	\$328.15	\$190.76	\$169.72	\$57.54	\$119.01	\$226.31	\$367.52	\$213.65	\$190.09	\$64.44	\$133.30
82	\$208.63	\$338.81	\$196.96	\$175.24	\$59.41	\$122.88	\$233.67	\$379.47	\$220.60	\$196.27	\$66.54	\$137.63
83	\$215.41	\$349.82	\$203.36	\$180.94	\$61.34	\$126.88	\$241.26	\$391.80	\$227.77	\$202.65	\$68.70	\$142.10
84	\$222.41	\$361.19	\$209.97	\$186.82	\$63.33	\$131.00	\$249.10	\$404.53	\$235.17	\$209.23	\$70.93	\$146.72
85	\$229.64	\$372.93	\$216.80	\$192.89	\$65.39	\$135.26	\$257.20	\$417.68	\$242.81	\$216.03	\$73.24	\$151.49
86	\$237.11	\$385.05	\$223.84	\$199.16	\$67.52	\$139.65	\$265.56	\$431.26	\$250.71	\$223.05	\$75.62	\$156.41
87	\$244.81	\$397.56	\$231.12	\$205.63	\$69.71	\$144.19	\$274.19	\$445.27	\$258.85	\$230.30	\$78.08	\$161.49
88	\$252.77	\$410.48	\$238.63	\$212.31	\$71.98	\$148.88	\$283.10	\$459.74	\$267.27	\$237.79	\$80.61	\$166.74
89	\$260.98	\$423.82	\$246.39	\$219.21	\$74.32	\$153.72	\$292.30	\$474.68	\$275.95	\$245.52	\$83.23	\$172.16
90	\$269.47	\$437.60	\$254.39	\$226.34	\$76.73	\$158.71	\$301.80	\$490.11	\$284.92	\$253.50	\$85.94	\$177.76
91	\$278.22	\$451.82	\$262.66	\$233.69	\$79.22	\$163.87	\$311.61	\$506.04	\$294.18	\$261.73	\$88.73	\$183.53
92	\$287.27	\$466.51	\$271.20	\$241.29	\$81.80	\$169.20	\$321.74	\$522.49	\$303.74	\$270.24	\$91.62	\$189.50
93	\$296.60	\$481.67	\$280.01	\$249.13	\$84.46	\$174.69	\$332.19	\$539.47	\$313.61	\$279.02	\$94.59	\$195.66
94	\$306.24	\$497.32	\$289.11	\$257.23	\$87.20	\$180.37	\$342.99	\$557.00	\$323.81	\$288.09	\$97.67	\$202.02
95	\$316.19	\$513.48	\$298.51	\$265.58	\$90.04	\$186.23	\$354.14	\$575.10	\$334.33	\$297.46	\$100.84	\$208.58
96	\$326.47	\$530.17	\$308.21	\$274.22	\$92.96	\$192.29	\$365.65	\$593.79	\$345.19	\$307.12	\$104.12	\$215.36
97	\$337.08	\$547.40	\$318.23	\$283.13	\$95.98	\$198.54	\$377.53	\$613.09	\$356.41	\$317.10	\$107.50	\$222.36
98	\$348.04	\$565.19	\$328.57	\$292.33	\$99.10	\$204.99	\$389.80	\$633.02	\$368.00	\$327.41	\$111.00	\$229.59
99+	\$359.35	\$583.56	\$339.25	\$301.83	\$102.33	\$211.65	\$402.47	\$653.59	\$379.96	\$338.05	\$114.60	\$237.05

Modal Factors: Annual = Monthly\*12; Semi-Annual = Monthly\*6; Quarterly = Monthly\*3

The rates above do not include a one time \$15 policy fee.

To calculate a Household discount of 7%:

Monthly premium X modal factor = modal premium (round to the nearest whole cent)

Modal premium X 0.93 = discounted premium

**MedMutual Life Insurance Company**  
South Dakota Monthly Premiums

For Use in Zip Codes: All of State  
Male Rates

Attained Age	Preferred						Standard					
	A	D	F	G	GHD	N	A	D	F	G	GHD	N
Under 65	\$184.79	\$300.09	\$174.46	\$155.22	\$52.62	\$108.84	\$206.97	\$336.11	\$195.39	\$173.84	\$58.93	\$121.90
65	\$146.66	\$238.17	\$138.46	\$123.19	\$41.76	\$86.38	\$164.26	\$266.75	\$155.07	\$137.97	\$46.77	\$96.75
66	\$146.66	\$238.17	\$138.46	\$123.19	\$41.76	\$86.38	\$164.26	\$266.75	\$155.07	\$137.97	\$46.77	\$96.75
67	\$146.66	\$238.17	\$138.46	\$123.19	\$41.76	\$86.38	\$164.26	\$266.75	\$155.07	\$137.97	\$46.77	\$96.75
68	\$146.66	\$238.17	\$138.46	\$123.19	\$41.76	\$86.38	\$164.26	\$266.75	\$155.07	\$137.97	\$46.77	\$96.75
69	\$151.43	\$245.91	\$142.96	\$127.19	\$43.12	\$89.19	\$169.60	\$275.42	\$160.11	\$142.45	\$48.29	\$99.89
70	\$156.35	\$253.90	\$147.60	\$131.32	\$44.52	\$92.09	\$175.11	\$284.37	\$165.32	\$147.08	\$49.86	\$103.14
71	\$161.43	\$262.15	\$152.40	\$135.59	\$45.97	\$95.08	\$180.80	\$293.61	\$170.69	\$151.86	\$51.48	\$106.49
72	\$166.68	\$270.67	\$157.35	\$140.00	\$47.46	\$98.17	\$186.68	\$303.16	\$176.24	\$156.80	\$53.16	\$109.95
73	\$172.09	\$279.47	\$162.47	\$144.55	\$49.00	\$101.36	\$192.74	\$313.01	\$181.96	\$161.89	\$54.88	\$113.52
74	\$177.69	\$288.55	\$167.75	\$149.25	\$50.60	\$104.65	\$199.01	\$323.18	\$187.88	\$167.16	\$56.67	\$117.21
75	\$183.46	\$297.93	\$173.20	\$154.10	\$52.24	\$108.06	\$205.48	\$333.68	\$193.98	\$172.59	\$58.51	\$121.02
76	\$189.42	\$307.62	\$178.83	\$159.11	\$53.94	\$111.57	\$212.15	\$344.53	\$200.29	\$178.20	\$60.41	\$124.96
77	\$195.58	\$317.61	\$184.64	\$164.28	\$55.69	\$115.19	\$219.05	\$355.73	\$206.80	\$183.99	\$62.38	\$129.02
78	\$201.94	\$327.94	\$190.64	\$169.62	\$57.50	\$118.94	\$226.17	\$367.29	\$213.52	\$189.97	\$64.40	\$133.21
79	\$208.50	\$338.59	\$196.84	\$175.13	\$59.37	\$122.80	\$233.52	\$379.22	\$220.46	\$196.14	\$66.50	\$137.54
80	\$215.28	\$349.60	\$203.23	\$180.82	\$61.30	\$126.79	\$241.11	\$391.55	\$227.62	\$202.52	\$68.66	\$142.01
81	\$222.27	\$360.96	\$209.84	\$186.70	\$63.29	\$130.92	\$248.94	\$404.27	\$235.02	\$209.10	\$70.89	\$146.62
82	\$229.50	\$372.69	\$216.66	\$192.76	\$65.35	\$135.17	\$257.04	\$417.41	\$242.66	\$215.90	\$73.19	\$151.39
83	\$236.95	\$384.80	\$223.70	\$199.03	\$67.47	\$139.56	\$265.39	\$430.98	\$250.54	\$222.91	\$75.57	\$156.31
84	\$244.66	\$397.31	\$230.97	\$205.50	\$69.67	\$144.10	\$274.01	\$444.99	\$258.69	\$230.16	\$78.03	\$161.39
85	\$252.61	\$410.22	\$238.48	\$212.18	\$71.93	\$148.78	\$282.92	\$459.45	\$267.10	\$237.64	\$80.56	\$166.64
86	\$260.82	\$423.55	\$246.23	\$219.07	\$74.27	\$153.62	\$292.11	\$474.38	\$275.78	\$245.36	\$83.18	\$172.05
87	\$269.29	\$437.32	\$254.23	\$226.19	\$76.68	\$158.61	\$301.61	\$489.80	\$284.74	\$253.33	\$85.88	\$177.64
88	\$278.05	\$451.53	\$262.49	\$233.54	\$79.17	\$163.76	\$311.41	\$505.72	\$293.99	\$261.57	\$88.68	\$183.42
89	\$287.08	\$466.21	\$271.02	\$241.13	\$81.75	\$169.09	\$321.53	\$522.15	\$303.55	\$270.07	\$91.56	\$189.38
90	\$296.41	\$481.36	\$279.83	\$248.97	\$84.40	\$174.58	\$331.98	\$539.12	\$313.41	\$278.85	\$94.53	\$195.53
91	\$306.05	\$497.00	\$288.93	\$257.06	\$87.15	\$180.26	\$342.77	\$556.64	\$323.60	\$287.91	\$97.61	\$201.89
92	\$315.99	\$513.16	\$298.32	\$265.42	\$89.98	\$186.11	\$353.91	\$574.73	\$334.12	\$297.27	\$100.78	\$208.45
93	\$326.26	\$529.83	\$308.01	\$274.04	\$92.90	\$192.16	\$365.41	\$593.41	\$344.97	\$306.93	\$104.05	\$215.22
94	\$336.86	\$547.05	\$318.02	\$282.95	\$95.92	\$198.41	\$377.29	\$612.70	\$356.19	\$316.90	\$107.43	\$222.22
95	\$347.81	\$564.83	\$328.36	\$292.14	\$99.04	\$204.86	\$389.55	\$632.61	\$367.76	\$327.20	\$110.93	\$229.44
96	\$359.12	\$583.19	\$339.03	\$301.64	\$102.26	\$211.51	\$402.21	\$653.17	\$379.71	\$337.83	\$114.53	\$236.90
97	\$370.79	\$602.14	\$350.05	\$311.44	\$105.58	\$218.39	\$415.28	\$674.40	\$392.05	\$348.81	\$118.25	\$244.60
98	\$382.84	\$621.71	\$361.43	\$321.56	\$109.01	\$225.49	\$428.78	\$696.32	\$404.80	\$360.15	\$122.10	\$252.54
99+	\$395.28	\$641.92	\$373.17	\$332.01	\$112.56	\$232.81	\$442.71	\$718.95	\$417.95	\$371.86	\$126.06	\$260.75

Modal Factors: Annual = Monthly\*12; Semi-Annual = Monthly\*6; Quarterly = Monthly\*3

The rates above do not include a one time \$15 policy fee.

To calculate a Household discount of 7%:

Monthly premium X modal factor = modal premium (round to the nearest whole cent)

Modal premium X 0.93 = discounted premium

### **PREMIUM INFORMATION**

MedMutual Life Insurance Company may change your premium on any premium due date if a new table of rates is applicable to the policy. The change in the table of rates will apply to all covered persons in the same class. Class is defined as attained age, gender, underwriting class, state of issue, and your most recent zip code of residence in the state of issue. Premiums are based on your attained age and will change on your policy anniversary date.

### **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 MedMutual Life Insurance Company.

### **RIGHT TO RETURN POLICY**

If you find that you are not satisfied with your policy, you may return it to: MedMutual Life Insurance Company, Medicare Supplement Administration, P.O. Box 10863, Clearwater, Florida 33757-8863. 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 MedMutual 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 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. MedMutual Life Insurance 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. Please refer to your policy for details.**

## 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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1676 All but \$419 a day All but \$838 a day \$0 \$0	\$0 \$419 a day \$838 a day 100% of Medicare eligible expenses \$0	\$1676 (Part A deductible) \$0 \$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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$209.50 a day \$0	\$0 \$0 \$0	\$0 Up to \$209.50 a day All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ 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 \$257 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
<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 \$257 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	      \$0  Generally 80%	      \$0  Generally 20%	      \$257 (Part B deductible)  \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next \$257 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$257 (Part B deductible) \$0
<b>CLINICAL LABORATORY</b> <b>SERVICES – TESTS FOR DIAGNOSTIC</b> <b>SERVICES</b>	100%	\$0	\$0

## PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First \$257 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	      100%  \$0  80%	      \$0  \$0  20%	      \$0  \$257 (Part B deductible)  \$0

## PLAN D

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1676 All but \$419 a day  All but \$838 a day  \$0 \$0	\$1676 (Part A deductible) \$419 a day  \$838 a day  100% of Medicare eligible expenses \$0	\$0 \$0  \$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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$209.50 a day \$0	\$0 Up to \$209.50 a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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

\*Once you have been billed \$257 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
<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 \$257 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0     Generally 80%	\$0     Generally 20%	\$257 (Unless Part B deductible has been met)    \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	0%	All costs
<b>BLOOD</b> First 3 pints  Next \$257 of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	\$0  \$0  80%	All costs  \$0  20%	\$0  \$257 (Part B deductible)  \$0
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)



**PLAN D**  
**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment	100%	\$0	\$0
- First \$257 of Medicare Approved Amounts*	\$0	\$0	\$257 (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 maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

## 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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1676 All but \$419 a day  All but \$838 a day  \$0 \$0	\$1676 (Part A deductible) \$419 a day  \$838 a day  100% of Medicare eligible expenses \$0	\$0 \$0  \$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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$209.50 a day \$0	\$0 Up to \$209.50 a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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, 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 \$257 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
<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 \$257 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	       \$0  Generally 80%	       \$257 (Part B deductible)  Generally 20%	       \$0  \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$257 of Medicare Approved amounts* Remainder of Medicare Approved amounts	\$0 \$0 80%	All costs \$257 (Part B deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES –</b> <b>TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

(continued)

**PLAN F**  
**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment	100%	\$0	\$0
- First \$257 of Medicare Approved Amounts*	\$0	\$257 (Part B deductible)	\$0
- 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 Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1676 All but \$419 a day  All but \$838 a day  \$0 \$0	\$1676 (Part A deductible) \$419 a day  \$838 a day  100% of Medicare eligible expenses \$0	\$0 \$0  \$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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$209.50 a day \$0	\$0 Up to \$209.50 a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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, 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 \$257 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
<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 \$257 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0  Generally 80%	\$0  Generally 20%	\$257 (Unless Part B deductible has been met)  \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints  Next \$257 of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	\$0  \$0  80%	All costs  \$0  20%	\$0  \$257 (Unless Part B deductible has been met)  \$0
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

**PLAN G**  
**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment	100%	\$0	\$0
- First \$257 of Medicare Approved Amounts*	\$0	\$0	\$257 (Unless Part B deductible has been met)
- 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 maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

**HIGH DEDUCTIBLE 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. \*\*This high deductible plan pays the same benefits as Plan G after you have paid a calendar year \$2870 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are \$2870. 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.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2870 DEDUCTIBLE ** PLAN PAYS	IN ADDITION TO \$2870 DEDUCTIBLE ** YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1676 All but \$419 a day  All but \$838 a day  \$0 \$0	\$1676 (Part A deductible) \$419 a day  \$838 a day  100% of Medicare eligible expenses \$0	\$0 \$0  \$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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$209.50 a day \$0	\$0 Up to \$209.50 a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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, 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

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

\*Once you have been billed \$257 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 \$2870 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are \$2870. 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.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2870 DEDUCTIBLE ** PLAN PAYS	IN ADDITION TO \$2870 DEDUCTIBLE ** 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 \$257 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0  Generally 80%	\$0  Generally 20%	\$257 (Unless Part B deductible has been met)  \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints  Next \$257 of Medicare Approved amounts*  Remainder of Medicare Approved amounts	\$0  \$0  80%	All costs  \$0  20%	\$0  \$257 (Unless Part B deductible has been met)  \$0
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

**HIGH DEDUCTIBLE PLAN G****PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>AFTER YOU PAY \$2870 DEDUCTIBLE ** PLAN PAYS</b>	<b>IN ADDITION TO \$2870 DEDUCTIBLE ** YOU PAY</b>
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment <ul style="list-style-type: none"><li>- First \$257 of Medicare Approved Amounts*</li><li>- Remainder of Medicare Approved Amounts</li></ul>	100%  \$0  80%	\$0  \$0  20%	\$0  \$257 (Unless Part B deductible has been met)  \$0

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>AFTER YOU PAY \$2870 DEDUCTIBLE ** PLAN PAYS</b>	<b>IN ADDITION TO \$2870 DEDUCTIBLE ** 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 Remainder of charges	  \$0  \$0	  \$0  80% to a lifetime maximum benefit of \$50,000	  \$250  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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1676 All but \$419 a day All but \$838 a day \$0 \$0	\$1676 (Part A deductible) \$419 a day \$838 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$209.50 a day \$0	\$0 Up to \$209.50 a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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, 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 \$257 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
<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 \$257 of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	\$0  Generally 80%	\$0  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.	\$257 (Part B deductible)  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 Next \$257 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$257 (Part B deductible) \$0
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

**PLAN N**  
**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment	100%	\$0	\$0
- First \$257 of Medicare Approved Amounts*	\$0	\$0	\$257 (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 Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000.	\$250 20% and amounts over the \$50,000 lifetime maximum.