AMERICAN BENEFIT LIFE INSURANCE COMPANY

OUTLINE OF MEDICARE SUPPLEMENT PLANS SOLD FOR EFFECTIVE DATE 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.

Medicare Supplement Benefit Plans A, C, D, F, G, and N are offered by American Benefit Life Insurance Company.

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 2024[2]					$7,060[2]	$3,530[2]				

[1] Plans F and G also have a high deductible option which require first paying a plan deductible of $2,800 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 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.

American Benefit Life Insurance Company

Monthly Attained Age Premiums

ZIP Codes: 070-089

Standard Plans - Preferred

Rates Effective: 09/01/2023

FEMALE						Attained	MALE					
Plan A	Plan C	Plan D	Plan F	Plan G	Plan N	Age	Plan A	Plan C	Plan D	Plan F	Plan G	Plan N
--	190.08	148.06	--	--	--	50-64	--	218.59	170.27	--	--	--
147.47	190.08	148.06	181.03	148.21	110.54	65	169.59	218.59	170.27	208.19	170.44	127.13
147.47	190.08	148.06	181.03	148.21	111.15	66	169.59	218.59	170.27	208.19	170.44	127.82
147.47	190.08	148.06	181.03	148.21	112.19	67	169.59	218.59	170.27	208.19	170.44	129.01
147.47	190.08	148.06	181.03	148.21	116.34	68	169.59	218.59	170.27	208.19	170.44	133.80
147.47	193.47	148.06	184.26	148.21	119.26	69	169.59	222.49	170.27	211.90	170.44	137.14
154.74	198.21	155.36	188.77	155.51	123.17	70	177.95	227.94	178.66	217.09	178.84	141.64
160.23	204.54	160.87	194.80	161.03	128.32	71	184.26	235.22	185.00	224.02	185.19	147.56
167.05	212.56	167.72	202.44	167.89	134.53	72	192.10	244.44	192.88	232.80	193.07	154.71
174.31	221.13	175.01	210.60	175.19	141.12	73	200.46	254.30	201.26	242.19	201.46	162.29
182.06	230.31	182.79	219.34	182.98	147.83	74	209.37	264.85	210.21	252.24	210.42	170.00
190.35	240.15	191.11	228.71	191.30	154.65	75	218.90	276.17	219.78	263.02	220.00	177.85
197.43	248.65	198.23	236.81	198.43	160.35	76	227.05	285.95	227.96	272.33	228.19	184.41
205.10	257.87	205.93	245.59	206.13	166.15	77	235.87	296.55	236.82	282.43	237.05	191.08
213.82	267.86	214.68	255.11	214.89	172.05	78	245.89	308.04	246.88	293.37	247.13	197.86
223.26	278.16	224.15	264.91	224.38	178.06	79	256.75	319.88	257.78	304.65	258.04	204.76
233.03	288.75	233.96	275.00	234.20	184.16	80	267.98	332.07	269.06	316.25	269.33	211.79
243.03	299.54	244.00	285.28	244.25	190.28	81	279.48	344.47	280.60	328.07	280.88	218.82
253.37	310.65	254.39	295.85	254.65	196.51	82	291.38	357.24	292.55	340.23	292.84	225.98
264.08	322.07	265.14	306.74	265.40	202.83	83	303.69	370.39	304.91	352.75	305.21	233.26
275.15	333.84	276.26	317.94	276.53	209.27	84	316.42	383.91	317.69	365.63	318.01	240.66
286.60	345.94	287.75	329.47	288.04	215.81	85	329.59	397.83	330.92	378.89	331.25	248.19
297.06	356.85	298.26	339.86	298.55	221.22	86	341.62	410.38	342.99	390.84	343.34	254.40
307.07	368.06	309.10	350.54	309.41	226.71	87	353.13	423.27	355.46	403.12	355.82	260.71
308.33	379.58	320.29	361.51	320.61	232.28	88	354.58	436.52	368.33	415.73	368.70	267.12
309.59	391.41	331.84	372.77	332.17	237.95	89	356.03	450.12	381.61	428.69	381.99	273.64
310.86	403.56	343.75	384.35	344.10	243.70	90	357.48	464.10	395.32	442.00	395.71	280.26
311.16	415.10	355.18	395.33	355.54	248.83	91	357.83	477.36	408.46	454.63	408.87	286.16
311.46	426.93	366.96	406.60	367.33	254.04	92	358.17	490.97	422.01	467.59	422.43	292.14
311.76	439.07	379.10	418.16	379.48	259.32	93	358.52	504.93	435.97	480.89	436.41	298.22
312.06	451.53	391.62	430.03	392.01	264.68	94	358.86	519.26	450.36	494.53	450.81	304.38
312.35	464.31	404.51	442.20	404.92	270.13	95	359.21	533.96	465.19	508.53	465.66	310.65
312.65	477.45	417.83	454.71	418.25	275.69	96	359.55	549.07	480.51	522.92	480.99	317.04
312.95	490.96	431.59	467.58	432.02	281.36	97	359.90	564.61	496.33	537.72	496.83	323.56
313.25	504.86	445.80	480.82	446.25	287.15	98	360.24	580.59	512.67	552.94	513.19	330.22
313.55	519.15	460.48	494.42	460.94	293.05	99	360.59	597.02	529.55	568.59	530.08	337.01

Preferred rates will be applied during Open Enrollment and Guarantee Issue periods.

Modal Factors: Semi-Annual - 0.5200, Quarterly - 0.2650, Monthly - 0.08333

Add a One-Time Policy Fee $25

To calculate a Household discount:

Annual premium x modal factor = modal premium (round to nearest whole cent)

Modal premium x .90 = discounted premium

American Benefit Life Insurance Company

Monthly Attained Age Premiums

ZIP Codes: 070-089

Standard Plans - Standard

Rates Effective: 09/01/2023

Female						Attained	Male					
Plan A	Plan C	Plan D	Plan F	Plan G	Plan N	Age	Plan A	Plan C	Plan D	Plan F	Plan G	Plan N
--	218.59	170.27	--	--	--	50-64	--	251.38	195.82	--	--	--
169.59	218.59	170.27	208.19	170.44	127.13	65	195.03	251.38	195.82	239.41	196.01	146.20
169.59	218.59	170.27	208.19	170.44	127.82	66	195.03	251.38	195.82	239.41	196.01	146.99
169.59	218.59	170.27	208.19	170.44	129.01	67	195.03	251.38	195.82	239.41	196.01	148.37
169.59	218.59	170.27	208.19	170.44	133.80	68	195.03	251.38	195.82	239.41	196.01	153.87
169.59	222.49	170.27	211.90	170.44	137.14	69	195.03	255.86	195.82	243.68	196.01	157.72
177.95	227.94	178.66	217.09	178.84	141.64	70	204.64	262.13	205.46	249.65	205.67	162.89
184.26	235.22	185.00	224.02	185.19	147.56	71	211.90	270.51	212.75	257.63	212.97	169.70
192.10	244.44	192.88	232.80	193.07	154.71	72	220.92	281.11	221.81	267.72	222.03	177.92
200.46	254.30	201.26	242.19	201.46	162.29	73	230.52	292.45	231.45	278.52	231.68	186.63
209.37	264.85	210.21	252.24	210.42	170.00	74	240.77	304.58	241.74	290.08	241.98	195.50
218.90	276.17	219.78	263.02	220.00	177.85	75	251.73	317.60	252.75	302.47	253.00	204.52
227.05	285.95	227.96	272.33	228.19	184.41	76	261.11	328.84	262.16	313.18	262.42	212.07
235.87	296.55	236.82	282.43	237.05	191.08	77	271.25	341.03	272.34	324.79	272.61	219.74
245.89	308.04	246.88	293.37	247.13	197.86	78	282.78	354.25	283.91	337.38	284.20	227.54
256.75	319.88	257.78	304.65	258.04	204.76	79	295.26	367.86	296.44	350.34	296.74	235.48
267.98	332.07	269.06	316.25	269.33	211.79	80	308.18	381.87	309.41	363.69	309.72	243.55
279.48	344.47	280.60	328.07	280.88	218.82	81	321.40	396.14	322.69	377.28	323.02	251.65
291.38	357.24	292.55	340.23	292.84	225.98	82	335.09	410.83	336.43	391.27	336.77	259.88
303.69	370.39	304.91	352.75	305.21	233.26	83	349.24	425.94	350.65	405.66	351.00	268.25
316.42	383.91	317.69	365.63	318.01	240.66	84	363.89	441.50	365.35	420.48	365.71	276.76
329.59	397.83	330.92	378.89	331.25	248.19	85	379.03	457.51	380.55	435.72	380.93	285.41
341.62	410.38	342.99	390.84	343.34	254.40	86	392.86	471.94	394.44	449.46	394.84	292.56
353.13	423.27	355.46	403.12	355.82	260.71	87	406.10	486.76	408.78	463.59	409.19	299.82
354.58	436.52	368.33	415.73	368.70	267.12	88	407.77	502.00	423.58	478.09	424.00	307.20
356.03	450.12	381.61	428.69	381.99	273.64	89	409.44	517.64	438.85	492.99	439.29	314.69
357.48	464.10	395.32	442.00	395.71	280.26	90	411.11	533.71	454.61	508.30	455.07	322.30
357.83	477.36	408.46	454.63	408.87	286.16	91	411.50	548.97	469.73	522.83	470.20	329.08
358.17	490.97	422.01	467.59	422.43	292.14	92	411.90	564.62	485.31	537.73	485.80	335.96
358.52	504.93	435.97	480.89	436.41	298.22	93	412.30	580.68	501.37	553.02	501.87	342.95
358.86	519.26	450.36	494.53	450.81	304.38	94	412.69	597.15	517.91	568.71	518.43	350.04
359.21	533.96	465.19	508.53	465.66	310.65	95	413.09	614.05	534.97	584.81	535.50	357.25
359.55	549.07	480.51	522.92	480.99	317.04	96	413.48	631.43	552.58	601.36	553.14	364.59
359.90	564.61	496.33	537.72	496.83	323.56	97	413.88	649.30	570.78	618.38	571.35	372.10
360.24	580.59	512.67	552.94	513.19	330.22	98	414.28	667.67	589.57	635.88	590.16	379.75
360.59	597.02	529.55	568.59	530.08	337.01	99	414.68	686.57	608.99	653.88	609.60	387.56

Preferred rates will be applied during Open Enrollment and Guarantee Issue periods.

Modal Factors: Semi-Annual - 0.5200, Quarterly - 0.2650, Monthly - 0.08333

Add a One-Time Policy Fee $25

To calculate a Household discount:

Annual premium x modal factor = modal premium (round to nearest whole cent)

Modal premium x .90 = discounted premium

PREMIUM INFORMATION

American Benefit Life Insurance Company can only raise your premium if we raise the premium for all policies like yours in this state. Premiums for this policy will increase due to the increase in your age. Upon attainment of an age requiring a rate increase, the renewal premium for the policy will be the renewal premium then in effect for your attained age.

HOUSEHOLD DISCOUNT

You are eligible for a Household Premium Discount if: (1) you reside with your spouse, including validly recognized civil union or domestic partner, who currently holds or is applying for a Medicare Supplement policy with American Benefit Life Insurance Company or (2) you have been living with a family member for the last twelve months who is age 50 or older and who holds or is applying for a Medicare Supplement policy with American Benefit Life Insurance Company. If you are eligible, based on the above requirements, the discount will be applicable when a policy for each applicant is issued. The discounted rates will be 10 percent lower than the individual rates and will apply as long as these requirements are met.

DISCLOSURES

Use this outline to compare benefits and premium 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 American Benefit Life Insurance Company's administrative office, 1021 Reams Fleming Boulevard, Franklin, TN 37064. 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 your payments.

POLICY REPLACEMENT

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

NOTICE

The policy may not cover all of your medical costs.

Neither American Benefit Life Insurance Company nor its agents are connected with Medicare.

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

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely any 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.

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 $1,632	$0	$1,632 (Part A Deductible)
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after			
While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	$0	Up to $204 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 $240 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 test, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare Approved amounts	80%	20%	$0

PLAN C

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after			
While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 C

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

*Once you have been billed $240 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 test, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	0%	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-Approved amounts*	$0	$240 (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 $240 of Medicare Approved amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare Approved amounts	80%	20%	$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
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after			
While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 D

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

*Once you have been billed $240 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 test, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$240 (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 $240 of Medicare Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare Approved amounts	80%	20%	$0

PLAN D

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year 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 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 $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after			
While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 $240 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 test, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$240 (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 $240 of Medicare Approved amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare Approved amounts	80%	20%	$0

PLAN F

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year 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
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 $240 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 test, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Unless Part B Deductible has been met)
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 $240 of Medicare-Approved amounts*	$0	$0	$240 (Unless Part B Deductible has been met)
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 $240 of Medicare Approved amounts*	$0	$0	$240 (Unless Part B Deductible has been met)
Remainder of Medicare Approved amounts	80%	20%	$0

PLAN G

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN 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 $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 co-payment/ 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 $240 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 test, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (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 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.
Part B Excess Charges (Above Medicare-Approved amounts)	$0	0%	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N 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 $240 of Medicare Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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