

Outline of Medicare Supplement Coverage Sold on or After June 1, 2010.
 Shaded sections show Benefit Plans A, B, D, and F which are available.

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This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make available Plans A, B and C or F. Some plans may not be available in your state.

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.

A	B	C	D	F	F*	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 \$4660; paid at 100% after limit reached	Out-of-pocket \$2330; 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 \$2070 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed \$2070. 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.

MONTHLY PREMIUMS FOR MEDICARE SUPPLEMENT INSURANCE POLICY SERIES A20 – PLANS A, B, D AND F
Zip Codes: 189, 190, 191, 192, 193 and 194

Attained Age	Female							
	Preferred, Open Enrollment and Guaranteed Issue				Standard			
	Plan A	Plan B	Plan D	Plan F	Plan A	Plan B	Plan D	Plan F
0 - 67	\$105.30	\$128.27	\$141.74	\$154.83	\$121.03	\$147.43	\$162.92	\$177.96
68	109.88	134.11	148.54	161.65	126.30	154.15	170.73	185.80
69	114.39	139.90	155.32	168.46	131.48	160.81	178.53	193.63
70	118.81	145.62	162.06	175.22	136.57	167.38	186.27	201.40
71	123.26	151.40	169.24	182.46	141.68	174.02	194.53	209.73
72	127.59	157.06	176.30	189.59	146.66	180.53	202.65	217.92
73	131.68	162.47	183.13	196.48	151.36	186.75	210.49	225.84
74	135.40	167.51	189.60	203.03	155.64	192.55	217.93	233.37
75	138.64	172.07	195.60	209.11	159.35	197.78	224.83	240.36
76	141.31	176.06	201.06	214.65	162.43	202.37	231.11	246.73
77	143.52	179.58	206.08	219.76	164.97	206.41	236.87	252.60
78	145.42	182.76	210.81	224.58	167.15	210.07	242.31	258.14
79	147.15	185.75	215.41	229.25	169.14	213.50	247.59	263.51
80	148.86	188.68	220.01	233.92	171.11	216.87	252.89	268.88
81	150.67	191.66	224.75	238.70	173.18	220.30	258.33	274.37
82	152.55	194.68	229.59	243.57	175.35	223.77	263.90	279.97
83	154.48	197.69	234.47	248.47	177.57	227.23	269.51	285.60
84	156.41	200.63	239.34	253.35	179.78	230.61	275.10	291.21
85	158.30	203.47	244.13	258.15	181.96	233.87	280.61	296.73
86	160.11	206.15	248.78	262.82	184.04	236.95	285.95	302.10
87	161.80	208.64	253.25	267.32	185.98	239.82	291.09	307.26
88	163.34	210.91	257.51	271.60	187.75	242.42	295.99	312.19
89	164.68	212.91	261.51	275.63	189.29	244.73	300.59	316.82
90	165.80	214.63	265.23	279.37	190.57	246.70	304.86	321.11
91	166.66	216.04	268.63	282.79	191.56	248.33	308.77	325.05
92	167.30	217.20	271.76	285.94	192.30	249.65	312.37	328.67
93	167.79	218.15	274.70	288.90	192.86	250.75	315.75	332.07
94	168.17	218.98	277.51	291.72	193.30	251.70	318.98	335.32
95 & Over	168.49	219.74	280.25	294.48	193.67	252.58	322.13	338.48

*Premium rates shown above were approved in Pennsylvania on June 28, 2011, and are effective October 1, 2011.

Premiums payable other than by the monthly bank withdrawal mode may be determined by the following factors (monthly direct bill is not available):

	Quarterly	Semi-Annual	Annual
Automatic Bank Withdrawal	3	N/A	N/A
Direct Billed	3.24	6.24	12

Note: Due to rounding, premium amounts you calculate may differ by a few cents from the actual premium you will be charged.

MONTHLY PREMIUMS FOR MEDICARE SUPPLEMENT INSURANCE POLICY SERIES A20 – PLANS A, B, D AND F
Zip Codes: 189, 190, 191, 192, 193 and 194

Attained Age	Male							
	Preferred, Open Enrollment and Guaranteed Issue				Standard			
	Plan A	Plan B	Plan D	Plan F	Plan A	Plan B	Plan D	Plan F
0 - 67	\$123.88	\$150.90	\$163.02	\$178.19	\$142.39	\$173.45	\$187.38	\$204.82
68	129.27	157.78	170.75	186.04	148.59	181.35	196.27	213.84
69	134.58	164.59	178.46	193.86	154.69	189.18	205.13	222.83
70	139.78	171.32	186.12	201.63	160.67	196.92	213.93	231.75
71	144.35	177.47	192.97	208.53	165.93	203.98	221.80	239.69
72	148.95	183.63	199.87	215.48	171.21	211.07	229.73	247.69
73	153.60	189.83	206.86	222.52	176.55	218.20	237.77	255.78
74	158.31	196.10	214.01	229.69	181.96	225.40	245.98	264.01
75	163.11	202.44	221.34	237.03	187.48	232.69	254.41	272.45
76	167.98	208.85	228.87	244.55	193.09	240.05	263.07	281.10
77	172.81	215.19	236.45	252.10	198.64	247.34	271.78	289.77
78	177.43	221.29	243.86	259.48	203.94	254.36	280.30	298.25
79	181.68	227.00	250.91	266.50	208.83	260.92	288.41	306.33
80	185.39	232.13	257.41	272.99	213.09	266.82	295.87	313.78
81	188.46	236.59	263.19	278.79	216.63	271.94	302.52	320.45
82	191.01	240.46	268.39	284.02	219.55	276.39	308.49	326.46
83	193.18	243.91	273.15	288.84	222.05	280.35	313.97	332.00
84	195.16	247.08	277.65	293.39	224.32	284.00	319.14	337.23
85	197.10	250.13	282.05	297.85	226.55	287.51	324.20	342.36
86	199.12	253.18	286.47	302.32	228.87	291.01	329.28	347.50
87	201.16	256.16	290.86	306.75	231.22	294.44	334.32	352.59
88	203.13	258.98	295.09	311.02	233.48	297.68	339.19	357.50
89	204.91	261.55	299.07	315.03	235.53	300.63	343.76	362.11
90	206.40	263.75	302.68	318.68	237.25	303.16	347.91	366.30
91	207.54	265.53	305.86	321.88	238.55	305.21	351.57	369.98
92	208.36	266.95	308.66	324.70	239.50	306.84	354.78	373.22
93	208.95	268.09	311.18	327.24	240.17	308.15	357.68	376.14
94	209.38	269.05	313.50	329.59	240.67	309.25	360.35	378.84
95 & Over	209.74	269.92	315.74	331.84	241.08	310.25	362.92	381.43

*Premium rates shown above were approved in Pennsylvania on June 28, 2011, and are effective October 1, 2011.

Premiums payable other than by the monthly bank withdrawal mode may be determined by the following factors (monthly direct bill is not available):

	Quarterly	Semi-Annual	Annual
Automatic Bank Withdrawal	3	N/A	N/A
Direct Billed	3.24	6.24	12

Note: Due to rounding, premium amounts you calculate may differ by a few cents from the actual premium you will be charged.

MONTHLY PREMIUMS FOR MEDICARE SUPPLEMENT INSURANCE POLICY SERIES A20 – PLANS A, B, D AND F
Zip Codes: 150, 151, 152, 153, 154 and 156

Attained Age	Female							
	Preferred, Open Enrollment and Guaranteed Issue				Standard			
	Plan A	Plan B	Plan D	Plan F	Plan A	Plan B	Plan D	Plan F
0 - 67	\$100.09	\$121.92	\$134.72	\$147.16	\$115.04	\$140.13	\$154.85	\$169.15
68	104.44	127.47	141.18	153.65	120.05	146.52	162.28	176.61
69	108.73	132.97	147.63	160.12	124.97	152.85	169.69	184.04
70	112.93	138.41	154.03	166.55	129.80	159.10	177.05	191.43
71	117.16	143.91	160.86	173.43	134.67	165.41	184.90	199.35
72	121.28	149.28	167.57	180.20	139.40	171.59	192.61	207.13
73	125.16	154.43	174.06	186.76	143.86	177.50	200.07	214.66
74	128.70	159.22	180.22	192.98	147.93	183.01	207.14	221.81
75	131.78	163.55	185.92	198.76	151.47	187.99	213.70	228.46
76	134.32	167.34	191.11	204.03	154.39	192.35	219.66	234.52
77	136.42	170.69	195.88	208.88	156.80	196.19	225.15	240.10
78	138.22	173.71	200.38	213.46	158.88	199.67	230.32	245.36
79	139.87	176.55	204.74	217.90	160.77	202.93	235.34	250.46
80	141.49	179.34	209.12	222.34	162.64	206.14	240.37	255.57
81	143.21	182.17	213.62	226.89	164.61	209.40	245.55	260.79
82	145.00	185.04	218.23	231.51	166.67	212.69	250.83	266.11
83	146.83	187.90	222.87	236.17	168.77	215.98	256.17	271.46
84	148.67	190.70	227.49	240.81	170.88	219.20	261.49	276.79
85	150.47	193.40	232.04	245.37	172.95	222.30	266.71	282.04
86	152.19	195.94	236.46	249.81	174.93	225.22	271.80	287.14
87	153.79	198.31	240.71	254.09	176.78	227.94	276.68	292.05
88	155.25	200.47	244.76	258.16	178.45	230.42	281.33	296.73
89	156.53	202.37	248.57	261.99	179.92	232.61	285.71	301.13
90	157.59	204.01	252.10	265.54	181.14	234.49	289.77	305.22
91	158.41	205.35	255.33	268.79	182.08	236.03	293.48	308.96
92	159.02	206.44	258.31	271.79	182.78	237.29	296.91	312.40
93	159.48	207.35	261.10	274.60	183.31	238.34	300.12	315.63
94	159.84	208.14	263.77	277.28	183.73	239.24	303.19	318.72
95 & Over	160.15	208.87	266.38	279.90	184.08	240.08	306.18	321.73

*Premium rates shown above were approved in Pennsylvania on June 28, 2011, and are effective October 1, 2011.

Premiums payable other than by the monthly bank withdrawal mode may be determined by the following factors (monthly direct bill is not available):

	Quarterly	Semi-Annual	Annual
Automatic Bank Withdrawal	3	N/A	N/A
Direct Billed	3.24	6.24	12

Note: Due to rounding, premium amounts you calculate may differ by a few cents from the actual premium you will be charged.

MONTHLY PREMIUMS FOR MEDICARE SUPPLEMENT INSURANCE POLICY SERIES A20 – PLANS A, B, D AND F
Zip Codes: 150, 151, 152, 153, 154 and 156

Attained Age	Male							
	Preferred, Open Enrollment and Guaranteed Issue				Standard			
	Plan A	Plan B	Plan D	Plan F	Plan A	Plan B	Plan D	Plan F
0 - 67	\$117.75	\$143.43	\$154.95	\$169.37	\$135.34	\$164.86	\$178.10	\$194.68
68	122.87	149.96	162.30	176.83	141.23	172.37	186.55	203.25
69	127.92	156.44	169.63	184.27	147.03	179.82	194.98	211.80
70	132.86	162.84	176.90	191.64	152.71	187.17	203.34	220.28
71	137.21	168.68	183.41	198.21	157.71	193.88	210.82	227.83
72	141.58	174.54	189.97	204.82	162.74	200.62	218.36	235.42
73	145.99	180.44	196.62	211.51	167.81	207.40	226.00	243.11
74	150.47	186.39	203.41	218.32	172.95	214.24	233.81	250.94
75	155.03	192.42	210.38	225.30	178.20	221.17	241.82	258.97
76	159.67	198.51	217.54	232.45	183.53	228.17	250.05	267.18
77	164.26	204.54	224.74	239.62	188.80	235.10	258.32	275.42
78	168.65	210.34	231.79	246.63	193.85	241.77	266.42	283.49
79	172.68	215.76	238.49	253.31	198.49	248.00	274.13	291.17
80	176.21	220.64	244.66	259.47	202.54	253.61	281.22	298.25
81	179.13	224.88	250.17	264.99	205.90	258.48	287.55	304.59
82	181.55	228.56	255.10	269.96	208.68	262.71	293.22	310.30
83	183.62	231.83	259.63	274.54	211.06	266.47	298.42	315.56
84	185.50	234.85	263.90	278.87	213.22	269.94	303.34	320.54
85	187.34	237.75	268.09	283.10	215.34	273.28	308.15	325.41
86	189.26	240.65	272.29	287.36	217.54	276.60	312.98	330.29
87	191.21	243.48	276.46	291.56	219.78	279.86	317.77	335.13
88	193.07	246.16	280.48	295.63	221.92	282.95	322.39	339.80
89	194.77	248.60	284.26	299.44	223.87	285.74	326.74	344.18
90	196.19	250.69	287.70	302.90	225.50	288.15	330.69	348.16
91	197.27	252.39	290.72	305.95	226.74	290.10	334.16	351.66
92	198.05	253.73	293.38	308.63	227.64	291.65	337.22	354.75
93	198.61	254.82	295.77	311.04	228.28	292.89	339.97	357.52
94	199.02	255.73	297.98	313.27	228.75	293.94	342.51	360.08
95 & Over	199.35	256.56	300.11	315.41	229.14	294.89	344.95	362.54

*Premium rates shown above were approved in Pennsylvania on June 28, 2011, and are effective October 1, 2011.

Premiums payable other than by the monthly bank withdrawal mode may be determined by the following factors (monthly direct bill is not available):

	Quarterly	Semi-Annual	Annual
Automatic Bank Withdrawal	3	N/A	N/A
Direct Billed	3.24	6.24	12

Note: Due to rounding, premium amounts you calculate may differ by a few cents from the actual premium you will be charged.

MONTHLY PREMIUMS FOR MEDICARE SUPPLEMENT INSURANCE POLICY SERIES A20 – PLANS A, B, D AND F

Zip Codes: 155, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 195 and 196

Attained Age	Female							
	Preferred, Open Enrollment and Guaranteed Issue				Standard			
	Plan A	Plan B	Plan D	Plan F	Plan A	Plan B	Plan D	Plan F
0 - 67	\$81.32	\$99.06	\$109.46	\$119.57	\$93.47	\$113.86	\$125.82	\$137.44
68	84.86	103.57	114.71	124.84	97.54	119.04	131.85	143.49
69	88.34	108.04	119.95	130.09	101.54	124.19	137.87	149.53
70	91.75	112.46	125.15	135.32	105.47	129.26	143.85	155.54
71	95.19	116.92	130.70	140.91	109.42	134.39	150.23	161.97
72	98.54	121.29	136.15	146.41	113.26	139.42	156.50	168.29
73	101.69	125.47	141.42	151.74	116.89	144.22	162.56	174.41
74	104.57	129.37	146.42	156.79	120.19	148.70	168.30	180.22
75	107.07	132.89	151.06	161.49	123.07	152.74	173.63	185.62
76	109.13	135.97	155.27	165.77	125.44	156.28	178.48	190.54
77	110.84	138.68	159.15	169.72	127.40	159.40	182.93	195.08
78	112.31	141.14	162.80	173.44	129.09	162.23	187.13	199.35
79	113.64	143.45	166.35	177.05	130.62	164.88	191.21	203.50
80	114.96	145.71	169.91	180.65	132.14	167.48	195.30	207.65
81	116.35	148.02	173.57	184.34	133.74	170.13	199.50	211.89
82	117.81	150.35	177.31	188.10	135.42	172.81	203.80	216.21
83	119.30	152.67	181.08	191.89	137.13	175.48	208.14	220.56
84	120.79	154.94	184.84	195.66	138.84	178.10	212.46	224.89
85	122.25	157.13	188.53	199.36	140.52	180.61	216.70	229.15
86	123.65	159.20	192.12	202.97	142.13	182.99	220.83	233.30
87	124.96	161.13	195.58	206.44	143.63	185.20	224.80	237.29
88	126.14	162.88	198.87	209.75	144.99	187.22	228.58	241.09
89	127.18	164.43	201.96	212.86	146.18	189.00	232.14	244.67
90	128.04	165.75	204.83	215.75	147.17	190.52	235.43	247.99
91	128.70	166.84	207.45	218.39	147.94	191.78	238.45	251.03
92	129.20	167.73	209.88	220.83	148.51	192.80	241.24	253.83
93	129.58	168.47	212.15	223.11	148.94	193.65	243.85	256.45
94	129.87	169.11	214.31	225.29	149.28	194.38	246.34	258.96
95 & Over	130.12	169.70	216.43	227.42	149.57	195.06	248.77	261.40

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Direct Billed	3.24	6.24	12

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MONTHLY PREMIUMS FOR MEDICARE SUPPLEMENT INSURANCE POLICY SERIES A20 – PLANS A, B, D AND F
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Attained Age	Male							
	Preferred, Open Enrollment and Guaranteed Issue				Standard			
	Plan A	Plan B	Plan D	Plan F	Plan A	Plan B	Plan D	Plan F
0 - 67	\$95.67	\$116.54	\$125.89	\$137.61	\$109.97	\$133.95	\$144.71	\$158.18
68	99.83	121.85	131.87	143.67	114.75	140.05	151.57	165.14
69	103.93	127.11	137.82	149.72	119.46	146.10	158.42	172.09
70	107.95	132.31	143.73	155.71	124.08	152.08	165.21	178.98
71	111.48	137.05	149.02	161.04	128.14	157.53	171.29	185.11
72	115.03	141.81	154.35	166.41	132.22	163.00	177.42	191.28
73	118.62	146.60	159.76	171.85	136.34	168.51	183.63	197.53
74	122.26	151.44	165.27	177.38	140.52	174.07	189.97	203.89
75	125.96	156.34	170.93	183.05	144.78	179.70	196.48	210.41
76	129.73	161.29	176.75	188.86	149.11	185.39	203.16	217.08
77	133.46	166.18	182.60	194.69	153.40	191.02	209.89	223.78
78	137.02	170.90	188.33	200.39	157.50	196.44	216.47	230.33
79	140.30	175.30	193.77	205.81	161.27	201.50	222.73	236.57
80	143.17	179.27	198.79	210.82	164.57	206.06	228.49	242.32
81	145.54	182.71	203.26	215.30	167.29	210.01	233.63	247.48
82	147.51	185.70	207.27	219.34	169.55	213.45	238.24	252.12
83	149.19	188.36	210.95	223.06	171.48	216.51	242.47	256.39
84	150.72	190.81	214.42	226.58	173.24	219.33	246.46	260.44
85	152.21	193.17	217.82	230.02	174.96	222.04	250.37	264.39
86	153.77	195.52	221.24	233.48	176.75	224.74	254.29	268.36
87	155.35	197.83	224.62	236.89	178.57	227.39	258.19	272.29
88	156.87	200.01	227.89	240.19	180.31	229.89	261.94	276.09
89	158.25	201.98	230.96	243.29	181.89	232.17	265.48	279.65
90	159.40	203.69	233.75	246.11	183.22	234.12	268.69	282.88
91	160.28	205.06	236.21	248.58	184.23	235.70	271.50	285.73
92	160.91	206.16	238.37	250.76	184.96	236.96	273.99	288.23
93	161.37	207.04	240.31	252.72	185.48	237.98	276.22	290.48
94	161.70	207.78	242.11	254.53	185.86	238.83	278.29	292.57
95 & Over	161.97	208.45	243.84	256.27	186.18	239.60	280.27	294.57

*Premium rates shown above were approved in Pennsylvania on June 28, 2011, and are effective October 1, 2011.

Premiums payable other than by the monthly bank withdrawal mode may be determined by the following factors (monthly direct bill is not available):

	Quarterly	Semi-Annual	Annual
Automatic Bank Withdrawal	3	N/A	N/A
Direct Billed	3.24	6.24	12

Note: Due to rounding, premium amounts you calculate may differ by a few cents from the actual premium you will be charged.

Premium Information

Your premium will increase each year because of the increase in your attained age.

Additionally, we reserve the right to revise the table of rates. We can only raise your premium if we raise the premium for all policies like yours in Pennsylvania.

In either case, we will notify you in writing 30 days in advance of the change in premium. The premiums change automatically on the policy renewal 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 your insurance company.

Right To Return Policy

If you find that you are not satisfied with your policy, you may return it to 1515 South 75th Street, Omaha, NE 68124. 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 Medico Insurance Company nor its producers 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 61st thru 90th day 91st day and after: -While using 60 lifetime reserve days -Once lifetime reserve days are used: -Additional lifetime maximum of 365 days -Beyond the additional 365 days	All but \$1,156 All but \$289 a day All but \$578 a day \$0 \$0	\$0 \$289 a day \$578 a day 100% of Medicare eligible expense \$0	\$1,156 (Part A Deductible) \$0 \$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 21st thru 100th day 101st day and after	All approved amounts All but \$144.50 a day \$0	\$0 \$0 \$0	\$0 Up to \$144.50 a day All costs
Blood First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment and coinsurance for outpatient drugs and inpatient respite care	Medicare copayment and 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 \$140 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 \$140 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$140 (Part B Deductible) \$0
Part B Excess Charges – Above Medicare-Approved Amounts	\$0	\$0	All costs
Blood First 3 Pints Next \$140 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$140 (Part B Deductible) \$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 -Durable medical equipment: -First \$140 of Medicare-Approved Amounts* -Remainder of Medicare-Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$140 (Part B Deductible) \$0

Plan B

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
<p>Hospitalization*</p> <p>Semiprivate room and board, general nursing and miscellaneous services and supplies</p> <p>First 60 days</p> <p>61st thru 90th day</p> <p>91st day and after:</p> <ul style="list-style-type: none"> -While using 60 lifetime reserve days -Once lifetime reserve days are used: <ul style="list-style-type: none"> -Additional lifetime maximum of 365 days -Beyond the additional 365 days 	<p>All but \$1,156</p> <p>All but \$289 a day</p> <p>All but \$578 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$1,156 (Part A Deductible)</p> <p>\$289 a day</p> <p>\$578 a day</p> <p>100% of Medicare eligible expense</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p>Skilled Nursing Facility Care*</p> <p>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.</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$144.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$144.50 a day</p> <p>All costs</p>
<p>Blood</p> <p>First 3 pints</p> <p>Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p>Hospice Care</p> <p>You must meet Medicare's requirements, including a doctor's certification of terminal illness.</p>	<p>All but very limited co-payment and coinsurance for outpatient drugs and inpatient respite care</p>	<p>Medicare copayment and coinsurance</p>	<p>\$0</p>

**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 B

Medicare (Part B) - Medical Services - Per Calendar Year

*Once you have been billed \$140 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 \$140 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$140 (Part B Deductible) \$0
Part B Excess Charges – Above Medicare-Approved Amounts	\$0	\$0	All costs
Blood First 3 pints Next \$140 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$140 (Part B Deductible) \$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 -Durable medical equipment: -First \$140 of Medicare-Approved Amounts* -Remainder of Medicare-Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$140 (Part B Deductible) \$0

Plan D

Medicare (Part A) - Hospital Services - Per Benefit Period

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

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: -While using 60 lifetime reserve days -Once lifetime reserve days are used: -Additional lifetime maximum of 365 days -Beyond the additional 365 days	All but \$1,156 All but \$289 a day All but \$578 a day \$0 \$0	\$1,156 (Part A Deductible) \$289 a day \$578 a day 100% of Medicare eligible expense \$0	\$0 \$0 \$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 21st thru 100th day 101st day and after	All approved amounts All but \$144.50 a day \$0	\$0 Up to \$144.50 a day \$0	\$0 \$0 All costs
Blood First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment and coinsurance for outpatient drugs and inpatient respite care	Medicare copayment and coinsurance	\$0

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

Plan D

Medicare (Part B) - Medical Services - Per Calendar Year

*Once you have been billed \$140 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 \$140 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$140 (Part B Deductible) \$0
Part B Excess Charges – Above Medicare-Approved Amounts	\$0	\$0	All costs
Blood First 3 Pints Next \$140 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$140 (Part B Deductible) \$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 \$140 of Medicare-Approved Amounts*	\$0	\$0	\$140 (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 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
<p>Hospitalization*</p> <p>Semiprivate room and board, general nursing and miscellaneous services and supplies</p> <p>First 60 days</p> <p>61st thru 90th day</p> <p>91st day and after:</p> <ul style="list-style-type: none"> -While using 60 lifetime reserve days -Once lifetime reserve days are used: <ul style="list-style-type: none"> -Additional lifetime maximum of 365 days -Beyond the additional 365 days 	<p>All but \$1,156</p> <p>All but \$289 a day</p> <p>All but \$578 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$1,156 (Part A Deductible)</p> <p>\$289 a day</p> <p>\$578 a day</p> <p>100% of Medicare eligible expense</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p>Skilled Nursing Facility Care*</p> <p>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.</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$144.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$144.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p>Blood</p> <p>First 3 pints</p> <p>Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p>Hospice Care</p> <p>You must meet Medicare's requirements, including a doctor's certification of terminal illness.</p>	<p>All but very limited copayment and coinsurance for outpatient drugs and inpatient respite care</p>	<p>Medicare copayment and coinsurance</p>	<p>\$0</p>

**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 \$140 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 \$140 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$140 (Part B Deductible) Generally 20%	\$0 \$0
Part B Excess Charges – Above Medicare-Approved Amounts	\$0	100%	\$0
Blood First 3 Pints Next \$140 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All costs \$140 (Part B Deductible) 20%	\$0 \$0 \$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 -Durable medical equipment: -First \$140 of Medicare-Approved Amounts* -Remainder of Medicare-Approved Amounts	100% \$0 80%	\$0 \$140 (Part B Deductible) 20%	\$0 \$0 \$0

Other Benefits – Not Covered By Medicare

Services	Medicare Pays	Plan Pays	You Pay
<p>Foreign Travel – Not Covered By Medicare</p> <p>Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA</p> <ul style="list-style-type: none"> -First \$250 each calendar year -Remainder of charges 	<p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>80% to a lifetime maximum benefit of \$50,000</p>	<p>\$250</p> <p>20% and amounts over the \$50,000 lifetime maximum</p>

Printed Name of Producer, if any: _____
First
Middle Initial
Last

Address: _____
Street Address, Rural Route or Box Number

City
State
Zip

Phone Number
Date
Producer/Home Office Employee Signature