Anthem®

Underwritten by Community Insurance Company
or Anthem Insurance Companies, Inc.

Anthem Blue Cross and Blue Shield – Ohio

Outline of Medicare Supplement Coverage (Cover Page: 1 of 1)
Benefit Chart of Medicare Supplement Plans Sold for Effective Dates On or After June 1, 2010

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Plans A, G, N, Select G and Select N are offered by Community Insurance Company.
Plan F and Select F are offered by Anthem Insurance Companies, Inc.

This chart shows the benefits included in each of the standard Medicare supplement plans with an effective date for coverage on or after June 1, 2010. Every company must make Plan "A" available. Some plans may not be available in your state. Plans shown in gray are available for purchase.

Basic Benefits:

- **Hospitalization –** Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses –** Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.
- **Blood –** First three pints of blood each year.
- **Hospice –** Part A coinsurance.

Plan A	B	C	D	F | F*[1]	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance*	Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility coinsurance	Skilled Nursing Facility coinsurance	Skilled Nursing Facility coinsurance	Skilled Nursing Facility coinsurance	50% Skilled Nursing Facility coinsurance	75% Skilled Nursing Facility coinsurance	Skilled Nursing Facility coinsurance	Skilled Nursing Facility coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out-of-pocket limit $5,560; paid at 100% after limit reached	Out-of-pocket limit $2,780; paid at 100% after limit reached		

* Plan F also has an option called a High Deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,300 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses exceed $2,300. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

[1] High Deductible Plan F is not available.

Monthly Premium

Plans A, F, G & N Effective July 1, 2019

Premiums are subject to change.

FIND YOUR PREMIUM

Premium is based upon your age, gender, area and plan.

AREA 1

Age*	MALE				FEMALE			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
65	$118.33	$147.03	$114.66	$107.92	$107.86	$132.19	$104.52	$98.37
66	121.39	157.13	121.58	114.43	110.65	141.40	110.83	104.31
67	124.02	167.25	128.48	120.93	113.04	150.61	117.12	110.23
68	129.65	177.35	135.40	127.44	118.17	159.82	123.42	116.16
69	135.21	187.46	142.30	133.93	123.25	169.04	129.71	122.08
70	141.10	197.56	149.21	140.44	128.61	178.25	136.01	128.01
71	146.96	207.67	156.12	146.94	133.96	187.46	142.31	133.94
72	152.75	217.76	163.03	153.44	139.23	196.67	148.60	139.87
73	158.62	227.88	169.94	159.95	144.59	205.88	154.90	145.80
74	164.39	237.98	176.85	166.45	149.85	215.09	161.20	151.73
75	169.70	248.09	183.75	172.95	154.68	224.31	167.49	157.65
76	175.01	256.93	190.66	179.45	159.52	232.37	173.80	163.58
77	180.30	265.33	197.57	185.95	164.35	240.03	180.09	169.50
78	185.61	273.77	204.49	192.47	169.19	247.71	186.40	175.44
79	190.56	281.64	211.39	198.96	173.70	254.89	192.69	181.36
80	194.98	288.57	218.30	205.47	177.73	261.20	198.99	187.29
81+	198.65	294.44	218.30	205.47	181.08	266.55	198.99	187.29

- **Area 1:** Allen, Ashland, Athens, Auglaize, Belmont, Champaign, Clark, Clinton, Coshocton, Crawford, Defiance, Delaware, Fairfield, Fayette, Franklin, Gallia, Greene, Guernsey, Hancock, Hardin, Henry, Hocking, Holmes, Huron, Jefferson, Knox, Lawrence, Licking, Logan, Madison, Marion, Meigs, Mercer, Miami, Monroe, Morgan, Morrow, Muskingum, Noble, Paulding, Perry, Pickaway, Putnam, Richland, Ross, Seneca, Shelby, Union, Van Wert, Washington, Wayne, Williams, Wyandot

* Attained age at the time of enrollment.

(SEE NEXT PAGE FOR MORE AREAS)

Monthly Premium

Plans A, F, G & N Effective July 1, 2019

Premiums are subject to change.

FIND YOUR PREMIUM *(continued)*

Premium is based upon your age, gender, area and plan.

AREA 2

Age*	MALE				FEMALE			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
65	$125.67	$157.43	$121.77	$114.61	$114.55	$141.67	$111.00	$104.47
66	128.91	168.16	129.12	121.53	117.51	151.45	117.70	110.78
67	131.71	178.90	136.45	128.43	120.05	161.24	124.38	117.07
68	137.68	189.62	143.79	135.34	125.50	171.01	131.07	123.36
69	143.59	200.37	151.12	142.24	130.89	180.80	137.75	129.65
70	149.85	211.09	158.46	149.15	136.59	190.58	144.44	135.95
71	156.08	221.83	165.80	156.06	142.27	200.38	151.13	142.25
72	162.22	232.55	173.13	162.96	147.86	210.15	157.82	148.54
73	168.46	243.30	180.48	169.86	153.55	219.94	164.51	154.84
74	174.59	254.02	187.82	176.77	159.14	229.72	171.20	161.13
75	180.22	264.76	195.15	183.67	164.27	239.50	177.88	167.42
76	185.86	274.14	202.49	190.58	169.42	248.06	184.57	173.72
77	191.48	283.07	209.82	197.48	174.54	256.19	191.25	180.01
78	197.12	292.03	217.17	204.40	179.68	264.36	197.95	186.32
79	202.37	300.39	224.50	211.30	184.47	271.99	204.64	192.61
80	207.07	307.75	231.84	218.21	188.75	278.68	211.33	198.90
81+	210.97	313.98	231.84	218.21	192.30	284.37	211.33	198.90

■ **Area 2:** Adams, Brown, Butler, Clermont, Darke, Hamilton, Highland, Jackson, Montgomery, Pike, Preble, Scioto, Vinton, Warren

* Attained age at the time of enrollment.

(SEE NEXT PAGE FOR MORE AREAS)

Monthly Premium

Plans A, F, G & N Effective July 1, 2019

Premiums are subject to change.

FIND YOUR PREMIUM *(continued)*

Premium is based upon your age, gender, area and plan.

AREA 3

Age*	MALE				FEMALE			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
65	$133.90	$169.10	$129.74	$122.12	122.05	$152.30	$118.26	$111.31
66	137.36	180.52	137.58	129.49	125.20	162.72	125.40	118.03
67	140.33	191.97	145.39	136.84	127.92	173.16	132.52	124.73
68	146.70	203.40	153.21	144.20	133.72	183.57	139.65	131.44
69	152.99	214.83	161.02	151.55	139.46	194.00	146.77	138.14
70	159.66	226.27	168.84	158.91	145.53	204.41	153.90	144.85
71	166.30	237.71	176.66	166.27	151.58	214.85	161.03	151.56
72	172.84	249.13	184.47	173.63	157.55	225.27	168.15	158.26
73	179.49	260.58	192.29	180.99	163.61	235.69	175.28	164.97
74	186.02	272.01	200.11	188.35	169.56	246.11	182.41	171.68
75	192.02	283.45	207.92	195.70	175.03	256.54	189.53	178.38
76	198.03	293.45	215.75	203.06	180.51	265.65	196.66	185.10
77	204.02	302.97	223.56	210.41	185.97	274.33	203.78	191.80
78	210.03	312.50	231.39	217.78	191.45	283.02	210.92	198.52
79	215.62	321.42	239.20	225.14	196.55	291.15	218.03	205.22
80	220.63	329.25	247.02	232.50	201.11	298.29	225.16	211.93
81+	224.78	335.89	247.02	232.50	204.89	304.34	225.16	211.93

- **Area 3:** Ashtabula, Carroll, Columbiana, Cuyahoga, Erie, Fulton, Geauga, Harrison, Lake, Lorain, Lucas, Mahoning, Medina, Ottawa, Portage, Sandusky, Stark, Summit, Trumbull, Tuscarawas, Wood

* Attained age at the time of enrollment.

(SEE NEXT PAGE FOR SELECT PLANS)

Monthly Premium

Plans F, G & N Effective July 1, 2019

Premiums are subject to change.

FIND YOUR PREMIUM **SELECT PLANS**

Select Plans require use of a network hospital. Premium is based upon your age, gender, area and plan.

AREA 1

Age*	MALE			FEMALE		
	Plan F	Plan G	Plan N	Plan F	Plan G	Plan N
65	$118.53	$93.53	$88.04	$106.20	$85.26	$80.25
66	126.90	99.18	93.35	113.84	90.41	85.10
67	135.30	104.81	98.65	121.50	95.54	89.92
68	143.67	110.46	103.96	129.14	100.68	94.76
69	152.06	116.08	109.26	136.79	105.81	99.59
70	160.47	121.72	114.56	144.42	110.95	104.42
71	168.85	127.36	119.88	152.07	116.09	109.27
72	177.23	132.99	125.18	159.72	121.22	114.10
73	185.62	138.62	130.47	167.37	126.37	118.94
74	194.00	144.27	135.79	175.01	131.50	123.77
75	202.40	149.89	141.09	182.66	136.63	128.59
76	209.72	155.53	146.39	189.34	141.77	133.44
77	216.71	161.17	151.69	195.71	146.91	138.27
78	223.69	166.82	157.02	202.08	152.06	143.11
79	230.25	172.45	162.30	208.04	157.18	147.94
80	235.99	178.09	167.62	213.29	162.33	152.79
81+	240.87	178.09	167.62	217.72	162.33	152.79

- **Area 1:** Allen, Ashland, Athens, Auglaize, Belmont, Champaign, Clark, Clinton, Coshocton, Crawford, Defiance, Delaware, Fairfield, Fayette, Franklin, Gallia, Greene, Guernsey, Hancock, Hardin, Henry, Hocking, Holmes, Huron, Jefferson, Knox, Lawrence, Licking, Logan, Madison, Marion, Meigs, Mercer, Miami, Monroe, Morgan, Morrow, Muskingum, Noble, Paulding, Perry, Pickaway, Putnam, Richland, Ross, Seneca, Shelby, Union, Van Wert, Washington, Wayne, Williams, Wyandot

* Attained age at the time of enrollment.

(SEE NEXT PAGE FOR MORE AREAS)

Monthly Premium

Plans F, G & N Effective July 1, 2019

Premiums are subject to change.

FIND YOUR PREMIUM **SELECT PLANS** *(continued)*

Select Plans require use of a network hospital. Premium is based upon your age, gender, area and plan.

AREA 2

Age*	MALE			FEMALE		
	Plan F	Plan G	Plan N	Plan F	Plan G	Plan N
65	$127.15	$99.33	$93.49	$114.08	$90.56	$85.23
66	136.06	105.33	99.14	122.18	96.01	90.36
67	144.97	111.31	104.76	130.31	101.46	95.50
68	153.87	117.31	110.41	138.42	106.92	100.64
69	162.78	123.28	116.03	146.55	112.38	105.76
70	171.69	129.27	121.67	154.67	117.84	110.91
71	180.61	135.26	127.31	162.80	123.29	116.04
72	189.51	141.23	132.93	170.91	128.74	121.18
73	198.42	147.23	138.57	179.02	134.20	126.32
74	207.32	153.21	144.21	187.14	139.65	131.44
75	216.23	159.20	149.84	195.26	145.11	136.58
76	224.02	165.18	155.46	202.36	150.56	141.71
77	231.44	171.15	161.09	209.12	156.01	146.83
78	238.87	177.16	166.74	215.90	161.48	151.99
79	245.80	183.13	172.37	222.24	166.93	157.12
80	251.91	189.13	178.01	227.79	172.39	162.26
81+	257.08	189.13	178.01	232.51	172.39	162.26

■ **Area 2:** Adams, Brown, Butler, Clermont, Darke, Hamilton, Highland, Jackson, Montgomery, Pike, Preble, Scioto, Vinton, Warren

* Attained age at the time of enrollment.

(SEE NEXT PAGE FOR MORE AREAS)

Monthly Premium

Plans F, G & N Effective July 1, 2019

Premiums are subject to change.

FIND YOUR PREMIUM **SELECT PLANS** *(continued)*

Select Plans require use of a network hospital. Premium is based upon your age, gender, area and plan.

AREA 3

Age*	MALE			FEMALE		
	Plan F	Plan G	Plan N	Plan F	Plan G	Plan N
65	$136.84	$105.83	$99.61	$122.90	$96.48	$90.80
66	146.33	112.22	105.63	131.54	102.30	96.29
67	155.81	118.59	111.62	140.20	108.11	101.74
68	165.30	124.98	117.63	148.84	113.91	107.22
69	174.80	131.35	123.62	157.50	119.73	112.70
70	184.29	137.74	129.64	166.16	125.55	118.17
71	193.77	144.11	135.63	174.80	131.36	123.64
72	203.26	150.49	141.63	183.44	137.18	129.11
73	212.75	156.86	147.64	192.11	142.99	134.59
74	222.25	163.24	153.65	200.76	148.80	140.05
75	231.75	169.62	159.65	209.40	154.60	145.52
76	240.05	176.00	165.66	216.98	160.42	150.99
77	247.93	182.37	171.65	224.17	166.23	156.46
78	255.86	188.76	177.66	231.38	172.06	161.94
79	263.25	195.13	183.65	238.13	177.87	167.41
80	269.75	201.52	189.67	244.06	183.68	172.89
81+	275.28	201.52	189.67	249.09	183.68	172.89

- **Area 3:** Ashtabula, Carroll, Columbiana, Cuyahoga, Erie, Fulton, Geauga, Harrison, Lake, Lorain, Lucas, Mahoning, Medina, Ottawa, Portage, Sandusky, Stark, Summit, Trumbull, Tuscarawas, Wood

* Attained age at the time of enrollment.

PREMIUM INFORMATION

We, Anthem, can only raise your premium if we raise the premium for all plans like yours in this State. We will recalculate your age each year to determine your new attained age. Your premium may increase annually at your plan renewal based upon your new attained age.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

Medicare deductibles and coinsurance amounts are effective as of January 1, 2019. Medicare may change their amounts annually.

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 Anthem.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to us at our Administrative Office: P.O. Box 659816, San Antonio, TX 78265-9116. 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.

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 Anthem 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. 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 $1,364	$0	$1,364 (Part A deductible)
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after: · While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	$0	Up to $170.50 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 $185 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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$0	$185 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES Tests for Diagnostic Services	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE — MEDICARE APPROVED SERVICES			
· Medically necessary skilled care services and medical supplies	100%	$0	$0
· Durable medical equipment:			
— First $185 of Medicare approved amounts*	$0	$0	$185 (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
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,364	$1,364 (Part A deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after: · While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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 $185 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 $185 of Medicare Approved Amounts*	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$185 (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			
HOME HEALTH CARE — MEDICARE APPROVED SERVICES			
· Medically necessary skilled care services and medical supplies	100%	$0	$0
· Durable medical equipment:			
— First $185 of Medicare approved amounts*	$0	$185 (Part B deductible)	$0
— Remainder of Medicare approved amounts	80%	20%	$0
OTHER BENEFITS – NOT COVERED BY MEDICARE			
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 $1,364	$1,364 (Part A deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after: · While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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 $185 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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$0	$185 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES Tests for Diagnostic Services	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE — MEDICARE APPROVED SERVICES			
· Medically necessary skilled care services and medical supplies	100%	$0	$0
· Durable medical equipment:			
— First $185 of Medicare approved amounts*	$0	$0	$185 (Part B deductible)
— Remainder of Medicare approved amounts	80%	20%	$0
OTHER BENEFITS – NOT COVERED BY MEDICARE			
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 $1,364	$1,364 (Part A deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after: · While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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 $185 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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 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.
Part B Excess Charges			
Above Medicare Approved Amounts	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $185 of Medicare Approved Amounts*	$0	$0	$185 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Tests for Diagnostic Services	100%	$0	$0

(Continued)

PLAN N

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

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 $185 of Medicare approved amounts*	$0	$0	$185 (Part B deductible)
— Remainder of Medicare approved amounts	80%	20%	$0
OTHER BENEFITS – NOT COVERED BY MEDICARE			
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