CENTRAL STATES HEALTH & LIFE CO. OF OMAHA
Outline of Medicare Supplement Coverage
Benefit Plans A, C, F, G, and N

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 2020[2]						$5880[2]	$2940[2]					

[1]Plans F and G also have a high deductible option which requires first paying a plan deductible of $2340 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

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

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

Rates Effective 03-01-2020

CENTRAL STATES HEALTH AND LIFE CO. OF OMAHA

NEVADA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 889-892

Policy Fee $25

	Preferred						Standard				
Attained Age	Plan A	Plan C	Plan F	Plan G	Plan N	Attained Age	Plan A	Plan C	Plan F	Plan G	Plan N
65	1,830	2,156	2,177	1,768	1,347	65	2,105	2,479	2,504	2,033	1,549
66	1,830	2,156	2,177	1,768	1,347	66	2,105	2,479	2,504	2,033	1,549
67	1,830	2,156	2,177	1,768	1,347	67	2,105	2,479	2,504	2,033	1,549
68	1,830	2,168	2,190	1,768	1,347	68	2,105	2,494	2,519	2,033	1,549
69	1,894	2,181	2,203	1,835	1,396	69	2,178	2,508	2,533	2,110	1,606
70	1,965	2,193	2,216	1,906	1,450	70	2,259	2,523	2,548	2,192	1,667
71	2,023	2,264	2,287	1,975	1,502	71	2,327	2,604	2,630	2,271	1,728
72	2,082	2,334	2,358	2,044	1,555	72	2,394	2,685	2,712	2,350	1,789
73	2,141	2,405	2,429	2,113	1,608	73	2,462	2,766	2,794	2,429	1,849
74	2,200	2,475	2,500	2,181	1,661	74	2,530	2,847	2,875	2,508	1,910
75	2,286	2,576	2,602	2,277	1,735	75	2,628	2,963	2,993	2,619	1,995
76	2,357	2,673	2,700	2,368	1,807	76	2,711	3,074	3,105	2,723	2,078
77	2,436	2,779	2,807	2,467	1,885	77	2,801	3,195	3,228	2,837	2,167
78	2,521	2,893	2,922	2,573	1,969	78	2,900	3,327	3,360	2,959	2,264
79	2,615	3,016	3,047	2,688	2,060	79	3,007	3,469	3,504	3,092	2,368
80	2,714	3,147	3,179	2,811	2,156	80	3,121	3,619	3,656	3,232	2,479
81	2,808	3,285	3,318	2,939	2,260	81	3,229	3,778	3,816	3,380	2,599
82	2,908	3,428	3,462	3,075	2,370	82	3,345	3,942	3,981	3,537	2,726
83	3,015	3,575	3,611	3,220	2,487	83	3,467	4,112	4,153	3,703	2,860
84	3,129	3,729	3,766	3,374	2,612	84	3,598	4,288	4,331	3,880	3,003
85	3,249	3,887	3,927	3,537	2,744	85	3,737	4,470	4,516	4,068	3,155
86	3,364	4,034	4,075	3,693	2,870	86	3,868	4,639	4,686	4,247	3,300
87	3,486	4,186	4,228	3,859	3,004	87	4,009	4,814	4,863	4,438	3,455
88	3,616	4,343	4,387	4,036	3,147	88	4,158	4,995	5,045	4,642	3,619
89	3,754	4,506	4,551	4,224	3,299	89	4,317	5,181	5,234	4,858	3,794
90	3,883	4,674	4,721	4,404	3,445	90	4,465	5,375	5,429	5,065	3,962
91	3,995	4,827	4,875	4,570	3,581	91	4,595	5,551	5,607	5,256	4,118
92	4,111	4,984	5,035	4,742	3,722	92	4,728	5,732	5,790	5,454	4,281
93	4,214	5,147	5,199	4,901	3,854	93	4,846	5,919	5,979	5,637	4,432
94	4,315	5,309	5,363	5,060	3,985	94	4,962	6,106	6,167	5,819	4,583
95	4,414	5,471	5,526	5,219	4,117	95	5,077	6,292	6,355	6,002	4,734
96	4,507	5,586	5,642	5,329	4,203	96	5,183	6,424	6,489	6,128	4,834
97	4,597	5,698	5,755	5,435	4,287	97	5,287	6,552	6,618	6,251	4,930
98	4,685	5,806	5,865	5,539	4,369	98	5,387	6,677	6,744	6,369	5,024
99	4,769	5,910	5,970	5,638	4,447	99	5,484	6,797	6,866	6,484	5,114

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

Household Discount Factor: 0.93

CENTRAL STATES HEALTH AND LIFE CO. OF OMAHA

NEVADA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 889-892

	Preferred						Standard				
Attained Age	Plan A	Plan C	Plan F	Plan G	Plan N	Attained Age	Plan A	Plan C	Plan F	Plan G	Plan N
65	1,591	1,875	1,893	1,537	1,171	65	1,830	2,156	2,177	1,768	1,347
66	1,591	1,875	1,893	1,537	1,171	66	1,830	2,156	2,177	1,768	1,347
67	1,591	1,875	1,893	1,537	1,171	67	1,830	2,156	2,177	1,768	1,347
68	1,591	1,885	1,905	1,537	1,171	68	1,830	2,168	2,190	1,768	1,347
69	1,647	1,896	1,916	1,596	1,214	69	1,894	2,181	2,203	1,835	1,396
70	1,708	1,907	1,927	1,658	1,260	70	1,965	2,193	2,216	1,906	1,450
71	1,759	1,969	1,989	1,718	1,306	71	2,023	2,264	2,287	1,975	1,502
72	1,811	2,030	2,050	1,777	1,352	72	2,082	2,334	2,358	2,044	1,555
73	1,862	2,091	2,112	1,837	1,398	73	2,141	2,405	2,429	2,113	1,608
74	1,913	2,152	2,174	1,897	1,444	74	2,200	2,475	2,500	2,181	1,661
75	1,987	2,240	2,263	1,980	1,508	75	2,286	2,576	2,602	2,277	1,735
76	2,050	2,325	2,348	2,059	1,571	76	2,357	2,673	2,700	2,368	1,807
77	2,118	2,416	2,441	2,145	1,639	77	2,436	2,779	2,807	2,467	1,885
78	2,193	2,515	2,541	2,238	1,712	78	2,521	2,893	2,922	2,573	1,969
79	2,274	2,623	2,649	2,338	1,791	79	2,615	3,016	3,047	2,688	2,060
80	2,360	2,737	2,764	2,444	1,875	80	2,714	3,147	3,179	2,811	2,156
81	2,442	2,856	2,885	2,556	1,965	81	2,808	3,285	3,318	2,939	2,260
82	2,529	2,980	3,011	2,674	2,061	82	2,908	3,428	3,462	3,075	2,370
83	2,622	3,109	3,140	2,800	2,163	83	3,015	3,575	3,611	3,220	2,487
84	2,720	3,242	3,275	2,934	2,271	84	3,129	3,729	3,766	3,374	2,612
85	2,825	3,380	3,414	3,076	2,386	85	3,249	3,887	3,927	3,537	2,744
86	2,925	3,508	3,543	3,212	2,496	86	3,364	4,034	4,075	3,693	2,870
87	3,031	3,640	3,677	3,356	2,612	87	3,486	4,186	4,228	3,859	3,004
88	3,144	3,777	3,815	3,510	2,737	88	3,616	4,343	4,387	4,036	3,147
89	3,265	3,918	3,958	3,673	2,869	89	3,754	4,506	4,551	4,224	3,299
90	3,376	4,064	4,105	3,829	2,996	90	3,883	4,674	4,721	4,404	3,445
91	3,474	4,197	4,240	3,974	3,114	91	3,995	4,827	4,875	4,570	3,581
92	3,575	4,334	4,378	4,124	3,237	92	4,111	4,984	5,035	4,742	3,722
93	3,664	4,476	4,521	4,262	3,351	93	4,214	5,147	5,199	4,901	3,854
94	3,752	4,617	4,663	4,400	3,465	94	4,315	5,309	5,363	5,060	3,985
95	3,839	4,757	4,805	4,538	3,580	95	4,414	5,471	5,526	5,219	4,117
96	3,919	4,857	4,906	4,634	3,655	96	4,507	5,586	5,642	5,329	4,203
97	3,998	4,954	5,005	4,726	3,728	97	4,597	5,698	5,755	5,435	4,287
98	4,074	5,049	5,100	4,816	3,799	98	4,685	5,806	5,865	5,539	4,369
99	4,147	5,139	5,191	4,903	3,867	99	4,769	5,910	5,970	5,638	4,447

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

Household Discount Factor: 0.93

CENTRAL STATES HEALTH AND LIFE CO. OF OMAHA

NEVADA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 889-892

	Preferred						Standard				
Attained Age	Plan A	Plan C	Plan F	Plan G	Plan N	Attained Age	Plan A	Plan C	Plan F	Plan G	Plan N
65	1,614	1,901	1,920	1,559	1,188	65	1,856	2,186	2,208	1,792	1,366
66	1,614	1,901	1,920	1,559	1,188	66	1,856	2,186	2,208	1,792	1,366
67	1,614	1,901	1,920	1,559	1,188	67	1,856	2,186	2,208	1,792	1,366
68	1,614	1,912	1,931	1,559	1,188	68	1,856	2,199	2,221	1,792	1,366
69	1,670	1,923	1,943	1,618	1,231	69	1,921	2,212	2,234	1,861	1,416
70	1,732	1,934	1,954	1,681	1,278	70	1,992	2,224	2,247	1,933	1,470
71	1,784	1,996	2,017	1,742	1,325	71	2,052	2,296	2,319	2,003	1,524
72	1,836	2,059	2,079	1,802	1,372	72	2,112	2,367	2,391	2,073	1,577
73	1,888	2,121	2,142	1,863	1,418	73	2,171	2,439	2,463	2,142	1,631
74	1,940	2,183	2,205	1,924	1,465	74	2,231	2,510	2,536	2,212	1,684
75	2,015	2,272	2,295	2,008	1,530	75	2,318	2,613	2,639	2,309	1,759
76	2,079	2,357	2,381	2,088	1,593	76	2,391	2,711	2,738	2,401	1,832
77	2,148	2,450	2,475	2,175	1,662	77	2,470	2,818	2,846	2,501	1,911
78	2,223	2,551	2,577	2,269	1,736	78	2,557	2,933	2,963	2,609	1,996
79	2,306	2,660	2,687	2,371	1,816	79	2,652	3,059	3,090	2,726	2,089
80	2,393	2,775	2,803	2,478	1,901	80	2,752	3,192	3,224	2,850	2,186
81	2,476	2,897	2,926	2,592	1,993	81	2,848	3,331	3,365	2,981	2,292
82	2,565	3,022	3,053	2,712	2,090	82	2,949	3,476	3,511	3,119	2,404
83	2,659	3,153	3,185	2,840	2,193	83	3,058	3,626	3,662	3,266	2,522
84	2,759	3,288	3,321	2,975	2,303	84	3,173	3,781	3,819	3,421	2,648
85	2,865	3,428	3,463	3,119	2,419	85	3,295	3,942	3,982	3,587	2,782
86	2,966	3,557	3,593	3,257	2,531	86	3,411	4,091	4,132	3,745	2,910
87	3,074	3,691	3,729	3,403	2,649	87	3,535	4,245	4,288	3,914	3,046
88	3,189	3,830	3,869	3,559	2,775	88	3,667	4,404	4,449	4,093	3,191
89	3,311	3,973	4,013	3,725	2,909	89	3,807	4,569	4,615	4,284	3,346
90	3,424	4,121	4,163	3,883	3,038	90	3,937	4,739	4,787	4,466	3,494
91	3,523	4,256	4,299	4,030	3,158	91	4,052	4,895	4,944	4,635	3,632
92	3,625	4,395	4,440	4,182	3,283	92	4,169	5,055	5,106	4,809	3,775
93	3,716	4,539	4,585	4,322	3,398	93	4,273	5,220	5,272	4,970	3,908
94	3,805	4,682	4,729	4,462	3,514	94	4,376	5,384	5,439	5,132	4,041
95	3,893	4,824	4,873	4,602	3,630	95	4,477	5,548	5,604	5,293	4,175
96	3,975	4,926	4,976	4,699	3,706	96	4,571	5,665	5,722	5,404	4,262
97	4,054	5,024	5,075	4,793	3,780	97	4,662	5,778	5,836	5,512	4,348
98	4,131	5,120	5,171	4,884	3,852	98	4,751	5,888	5,947	5,617	4,430
99	4,205	5,212	5,265	4,972	3,922	99	4,836	5,994	6,054	5,718	4,510

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

Household Discount Factor: 0.93

Rates Effective 03-01-2020

CENTRAL STATES HEALTH AND LIFE CO. OF OMAHA

Policy Fee $25

NEVADA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 889-892

	Preferred						Standard				
Attained Age	Plan A	Plan C	Plan F	Plan G	Plan N	Attained Age	Plan A	Plan C	Plan F	Plan G	Plan N
65	1,403	1,653	1,670	1,355	1,033	65	1,614	1,901	1,920	1,559	1,188
66	1,403	1,653	1,670	1,355	1,033	66	1,614	1,901	1,920	1,559	1,188
67	1,403	1,653	1,670	1,355	1,033	67	1,614	1,901	1,920	1,559	1,188
68	1,403	1,663	1,679	1,355	1,033	68	1,614	1,912	1,931	1,559	1,188
69	1,452	1,672	1,689	1,407	1,071	69	1,670	1,923	1,943	1,618	1,231
70	1,506	1,682	1,699	1,462	1,112	70	1,732	1,934	1,954	1,681	1,278
71	1,552	1,736	1,754	1,515	1,152	71	1,784	1,996	2,017	1,742	1,325
72	1,597	1,790	1,808	1,567	1,193	72	1,836	2,059	2,079	1,802	1,372
73	1,642	1,844	1,863	1,620	1,233	73	1,888	2,121	2,142	1,863	1,418
74	1,687	1,898	1,917	1,673	1,274	74	1,940	2,183	2,205	1,924	1,465
75	1,753	1,976	1,995	1,746	1,330	75	2,015	2,272	2,295	2,008	1,530
76	1,808	2,050	2,071	1,816	1,385	76	2,079	2,357	2,381	2,088	1,593
77	1,868	2,131	2,152	1,891	1,445	77	2,148	2,450	2,475	2,175	1,662
78	1,933	2,218	2,241	1,973	1,510	78	2,223	2,551	2,577	2,269	1,736
79	2,005	2,313	2,336	2,061	1,579	79	2,306	2,660	2,687	2,371	1,816
80	2,081	2,413	2,438	2,155	1,653	80	2,393	2,775	2,803	2,478	1,901
81	2,153	2,519	2,544	2,254	1,733	81	2,476	2,897	2,926	2,592	1,993
82	2,230	2,628	2,655	2,358	1,817	82	2,565	3,022	3,053	2,712	2,090
83	2,312	2,742	2,769	2,469	1,907	83	2,659	3,153	3,185	2,840	2,193
84	2,399	2,859	2,888	2,587	2,003	84	2,759	3,288	3,321	2,975	2,303
85	2,491	2,981	3,011	2,712	2,104	85	2,865	3,428	3,463	3,119	2,419
86	2,579	3,093	3,125	2,832	2,201	86	2,966	3,557	3,593	3,257	2,531
87	2,673	3,210	3,242	2,959	2,304	87	3,074	3,691	3,729	3,403	2,649
88	2,773	3,330	3,364	3,095	2,413	88	3,189	3,830	3,869	3,559	2,775
89	2,879	3,455	3,490	3,239	2,530	89	3,311	3,973	4,013	3,725	2,909
90	2,977	3,584	3,620	3,377	2,642	90	3,424	4,121	4,163	3,883	3,038
91	3,064	3,701	3,738	3,504	2,746	91	3,523	4,256	4,299	4,030	3,158
92	3,152	3,822	3,861	3,636	2,854	92	3,625	4,395	4,440	4,182	3,283
93	3,231	3,947	3,987	3,758	2,955	93	3,716	4,539	4,585	4,322	3,398
94	3,309	4,071	4,112	3,880	3,056	94	3,805	4,682	4,729	4,462	3,514
95	3,385	4,195	4,238	4,002	3,157	95	3,893	4,824	4,873	4,602	3,630
96	3,456	4,283	4,327	4,086	3,223	96	3,975	4,926	4,976	4,699	3,706
97	3,525	4,369	4,413	4,168	3,287	97	4,054	5,024	5,075	4,793	3,780
98	3,592	4,452	4,497	4,247	3,350	98	4,131	5,120	5,171	4,884	3,852
99	3,657	4,532	4,578	4,323	3,410	99	4,205	5,212	5,265	4,972	3,922

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

Household Discount Factor: 0.93

PREMIUM INFORMATION

Central States Health & Life Co. of Omaha 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, sex, 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 Central States Health & Life Co. of Omaha.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to: Central States Health & Life Co. of Omaha, Medicare Supplement Administration, P.O. Box 10845, Clearwater, Florida 33757-8845. 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 Central States Health & Life Co. of Omaha 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. Central States Health & Life Co. of Omaha 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
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1408	$0	$1408 (Part A deductible)
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $704 a day	$704 a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $176 a day	$0	Up to $176 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited 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 $198 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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

PARTS A & B

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

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 $1408	$1408 (Part A deductible)	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $704 a day	$704 a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $176 a day	Up to $176 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN C

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

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

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

(continued)

PLAN C

PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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 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 $1408	$1408 (Part A deductible)	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $704 a day	$704 a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $176 a day	Up to $176 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F

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

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

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

(continued)

PLAN F

PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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 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 $1408	$1408 (Part A deductible)	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $704 a day	$704 a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $176 a day	Up to $176 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G

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

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

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

(continued)

PLAN G

PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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 $1408	$1408 (Part A deductible)	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $704 a day	$704 a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $176 a day	Up to $176 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $198 of Medicare Approved Amounts*	$0	$0	$198 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The 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.
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $198 of Medicare Approved Amounts*	$0	$0	$198 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

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 — Durable medical equipment First $198 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% $0 80%	$0 $0 20%	$0 $198 (Part B deductible) $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 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.