

# PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY

P.O. Box 4884, Houston, Texas 77210-4884

## BENEFIT CHART OF MEDICARE SUPPLEMENT PLANS SOLD ON OR AFTER JANUARY 1, 2011

This chart shows the benefits included in each of the Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state.

### BASIC BENEFITS

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

### *SHADED PLANS ARE AVAILABLE IN YOUR STATE*

A	B	C	D	F	F*	G	K	L	M	N
Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance*	Basic, including 100% Part B co-insurance	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 co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance, except up to \$20 co-payment for office visit, and up to \$50 co-payment for ER
		Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	50% Skilled Nursing Facility Co-insurance	75% Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance
	Part A Ded.	Part A Ded.	Part A Ded.	Part A Ded.	Part A Ded.	50% Part A Ded.	75% Part A Ded.	50% Part A Ded.	Part A Ded.	Part A Ded.
		Part B Ded.		Part B Ded.						
				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
*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 \$2,000 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed \$2,000. 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.						Out-of-pocket limit \$4,620; paid at 100% after limit reached.	Out-of-pocket limit \$2,310; paid at 100% after limit reached.			

PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY  
 MEDICARE SUPPLEMENT PREMIUM  
 OHIO  
 June 1, 2010

STANDARD PLAN A

Area 1				
Attained Age	MNTU	MTU	FNTU	FTU
65	93.09	107.06	86.20	99.13
66	93.77	107.84	86.83	99.85
67	94.37	108.52	87.38	100.48
68	94.87	109.10	87.85	101.02
69	95.29	109.58	88.23	101.47
70	95.62	109.96	88.54	101.82
71	97.82	112.49	90.57	104.16
72	101.96	117.26	94.41	108.57
73	106.36	122.32	98.49	113.26
74	111.03	127.68	102.80	118.22
75	115.02	132.28	106.50	122.48
76	119.19	137.07	110.37	126.92
77	123.54	142.07	114.39	131.55
78	128.05	147.25	118.56	136.34
79	132.71	152.62	122.88	141.31
80	140.13	161.15	129.75	149.21
81	147.93	170.12	136.97	157.52
82	156.11	179.53	144.55	166.23
83	164.69	189.40	152.49	175.37
84	171.95	197.75	159.22	183.10
85	179.48	206.40	166.18	191.11
86	187.26	215.35	173.39	199.40
87	195.30	224.60	180.83	207.96
88	203.60	234.14	188.52	216.80
89	212.17	243.99	196.45	225.92
90+	220.99	254.14	204.62	235.31

Area 2				
Attained Age	MNTU	MTU	FNTU	FTU
65	83.78	96.35	77.58	89.21
66	84.40	97.06	78.14	89.87
67	84.93	97.67	78.64	90.43
68	85.39	98.19	79.06	90.92
69	85.76	98.63	79.41	91.32
70	86.06	98.97	79.68	91.64
71	88.04	101.24	81.52	93.74
72	91.77	105.53	84.97	97.71
73	95.73	110.09	88.64	101.93
74	99.92	114.91	92.52	106.40
75	103.52	119.05	95.85	110.23
76	107.28	123.37	99.33	114.23
77	111.18	127.86	102.95	118.39
78	115.24	132.53	106.70	122.71
79	119.44	137.36	110.59	127.18
80	126.12	145.03	116.77	134.29
81	133.13	153.10	123.27	141.76
82	140.50	161.58	130.09	149.61
83	148.22	170.46	137.24	157.83
84	154.76	177.97	143.30	164.79
85	161.53	185.76	149.56	172.00
86	168.53	193.81	156.05	179.46
87	175.77	202.14	162.75	187.16
88	183.24	210.73	169.67	195.12
89	190.95	219.59	176.81	203.33
90+	198.89	228.72	184.16	211.78

Area 3				
Attained Age	MNTU	MTU	FNTU	FTU
65	79.13	91.00	73.27	84.26
66	79.71	91.66	73.80	84.87
67	80.21	92.24	74.27	85.41
68	80.64	92.74	74.67	85.87
69	81.00	93.15	75.00	86.25
70	81.28	93.47	75.26	86.55
71	83.15	95.62	76.99	88.54
72	86.67	99.67	80.25	92.28
73	90.41	103.97	83.71	96.27
74	94.37	108.53	87.38	100.49
75	97.77	112.43	90.53	104.11
76	101.32	116.51	93.81	107.88
77	105.01	120.76	97.23	111.81
78	108.84	125.16	100.78	115.89
79	112.80	129.73	104.45	120.12
80	119.11	136.98	110.29	126.83
81	125.74	144.60	116.42	133.89
82	132.70	152.60	122.87	141.30
83	139.99	160.99	129.62	149.06
84	146.16	168.09	135.33	155.63
85	152.56	175.44	141.25	162.44
86	159.17	183.05	147.38	169.49
87	166.01	190.91	153.71	176.77
88	173.06	199.02	160.24	184.28
89	180.34	207.39	166.98	192.03
90+	187.84	216.02	173.93	200.02

Area 1 includes zip codes: 434-436, 440-445  
 Area 2 includes zip codes: 430-433, 439, 450-456  
 Area 3 includes all other zip codes in Ohio  
 Modal Factors: Monthly Bank Draft = 1.0,  
 Bi-Monthly = 2.0, Quarterly = 3.0

<b>MNTU:</b> Male Non-Tobacco User
<b>MTU:</b> Male Tobacco User
<b>FNTU:</b> Female Non-Tobacco User
<b>FTU:</b> Female Tobacco User

**ADD ONE TIME NON-REFUNDABLE \$20 APPLICATION FEE**

PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY  
 MEDICARE SUPPLEMENT PREMIUM  
 OHIO  
 June 1, 2010

STANDARD PLAN C

Area 1				
Attained Age	MNTU	MTU	FNTU	FTU
65	139.17	160.05	128.86	148.19
66	142.79	164.21	132.21	152.04
67	146.40	168.36	135.56	155.89
68	150.02	172.52	138.91	159.74
69	153.63	176.68	142.25	163.59
70	157.25	180.84	145.60	167.44
71	160.86	184.99	148.95	171.29
72	167.68	192.83	155.26	178.54
73	174.92	201.15	161.96	186.25
74	182.58	209.97	169.06	194.42
75	189.15	217.53	175.14	201.41
76	196.02	225.42	181.50	208.72
77	203.16	233.63	188.11	216.33
78	210.57	242.16	194.97	224.22
79	218.24	250.98	202.08	232.39
80	230.44	265.01	213.37	245.38
81	243.27	279.76	225.25	259.03
82	256.73	295.24	237.71	273.37
83	270.84	311.46	250.77	288.39
84	282.78	325.20	261.83	301.11
85	295.15	339.42	273.29	314.28
86	307.95	354.14	285.14	327.91
87	321.17	369.35	297.38	341.99
88	334.83	385.05	310.02	356.53
89	348.91	401.24	323.06	371.52
90+	363.42	417.93	336.50	386.97

Area 2				
Attained Age	MNTU	MTU	FNTU	FTU
65	125.25	144.04	115.98	133.37
66	128.51	147.78	118.99	136.84
67	131.76	151.53	122.00	140.30
68	135.02	155.27	125.01	143.77
69	138.27	159.01	128.03	147.23
70	141.52	162.75	131.04	150.70
71	144.78	166.49	134.05	154.16
72	150.91	173.54	139.73	160.69
73	157.43	181.04	145.76	167.63
74	164.33	188.97	152.15	174.98
75	170.24	195.77	157.63	181.27
76	176.41	202.88	163.35	187.85
77	182.84	210.27	169.30	194.69
78	189.51	217.94	175.48	201.80
79	196.42	225.88	181.87	209.15
80	207.40	238.51	192.04	220.84
81	218.94	251.78	202.72	233.13
82	231.05	265.71	213.94	246.03
83	243.75	280.31	225.70	259.55
84	254.50	292.68	235.65	271.00
85	265.63	305.48	245.96	282.85
86	277.15	318.73	256.62	295.12
87	289.06	332.41	267.64	307.79
88	301.34	346.55	279.02	320.88
89	314.02	361.12	290.76	334.37
90+	327.08	376.14	302.85	348.27

Area 3				
Attained Age	MNTU	MTU	FNTU	FTU
65	118.30	136.04	109.53	125.96
66	121.37	139.57	112.38	129.24
67	124.44	143.11	115.22	132.51
68	127.51	146.64	118.07	135.78
69	130.59	150.18	120.91	139.05
70	133.66	153.71	123.76	142.32
71	136.73	157.24	126.61	145.60
72	142.52	163.90	131.97	151.76
73	148.68	170.98	137.67	158.32
74	155.20	178.48	143.70	165.26
75	160.78	184.90	148.87	171.20
76	166.61	191.61	154.27	177.41
77	172.68	198.59	159.89	183.88
78	178.98	205.83	165.73	190.59
79	185.51	213.33	171.77	197.53
80	195.88	225.26	181.37	208.57
81	206.78	237.79	191.46	220.18
82	218.22	250.95	202.05	232.36
83	230.21	264.74	213.16	245.13
84	240.36	276.42	222.56	255.94
85	250.88	288.51	232.29	267.14
86	261.76	301.02	242.37	278.72
87	273.00	313.95	252.78	290.69
88	284.60	327.29	263.52	303.05
89	296.57	341.06	274.60	315.79
90+	308.90	355.24	286.02	328.93

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 Bi-Monthly = 2.0, Quarterly = 3.0

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PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY  
 MEDICARE SUPPLEMENT PREMIUM  
 OHIO  
 June 1, 2010

STANDARD PLAN G

Area 1				
Attained Age	MNTU	MTU	FNTU	FTU
65	106.63	122.63	98.73	113.54
66	109.40	125.81	101.30	116.49
67	112.17	129.00	103.86	119.44
68	114.94	132.18	106.43	122.39
69	117.71	135.37	108.99	125.34
70	120.48	138.55	111.56	128.29
71	123.25	141.74	114.12	131.24
72	128.47	147.74	118.95	136.80
73	134.02	154.12	124.09	142.71
74	139.89	160.88	129.53	148.96
75	144.93	166.67	134.19	154.32
76	150.19	172.71	139.06	159.92
77	155.66	179.01	144.13	165.75
78	161.34	185.54	149.39	171.79
79	167.22	192.30	154.83	178.05
80	176.56	203.05	163.48	188.01
81	186.39	214.35	172.58	198.47
82	196.70	226.21	182.13	209.45
83	207.51	238.64	192.14	220.96
84	216.66	249.16	200.61	230.71
85	226.14	260.06	209.39	240.80
86	235.95	271.34	218.47	251.24
87	246.08	282.99	227.85	262.03
88	256.54	295.02	237.54	273.17
89	267.33	307.43	247.53	284.66
90+	278.45	320.21	257.82	296.49

Area 2				
Attained Age	MNTU	MTU	FNTU	FTU
65	95.97	110.36	88.86	102.19
66	98.46	113.23	91.17	104.84
67	100.95	116.10	93.48	107.50
68	103.45	118.96	95.79	110.15
69	105.94	121.83	98.09	112.81
70	108.43	124.70	100.40	115.46
71	110.93	127.57	102.71	118.12
72	115.62	132.97	107.06	123.12
73	120.62	138.71	111.68	128.44
74	125.91	144.79	116.58	134.07
75	130.44	150.00	120.77	138.89
76	135.17	155.44	125.15	143.93
77	140.09	161.11	129.71	149.17
78	145.20	166.98	134.45	154.61
79	150.49	173.07	139.35	160.25
80	158.91	182.74	147.14	169.21
81	167.75	192.91	155.32	178.62
82	177.03	203.59	163.92	188.51
83	186.76	214.77	172.93	198.87
84	195.00	224.25	180.55	207.64
85	203.53	234.06	188.45	216.72
86	212.35	244.20	196.62	226.12
87	221.47	254.69	205.07	235.83
88	230.89	265.52	213.78	245.85
89	240.60	276.69	222.77	256.19
90+	250.60	288.19	232.04	266.84

Area 3				
Attained Age	MNTU	MTU	FNTU	FTU
65	90.64	104.23	83.92	96.51
66	92.99	106.94	86.10	99.02
67	95.35	109.65	88.28	101.53
68	97.70	112.36	90.46	104.03
69	100.06	115.06	92.64	106.54
70	102.41	117.77	94.82	109.05
71	104.76	120.48	97.00	111.55
72	109.20	125.58	101.11	116.28
73	113.92	131.00	105.48	121.30
74	118.91	136.75	110.10	126.62
75	123.19	141.67	114.06	131.17
76	127.66	146.81	118.20	135.93
77	132.31	152.16	122.51	140.88
78	137.14	157.71	126.98	146.02
79	142.13	163.45	131.61	151.35
80	150.08	172.59	138.96	159.81
81	158.43	182.19	146.69	168.70
82	167.20	192.28	154.81	178.03
83	176.38	202.84	163.32	187.82
84	184.16	211.79	170.52	196.10
85	192.22	221.05	177.98	204.68
86	200.55	230.64	185.70	213.55
87	209.17	240.54	193.67	222.72
88	218.06	250.77	201.91	232.19
89	227.23	261.31	210.40	241.96
90+	236.68	272.18	219.15	252.02

Area 1 includes zip codes: 434-436, 440-445  
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 Modal Factors: Monthly Bank Draft = 1.0,  
 Bi-Monthly = 2.0, Quarterly = 3.0

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MTU:	Male Tobacco User
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**ADD ONE TIME NON-REFUNDABLE \$20 APPLICATION FEE**

PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY  
 MEDICARE SUPPLEMENT PREMIUM  
 OHIO  
 June 1, 2010

STANDARD PLAN N

Area 1				
Attained Age	MNTU	MTU	FNTU	FTU
65	98.78	113.60	91.47	105.19
66	101.35	116.55	93.84	107.92
67	103.91	119.50	96.22	110.65
68	106.48	122.45	98.59	113.38
69	109.05	125.40	100.97	116.11
70	111.61	128.36	103.35	118.85
71	114.18	131.31	105.72	121.58
72	119.01	136.87	110.20	126.73
73	124.15	142.78	114.96	132.20
74	129.60	149.04	120.00	138.00
75	134.26	154.40	124.31	142.96
76	139.13	160.00	128.82	148.15
77	144.20	165.83	133.52	153.55
78	149.46	171.88	138.39	159.15
79	154.91	178.14	143.43	164.95
80	163.57	188.10	151.45	174.17
81	172.67	198.57	159.88	183.86
82	182.22	209.55	168.72	194.03
83	192.24	221.07	178.00	204.70
84	200.71	230.82	185.85	213.72
85	209.49	240.92	193.98	223.07
86	218.58	251.36	202.39	232.75
87	227.97	262.16	211.08	242.74
88	237.66	273.31	220.05	253.06
89	247.65	284.80	229.31	263.70
90+	257.95	296.64	238.84	274.67

Area 2				
Attained Age	MNTU	MTU	FNTU	FTU
65	88.90	102.24	82.32	94.67
66	91.21	104.90	84.46	97.13
67	93.52	107.55	86.60	99.59
68	95.83	110.21	88.73	102.04
69	98.14	112.86	90.87	104.50
70	100.45	115.52	93.01	106.96
71	102.76	118.18	95.15	109.42
72	107.11	123.18	99.18	114.06
73	111.74	128.50	103.46	118.98
74	116.64	134.13	108.00	124.20
75	120.83	138.96	111.88	128.67
76	125.22	144.00	115.94	133.33
77	129.78	149.25	120.17	138.19
78	134.51	154.69	124.55	143.23
79	139.42	160.33	129.09	148.45
80	147.21	169.29	136.31	156.75
81	155.40	178.71	143.89	165.47
82	164.00	188.60	151.85	174.63
83	173.01	198.96	160.20	184.23
84	180.64	207.74	167.26	192.35
85	188.54	216.83	174.58	200.77
86	196.72	226.23	182.15	209.47
87	205.17	235.94	189.97	218.47
88	213.89	245.97	198.05	227.75
89	222.89	256.32	206.38	237.33
90+	232.15	266.98	214.96	247.20

Area 3				
Attained Age	MNTU	MTU	FNTU	FTU
65	83.97	96.56	77.75	89.41
66	86.15	99.07	79.77	91.73
67	88.33	101.58	81.78	94.05
68	90.51	104.09	83.80	96.38
69	92.69	106.59	85.82	98.70
70	94.87	109.10	87.84	101.02
71	97.05	111.61	89.86	103.34
72	101.16	116.34	93.67	107.72
73	105.53	121.36	97.71	112.37
74	110.16	126.68	102.00	117.30
75	114.12	131.24	105.67	121.52
76	118.26	136.00	109.50	125.93
77	122.57	140.96	113.49	130.51
78	127.04	146.10	117.63	135.28
79	131.67	151.42	121.92	140.21
80	139.03	159.89	128.73	148.04
81	146.77	168.78	135.90	156.28
82	154.89	178.12	143.42	164.93
83	163.40	187.91	151.30	173.99
84	170.61	196.20	157.97	181.66
85	178.07	204.78	164.88	189.61
86	185.79	213.66	172.03	197.83
87	193.77	222.84	179.42	206.33
88	202.01	232.31	187.04	215.10
89	210.50	242.08	194.91	224.15
90+	219.26	252.15	203.02	233.47

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**ADD ONE TIME NON-REFUNDABLE \$20 APPLICATION FEE**

## **PREMIUM INFORMATION**

We, Philadelphia American Life Insurance Company, can only raise your premium if we raise the premium for all policies like yours in this state. There are two distinct occurrences (attained age and table of rates changes) which might affect a change in premiums. Premiums will change upon each change in attained age. Additionally, we reserve the right to revise the table of premium rates.

## **DISCLOSURES**

Use this outline to compare benefits and premiums among policies.

**This outline shows benefits and premiums of policies sold for effective dates on or after January 1, 2011. Policies sold for effective dates prior to January 1, 2011 have different benefits and premiums. Plans E, H, and J are no longer available for sale.**

## **READ YOUR POLICY CAREFULLY**

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

## **RIGHT TO RETURN POLICY**

If you find that you are not satisfied with your policy, you may return it to P.O. Box 4884, Houston Texas 77210-4884. If you send the policy back to us within 30 days after you receive it, we'll treat the policy as if it had never been issued and return all your payments.

## **POLICY REPLACEMENT**

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

## **NOTICE**

This policy may not fully cover all of your medical costs. Neither Philadelphia American Life Insurance Company nor its agents are connected to 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 60 days in a row.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION *</b> Semi-private room and board, general nursing and miscellaneous services and supplies. First 60 days  61st thru 90th day 91st day and after: - While using 60 lifetime reserve days Once lifetime reserve days are used: - Additional 365 days  Beyond the Additional 365 days	All but \$1,132  All but \$283 a day  All but \$566 a day  \$0  \$0	\$0  \$283 a day  \$566 a day  100% of Medicare eligible expenses \$0	\$1,132 (Part A deductible) \$0  \$0  \$0**  All Costs
<b>SKILLED NURSING FACILITY CARE *</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days 21st thru 100th day  101st day and after	All approved amounts All but \$141.50 a day  \$0	\$0 \$0  \$0	\$0 Up to \$141.50 a day All Costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment / coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment / coinsurance	\$0

(continued)

\*\* 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 (continued)**

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

\* Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES -</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$162 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0  Generally 80%	\$0  Generally 20%	\$162 (Part B deductible) \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All Costs
<b>BLOOD</b> First 3 pints Next \$162 of Medicare Approved Amount*  Remainder of Medicare Approved Amounts	\$0 \$0  Generally 80%	All Costs \$0  Generally 20%	\$0 \$162 (Part B deductible) \$0
<b>CLINICAL LABORATORY SERVICES</b> BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies - Durable medical equipment: First \$162 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0  Generally 80%	\$0 \$0  Generally 20%	\$0 \$162 (Part B deductible) \$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 60 days in a row.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION *</b> Semi-private room and board, general nursing and miscellaneous services and supplies. First 60 days 61st thru 90th day 91st day and after: - While using 60 lifetime reserve days Once lifetime reserve days are used: - Additional 365 days - Beyond the Additional 365 days	All but \$1,132 All but \$283 a day All but \$566 a day \$0 \$0	\$1,132 (Part A deductible) \$283 a day \$566 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0 ** All Costs
<b>SKILLED NURSING FACILITY CARE *</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$141.50 a day \$0	\$0 Up to \$141.50 a day \$0	\$0 \$0 All Costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment / coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment / coinsurance	\$0

(continued)

\*\* 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 (continued)**

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

\* Once you have been billed \$162 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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES -</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$162 of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	\$0  Generally 80%	\$162 (Part B deductible) Generally 20%	\$0  \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amount)	\$0	\$0	All Costs
<b>BLOOD</b> First 3 pints Next \$162 of Medicare Approved Amount*  Remainder of Medicare Approved Amounts	\$0 \$0  Generally 80%	All Costs \$162 (Part B deductible) Generally 20%	\$0 \$0  \$0
<b>CLINICAL LABORATORY SERVICES</b> BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies - Durable medical equipment: First \$162 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0  Generally 80%	\$0 \$162 (Part B deductible) Generally 20%	\$0 \$0  \$0

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

<b>FOREIGN TRAVEL - NOT COVERED BY                      MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over \$50,000 lifetime maximum
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(continued)

**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 60 days in a row.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION *</b> Semi-private room and board, general nursing and miscellaneous services and supplies. First 60 days  61st thru 90th day 91st day and after: - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days  - Beyond the Additional 365 days	All but \$1,132  All but \$283 a day  All but \$566 a day  \$0  \$0	\$1,132 (Part A deductible) \$283 a day \$566 a day  100% of Medicare eligible expenses \$0	\$0  \$0  \$0  \$0 **  All Costs
<b>SKILLED NURSING FACILITY CARE *</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days 21st thru 100th day  101st day and after	All approved amounts All but \$141.50 a day  \$0	\$0 Up to \$141.50 a day \$0	\$0 \$0  All Costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment / coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment / coinsurance	\$0

(continued)

\*\* 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 (continued)**

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

\* Once you have been billed \$162 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES -</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$162 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0  Generally 80%	\$0  Generally 20%	\$162 (Part B deductible) \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amount)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$162 of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	\$0 \$0  Generally 80%	All Costs \$0  Generally 20%	\$0 \$162 (Part B deductible) \$0
<b>CLINICAL LABORATORY SERVICES</b> BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies - Durable medical equipment: First \$162 of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	100% \$0  Generally 80%	\$0 \$0  Generally 20%	\$0 \$162 (Part B deductible) \$0

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

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

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION *</b> Semi-private room and board, general nursing and miscellaneous services and supplies. First 60 days  61st thru 90th day 91st day and after: - While using 60 lifetime reserve days Once lifetime reserve days are used: - Additional 365 days  - Beyond the Additional 365 days	All but \$1,132  All but \$283 a day  All but \$566 a day  \$0  \$0	\$1,132 (Part A deductible) \$283 a day  \$566 a day  100% of Medicare Eligible Expenses \$0	\$0  \$0  \$0  \$0 **  All Costs
<b>SKILLED NURSING FACILITY CARE *</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days 21st thru 100th day  101st day and after	All approved amounts All but \$141.50 a day  \$0	\$0 Up to \$141.50 a day \$0	\$0 \$0  All Costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment / coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment / coinsurance	\$0

(continued)

\*\* 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** (continued)

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

\* Once you have been billed \$162 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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES -</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$162 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0  Generally 80%	\$0  Balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. The 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.	\$162 (Part B deductible) 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.
<b>Part B Excess Charges</b> (Above Medicare Approved Amount)	\$0	\$0	All Costs
<b>BLOOD</b> First 3 pints Next \$162 of Medicare Approved Amount*  Remainder of Medicare Approved Amounts	\$0 \$0  Generally 80%	All Costs \$0  Generally 20%	\$0 \$162 (Part B deductible) \$0
<b>CLINICAL LABORATORY SERVICES</b> BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies - Durable medical equipment: First \$162 of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	100% \$0  Generally 80%	\$0 \$0  Generally 20%	\$0 \$162 (Part B deductible) \$0

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

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