

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE

BENEFIT PLANS A, 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 ¹	K	L	M	N	C	F	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						\$7060 ²	\$3530 ²					

¹Plans F and G also have a high deductible option which requires first paying a plan deductible of \$2800 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.

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

³Plan 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.

MICHIGAN Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 480-485

Attained Age	Preferred					Attained Age	Standard				
	HD						HD				
	Plan A	Plan F	Plan G	Plan G	Plan N		Plan A	Plan F	Plan G	Plan G	Plan N
65	2,029	2,406	2,050	796	1,525	65	2,254	2,674	2,278	886	1,695
66	2,029	2,406	2,050	796	1,525	66	2,254	2,674	2,278	886	1,695
67	2,029	2,406	2,050	796	1,525	67	2,254	2,674	2,278	886	1,695
68	2,029	2,406	2,050	796	1,525	68	2,254	2,674	2,278	886	1,695
69	2,029	2,406	2,050	796	1,571	69	2,254	2,674	2,278	886	1,746
70	2,089	2,479	2,112	820	1,618	70	2,321	2,754	2,345	910	1,799
71	2,153	2,553	2,175	845	1,667	71	2,390	2,837	2,417	938	1,852
72	2,227	2,642	2,251	874	1,725	72	2,474	2,937	2,501	971	1,915
73	2,304	2,735	2,330	905	1,784	73	2,560	3,040	2,588	1,005	1,983
74	2,386	2,830	2,411	936	1,848	74	2,652	3,145	2,680	1,040	2,054
75	2,469	2,929	2,494	969	1,912	75	2,742	3,253	2,773	1,077	2,125
76	2,556	3,033	2,583	1,003	1,979	76	2,839	3,369	2,870	1,115	2,198
77	2,657	3,154	2,685	1,043	2,058	77	2,952	3,505	2,985	1,160	2,288
78	2,764	3,279	2,792	1,084	2,140	78	3,072	3,643	3,103	1,204	2,378
79	2,875	3,409	2,905	1,129	2,225	79	3,194	3,789	3,227	1,253	2,473
80	2,989	3,547	3,021	1,174	2,315	80	3,322	3,941	3,356	1,302	2,572
81	3,110	3,688	3,141	1,220	2,408	81	3,454	4,097	3,491	1,355	2,675
82	3,235	3,835	3,267	1,269	2,503	82	3,594	4,260	3,629	1,409	2,782
83	3,364	3,989	3,397	1,320	2,604	83	3,740	4,433	3,774	1,465	2,892
84	3,501	4,149	3,532	1,372	2,708	84	3,890	4,610	3,924	1,523	3,010
85	3,641	4,315	3,674	1,426	2,816	85	4,045	4,796	4,083	1,585	3,131
86	3,785	4,488	3,821	1,485	2,931	86	4,205	4,987	4,245	1,649	3,257
87	3,938	4,666	3,975	1,542	3,048	87	4,375	5,185	4,417	1,714	3,388
88	4,094	4,853	4,132	1,605	3,171	88	4,550	5,393	4,592	1,783	3,523
89	4,257	5,047	4,298	1,669	3,298	89	4,730	5,610	4,775	1,854	3,664
90	4,427	5,250	4,470	1,736	3,430	90	4,921	5,833	4,967	1,929	3,811
91	4,604	5,461	4,648	1,806	3,568	91	5,118	6,067	5,164	2,007	3,965
92	4,789	5,679	4,835	1,877	3,710	92	5,322	6,310	5,371	2,084	4,121
93	4,981	5,905	5,026	1,953	3,859	93	5,535	6,562	5,587	2,170	4,289
94	5,180	6,143	5,227	2,030	4,013	94	5,756	6,824	5,809	2,256	4,458
95	5,386	6,389	5,437	2,112	4,173	95	5,985	7,097	6,040	2,346	4,637
96	5,603	6,645	5,653	2,196	4,341	96	6,224	7,383	6,282	2,441	4,821
97	5,826	6,910	5,880	2,284	4,514	97	6,473	7,679	6,532	2,538	5,016
98	6,060	7,187	6,114	2,374	4,694	98	6,732	7,983	6,792	2,637	5,217
99	6,301	7,474	6,359	2,469	4,883	99	7,000	8,304	7,065	2,744	5,425

Modal Factors: Semi Annual: 0.5000 Quarterly: 0.25000 Monthly: Divide by 12

MICHIGAN Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 486-489, 492

Attained Age	Preferred					Attained Age	Standard				
	HD						HD				
	Plan A	Plan F	Plan G	Plan G	Plan N		Plan A	Plan F	Plan G	Plan G	Plan N
65	1,763	2,091	1,782	692	1,325	65	1,959	2,324	1,980	770	1,474
66	1,763	2,091	1,782	692	1,325	66	1,959	2,324	1,980	770	1,474
67	1,763	2,091	1,782	692	1,325	67	1,959	2,324	1,980	770	1,474
68	1,763	2,091	1,782	692	1,325	68	1,959	2,324	1,980	770	1,474
69	1,763	2,091	1,782	692	1,366	69	1,959	2,324	1,980	770	1,518
70	1,816	2,155	1,836	713	1,406	70	2,018	2,394	2,038	791	1,564
71	1,871	2,219	1,891	734	1,449	71	2,078	2,466	2,101	815	1,610
72	1,936	2,296	1,957	759	1,500	72	2,151	2,553	2,174	844	1,665
73	2,003	2,377	2,025	787	1,551	73	2,225	2,642	2,250	873	1,724
74	2,074	2,460	2,096	814	1,607	74	2,305	2,734	2,329	904	1,786
75	2,146	2,546	2,168	842	1,662	75	2,383	2,828	2,410	936	1,847
76	2,222	2,636	2,245	872	1,720	76	2,467	2,928	2,494	969	1,910
77	2,310	2,741	2,334	906	1,789	77	2,566	3,047	2,595	1,009	1,989
78	2,403	2,850	2,427	942	1,860	78	2,670	3,166	2,697	1,046	2,067
79	2,499	2,964	2,525	981	1,934	79	2,777	3,294	2,805	1,089	2,150
80	2,598	3,083	2,626	1,020	2,012	80	2,888	3,426	2,917	1,132	2,235
81	2,703	3,206	2,730	1,061	2,093	81	3,003	3,561	3,034	1,178	2,326
82	2,812	3,334	2,840	1,103	2,176	82	3,124	3,703	3,154	1,224	2,418
83	2,924	3,467	2,953	1,147	2,264	83	3,251	3,853	3,280	1,273	2,514
84	3,043	3,606	3,070	1,192	2,354	84	3,382	4,007	3,411	1,324	2,616
85	3,165	3,751	3,193	1,240	2,448	85	3,516	4,169	3,549	1,378	2,722
86	3,290	3,901	3,322	1,291	2,547	86	3,655	4,335	3,690	1,433	2,831
87	3,423	4,056	3,455	1,341	2,649	87	3,803	4,507	3,840	1,490	2,945
88	3,559	4,219	3,592	1,395	2,756	88	3,955	4,688	3,991	1,550	3,062
89	3,701	4,387	3,736	1,451	2,867	89	4,111	4,876	4,150	1,611	3,185
90	3,848	4,563	3,885	1,509	2,982	90	4,277	5,070	4,318	1,677	3,313
91	4,002	4,747	4,040	1,570	3,102	91	4,448	5,273	4,489	1,744	3,447
92	4,162	4,936	4,203	1,631	3,225	92	4,626	5,485	4,668	1,812	3,582
93	4,330	5,133	4,369	1,698	3,354	93	4,811	5,704	4,857	1,887	3,728
94	4,502	5,339	4,544	1,764	3,488	94	5,003	5,932	5,050	1,961	3,875
95	4,682	5,553	4,726	1,836	3,627	95	5,202	6,169	5,250	2,040	4,031
96	4,870	5,776	4,914	1,909	3,773	96	5,410	6,417	5,460	2,121	4,191
97	5,064	6,007	5,111	1,985	3,924	97	5,627	6,675	5,678	2,206	4,360
98	5,267	6,247	5,315	2,063	4,080	98	5,851	6,939	5,904	2,292	4,535
99	5,477	6,497	5,528	2,146	4,244	99	6,085	7,218	6,141	2,385	4,715

Modal Factors: Semi Annual: 0.5000 Quarterly: 0.25000 Monthly: Divide by 12

MICHIGAN Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 480-489, 492

Attained Age	Preferred					Attained Age	Standard				
	HD						HD				
	Plan A	Plan F	Plan G	Plan G	Plan N		Plan A	Plan F	Plan G	Plan G	Plan N
65	1,592	1,887	1,608	624	1,196	65	1,768	2,098	1,787	695	1,330
66	1,592	1,887	1,608	624	1,196	66	1,768	2,098	1,787	695	1,330
67	1,592	1,887	1,608	624	1,196	67	1,768	2,098	1,787	695	1,330
68	1,592	1,887	1,608	624	1,196	68	1,768	2,098	1,787	695	1,330
69	1,592	1,887	1,608	624	1,233	69	1,768	2,098	1,787	695	1,370
70	1,639	1,945	1,657	644	1,269	70	1,821	2,161	1,840	714	1,412
71	1,689	2,003	1,707	663	1,308	71	1,875	2,226	1,896	736	1,453
72	1,747	2,073	1,766	685	1,354	72	1,942	2,304	1,962	761	1,503
73	1,808	2,146	1,828	710	1,400	73	2,009	2,385	2,031	788	1,556
74	1,872	2,221	1,892	735	1,450	74	2,081	2,468	2,103	816	1,612
75	1,937	2,298	1,957	760	1,500	75	2,151	2,553	2,175	845	1,668
76	2,005	2,379	2,026	787	1,553	76	2,227	2,643	2,251	875	1,724
77	2,085	2,474	2,107	818	1,615	77	2,317	2,750	2,342	910	1,795
78	2,169	2,573	2,191	850	1,679	78	2,410	2,858	2,435	945	1,866
79	2,256	2,675	2,279	886	1,746	79	2,506	2,973	2,532	983	1,941
80	2,345	2,783	2,371	921	1,816	80	2,607	3,092	2,633	1,022	2,018
81	2,440	2,894	2,464	957	1,889	81	2,710	3,215	2,739	1,064	2,099
82	2,538	3,009	2,564	996	1,964	82	2,820	3,342	2,847	1,105	2,183
83	2,640	3,130	2,665	1,036	2,043	83	2,934	3,478	2,961	1,149	2,269
84	2,747	3,255	2,771	1,076	2,125	84	3,052	3,617	3,079	1,195	2,362
85	2,857	3,386	2,882	1,119	2,209	85	3,174	3,763	3,203	1,243	2,457
86	2,970	3,521	2,998	1,165	2,299	86	3,299	3,913	3,330	1,294	2,555
87	3,090	3,661	3,119	1,210	2,392	87	3,433	4,068	3,466	1,345	2,658
88	3,212	3,808	3,242	1,259	2,488	88	3,570	4,232	3,603	1,399	2,764
89	3,340	3,960	3,372	1,310	2,588	89	3,711	4,401	3,746	1,454	2,875
90	3,474	4,119	3,507	1,362	2,691	90	3,861	4,577	3,897	1,513	2,990
91	3,613	4,285	3,647	1,417	2,800	91	4,015	4,760	4,052	1,574	3,111
92	3,757	4,456	3,794	1,473	2,911	92	4,175	4,951	4,214	1,635	3,233
93	3,908	4,633	3,944	1,533	3,028	93	4,343	5,148	4,384	1,703	3,365
94	4,064	4,820	4,101	1,593	3,149	94	4,516	5,355	4,558	1,770	3,498
95	4,226	5,013	4,266	1,657	3,274	95	4,696	5,569	4,739	1,841	3,638
96	4,396	5,213	4,436	1,723	3,406	96	4,884	5,793	4,929	1,915	3,783
97	4,571	5,422	4,613	1,792	3,542	97	5,079	6,025	5,125	1,991	3,936
98	4,754	5,639	4,798	1,862	3,683	98	5,282	6,264	5,329	2,069	4,093
99	4,944	5,864	4,989	1,937	3,831	99	5,492	6,515	5,543	2,153	4,256

Modal Factors: Semi Annual: 0.5000 Quarterly: 0.25000 Monthly: Divide by 12

MICHIGAN Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 480-485

Attained Age	Preferred					Attained Age	Standard				
	HD						HD				
	Plan A	Plan F	Plan G	Plan G	Plan N		Plan A	Plan F	Plan G	Plan G	Plan N
65	1,811	2,148	1,831	710	1,362	65	2,012	2,387	2,033	790	1,514
66	1,811	2,148	1,831	710	1,362	66	2,012	2,387	2,033	790	1,514
67	1,811	2,148	1,831	710	1,362	67	2,012	2,387	2,033	790	1,514
68	1,811	2,148	1,831	710	1,362	68	2,012	2,387	2,033	790	1,514
69	1,811	2,148	1,831	710	1,402	69	2,012	2,387	2,033	790	1,559
70	1,866	2,213	1,885	732	1,444	70	2,072	2,459	2,093	814	1,605
71	1,921	2,279	1,942	753	1,488	71	2,134	2,534	2,158	838	1,653
72	1,988	2,359	2,009	779	1,540	72	2,209	2,622	2,233	867	1,710
73	2,058	2,442	2,079	807	1,594	73	2,286	2,713	2,311	897	1,772
74	2,130	2,526	2,153	837	1,650	74	2,366	2,808	2,392	930	1,833
75	2,205	2,615	2,228	865	1,708	75	2,449	2,906	2,476	961	1,897
76	2,282	2,706	2,306	895	1,768	76	2,535	3,007	2,562	995	1,963
77	2,373	2,816	2,399	932	1,837	77	2,636	3,128	2,664	1,036	2,042
78	2,467	2,927	2,493	968	1,911	78	2,742	3,252	2,771	1,076	2,123
79	2,566	3,044	2,593	1,007	1,987	79	2,851	3,383	2,881	1,118	2,209
80	2,668	3,166	2,698	1,047	2,067	80	2,965	3,519	2,997	1,163	2,296
81	2,777	3,293	2,805	1,089	2,149	81	3,085	3,658	3,116	1,211	2,389
82	2,888	3,425	2,916	1,133	2,236	82	3,208	3,805	3,239	1,259	2,483
83	3,005	3,561	3,033	1,178	2,325	83	3,338	3,958	3,370	1,308	2,583
84	3,125	3,705	3,154	1,224	2,419	84	3,473	4,117	3,504	1,360	2,686
85	3,251	3,852	3,280	1,274	2,516	85	3,610	4,281	3,646	1,416	2,796
86	3,380	4,007	3,411	1,325	2,617	86	3,755	4,453	3,790	1,473	2,907
87	3,516	4,167	3,549	1,377	2,722	87	3,906	4,630	3,944	1,530	3,023
88	3,655	4,333	3,691	1,432	2,831	88	4,063	4,815	4,100	1,592	3,145
89	3,802	4,506	3,838	1,491	2,944	89	4,223	5,008	4,264	1,656	3,272
90	3,954	4,687	3,991	1,549	3,063	90	4,394	5,209	4,436	1,721	3,403
91	4,112	4,874	4,150	1,612	3,186	91	4,569	5,417	4,612	1,791	3,541
92	4,275	5,070	4,316	1,675	3,313	92	4,751	5,634	4,796	1,862	3,680
93	4,447	5,272	4,489	1,743	3,445	93	4,942	5,859	4,988	1,937	3,829
94	4,624	5,485	4,668	1,813	3,583	94	5,139	6,093	5,187	2,015	3,982
95	4,810	5,704	4,853	1,885	3,726	95	5,344	6,338	5,393	2,095	4,140
96	5,001	5,933	5,047	1,960	3,875	96	5,558	6,592	5,608	2,179	4,305
97	5,201	6,169	5,248	2,039	4,031	97	5,780	6,855	5,832	2,266	4,479
98	5,410	6,417	5,459	2,120	4,192	98	6,010	7,128	6,065	2,356	4,657
99	5,627	6,673	5,679	2,204	4,358	99	6,251	7,414	6,308	2,450	4,843

Modal Factors: Semi Annual: 0.5000 Quarterly: 0.25000 Monthly: Divide by 12

MICHIGAN Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 486-489, 492

Attained Age	Preferred					Attained Age	Standard				
	Plan A	Plan F	Plan G	Plan G	Plan N		Plan A	Plan F	Plan G	Plan G	Plan N
65	1,574	1,867	1,591	617	1,184	65	1,749	2,075	1,767	687	1,316
66	1,574	1,867	1,591	617	1,184	66	1,749	2,075	1,767	687	1,316
67	1,574	1,867	1,591	617	1,184	67	1,749	2,075	1,767	687	1,316
68	1,574	1,867	1,591	617	1,184	68	1,749	2,075	1,767	687	1,316
69	1,574	1,867	1,591	617	1,219	69	1,749	2,075	1,767	687	1,355
70	1,622	1,924	1,639	636	1,255	70	1,801	2,137	1,820	707	1,395
71	1,669	1,981	1,688	655	1,293	71	1,855	2,202	1,876	729	1,437
72	1,728	2,051	1,746	677	1,338	72	1,920	2,279	1,941	753	1,487
73	1,789	2,123	1,807	701	1,386	73	1,987	2,359	2,009	780	1,540
74	1,851	2,196	1,871	727	1,434	74	2,057	2,441	2,079	808	1,593
75	1,916	2,273	1,937	752	1,484	75	2,129	2,526	2,152	835	1,649
76	1,983	2,353	2,004	778	1,537	76	2,203	2,614	2,227	865	1,706
77	2,063	2,448	2,085	810	1,597	77	2,291	2,719	2,316	901	1,775
78	2,145	2,544	2,167	841	1,661	78	2,383	2,827	2,409	935	1,845
79	2,230	2,646	2,254	876	1,728	79	2,478	2,940	2,504	972	1,920
80	2,320	2,752	2,345	910	1,796	80	2,577	3,059	2,606	1,011	1,996
81	2,414	2,862	2,438	947	1,868	81	2,681	3,180	2,708	1,052	2,076
82	2,510	2,977	2,535	985	1,943	82	2,789	3,307	2,816	1,094	2,158
83	2,612	3,096	2,636	1,024	2,021	83	2,901	3,440	2,929	1,137	2,245
84	2,717	3,220	2,741	1,064	2,102	84	3,019	3,578	3,045	1,182	2,335
85	2,825	3,349	2,851	1,107	2,187	85	3,138	3,721	3,169	1,230	2,430
86	2,938	3,483	2,965	1,152	2,275	86	3,264	3,870	3,295	1,280	2,527
87	3,056	3,622	3,085	1,197	2,366	87	3,395	4,024	3,428	1,330	2,628
88	3,177	3,766	3,208	1,245	2,461	88	3,532	4,186	3,564	1,383	2,734
89	3,305	3,917	3,336	1,296	2,559	89	3,671	4,353	3,707	1,439	2,844
90	3,437	4,074	3,470	1,347	2,663	90	3,819	4,528	3,856	1,496	2,958
91	3,575	4,237	3,608	1,401	2,769	91	3,972	4,709	4,008	1,557	3,078
92	3,716	4,407	3,752	1,456	2,880	92	4,129	4,897	4,169	1,618	3,199
93	3,865	4,583	3,902	1,515	2,995	93	4,296	5,092	4,336	1,684	3,328
94	4,019	4,767	4,057	1,576	3,115	94	4,467	5,297	4,508	1,751	3,461
95	4,181	4,958	4,219	1,639	3,239	95	4,645	5,509	4,688	1,821	3,599
96	4,347	5,157	4,387	1,704	3,368	96	4,831	5,730	4,875	1,894	3,742
97	4,521	5,363	4,562	1,773	3,504	97	5,024	5,959	5,069	1,970	3,893
98	4,703	5,578	4,745	1,843	3,644	98	5,224	6,196	5,272	2,048	4,048
99	4,891	5,800	4,936	1,916	3,788	99	5,433	6,444	5,484	2,130	4,210

Modal Factors: Semi Annual: 0.5000 Quarterly: 0.25000 Monthly: Divide by 12

MICHIGAN Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 480-489, 492

Attained Age	Preferred					Attained Age	Standard				
	Plan A	Plan F	Plan G	Plan G	Plan N		Plan A	Plan F	Plan G	Plan G	Plan N
65	1,421	1,686	1,436	557	1,069	65	1,579	1,873	1,595	620	1,188
66	1,421	1,686	1,436	557	1,069	66	1,579	1,873	1,595	620	1,188
67	1,421	1,686	1,436	557	1,069	67	1,579	1,873	1,595	620	1,188
68	1,421	1,686	1,436	557	1,069	68	1,579	1,873	1,595	620	1,188
69	1,421	1,686	1,436	557	1,100	69	1,579	1,873	1,595	620	1,223
70	1,464	1,736	1,479	574	1,133	70	1,626	1,929	1,643	638	1,259
71	1,507	1,788	1,523	591	1,167	71	1,675	1,988	1,693	658	1,297
72	1,560	1,851	1,576	612	1,208	72	1,733	2,057	1,752	680	1,342
73	1,615	1,916	1,632	633	1,251	73	1,794	2,129	1,814	704	1,390
74	1,671	1,982	1,689	657	1,295	74	1,857	2,203	1,876	729	1,438
75	1,730	2,052	1,748	679	1,340	75	1,922	2,280	1,943	754	1,489
76	1,790	2,124	1,809	703	1,387	76	1,989	2,360	2,010	781	1,540
77	1,862	2,210	1,882	731	1,442	77	2,068	2,454	2,090	813	1,602
78	1,936	2,297	1,956	759	1,499	78	2,151	2,552	2,174	844	1,665
79	2,013	2,388	2,034	790	1,559	79	2,237	2,654	2,260	877	1,733
80	2,094	2,484	2,117	821	1,621	80	2,326	2,761	2,352	912	1,801
81	2,179	2,584	2,201	855	1,686	81	2,420	2,870	2,445	950	1,874
82	2,266	2,687	2,288	889	1,754	82	2,517	2,985	2,542	987	1,948
83	2,357	2,794	2,379	924	1,824	83	2,619	3,105	2,644	1,026	2,026
84	2,452	2,907	2,474	961	1,898	84	2,725	3,230	2,749	1,067	2,108
85	2,550	3,023	2,574	999	1,974	85	2,833	3,359	2,860	1,111	2,193
86	2,652	3,144	2,676	1,040	2,053	86	2,946	3,494	2,974	1,156	2,281
87	2,759	3,270	2,784	1,081	2,136	87	3,064	3,633	3,094	1,201	2,372
88	2,868	3,400	2,896	1,123	2,221	88	3,188	3,778	3,217	1,249	2,468
89	2,983	3,536	3,012	1,170	2,310	89	3,314	3,929	3,346	1,299	2,567
90	3,102	3,678	3,132	1,216	2,403	90	3,447	4,087	3,480	1,351	2,670
91	3,227	3,825	3,256	1,265	2,500	91	3,585	4,250	3,618	1,405	2,778
92	3,355	3,978	3,387	1,314	2,599	92	3,727	4,420	3,763	1,461	2,887
93	3,489	4,137	3,522	1,368	2,703	93	3,877	4,597	3,914	1,520	3,004
94	3,628	4,303	3,662	1,422	2,811	94	4,032	4,781	4,069	1,581	3,124
95	3,774	4,475	3,808	1,479	2,924	95	4,193	4,973	4,232	1,644	3,248
96	3,924	4,655	3,960	1,538	3,041	96	4,361	5,173	4,400	1,709	3,378
97	4,080	4,841	4,118	1,600	3,163	97	4,535	5,379	4,576	1,778	3,514
98	4,245	5,035	4,283	1,663	3,289	98	4,716	5,593	4,759	1,849	3,654
99	4,415	5,235	4,456	1,730	3,420	99	4,905	5,817	4,950	1,922	3,800

Modal Factors: Semi Annual: 0.5000 Quarterly: 0.25000 Monthly: Divide by 12

PREMIUM INFORMATION

Elips 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 Elips Life Insurance Company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to: Elips Life Insurance Company, Medicare Supplement Administration, P.O. Box 10875, Clearwater, Florida 33757-8875. 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 Elips 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. Elips 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
<u>HOSPITALIZATION*</u> - Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but \$1632	\$0	\$1632 (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
<u>SKILLED NURSING FACILITY CARE*</u> - You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21 st thru 100 th day	All but \$204 a day	\$0	Up to \$204 a day
101 st day and after	\$0	\$0	All costs
<u>BLOOD</u>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<u>HOSPICE CARE</u> - 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 \$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
<u>MEDICAL EXPENSES</u> - 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 \$240 of Medicare Approved Amounts*	\$0	\$0	\$240 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
<u>PART B EXCESS CHARGES</u> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<u>BLOOD</u>			
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
<u>CLINICAL LABORATORY SERVICES</u> - Tests for diagnostic services	100%	\$0	\$0

PLAN A

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<u>HOME HEALTH CARE</u> – 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 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
<u>HOSPITALIZATION*</u> - Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but \$1632	\$1632 (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
<u>SKILLED NURSING FACILITY CARE*</u> - You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21 st thru 100 th day	All but \$204 a day	Up to \$204 a day	\$0
101 st day and after	\$0	\$0	All costs
<u>BLOOD</u>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<u>HOSPICE CARE</u> - 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 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
<u>MEDICAL EXPENSES</u> - 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 \$240 of Medicare Approved Amounts*	\$0	\$240 (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
<u>PART B EXCESS CHARGES</u> (Above Medicare Approved Amounts)	\$0	100%	\$0
<u>BLOOD</u>			
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
<u>CLINICAL LABORATORY SERVICES</u> - Tests for diagnostic services	100%	\$0	\$0

(continued)

PLAN F
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<u>HOME HEALTH CARE</u> – 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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<u>HOSPITALIZATION*</u> - Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but \$1632	\$1632 (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
<u>SKILLED NURSING FACILITY CARE*</u> - You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21 st thru 100 th day	All but \$204 a day	Up to \$204 a day	\$0
101 st day and after	\$0	\$0	All costs
<u>BLOOD</u>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<u>HOSPICE CARE</u> - 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 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
<u>MEDICAL EXPENSES</u> - 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 \$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
<u>PART B EXCESS CHARGES</u> (Above Medicare Approved Amounts)	\$0	100%	\$0
<u>BLOOD</u>			
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
<u>CLINICAL LABORATORY SERVICES</u> - Tests for diagnostic services	100%	\$0	\$0

(continued)

PLAN G
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<u>HOME HEALTH CARE</u> – 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

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<u>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</u> – 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 \$2800 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses exceed \$2800. 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 \$2800 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2800 DEDUCTIBLE** YOU PAY
<u>HOSPITALIZATION*</u> - Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but \$1632	\$1632 (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
<u>SKILLED NURSING FACILITY CARE*</u> - You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21 st thru 100 th day	All but \$204 a day	Up to \$204 a day	\$0
101 st day and after	\$0	\$0	All costs
<u>BLOOD</u>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0

(continued)

HIGH DEDUCTIBLE PLAN G

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

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2800 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2800 DEDUCTIBLE** YOU PAY
HOSPICE CARE - 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.

(continued)

HIGH DEDUCTIBLE 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.

**This high deductible plan pays the same benefits as Plan G after you have paid a calendar year \$2800 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses exceed \$2800. 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 \$2800 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2800 DEDUCTIBLE** YOU PAY
<u>MEDICAL EXPENSES</u> - 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 \$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
<u>PART B EXCESS CHARGES</u> (Above Medicare Approved Amounts)	\$0	100%	\$0
<u>BLOOD</u>			
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
<u>CLINICAL LABORATORY SERVICES</u> - Tests for diagnostic services	100%	\$0	\$0

(continued)

HIGH DEDUCTIBLE PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2800 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2800 DEDUCTIBLE** 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

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2800 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2800 DEDUCTIBLE** 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
<u>HOSPITALIZATION*</u> - Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but \$1632	\$1632 (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
<u>SKILLED NURSING FACILITY CARE*</u> - You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21 st thru 100 th day	All but \$204 a day	Up to \$204 a day	\$0
101 st day and after	\$0	\$0	All costs
<u>BLOOD</u>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<u>HOSPICE CARE</u> - 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 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
<u>MEDICAL EXPENSES</u> - 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 \$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 copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
<u>PART B EXCESS CHARGES</u> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<u>BLOOD</u>			
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
<u>CLINICAL LABORATORY SERVICES</u> - Tests for diagnostic services	100%	\$0	\$0

(continued)

PLAN N
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<u>HOME HEALTH CARE</u> – 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
<u>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</u> – 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