CENTRAL STATES INDEMNITY CO. OF OMAHA

Outline of Medicare Supplement Coverage

Benefit Plans A, B, C, F, and N

Benefit Chart of Medicare Supplement Plans Sold for Effective Dates on or After June 1, 2010

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. 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 limit $4660 paid at 100% after limit reached	Out-of -Pocket limit $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.**

CENTRAL STATES INDEMNITY CO. OF OMAHA

ILLINOIS Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 600-608

Attained Age	Non-Tobacco User					Attained Age	Tobacco User				
	Plan A	Plan B	Plan C	Plan F	Plan N		Plan A	Plan B	Plan C	Plan F	Plan N
Under 65	2,294	2,678	3,222	3,242	2,269	Under 65	2,550	2,976	3,579	3,603	2,522
65	1,188	1,387	1,662	1,727	1,209	65	1,320	1,541	1,846	1,919	1,344
66	1,188	1,387	1,662	1,727	1,209	66	1,320	1,541	1,846	1,919	1,344
67	1,247	1,455	1,740	1,803	1,262	67	1,385	1,616	1,935	2,004	1,403
68	1,302	1,520	1,819	1,876	1,313	68	1,448	1,690	2,020	2,084	1,459
69	1,358	1,585	1,897	1,951	1,365	69	1,509	1,761	2,107	2,168	1,517
70	1,413	1,650	1,976	2,029	1,421	70	1,571	1,833	2,196	2,253	1,578
71	1,468	1,713	2,058	2,109	1,477	71	1,631	1,904	2,286	2,344	1,641
72	1,522	1,775	2,139	2,194	1,535	72	1,691	1,973	2,378	2,436	1,706
73	1,574	1,837	2,223	2,277	1,593	73	1,749	2,042	2,470	2,531	1,771
74	1,626	1,899	2,302	2,354	1,648	74	1,807	2,109	2,557	2,615	1,831
75	1,679	1,958	2,378	2,428	1,699	75	1,865	2,176	2,642	2,697	1,889
76	1,728	2,017	2,449	2,497	1,748	76	1,921	2,242	2,721	2,776	1,943
77	1,777	2,074	2,519	2,564	1,794	77	1,975	2,305	2,798	2,848	1,993
78	1,825	2,129	2,584	2,626	1,838	78	2,027	2,366	2,871	2,918	2,044
79	1,867	2,179	2,645	2,687	1,881	79	2,074	2,421	2,939	2,985	2,090
80	1,908	2,227	2,703	2,741	1,919	80	2,120	2,474	3,002	3,046	2,133
81	1,946	2,272	2,756	2,794	1,956	81	2,162	2,524	3,062	3,105	2,173
82	1,982	2,312	2,809	2,843	1,990	82	2,202	2,569	3,121	3,159	2,211
83	2,015	2,351	2,857	2,887	2,020	83	2,238	2,612	3,174	3,208	2,246
84	2,045	2,386	2,902	2,930	2,051	84	2,272	2,651	3,224	3,255	2,278
85	2,073	2,420	2,944	2,970	2,080	85	2,305	2,689	3,271	3,300	2,310
86	2,101	2,452	2,981	3,006	2,104	86	2,335	2,724	3,313	3,339	2,338
87	2,125	2,480	3,015	3,040	2,128	87	2,360	2,755	3,351	3,377	2,364
88	2,146	2,506	3,048	3,073	2,152	88	2,386	2,785	3,387	3,414	2,390
89	2,167	2,529	3,076	3,100	2,170	89	2,409	2,811	3,418	3,445	2,412
90	2,185	2,551	3,099	3,122	2,185	90	2,428	2,834	3,444	3,469	2,429
91	2,203	2,571	3,121	3,143	2,200	91	2,448	2,857	3,468	3,491	2,445
92	2,218	2,588	3,142	3,161	2,213	92	2,465	2,876	3,490	3,513	2,459
93	2,233	2,607	3,159	3,179	2,226	93	2,481	2,895	3,510	3,531	2,472
94	2,247	2,623	3,174	3,194	2,236	94	2,497	2,915	3,527	3,549	2,485
95	2,261	2,639	3,188	3,205	2,244	95	2,511	2,932	3,541	3,561	2,493
96	2,273	2,653	3,198	3,217	2,251	96	2,525	2,947	3,555	3,574	2,502
97	2,281	2,662	3,208	3,227	2,260	97	2,535	2,960	3,565	3,587	2,510
98	2,290	2,673	3,217	3,238	2,267	98	2,543	2,969	3,574	3,597	2,519
99+	2,294	2,678	3,222	3,242	2,269	99+	2,550	2,976	3,579	3,603	2,522

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

A 2.4% processing fee will apply for credit card billing

CENTRAL STATES INDEMNITY CO. OF OMAHA

ILLINOIS Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 600-608

Attained Age	Non-Tobacco User					Attained Age	Tobacco User				
	Plan A	Plan B	Plan C	Plan F	Plan N		Plan A	Plan B	Plan C	Plan F	Plan N
Under 65	2,037	2,378	2,860	2,879	2,015	Under 65	2,264	2,642	3,178	3,199	2,239
65	1,055	1,231	1,475	1,533	1,074	65	1,172	1,368	1,639	1,703	1,193
66	1,055	1,231	1,475	1,533	1,074	66	1,172	1,368	1,639	1,703	1,193
67	1,107	1,292	1,545	1,601	1,120	67	1,229	1,435	1,718	1,779	1,245
68	1,156	1,350	1,615	1,665	1,166	68	1,285	1,500	1,794	1,851	1,296
69	1,206	1,407	1,684	1,732	1,212	69	1,340	1,564	1,871	1,925	1,347
70	1,255	1,465	1,755	1,801	1,262	70	1,395	1,627	1,949	2,001	1,401
71	1,303	1,521	1,827	1,872	1,311	71	1,448	1,690	2,029	2,081	1,457
72	1,351	1,576	1,899	1,948	1,363	72	1,501	1,752	2,111	2,163	1,514
73	1,397	1,631	1,974	2,022	1,415	73	1,553	1,813	2,193	2,247	1,572
74	1,444	1,686	2,043	2,090	1,463	74	1,605	1,872	2,271	2,322	1,625
75	1,491	1,739	2,111	2,156	1,509	75	1,656	1,932	2,346	2,395	1,677
76	1,534	1,791	2,175	2,217	1,552	76	1,705	1,990	2,416	2,464	1,725
77	1,578	1,841	2,236	2,276	1,593	77	1,754	2,046	2,484	2,529	1,770
78	1,621	1,891	2,294	2,331	1,632	78	1,799	2,100	2,549	2,591	1,815
79	1,658	1,934	2,348	2,385	1,670	79	1,841	2,150	2,610	2,651	1,855
80	1,694	1,977	2,400	2,434	1,703	80	1,882	2,196	2,666	2,705	1,893
81	1,728	2,017	2,447	2,480	1,737	81	1,920	2,241	2,719	2,757	1,929
82	1,759	2,053	2,494	2,524	1,767	82	1,955	2,281	2,771	2,804	1,963
83	1,789	2,087	2,537	2,563	1,794	83	1,987	2,319	2,818	2,848	1,994
84	1,815	2,119	2,576	2,601	1,821	84	2,017	2,354	2,862	2,890	2,023
85	1,840	2,149	2,613	2,637	1,847	85	2,046	2,387	2,904	2,930	2,051
86	1,866	2,177	2,647	2,669	1,868	86	2,073	2,419	2,941	2,965	2,076
87	1,887	2,202	2,677	2,699	1,890	87	2,096	2,446	2,975	2,998	2,099
88	1,906	2,225	2,707	2,728	1,910	88	2,119	2,473	3,007	3,031	2,122
89	1,924	2,246	2,731	2,752	1,927	89	2,138	2,496	3,034	3,059	2,141
90	1,940	2,265	2,751	2,772	1,940	90	2,156	2,517	3,058	3,080	2,157
91	1,956	2,283	2,771	2,790	1,953	91	2,174	2,537	3,079	3,100	2,171
92	1,969	2,298	2,789	2,806	1,965	92	2,189	2,554	3,099	3,119	2,183
93	1,983	2,314	2,804	2,822	1,976	93	2,203	2,571	3,116	3,135	2,195
94	1,995	2,328	2,818	2,836	1,986	94	2,217	2,588	3,131	3,151	2,206
95	2,007	2,343	2,830	2,845	1,992	95	2,230	2,603	3,144	3,162	2,214
96	2,018	2,355	2,840	2,857	1,999	96	2,242	2,616	3,156	3,173	2,221
97	2,025	2,364	2,848	2,865	2,006	97	2,251	2,628	3,165	3,184	2,229
98	2,033	2,373	2,857	2,875	2,013	98	2,258	2,636	3,173	3,194	2,236
99+	2,037	2,378	2,860	2,879	2,015	99+	2,264	2,642	3,178	3,199	2,239

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

A 2.4% processing fee will apply for credit card billing

ILLINOIS Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 600-608

Attained Age	Non-Tobacco User					Attained Age	Tobacco User				
	Plan A	Plan B	Plan C	Plan F	Plan N		Plan A	Plan B	Plan C	Plan F	Plan N
Under 65	1,996	2,328	2,801	2,819	1,974	Under 65	2,217	2,587	3,113	3,133	2,194
65	1,034	1,206	1,445	1,502	1,052	65	1,148	1,340	1,606	1,668	1,168
66	1,034	1,206	1,445	1,502	1,052	66	1,148	1,340	1,606	1,668	1,168
67	1,083	1,265	1,513	1,569	1,098	67	1,205	1,405	1,682	1,742	1,220
68	1,133	1,323	1,581	1,631	1,142	68	1,258	1,469	1,757	1,813	1,270
69	1,181	1,379	1,649	1,696	1,187	69	1,313	1,532	1,832	1,884	1,319
70	1,228	1,435	1,718	1,763	1,235	70	1,365	1,593	1,909	1,959	1,372
71	1,277	1,489	1,789	1,835	1,285	71	1,419	1,655	1,988	2,039	1,427
72	1,324	1,544	1,861	1,907	1,334	72	1,470	1,716	2,067	2,119	1,482
73	1,369	1,599	1,933	1,981	1,387	73	1,520	1,775	2,147	2,201	1,541
74	1,416	1,651	2,001	2,047	1,433	74	1,572	1,835	2,223	2,274	1,591
75	1,459	1,703	2,067	2,111	1,478	75	1,621	1,893	2,297	2,347	1,642
76	1,503	1,755	2,129	2,172	1,520	76	1,669	1,950	2,366	2,413	1,688
77	1,545	1,804	2,190	2,230	1,560	77	1,717	2,004	2,432	2,476	1,733
78	1,587	1,851	2,247	2,283	1,599	78	1,763	2,058	2,496	2,537	1,775
79	1,623	1,895	2,301	2,337	1,636	79	1,804	2,105	2,556	2,597	1,817
80	1,659	1,937	2,350	2,384	1,668	80	1,843	2,152	2,611	2,648	1,853
81	1,692	1,975	2,397	2,429	1,700	81	1,880	2,195	2,664	2,699	1,889
82	1,723	2,012	2,442	2,472	1,730	82	1,914	2,234	2,714	2,747	1,922
83	1,752	2,045	2,485	2,510	1,758	83	1,946	2,272	2,761	2,789	1,953
84	1,777	2,075	2,523	2,547	1,784	84	1,975	2,306	2,803	2,830	1,982
85	1,803	2,105	2,561	2,582	1,807	85	2,004	2,339	2,844	2,870	2,009
86	1,828	2,133	2,593	2,613	1,830	86	2,030	2,370	2,880	2,904	2,033
87	1,848	2,157	2,623	2,643	1,850	87	2,053	2,396	2,914	2,936	2,055
88	1,867	2,179	2,650	2,673	1,871	88	2,075	2,421	2,945	2,969	2,079
89	1,884	2,200	2,675	2,695	1,886	89	2,094	2,444	2,971	2,996	2,097
90	1,900	2,218	2,695	2,716	1,901	90	2,111	2,464	2,995	3,016	2,111
91	1,915	2,235	2,715	2,733	1,913	91	2,128	2,485	3,016	3,037	2,126
92	1,929	2,251	2,731	2,749	1,924	92	2,143	2,502	3,036	3,054	2,138
93	1,942	2,266	2,747	2,764	1,936	93	2,158	2,519	3,052	3,071	2,150
94	1,954	2,281	2,761	2,778	1,944	94	2,171	2,535	3,067	3,086	2,160
95	1,967	2,294	2,771	2,787	1,951	95	2,184	2,549	3,079	3,097	2,168
96	1,976	2,307	2,782	2,797	1,958	96	2,196	2,563	3,090	3,108	2,175
97	1,984	2,315	2,789	2,806	1,963	97	2,204	2,573	3,100	3,118	2,182
98	1,991	2,323	2,797	2,815	1,971	98	2,212	2,582	3,108	3,128	2,190
99+	1,996	2,328	2,801	2,819	1,974	99+	2,217	2,587	3,113	3,133	2,194

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

A 2.4% processing fee will apply for credit card billing

ILLINOIS Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 600-608

Attained Age	Non-Tobacco User					Attained Age	Tobacco User				
	Plan A	Plan B	Plan C	Plan F	Plan N		Plan A	Plan B	Plan C	Plan F	Plan N
Under 65	1,772	2,067	2,487	2,503	1,753	Under 65	1,968	2,297	2,764	2,782	1,948
65	918	1,071	1,283	1,334	934	65	1,019	1,189	1,426	1,481	1,037
66	918	1,071	1,283	1,334	934	66	1,019	1,189	1,426	1,481	1,037
67	961	1,123	1,343	1,393	975	67	1,070	1,247	1,493	1,547	1,083
68	1,006	1,174	1,404	1,448	1,014	68	1,117	1,304	1,560	1,609	1,128
69	1,049	1,225	1,464	1,506	1,054	69	1,166	1,360	1,626	1,673	1,171
70	1,091	1,274	1,526	1,566	1,096	70	1,212	1,415	1,695	1,739	1,218
71	1,133	1,322	1,588	1,629	1,141	71	1,260	1,470	1,765	1,811	1,267
72	1,175	1,371	1,652	1,693	1,185	72	1,305	1,524	1,835	1,881	1,316
73	1,215	1,419	1,717	1,758	1,231	73	1,350	1,576	1,907	1,954	1,368
74	1,257	1,466	1,777	1,817	1,272	74	1,396	1,629	1,974	2,019	1,413
75	1,296	1,512	1,835	1,874	1,312	75	1,439	1,681	2,040	2,083	1,458
76	1,335	1,558	1,891	1,929	1,350	76	1,482	1,731	2,100	2,142	1,499
77	1,372	1,602	1,945	1,980	1,385	77	1,525	1,779	2,159	2,198	1,539
78	1,409	1,644	1,995	2,027	1,419	78	1,566	1,827	2,216	2,252	1,576
79	1,441	1,682	2,043	2,075	1,453	79	1,602	1,869	2,270	2,306	1,613
80	1,473	1,720	2,086	2,117	1,481	80	1,636	1,910	2,318	2,351	1,645
81	1,502	1,754	2,128	2,157	1,510	81	1,669	1,948	2,366	2,396	1,677
82	1,530	1,786	2,168	2,195	1,536	82	1,700	1,984	2,409	2,439	1,706
83	1,555	1,815	2,206	2,229	1,561	83	1,728	2,017	2,451	2,477	1,734
84	1,578	1,842	2,240	2,261	1,584	84	1,754	2,047	2,489	2,513	1,759
85	1,601	1,869	2,273	2,292	1,605	85	1,779	2,077	2,525	2,548	1,784
86	1,623	1,893	2,302	2,320	1,625	86	1,802	2,104	2,557	2,578	1,805
87	1,641	1,915	2,328	2,347	1,643	87	1,823	2,127	2,587	2,607	1,825
88	1,658	1,934	2,353	2,373	1,662	88	1,842	2,150	2,614	2,636	1,846
89	1,673	1,953	2,375	2,393	1,675	89	1,859	2,170	2,638	2,660	1,862
90	1,687	1,969	2,393	2,411	1,688	90	1,874	2,188	2,659	2,678	1,874
91	1,701	1,985	2,410	2,426	1,699	91	1,890	2,206	2,678	2,696	1,888
92	1,713	1,999	2,424	2,441	1,708	92	1,903	2,221	2,695	2,711	1,898
93	1,724	2,012	2,439	2,454	1,719	93	1,916	2,236	2,709	2,727	1,909
94	1,735	2,025	2,451	2,466	1,726	94	1,928	2,251	2,723	2,740	1,918
95	1,746	2,037	2,461	2,475	1,732	95	1,939	2,263	2,734	2,749	1,925
96	1,755	2,048	2,470	2,483	1,739	96	1,949	2,275	2,744	2,760	1,931
97	1,761	2,056	2,477	2,491	1,743	97	1,957	2,285	2,752	2,768	1,937
98	1,768	2,062	2,483	2,499	1,750	98	1,964	2,292	2,760	2,777	1,945
99+	1,772	2,067	2,487	2,503	1,753	99+	1,968	2,297	2,764	2,782	1,948

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

A 2.4% processing fee will apply for credit card billing

PREMIUM INFORMATION

Central States Indemnity Co. of Omaha may change your premium on any premium due date if a new table of rates is applicable to the policy. The change in the table of rates will apply to all covered persons in the same class. Class is defined as attained age, sex, underwriting class, state of issue, and Your most recent zip code of residence in the state of issue.

Premiums are based on your attained age and will change on Your Policy Anniversary Date.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your Policy's most important features. The Policy is your insurance contract. You must read the Policy itself to understand all of the rights and duties of both you and Central States Indemnity Co. of Omaha.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your Policy, you may return it to: Central States Indemnity Co. of Omaha, Medicare Supplement Administration, P.O. Box 10817, Clearwater, Florida 33757-8817. 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 Central States Indemnity Co. of Omaha nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new Policy, be sure to answer truthfully and completely all questions about your medical and health history. Central States Indemnity Co. of Omaha may cancel your Policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

Please refer to your Policy for details.

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1156	$0	$1156 (Part A deductible)
61st thru 90th day	All but $289 a day	$289 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $578 a day	$578 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 $144.50 a day	$0	Up to $144.50 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 co-payment/ coinsurance for out-patient 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 $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*	$0	$0	$140 (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 $140 of Medicare Approved Amounts*	$0	$0	$140 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First $140 of Medicare Approved Amounts*	$0	$0	$140 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$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
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1156	$1156 (Part A deductible)	$0
61st thru 90th day	All but $289 a day	$289 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $578 a day	$578 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 $144.50 a day	$0	Up to $144.50 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 co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/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 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*	$0	$0	$140 (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 $140 of Medicare Approved Amounts*	$0	$0	$140 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First $140 of Medicare Approved Amounts*	$0	$0	$140 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN C

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1156	$1156 (Part A deductible)	$0
61st thru 90th day	All but $289 a day	$289 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $578 a day	$578 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 $144.50 a day	Up to $144.50 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 co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	$0

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

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

*Once you have been billed $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*	$0	$140 (Part B deductible)	$0
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 $140 of Medicare Approved Amounts*	$0	$140 (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 $140 of Medicare Approved Amounts*	$0	$140 (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 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 $1156	$1156 (Part A deductible)	$0
61st thru 90th day	All but $289 a day	$289 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $578 a day	$578 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 $144.50 a day	Up to $144.50 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 co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/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 $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*	$0	$140 (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 $140 of Medicare Approved amounts*	$0	$140 (Part B deductible)	$0
Remainder of Medicare Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment First $140 of Medicare Approved Amounts*	$0	$140 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER SERVICES – NOT COVERED BY MEDICARE

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

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1156	$1156 (Part A deductible)	$0
61st thru 90th day	All but $289 a day	$289 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $578 a day	$578 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 $144.50 a day	Up to $144.50 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 co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/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 $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*	$0	$0	$140 (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 $140 of Medicare Approved Amounts*	$0	$0	$140 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First $140 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 $140 (Part B deductible) $0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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