

**MUTUAL OF OMAHA INSURANCE COMPANY**  
**OUTLINE OF MEDICARE SUPPLEMENT COVERAGE – COVER PAGE**  
**BENEFIT PLANS A, F, G, HIGH DEDUCTIBLE G AND N**

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. Only applicants **first** eligible for Medicare before 2020 may purchase Plans C, F and High Deductible F.

Note: A ✓ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants (High Deductible G not available prior to July 1, 2019 with an Effective Date – January 1, 2020 or later.)									Medicare first eligible before 2020 only		
	Plan A	Plan B	Plan D	Plan G	G <sup>1</sup>	Plan K	Plan L	Plan M	Plan N	Plan C	Plan F	F <sup>1</sup>
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or Copayment	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓	✓
Blood (first three pints each year)	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓		50%	75%	✓	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓		50%	75%	50%	✓	✓	✓	✓
Medicare Part B deductible										✓	✓	✓
Medicare Part B excess charges				✓							✓	✓
Foreign travel emergency (up to plan limits)			✓	✓				✓	✓	✓	✓	✓
Out-of-pocket limit in 2019 <sup>2</sup>						\$5,560 <sup>2</sup>	\$2,780 <sup>2</sup>					

<sup>1</sup>Plans F and G also have a high deductible option which require first paying a plan deductible \$2,300 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

<sup>2</sup>Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

<sup>3</sup>Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to \$20 for some office visits and up to a \$50 co-payment for emergency room visits that do not result in an inpatient admission.

**MONTHLY NON-TOBACCO PREMIUMS\***  
**ZIP CODES: 304-310, 312, 315-319, 398**

FEMALE					Issue Age	MALE				
Plan A MM20	Plan F MM24	Plan G MM25	Plan High G MM36	Plan N MM35		Plan A MM20	Plan F MM24	Plan G MM25	Plan High G MM36	Plan N MM35
1,110.95	1,501.29	1,144.39	480.53	938.40	Thru 64‡	1,277.60	1,726.48	1,316.04	534.07	1,079.15
111.10	150.13	114.44	48.05	93.84	65	127.76	172.65	131.60	53.41	107.92
111.10	150.13	114.44	48.05	93.84	66	127.76	172.65	131.60	53.41	107.92
112.21	151.63	115.58	48.05	94.78	67	129.04	174.37	132.92	53.41	109.00
114.23	154.36	117.43	48.88	96.30	68	131.37	177.52	135.05	54.34	110.74
116.25	157.09	119.28	49.72	97.81	69	133.68	180.65	137.18	55.27	112.49
118.27	159.82	121.13	50.56	99.33	70	136.00	183.79	139.30	56.20	114.22
120.29	162.55	122.98	51.57	100.85	71	138.33	186.93	141.43	57.33	115.98
122.31	165.28	124.83	52.59	102.36	72	140.65	190.07	143.55	58.45	117.71
125.24	169.24	127.70	53.60	104.72	73	144.03	194.63	146.86	59.57	120.42
128.18	173.21	130.57	54.79	107.07	74	147.41	199.19	150.16	60.90	123.13
131.11	177.18	133.44	55.97	109.42	75	150.78	203.76	153.46	62.21	125.84
134.04	181.14	136.31	57.16	111.78	76	154.16	208.32	156.76	63.54	128.54
136.99	185.11	139.19	58.35	114.13	77	157.53	212.88	160.07	64.85	131.25
140.00	189.19	142.95	59.56	117.22	78	161.00	217.56	164.38	66.19	134.80
143.01	193.25	146.70	60.76	120.29	79	164.46	222.24	168.71	67.54	138.34
146.02	197.33	150.46	61.98	123.38	80	167.93	226.93	173.03	68.88	141.88
149.04	201.40	154.22	63.18	126.45	81	171.39	231.61	177.35	70.22	145.42
152.05	205.47	157.97	64.51	129.54	82	174.86	236.29	181.67	71.70	148.97
155.40	210.00	161.77	65.85	132.65	83	178.70	241.49	186.03	73.18	152.54
158.74	214.51	165.56	67.18	135.76	84	182.55	246.69	190.39	74.67	156.12
162.08	219.03	169.35	68.52	138.87	85	186.40	251.89	194.75	76.15	159.70
165.43	223.55	173.14	69.85	141.98	86	190.24	257.09	199.11	77.63	163.27
168.78	228.08	176.93	71.18	145.08	87	194.09	262.29	203.47	79.10	166.85
172.16	232.64	180.48	72.53	147.99	88	197.97	267.53	207.54	80.61	170.18
175.59	237.29	184.08	73.91	150.95	89	201.94	272.88	211.69	82.14	173.58
179.10	242.03	187.76	75.32	153.96	90	205.97	278.34	215.93	83.71	177.06
182.69	246.88	191.52	76.46	157.04	91	210.09	283.91	220.25	84.97	180.60
186.34	251.81	195.35	77.60	160.18	92	214.29	289.58	224.65	86.25	184.22
190.07	256.85	199.26	78.77	163.39	93	218.58	295.38	229.14	87.55	187.90
193.87	261.98	203.24	79.95	166.65	94	222.95	301.29	233.73	88.87	191.66
197.75	267.23	207.30	81.15	169.99	95	227.40	307.31	238.40	90.20	195.49
201.71	272.57	211.45	82.37	173.39	96	231.95	313.45	243.17	91.55	199.40
205.74	278.02	215.68	83.62	176.86	97	236.60	319.72	248.03	92.93	203.39
209.86	283.58	219.99	84.87	180.39	98	241.33	326.12	252.99	94.32	207.45
214.05	289.26	224.39	86.15	184.00	99+	246.16	332.64	258.06	95.74	211.61

\*See PREMIUM INFORMATION regarding Risk Class and Household Premium Discount rating.

‡Only individuals who are Disabled or have End Stage Renal Disease are eligible for coverage under the age of 65.

To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

**MONTHLY TOBACCO PREMIUMS\***  
**ZIP CODES: 304-310, 312, 315-319, 398**

FEMALE					Issue Age	MALE				
Plan A MM20	Plan F MM24	Plan G MM25	Plan High G MM36	Plan N MM35		Plan A MM20	Plan F MM24	Plan G MM25	Plan High G MM36	Plan N MM35
1,276.96	1,725.62	1,315.39	552.33	1,078.62	Thru 64‡	1,468.50	1,984.46	1,512.69	613.87	1,240.41
127.70	172.56	131.54	55.23	107.87	65	146.85	198.45	151.27	61.39	124.04
127.70	172.56	131.54	55.23	107.87	66	146.85	198.45	151.27	61.39	124.04
128.97	174.28	132.86	55.23	108.94	67	148.32	200.43	152.78	61.39	125.28
131.30	177.43	134.98	56.19	110.69	68	150.99	204.04	155.23	62.46	127.29
133.62	180.57	137.11	57.15	112.43	69	153.65	207.65	157.68	63.53	129.29
135.94	183.70	139.23	58.11	114.17	70	156.32	211.25	160.11	64.60	131.29
138.26	186.84	141.36	59.28	115.91	71	159.00	214.86	162.56	65.89	133.31
140.58	189.98	143.48	60.44	117.66	72	161.66	218.47	165.00	67.18	135.30
143.96	194.53	146.79	61.61	120.37	73	165.55	223.71	168.80	68.48	138.41
147.33	199.10	150.08	62.98	123.07	74	169.43	228.96	172.59	70.00	141.53
150.71	203.65	153.38	64.34	125.77	75	173.31	234.20	176.39	71.51	144.64
154.07	208.21	156.68	65.71	128.48	76	177.19	239.45	180.18	73.03	147.75
157.45	212.77	159.99	67.07	131.19	77	181.07	244.69	183.98	74.55	150.87
160.91	217.46	164.31	68.46	134.73	78	185.05	250.07	188.95	76.08	154.94
164.37	222.13	168.62	69.84	138.27	79	189.03	255.45	193.92	77.63	159.01
167.84	226.81	172.94	71.24	141.81	80	193.02	260.84	198.88	79.17	163.08
171.31	231.50	177.26	72.62	145.35	81	197.00	266.22	203.85	80.71	167.15
174.77	236.17	181.58	74.15	148.89	82	200.98	271.60	208.82	82.42	171.23
178.62	241.37	185.94	75.68	152.47	83	205.40	277.58	213.83	84.12	175.34
182.46	246.57	190.30	77.21	156.04	84	209.83	283.55	218.84	85.82	179.45
186.30	251.76	194.66	78.75	159.62	85	214.25	289.53	223.86	87.52	183.57
190.15	256.96	199.01	80.28	163.19	86	218.67	295.50	228.86	89.23	187.67
194.00	262.16	203.37	81.81	166.76	87	223.09	301.48	233.88	90.92	191.78
197.88	267.40	207.44	83.37	170.10	88	227.55	307.50	238.55	92.66	195.61
201.83	272.75	211.59	84.96	173.50	89	232.11	313.66	243.32	94.42	199.52
205.86	278.20	215.82	86.57	176.97	90	236.75	319.93	248.19	96.22	203.52
209.98	283.76	220.13	87.88	180.51	91	241.49	326.33	253.16	97.67	207.59
214.18	289.44	224.54	89.20	184.12	92	246.31	332.85	258.22	99.14	211.74
218.47	295.23	229.03	90.54	187.81	93	251.24	339.52	263.38	100.63	215.98
222.84	301.13	233.61	91.90	191.56	94	256.27	346.31	268.65	102.14	220.29
227.30	307.16	238.28	93.28	195.39	95	261.38	353.23	274.02	103.67	224.70
231.85	313.30	243.05	94.68	199.30	96	266.61	360.29	279.51	105.23	229.19
236.48	319.57	247.91	96.11	203.29	97	271.95	367.50	285.09	106.82	233.78
241.21	325.96	252.87	97.55	207.35	98	277.39	374.85	290.79	108.42	238.45
246.03	332.48	257.92	99.03	211.50	99+	282.94	382.35	296.62	110.05	243.23

\*See PREMIUM INFORMATION regarding Risk Class and Household Premium Discount rating.

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**MONTHLY NON-TOBACCO PREMIUMS\***  
**ZIP CODES: 300-303, 311, 313-314, 399**

FEMALE					Issue Age	MALE				
Plan A MM20	Plan F MM24	Plan G MM25	Plan High G MM36	Plan N MM35		Plan A MM20	Plan F MM24	Plan G MM25	Plan High G MM36	Plan N MM35
1,215.51	1,642.59	1,252.10	525.75	1,026.72	Thru 64‡	1,397.84	1,888.97	1,439.91	584.33	1,180.72
121.55	164.26	125.21	52.58	102.67	65	139.79	188.90	143.99	58.43	118.07
121.55	164.26	125.21	52.58	102.67	66	139.79	188.90	143.99	58.43	118.07
122.77	165.90	126.46	52.58	103.70	67	141.18	190.79	145.43	58.43	119.25
124.98	168.89	128.49	53.48	105.36	68	143.73	194.23	147.76	59.45	121.16
127.19	171.88	130.51	54.40	107.02	69	146.26	197.66	150.09	60.47	123.07
129.40	174.86	132.53	55.32	108.68	70	148.80	201.09	152.41	61.49	124.97
131.61	177.85	134.55	56.43	110.34	71	151.35	204.52	154.74	62.72	126.89
133.82	180.83	136.58	57.54	112.00	72	153.88	207.96	157.06	63.95	128.79
137.03	185.17	139.72	58.64	114.58	73	157.58	212.95	160.68	65.18	131.75
140.24	189.52	142.86	59.95	117.15	74	161.28	217.94	164.29	66.63	134.72
143.45	193.85	146.00	61.24	119.72	75	164.97	222.93	167.90	68.07	137.69
146.66	198.19	149.14	62.54	122.30	76	168.67	227.92	171.51	69.52	140.64
149.88	202.53	152.29	63.85	124.88	77	172.35	232.92	175.13	70.96	143.61
153.17	206.99	156.40	65.17	128.25	78	176.15	238.04	179.86	72.42	147.48
156.46	211.44	160.51	66.48	131.62	79	179.94	243.16	184.59	73.90	151.36
159.77	215.90	164.62	67.81	134.99	80	183.73	248.29	189.31	75.36	155.23
163.07	220.36	168.73	69.13	138.36	81	187.53	253.41	194.04	76.82	159.11
166.36	224.81	172.84	70.59	141.73	82	191.31	258.53	198.77	78.45	162.99
170.02	229.76	176.99	72.04	145.14	83	195.52	264.22	203.54	80.07	166.90
173.68	234.70	181.14	73.50	148.53	84	199.74	269.91	208.31	81.70	170.82
177.34	239.65	185.29	74.96	151.94	85	203.94	275.60	213.09	83.31	174.73
181.00	244.59	189.43	76.42	155.34	86	208.15	281.28	217.85	84.94	178.64
184.66	249.54	193.59	77.88	158.74	87	212.36	286.97	222.62	86.55	182.55
188.36	254.53	197.46	79.36	161.92	88	216.60	292.71	227.07	88.20	186.20
192.12	259.62	201.41	80.87	165.15	89	220.94	298.57	231.61	89.88	189.92
195.96	264.81	205.43	82.41	168.45	90	225.36	304.54	236.25	91.59	193.72
199.88	270.11	209.54	83.65	171.82	91	229.87	310.63	240.97	92.97	197.60
203.88	275.51	213.73	84.91	175.26	92	234.46	316.84	245.80	94.37	201.56
207.96	281.02	218.01	86.19	178.77	93	239.15	323.18	250.71	95.79	205.58
212.11	286.64	222.37	87.48	182.34	94	243.94	329.64	255.72	97.23	209.70
216.36	292.38	226.82	88.79	185.99	95	248.81	336.23	260.84	98.69	213.89
220.69	298.23	231.35	90.13	189.71	96	253.78	342.95	266.06	100.17	218.17
225.10	304.19	235.98	91.49	193.51	97	258.86	349.82	271.37	101.68	222.53
229.61	310.27	240.70	92.86	197.37	98	264.04	356.81	276.80	103.20	226.98
234.19	316.48	245.51	94.26	201.32	99+	269.33	363.95	282.34	104.75	231.52

\*See PREMIUM INFORMATION regarding Risk Class and Household Premium Discount rating.

‡Only individuals who are Disabled or have End Stage Renal Disease are eligible for coverage under the age of 65.

To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

**MONTHLY TOBACCO PREMIUMS\***  
**ZIP CODES: 300-303, 311, 313-314, 399**

FEMALE					Issue Age	MALE				
Plan A MM20	Plan F MM24	Plan G MM25	Plan High G MM36	Plan N MM35		Plan A MM20	Plan F MM24	Plan G MM25	Plan High G MM36	Plan N MM35
1,397.14	1,888.03	1,439.19	604.31	1,180.14	Thru 64‡	1,606.71	2,171.23	1,655.07	671.65	1,357.15
139.71	188.80	143.92	60.43	118.02	65	160.68	217.13	165.50	67.17	135.72
139.71	188.80	143.92	60.43	118.02	66	160.68	217.13	165.50	67.17	135.72
141.11	190.69	145.36	60.43	119.20	67	162.28	219.29	167.16	67.17	137.07
143.66	194.13	147.68	61.47	121.11	68	165.21	223.25	169.84	68.34	139.27
146.20	197.56	150.01	62.53	123.01	69	168.12	227.19	172.52	69.51	141.46
148.74	200.99	152.33	63.58	124.92	70	171.04	231.13	175.18	70.68	143.65
151.27	204.42	154.66	64.86	126.82	71	173.97	235.09	177.86	72.09	145.85
153.81	207.86	156.98	66.13	128.73	72	176.88	239.03	180.53	73.51	148.04
157.51	212.84	160.60	67.41	131.70	73	181.13	244.77	184.69	74.92	151.44
161.20	217.83	164.21	68.90	134.66	74	185.38	250.51	188.84	76.59	154.85
164.89	222.82	167.82	70.39	137.61	75	189.62	256.24	192.99	78.24	158.26
168.57	227.80	171.43	71.89	140.57	76	193.87	261.98	197.14	79.91	161.65
172.27	232.80	175.05	73.39	143.54	77	198.11	267.72	201.30	81.56	165.07
176.06	237.92	179.77	74.90	147.41	78	202.47	273.61	206.73	83.24	169.52
179.84	243.04	184.49	76.42	151.28	79	206.82	279.49	212.17	84.94	173.98
183.64	248.16	189.22	77.94	155.16	80	211.18	285.39	217.60	86.62	178.43
187.43	253.29	193.94	79.46	159.03	81	215.55	291.28	223.03	88.30	182.88
191.22	258.40	198.67	81.13	162.91	82	219.90	297.16	228.47	90.17	187.35
195.43	264.09	203.44	82.81	166.82	83	224.73	303.70	233.95	92.03	191.84
199.63	269.77	208.21	84.48	170.73	84	229.58	310.24	239.44	93.90	196.34
203.84	275.46	212.98	86.16	174.65	85	234.42	316.78	244.93	95.76	200.84
208.04	281.14	217.74	87.84	178.55	86	239.25	323.31	250.40	97.63	205.34
212.25	286.83	222.51	89.51	182.46	87	244.09	329.85	255.89	99.48	209.83
216.50	292.57	226.97	91.21	186.11	88	248.97	336.45	261.00	101.38	214.02
220.83	298.42	231.51	92.95	189.83	89	253.96	343.18	266.22	103.30	218.30
225.24	304.38	236.13	94.72	193.63	90	259.03	350.04	271.55	105.28	222.67
229.75	310.47	240.85	96.15	197.50	91	264.21	357.05	276.98	106.86	227.13
234.34	316.68	245.67	97.59	201.45	92	269.50	364.18	282.53	108.47	231.67
239.03	323.02	250.59	99.06	205.48	93	274.89	371.47	288.17	110.10	236.30
243.81	329.47	255.59	100.55	209.59	94	280.39	378.90	293.94	111.76	241.03
248.69	336.07	260.71	102.06	213.78	95	285.98	386.47	299.81	113.43	245.85
253.67	342.79	265.92	103.59	218.06	96	291.70	394.20	305.81	115.13	250.77
258.74	349.64	271.24	105.16	222.42	97	297.54	402.09	311.92	116.87	255.78
263.92	356.64	276.67	106.74	226.86	98	303.50	410.13	318.16	118.62	260.89
269.19	363.77	282.20	108.35	231.40	99+	309.57	418.33	324.53	120.41	266.12

\*See PREMIUM INFORMATION regarding Risk Class and Household Premium Discount rating.

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## **Disclosures**

Use this outline to compare benefits and premiums among policies.

## **Premium Information**

We, Mutual of Omaha Insurance Company, can only raise your premium if we raise the premium for all the policies like yours in the same geographic area of the state where you live. Until you are age 99, your premium may change each year. This change will only be made on the first renewal date that coincides with or follows each anniversary of the policy date. Schedules of rates may vary depending upon your policy date.

## **Risk Class Rating**

If, according to our underwriting standards, you are overweight or underweight for your height, you will be considered to be a greater insurable risk. In such a case, your premium will be priced either as Class I – 10% or Class II – 20% higher than the rates illustrated, based on your Body Mass Index (BMI) reading. Risk class rating will not be applicable when you apply for coverage during an open enrollment or guaranteed issue period.

## **Household Premium Discount**

You are eligible for a household premium discount if: (a) you reside with your spouse (including civil union/domestic partner) of any age or (b) for the past year you have resided with at least one, but not more than three, other adults who are age 60 or older. The discounted premium will be priced 12% lower than the rates illustrated. The policy's household premium discount will be removed if the other adult or spouse no longer resides with you (other than in the case of his or her death).

## **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 3300 Mutual of Omaha Plaza, Omaha, NE 68175. 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**

The policy may not fully cover all of your medical costs. Neither we nor our 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 & 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.

## **Exclusions**

Exclusions apply to your coverage. Please be sure to review the exclusions in your policy. This policy does not cover Part A benefits for benefit periods that begin while this policy is not in force, and other exclusions apply.

**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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days	All but \$1,364	\$0	\$1,364 (Part A deductible)
61 <sup>st</sup> through 90 <sup>th</sup> day	All but \$341 a day	\$341 a day	\$0
91 <sup>st</sup> day and after: While using 60 lifetime reserve days	All but \$682 a day	\$682 a day	\$0
Once lifetime reserve days are used: Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days	All approved amounts	\$0	\$0
21 <sup>st</sup> through 100 <sup>th</sup> day	All but \$170.50 a day	\$0	Up to \$170.50 a day
101 <sup>st</sup> day and after	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

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

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

\*Once you have been billed \$185 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$185 of Medicare-approved amounts*	\$0	\$0	\$185 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (above Medicare-approved amounts)	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next \$185 of Medicare-approved amounts*	\$0	\$0	\$185 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A AND B**

<b>HOME HEALTH CARE – MEDICARE-APPROVED SERVICES</b> Medically necessary skilled care services and medical supplies	100%	\$0	\$0
<b>DURABLE MEDICAL EQUIPMENT</b>			
First \$185 of Medicare-approved amounts*	\$0	\$0	\$185 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0



**PLAN F**  
**MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**  
**Medicare first eligible before 2020 only**

\*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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,364	\$1,364 (Part A deductible)	\$0
61 <sup>st</sup> through 90 <sup>th</sup> day	All but \$341 a day	\$341 a day	\$0
91 <sup>st</sup> day and after: While using 60 lifetime reserve days	All but \$682 a day	\$682 a day	\$0
Once lifetime reserve days are used: Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21 <sup>st</sup> through 100 <sup>th</sup> day	All but \$170.50 a day	Up to \$170.50 a day	\$0
101 <sup>st</sup> day and after	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

\*\*NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid up to an additional 365 days as provided in the policy's/certificate'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**  
**Medicare first eligible before 2020 only**

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$185 of Medicare-approved amounts	\$0	\$185 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (above Medicare-approved amounts)	\$0	100%	\$0
<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next \$185 of Medicare-approved amounts	\$0	\$185 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A AND B**

<b>HOME HEALTH CARE – MEDICARE-APPROVED SERVICES</b> Medically necessary skilled care services and medical supplies	100%	\$0	\$0
<b>DURABLE MEDICAL EQUIPMENT</b>			
First \$185 of Medicare-approved amounts	\$0	\$185 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0

**PLAN F**  
**MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**  
 Medicare first eligible before 2020 only

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year	\$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 benefit

**PLAN G**  
**MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

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

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,364	\$1,364 (Part A deductible)	\$0
61 <sup>st</sup> through 90 <sup>th</sup> day	All but \$341 a day	\$341 a day	\$0
91 <sup>st</sup> day and after: While using 60 lifetime reserve days	All but \$682 a day	\$682 a day	\$0
Once lifetime reserve days are used: Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 <sup>st</sup> through 100 <sup>th</sup> day	All but \$170.50 a day	Up to \$170.50 a day	\$0
101 <sup>st</sup> day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

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

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

\*Once you have been billed \$185 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$185 of Medicare-approved amounts*	\$0	\$0	\$185 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (above Medicare-approved amounts)	\$0	100%	\$0
<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next \$185 of Medicare-approved amounts*	\$0	\$0	\$185 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A AND B**

<b>HOME HEALTH CARE – MEDICARE-APPROVED SERVICES</b> Medically necessary skilled care services and medical supplies	100%	\$0	\$0
<b>DURABLE MEDICAL EQUIPMENT</b>			
First \$185 of Medicare-approved amounts*	\$0	\$0	\$185 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0

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

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN G PAYS</b>	<b>YOU PAY</b>
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year	\$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 benefit

**HIGH DEDUCTIBLE PLAN G**  
**MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

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

\*\*\*This high deductible plan pays the same benefits as Plan G after you have paid a calendar year \$2,300 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are \$2,300. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,300 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO \$2,300 DEDUCTIBLE*** YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,364	\$1,364 (Part A deductible)	\$0
61 <sup>st</sup> through 90 <sup>th</sup> day	All but \$341 a day	\$341 a day	\$0
91 <sup>st</sup> day and after: While using 60 lifetime reserve days	All but \$682 a day	\$682 a day	\$0
Once lifetime reserve days are used: Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21 <sup>st</sup> through 100 <sup>th</sup> day	All but \$170.50 a day	Up to \$170.50 a day	\$0
101 <sup>st</sup> day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

\*\*NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid up to an additional 365 days as provided in the policy's/certificate'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.

**HIGH DEDUCTIBLE PLAN G  
 MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

\*Once you have been billed \$185 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

\*\*\*This high deductible plan pays the same benefits as Plan G after you have paid a calendar year \$2,300 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are \$2,300. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,300 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO \$2,300 DEDUCTIBLE*** YOU PAY
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$185 of Medicare-approved amounts*	\$0	\$0	\$185 (Unless Part B deductible has been met)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (above Medicare-approved amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints	\$0	All costs	\$0
Next \$185 of Medicare-approved amounts*	\$0	\$0	\$185 (Unless Part B deductible has been met)
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A AND B**

<b>HOME HEALTH CARE – MEDICARE-APPROVED SERVICES</b> Medically necessary skilled care services and medical supplies	100%	\$0	\$0
<b>DURABLE MEDICAL EQUIPMENT</b> First \$185 of Medicare-approved amounts*	\$0	\$0	\$185 (Unless Part B deductible has been met)
Remainder of Medicare-approved amounts	80%	20%	\$0



**HIGH DEDUCTIBLE PLAN G**  
**MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

\*\*\*This high deductible plan pays the same benefits as Plan G after you have paid a calendar year \$2,300 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are \$2,300. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,300 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO \$2,300 DEDUCTIBLE*** YOU PAY
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year	\$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 benefit

**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 N PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,364	\$1,364 (Part A deductible)	\$0
61 <sup>st</sup> through 90 <sup>th</sup> day	All but \$341 a day	\$341 a day	\$0
91 <sup>st</sup> day and after: While using 60 lifetime reserve days	All but \$682 a day	\$682 a day	\$0
Once lifetime reserve days are used: Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21 <sup>st</sup> through 100 <sup>th</sup> day	All but \$170.50 a day	Up to \$170.50 a day	\$0
101 <sup>st</sup> day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

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

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

\*Once you have been billed \$185 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$185 of Medicare-approved amounts*	\$0	\$0	\$185 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. The copayment 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 copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense
<b>Part B Excess Charges</b> (above Medicare-approved amounts)	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next \$185 of Medicare-approved amounts*	\$0	\$0	\$185 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

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

**PARTS A AND B**

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
<b>HOME HEALTH CARE – MEDICARE-APPROVED SERVICES</b> Medically necessary skilled care services and medical supplies	100%	\$0	\$0
<b>DURABLE MEDICAL EQUIPMENT</b> First \$185 of Medicare-approved amounts*	\$0	\$0	\$185 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year	\$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 benefit