THE ORDER OF UNITED COMMERCIAL TRAVELERS OF AMERICA
A Fraternal Benefit Society
PEOPLE HELPING PEOPLE

Home Office:
The Order of United Commercial Travelers of America
632 N. Park St., P.O. Box 159019, Columbus, OH 43215
(614) 228-3276 • Toll-free: (800) 848-0123 • Fax: (614) 228-1898
Visit our web site at www.uct.org

# Outline of Medicare Supplement Coverage – Cover Page: 1 of 2

## Benefit Plans A, B, C and F

These charts show the benefits included in each Medicare supplement plans. Every company must make available Plan "A". Some plans may not be available in your state.

## See Outlines of Coverage sections for details about ALL plans.

**Basic Benefits for Plans A-J:**

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.
Blood: First three pints of blood each year.

| A | B | C | D | E | F | F* | G | H | I | J | J* |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Basic Benefits | Basic Benefits | Basic Benefits | Basic Benefits | Basic Benefits | Basic Benefits | | Basic Benefits | Basic Benefits | Basic Benefits | Basic Benefits | |
| | | Skilled Nursing Facility Coinsurance | Skilled Nursing Facility Coinsurance | Skilled Nursing Facility Coinsurance | Skilled Nursing Facility Coinsurance | | Skilled Nursing Facility Coinsurance | 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 | | Part A Deductible | Part A Deductible | Part A Deductible | Part A Deductible | |
| | | Part B Deductible | | | Part B Deductible | | | | | Part B Deductible | |
| | | | | | Part B Excess (100%) | | Part B Excess (80%) | | 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 | Foreign Travel Emergency | Foreign Travel Emergency | |
| | | | At-Home Recovery | | | | At-Home Recovery | | At-Home Recovery | At-Home Recovery | |
| | | | | | | | | | | | |
| | | | | Preventive Care NOT covered by Medicare | | | | | | Preventive Care NOT covered by Medicare | |

*Plans F and J also have an option called a high deductible Plan F and a high deductible Plan J. These high deductible plans pay the same or offer the same benefits as Plans F and J after one has paid a calendar year $1,860 deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses are $1,860. 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 does not include, in Plan J, the plan's separate prescription drug deductible or, in Plans F and J, the plan's separate foreign emergency deductible.

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# Outline of Medicare Supplement Coverage – Cover Page 2

**Basic Benefits for Plans K and L include similar services as plans A-J, but cost-sharing for the basic benefits is at different levels.**

| J | K** | L** |
|---|---|---|
| Basic Benefits | 100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End<br><br>50% Hospice cost-sharing<br><br>50% of Medicare-eligible expenses for the first three pints of blood<br><br>50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services | 100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End<br><br>75% Hospice cost-sharing<br><br>75% of Medicare-eligible expenses for the first three pints of blood<br><br>75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services |
| Skilled Nursing Coinsurance | 50% Skilled Nursing Facility Coinsurance | 75% Skilled Nursing Facility Coinsurance |
| Part A Deductible | 50% Part A Deductible | 75% Part A Deductible |
| Part B Deductible | | |
| Part B Excess (100%) | | |
| Foreign Travel Emergency | | |
| At-Home Recovery | | |
| Preventative Care NOT covered by Medicare | | |
| | $4,140 Out of Pocket Annual Limit *** | $2,070 Out of Policy Annual Limit *** |

**** Plans K and L provide for different cost-sharing for items and services than Plans A-J.**
**Once you reach the annual limit, the plans pays 100% of the Medicare copayments, coinsurances, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges". You will be responsible for paying excess charges.**

***** The out-of-pocket annual limit will increase each year for inflation.**

**See Outlines of Coverage for details and exceptions.**

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# Annual Premium Rates
# For Use In Missouri Zip Codes
# 63000-63399, 64000-64199

| Issue Age | Plan A | Plan B | Plan C | Plan F |
|---|---|---|---|---|
| **0 - 64** | $1,950.06 | $3,542.60 | $3,977.50 | $4,058.67 |
| **65** | $1,791.15 | $3,105.39 | $3,486.58 | $3,623.92 |
| **66** | $1,791.15 | $3,105.39 | $3,486.58 | $3,623.92 |
| **67** | $1,791.15 | $3,105.39 | $3,486.58 | $3,623.92 |
| **68** | $1,791.15 | $3,105.39 | $3,486.58 | $3,623.92 |
| **69** | $1,791.15 | $3,105.39 | $3,486.58 | $3,623.92 |
| **70** | $1,992.40 | $3,539.15 | $4,074.99 | $4,107.91 |
| **71** | $1,992.40 | $3,539.15 | $4,074.99 | $4,107.91 |
| **72** | $1,992.40 | $3,539.15 | $4,074.99 | $4,107.91 |
| **73** | $1,992.40 | $3,539.15 | $4,074.99 | $4,107.91 |
| **74** | $1,992.40 | $3,539.15 | $4,074.99 | $4,107.91 |
| **75** | $2,153.40 | $3,911.49 | $4,612.23 | $4,591.89 |
| **76** | $2,153.40 | $3,911.49 | $4,612.23 | $4,591.89 |
| **77** | $2,153.40 | $3,911.49 | $4,612.23 | $4,591.89 |
| **78** | $2,153.40 | $3,911.49 | $4,612.23 | $4,591.89 |
| **79** | $2,153.40 | $3,911.49 | $4,612.23 | $4,591.89 |
| **80** | $2,290.93 | $4,222.41 | $5,080.03 | $4,974.30 |
| **81** | $2,290.93 | $4,222.41 | $5,080.03 | $4,974.30 |
| **82** | $2,290.93 | $4,222.41 | $5,080.03 | $4,974.30 |
| **83** | $2,290.93 | $4,222.41 | $5,080.03 | $4,974.30 |
| **84** | $2,290.93 | $4,222.41 | $5,080.03 | $4,974.30 |
| **85** | $2,428.44 | $4,656.17 | $5,555.15 | $5,362.69 |
| **86** | $2,428.44 | $4,656.17 | $5,555.15 | $5,362.69 |
| **87** | $2,428.44 | $4,656.17 | $5,555.15 | $5,362.69 |
| **88** | $2,428.44 | $4,656.17 | $5,555.15 | $5,362.69 |
| **89** | $2,428.44 | $4,656.17 | $5,555.15 | $5,362.69 |
| **90** | $2,428.44 | $4,656.17 | $5,555.15 | $5,362.69 |
| **91** | $2,428.44 | $4,656.17 | $5,555.15 | $5,362.69 |
| **92** | $2,428.44 | $4,656.17 | $5,555.15 | $5,362.69 |
| **93** | $2,428.44 | $4,656.17 | $5,555.15 | $5,362.69 |
| **94** | $2,428.44 | $4,656.17 | $5,555.15 | $5,362.69 |
| **95** | $2,428.44 | $4,656.17 | $5,555.15 | $5,362.69 |
| **96** | $2,428.44 | $4,656.17 | $5,555.15 | $5,362.69 |
| **97** | $2,428.44 | $4,656.17 | $5,555.15 | $5,362.69 |
| **98** | $2,428.44 | $4,656.17 | $5,555.15 | $5,362.69 |
| **99** | $2,428.44 | $4,656.17 | $5,555.15 | $5,362.69 |

**MODAL FACTORS**

| Semi Annual | Quarterly | Direct Monthly | Monthly EFT |
|---|---|---|---|
| **0.51500** | **0.26250** | **0.10000** | **0.08333** |

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# Annual Premium Rates
# For Use In Missouri Zip Codes
# All Other Zip Codes

| Issue Age | Plan A | Plan B | Plan C | Plan F |
|---|---|---|---|---|
| **0 - 64** | $1,772.79 | $3,220.55 | $3,615.91 | $3,689.70 |
| **65** | $1,626.80 | $2,821.34 | $3,168.63 | $3,295.29 |
| **66** | $1,626.80 | $2,821.34 | $3,168.63 | $3,295.29 |
| **67** | $1,626.80 | $2,821.34 | $3,168.63 | $3,295.29 |
| **68** | $1,626.80 | $2,821.34 | $3,168.63 | $3,295.29 |
| **69** | $1,626.80 | $2,821.34 | $3,168.63 | $3,295.29 |
| **70** | $1,811.27 | $3,216.71 | $3,705.87 | $3,734.46 |
| **71** | $1,811.27 | $3,216.71 | $3,705.87 | $3,734.46 |
| **72** | $1,811.27 | $3,216.71 | $3,705.87 | $3,734.46 |
| **73** | $1,811.27 | $3,216.71 | $3,705.87 | $3,734.46 |
| **74** | $1,811.27 | $3,216.71 | $3,705.87 | $3,734.46 |
| **75** | $1,958.85 | $3,554.50 | $4,191.94 | $4,173.63 |
| **76** | $1,958.85 | $3,554.50 | $4,191.94 | $4,173.63 |
| **77** | $1,958.85 | $3,554.50 | $4,191.94 | $4,173.63 |
| **78** | $1,958.85 | $3,554.50 | $4,191.94 | $4,173.63 |
| **79** | $1,958.85 | $3,554.50 | $4,191.94 | $4,173.63 |
| **80** | $2,082.97 | $3,838.56 | $4,619.54 | $4,523.18 |
| **81** | $2,082.97 | $3,838.56 | $4,619.54 | $4,523.18 |
| **82** | $2,082.97 | $3,838.56 | $4,619.54 | $4,523.18 |
| **83** | $2,082.97 | $3,838.56 | $4,619.54 | $4,523.18 |
| **84** | $2,082.97 | $3,838.56 | $4,619.54 | $4,523.18 |
| **85** | $2,207.06 | $4,233.93 | $5,050.80 | $4,875.71 |
| **86** | $2,207.06 | $4,233.93 | $5,050.80 | $4,875.71 |
| **87** | $2,207.06 | $4,233.93 | $5,050.80 | $4,875.71 |
| **88** | $2,207.06 | $4,233.93 | $5,050.80 | $4,875.71 |
| **89** | $2,207.06 | $4,233.93 | $5,050.80 | $4,875.71 |
| **90** | $2,207.06 | $4,233.93 | $5,050.80 | $4,875.71 |
| **91** | $2,207.06 | $4,233.93 | $5,050.80 | $4,875.71 |
| **92** | $2,207.06 | $4,233.93 | $5,050.80 | $4,875.71 |
| **93** | $2,207.06 | $4,233.93 | $5,050.80 | $4,875.71 |
| **94** | $2,207.06 | $4,233.93 | $5,050.80 | $4,875.71 |
| **95** | $2,207.06 | $4,233.93 | $5,050.80 | $4,875.71 |
| **96** | $2,207.06 | $4,233.93 | $5,050.80 | $4,875.71 |
| **97** | $2,207.06 | $4,233.93 | $5,050.80 | $4,875.71 |
| **98** | $2,207.06 | $4,233.93 | $5,050.80 | $4,875.71 |
| **99** | $2,207.06 | $4,233.93 | $5,050.80 | $4,875.71 |

**MODAL FACTORS**

| Semi Annual | Quarterly | Direct Monthly | Monthly EFT |
|---|---|---|---|
| **0.51500** | **0.26250** | **0.10000** | **0.08333** |

## PREMIUM INFORMATION

We, The Order of United Commercial Travelers of America, can only raise your premium if we raise the premium for all policies like yours in this State. Premiums are based on your issue age.

## 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: The Order of United Commercial Travelers of America, 632 North Park Street, P.O. Box 159019, Columbus, Ohio 43215-8619, or to the representative through whom the policy was purchased. 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 The Order of United Commercial Travelers of America nor its agents are connected with Medicare.

This outline of coverage does not give all of the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare & 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 A PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** | | | |
| Semi-private room and board, general nursing and miscellaneous services and supplies: | | | |
| First 60 days | All but $992 | $0 | $992 (Part A Deductible) |
| 61st - 90th day | All but $248 a day | $248 a day | $0 |
| 91st day and after: | | | |
| - While using 60 lifetime reserve days | All but $496 a day | $496 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 - 100th day | All but $124 a day | $0 | Up to $124 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** | | | |
| Available as long as your doctor certifies that you are terminally ill and you elect to receive these services | All but very limited coinsurance for outpatient drugs and inpatient respite care | $0 | Balance |

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand 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 $131 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 A 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 $131 of Medicare Approved Amounts* | $0 | $0 | $131 (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 $131 of Medicare Approved Amounts* | $0 | $0 | $131 (Part B Deductible) |
| Remainder of Medicare Approved Amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES** | 100% | $0 | $0 |

### MEDICARE (PARTS A & B)

| SERVICES | MEDICARE PAYS | PLAN A PAYS | YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE MEDICARE APPROVED SERVICES** | | | |
| - Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| - Durable medical equipment | | | |
| First $131 of Medicare Approved Amounts* | $0 | $0 | $131 (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 B PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** | | | |
| Semi-private room and board, general nursing and miscellaneous services and supplies: | | | |
| First 60 days | All but $992 | $992 (Part A Deductible) | $0 |
| 61st - 90th day | All but $248 a day | $248 a day | $0 |
| 91st day and after: | | | |
| - While using 60 lifetime reserve days | All but $496 a day | $496 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 - 100th day | All but $124 a day | $0 | Up to $124 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** | | | |
| Available as long as your doctor certifies that you are terminally ill and you elect to receive these services | All but very limited coinsurance for outpatient drugs and inpatient respite care | $0 | Balance |

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand 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 $131 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 B 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 $131 of Medicare Approved Amounts* | $0 | $0 | $131 (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 $131 of Medicare Approved Amounts* | $0 | $0 | $131 (Part B Deductible) |
| Remainder of Medicare Approved Amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES** | 100% | $0 | $0 |

### MEDICARE (PARTS A & B)

| SERVICES | MEDICARE PAYS | PLAN B PAYS | YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE MEDICARE APPROVED SERVICES** | | | |
| - Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| - Durable medical equipment | | | |
| First $131 of Medicare Approved Amounts* | $0 | $0 | $131 (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 C PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** | | | |
| Semi-private room and board, general nursing and miscellaneous services and supplies: | | | |
| First 60 days | All but $992 | $992 (Part A Deductible) | $0 |
| 61st - 90th day | All but $248 a day | $248 a day | $0 |
| 91st day and after: | | | |
| - While using 60 lifetime reserve days | All but $496 a day | $496 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 - 100th day | All but $124 a day | Up to $124 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** | | | |
| Available as long as your doctor certifies that you are terminally ill and you elect to receive these services | All but very limited coinsurance for outpatient drugs and inpatient respite care | $0 | Balance |

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand 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 $131 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 C 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 $131 of Medicare Approved Amounts* | $0 | $131 (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 $131 of Medicare Approved Amounts* | $0 | $131 (Part B Deductible) | $0 |
| Remainder of Medicare Approved Amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES –** TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

## MEDICARE (PARTS A & B)

| SERVICES | MEDICARE PAYS | PLAN C PAYS | YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE MEDICARE APPROVED SERVICES** | | | |
| - Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| - Durable medical equipment | | | |
| First $131 of Medicare Approved Amounts* | $0 | $131 (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 F PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** | | | |
| Semi-private room and board, general nursing and miscellaneous services and supplies: | | | |
| First 60 days | All but $992 | $992 (Part A Deductible) | $0 |
| 61st - 90th day | All but $248 a day | $248 a day | $0 |
| 91st day and after: | | | |
| - While using 60 lifetime reserve days | All but $496 a day | $496 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 - 100th day | All but $124 a day | Up to $124 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** | | | |
| Available as long as your doctor certifies that you are terminally ill and you elect to receive these services | All but very limited coinsurance for outpatient drugs and inpatient respite care | $0 | Balance |

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand 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 $131 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 F 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 $131 of Medicare Approved Amounts* | $0 | $131 (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 $131 of Medicare Approved Amounts* | $0 | $131 (Part B Deductible) | $0 |
| Remainder of Medicare Approved Amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES –** TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

## MEDICARE (PARTS A & B)

| SERVICES | MEDICARE PAYS | PLAN F PAYS | YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE MEDICARE APPROVED SERVICES** | | | |
| - Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| - Durable medical equipment | | | |
| First $131 of Medicare Approved Amounts* | $0 | $131 (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 |