

Medical Health Insuring Corporation

Plans A, C, F, High-Deductible F, G and N



Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020

This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available. 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								Medicare first eligible before 2020 only	
	A	B	D	G*	K	L	M	N	C	F*
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%	✓	✓ Copays apply***	✓	✓
Blood (first three pints)	✓	✓	✓	✓	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 2021					\$6,220**	\$3,110**				

* Plans F and G also have a high deductible options which require first paying a plan deductible of \$2,370 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.

** 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.

***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.

PREMIUM INFORMATION

We, Medical Mutual®, can only raise your premium if we raise the premium for all policies like yours in this State. We determine your premium based upon attained age. This means your premium will increase each year on the anniversary date of your policy based upon your age on that date.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to Medical Mutual, 3737 Sylvania Avenue, Toledo, Ohio 43623. 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 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 Medical Mutual 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. Medical Mutual 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.

2021 MEDICARE SUPPLEMENT MONTHLY PREMIUM RATES - PREFERRED

Age	Plan A		Plan C		Plan F		High-Deductible Plan F		Plan G		Plan N	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
65	\$94.63	\$101.30	\$152.82	\$163.59	\$153.95	\$164.80	\$64.63	\$69.18	\$116.81	\$125.05	\$111.91	\$119.80
66	\$94.63	\$101.30	\$152.82	\$163.59	\$153.95	\$164.80	\$64.63	\$69.18	\$116.81	\$125.05	\$111.91	\$119.80
67	\$99.84	\$106.88	\$161.21	\$172.58	\$162.41	\$173.86	\$68.18	\$72.99	\$123.24	\$131.93	\$118.07	\$126.40
68	\$105.84	\$113.30	\$170.88	\$182.93	\$172.16	\$184.29	\$72.27	\$77.36	\$130.63	\$139.84	\$125.15	\$133.98
69	\$112.20	\$120.10	\$181.14	\$193.91	\$182.49	\$195.35	\$76.61	\$82.01	\$138.47	\$148.23	\$132.66	\$142.02
70	\$118.35	\$126.70	\$191.10	\$204.57	\$192.53	\$206.10	\$80.83	\$86.53	\$146.09	\$156.39	\$139.96	\$149.83
71	\$124.52	\$133.30	\$201.04	\$215.22	\$202.53	\$216.81	\$85.01	\$91.00	\$153.68	\$164.52	\$147.24	\$157.62
72	\$129.50	\$138.63	\$209.08	\$223.82	\$210.64	\$225.49	\$88.42	\$94.66	\$159.83	\$171.10	\$153.13	\$163.93
73	\$134.68	\$144.17	\$217.44	\$232.77	\$219.07	\$234.51	\$91.97	\$98.45	\$166.22	\$177.94	\$159.26	\$170.48
74	\$140.06	\$149.93	\$226.13	\$242.08	\$227.83	\$243.89	\$95.64	\$102.38	\$172.87	\$185.06	\$165.62	\$177.30
75	\$145.66	\$155.93	\$235.19	\$251.77	\$236.94	\$253.64	\$99.46	\$106.47	\$179.78	\$192.46	\$172.24	\$184.39
76	\$151.49	\$162.17	\$244.60	\$261.84	\$246.42	\$263.79	\$103.44	\$110.73	\$186.97	\$200.15	\$179.13	\$191.76
77	\$156.03	\$167.03	\$251.93	\$269.69	\$253.82	\$271.71	\$106.55	\$114.06	\$192.60	\$206.18	\$184.52	\$197.53
78	\$160.70	\$172.03	\$259.50	\$277.79	\$261.44	\$279.87	\$109.74	\$117.48	\$198.37	\$212.35	\$190.06	\$203.46
79	\$165.54	\$177.21	\$267.27	\$286.11	\$269.28	\$288.26	\$113.03	\$121.00	\$204.32	\$218.72	\$195.75	\$209.55
80	\$170.50	\$182.52	\$275.30	\$294.71	\$277.36	\$296.91	\$116.42	\$124.62	\$210.44	\$225.28	\$201.62	\$215.84
81	\$175.10	\$187.45	\$282.73	\$302.67	\$284.85	\$304.93	\$119.57	\$128.00	\$216.12	\$231.36	\$207.07	\$221.67
82	\$178.61	\$191.20	\$288.38	\$308.72	\$290.54	\$311.02	\$121.96	\$130.56	\$220.45	\$235.99	\$211.20	\$226.09
83	\$182.19	\$195.03	\$294.16	\$314.90	\$296.35	\$317.24	\$124.40	\$133.17	\$224.87	\$240.72	\$215.44	\$230.62
84	\$185.83	\$198.93	\$300.03	\$321.19	\$302.28	\$323.59	\$126.88	\$135.83	\$229.35	\$245.52	\$219.74	\$235.23
85	\$189.55	\$202.91	\$306.04	\$327.62	\$308.33	\$330.06	\$129.43	\$138.55	\$233.94	\$250.43	\$224.14	\$239.94
86	\$191.83	\$205.35	\$309.71	\$331.55	\$312.03	\$334.03	\$130.98	\$140.21	\$236.76	\$253.45	\$226.83	\$242.83
87	\$193.75	\$207.41	\$312.80	\$334.86	\$315.14	\$337.36	\$132.29	\$141.62	\$239.12	\$255.97	\$229.09	\$245.24
88	\$195.69	\$209.48	\$315.93	\$338.21	\$318.29	\$340.73	\$133.62	\$143.04	\$241.51	\$258.54	\$231.39	\$247.70
89	\$197.63	\$211.56	\$319.10	\$341.59	\$321.48	\$344.15	\$134.96	\$144.47	\$243.93	\$261.13	\$233.71	\$250.19
90+	\$199.61	\$213.68	\$322.29	\$345.01	\$324.70	\$347.59	\$136.31	\$145.92	\$246.37	\$263.73	\$236.04	\$252.68

2020 MEDICARE SUPPLEMENT MONTHLY PREMIUM RATES - PREFERRED

Age	Plan A		Plan C		Plan F		High-Deductible Plan F		Plan G		Plan N	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
65	\$90.99	\$95.54	\$149.82	\$157.31	\$150.93	\$158.48	\$60.40	\$63.42	\$112.32	\$117.94	\$107.61	\$112.99
66	\$90.99	\$95.54	\$149.82	\$157.31	\$150.93	\$158.48	\$60.40	\$63.42	\$112.32	\$117.94	\$107.61	\$112.99
67	\$96.00	\$100.80	\$158.05	\$165.95	\$159.23	\$167.19	\$63.72	\$66.91	\$118.50	\$124.42	\$113.53	\$119.21
68	\$101.77	\$106.86	\$167.53	\$175.91	\$168.78	\$177.22	\$67.54	\$70.92	\$125.61	\$131.89	\$120.34	\$126.36
69	\$107.88	\$113.27	\$177.59	\$186.47	\$178.91	\$187.85	\$71.60	\$75.18	\$133.14	\$139.80	\$127.56	\$133.94
70	\$113.80	\$119.49	\$187.35	\$196.72	\$188.75	\$198.19	\$75.54	\$79.31	\$140.47	\$147.49	\$134.58	\$141.31
71	\$119.73	\$125.72	\$197.10	\$206.95	\$198.56	\$208.49	\$79.45	\$83.43	\$147.77	\$155.15	\$141.58	\$148.66
72	\$124.52	\$130.75	\$204.98	\$215.23	\$206.51	\$216.84	\$82.64	\$86.77	\$153.68	\$161.37	\$147.24	\$154.60
73	\$129.50	\$135.98	\$213.18	\$223.84	\$214.77	\$225.51	\$85.95	\$90.24	\$159.83	\$167.82	\$153.13	\$160.79
74	\$134.67	\$141.40	\$221.70	\$232.79	\$223.36	\$234.52	\$89.38	\$93.85	\$166.22	\$174.53	\$159.25	\$167.21
75	\$140.06	\$147.06	\$230.58	\$242.10	\$232.29	\$243.91	\$92.95	\$97.60	\$172.87	\$181.51	\$165.62	\$173.90
76	\$145.66	\$152.94	\$239.80	\$251.79	\$241.59	\$253.67	\$96.67	\$101.51	\$179.78	\$188.77	\$172.24	\$180.86
77	\$150.03	\$157.53	\$246.99	\$259.34	\$248.84	\$261.28	\$99.58	\$104.56	\$185.19	\$194.44	\$177.42	\$186.29
78	\$154.52	\$162.25	\$254.41	\$267.13	\$256.31	\$269.12	\$102.56	\$107.69	\$190.74	\$200.28	\$182.75	\$191.88
79	\$159.17	\$167.13	\$262.03	\$275.14	\$264.00	\$277.20	\$105.64	\$110.92	\$196.46	\$206.28	\$188.22	\$197.63
80	\$163.94	\$172.14	\$269.90	\$283.40	\$271.92	\$285.51	\$108.80	\$114.24	\$202.35	\$212.46	\$193.87	\$203.56
81	\$168.37	\$176.79	\$277.19	\$291.05	\$279.26	\$293.22	\$111.75	\$117.33	\$207.81	\$218.21	\$199.11	\$209.06
82	\$171.74	\$180.33	\$282.73	\$296.87	\$284.84	\$299.08	\$113.98	\$119.68	\$211.97	\$222.57	\$203.08	\$213.24
83	\$175.18	\$183.94	\$288.39	\$302.81	\$290.54	\$305.07	\$116.26	\$122.08	\$216.22	\$227.03	\$207.15	\$217.51
84	\$178.68	\$187.62	\$294.15	\$308.85	\$296.35	\$311.16	\$118.58	\$124.51	\$220.53	\$231.55	\$211.29	\$221.85
85	\$182.26	\$191.37	\$300.04	\$315.05	\$302.28	\$317.39	\$120.96	\$127.01	\$224.94	\$236.19	\$215.52	\$226.30
86	\$184.45	\$193.68	\$303.64	\$318.82	\$305.91	\$321.20	\$122.41	\$128.53	\$227.65	\$239.03	\$218.11	\$229.01
87	\$186.30	\$195.61	\$306.67	\$322.00	\$308.96	\$324.40	\$123.64	\$129.82	\$229.92	\$241.42	\$220.28	\$231.30
88	\$188.16	\$197.56	\$309.74	\$325.22	\$312.05	\$327.65	\$124.88	\$131.12	\$232.22	\$243.83	\$222.49	\$233.62
89	\$190.03	\$199.53	\$312.84	\$328.48	\$315.18	\$330.94	\$126.13	\$132.43	\$234.55	\$246.27	\$224.72	\$235.96
90+	\$191.93	\$201.53	\$315.97	\$331.76	\$318.33	\$334.25	\$127.39	\$133.76	\$236.89	\$248.74	\$226.96	\$238.31

Important Note:

The benefit amounts listed on the following pages for Plans A, C, F, High-Deductible F, G and N are set by Medicare and may change effective January 2022. We will send you an updated Outline of Coverage if there are any changes for 2022.

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

* A benefit period begins on the first day you receive services 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* Semi-private room and board, general nursing and miscellaneous services and supplies First 60 days 61 st through 90 th day 91 st day and after: <ul style="list-style-type: none"> • While using 60 lifetime reserve days Once lifetime reserve days are used: <ul style="list-style-type: none"> • Additional 365 days • Beyond the additional 365 days 	All but \$1,484 All but \$371 a day All but \$742 a day \$0 \$0	\$0 \$371 a day \$742 a day 100% of Medicare-eligible expenses \$0	\$1,484 (Part A deductible) \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days 21 st through 100 th day 101 st day and after	All approved amounts All but \$185.50 a day \$0	\$0 \$0 \$0	\$0 Up to \$185.50 a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.	All but very limited copayment/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 \$203 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 \$203 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$203 (Part B deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$203 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$203 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE – MEDICARE APPROVED SERVICES TREATMENT - Medically necessary skilled care services and medical supplies - Durable medical equipment First \$203 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$203 (Part B deductible) \$0
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PLAN C
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive services 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* Semi-private room and board, general nursing and miscellaneous services and supplies First 60 days 61 st through 90 th day 91 st day and after: <ul style="list-style-type: none"> • While using 60 lifetime reserve days Once lifetime reserve days are used: <ul style="list-style-type: none"> • Additional 365 days • Beyond the additional 365 days 	All but \$1,484 All but \$371 a day All but \$742 a day \$0 \$0	\$1,484 (Part A deductible) \$371 a day \$742 a day 100% of Medicare-eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days 21 st through 100 th day 101 st day and after	All approved amounts All but \$185.50 a day \$0	\$0 Up to \$185.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/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 C
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed \$203 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 \$203 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$203 (Part B deductible) Generally 20%	\$0 \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$203 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$203 (Part B deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE – MEDICARE APPROVED SERVICES TREATMENT - Medically necessary skilled care services and medical supplies - Durable medical equipment First \$203 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$203 (Part B deductible) 20%	\$0 \$0 \$0
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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 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
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PLAN F
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive services 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* Semi-private room and board, general nursing and miscellaneous services and supplies First 60 days 61 st through 90 th day 91 st day and after: <ul style="list-style-type: none"> • While using 60 lifetime reserve days Once lifetime reserve days are used: <ul style="list-style-type: none"> • Additional 365 days • Beyond the additional 365 days 	All but \$1,484 All but \$371 a day All but \$742 a day \$0 \$0	\$1,484 (Part A deductible) \$371 a day \$742 a day 100% of Medicare-eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days 21 st through 100 th day 101 st day and after	All approved amounts All but \$185.50 a day \$0	\$0 Up to \$185.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/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 F
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed \$203 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 \$203 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$203 (Part B deductible) Generally 20%	\$0 \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$203 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$203 (Part B deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE – MEDICARE APPROVED SERVICES TREATMENT - Medically necessary skilled care services and medical supplies - Durable medical equipment First \$203 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$203 (Part B deductible) 20%	\$0 \$0 \$0
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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 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
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**HIGH DEDUCTIBLE PLAN F
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

* A benefit period begins on the first day you receive services 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 F after one has paid a calendar year \$2,370 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$2,370. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,370 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2,370 DEDUCTIBLE** YOU PAY
<p>HOSPITALIZATION* Semi-private room and board, general nursing and miscellaneous services and supplies</p> <p>First 60 days</p> <p>61st through 90th day</p> <p>91st day and after:</p> <ul style="list-style-type: none"> • While using 60 lifetime reserve days <p>Once lifetime reserve days are used:</p> <ul style="list-style-type: none"> • Additional 365 days • Beyond the additional 365 days 	<p>All but \$1,484</p> <p>All but \$371 a day</p> <p>All but \$742 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$1,484 (Part A deductible)</p> <p>\$371 a day</p> <p>\$742 a day</p> <p>100% of Medicare-eligible expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0***</p> <p>All costs</p>
<p>SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.</p> <p>First 20 days</p> <p>21st through 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$185.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$185.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p>HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.</p>	<p>All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care</p>	<p>Medicare copayment/coinsurance</p>	<p>\$0</p>

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

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

* Once you have been billed \$203 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 F after one has paid a calendar year \$2,370 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$2,370. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,370 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2,370 DEDUCTIBLE** 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 \$203 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$203 (Part B deductible) Generally 20%	\$0 \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$203 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$203 (Part B deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

HIGH DEDUCTIBLE PLAN F (continued)

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,370 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2,370 DEDUCTIBLE** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES TREATMENT			
- Medically necessary skilled care services and medical supplies	100%	\$0	\$0
- Durable medical equipment			
First \$203 of Medicare Approved Amounts*	\$0	\$203 (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 G
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive services 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* Semi-private room and board, general nursing and miscellaneous services and supplies First 60 days 61 st through 90 th day 91 st day and after: <ul style="list-style-type: none"> • While using 60 lifetime reserve days Once lifetime reserve days are used: <ul style="list-style-type: none"> • Additional 365 days • Beyond the additional 365 days 	All but \$1,484 All but \$371 a day All but \$742 a day \$0 \$0	\$1,484 (Part A deductible) \$371 a day \$742 a day 100% of Medicare-eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days 21 st through 100 th day 101 st day and after	All approved amounts All but \$185.50 a day \$0	\$0 Up to \$185.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/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 G
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed \$203 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 \$203 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$203 (Unless Part B deductible has been met) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$203 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$203 (Unless Part B deductible has been met) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

Plan G

PARTS A & B

HOME HEALTH CARE – MEDICARE APPROVED SERVICES TREATMENT			
- Medically necessary skilled care services and medical supplies	100%	\$0	\$0
- Durable medical equipment			
First \$203 of Medicare Approved Amounts*	\$0	\$0	\$203 (Unless Part B deductible has been met)
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	\$0	\$0	\$250
First \$250 each calendar year	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum
Remainder of charges			

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

* A benefit period begins on the first day you receive services 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* Semi-private room and board, general nursing and miscellaneous services and supplies First 60 days 61 st through 90 th day 91 st day and after: <ul style="list-style-type: none"> • While using 60 lifetime reserve days Once lifetime reserve days are used: <ul style="list-style-type: none"> • Additional 365 days • Beyond the additional 365 days 	All but \$1,484 All but \$371 a day All but \$742 a day \$0 \$0	\$1,484 (Part A deductible) \$371 a day \$742 a day 100% of Medicare-eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days 21 st through 100 th day 101 st day and after	All approved amounts All but \$185.50 a day \$0	\$0 Up to \$185.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/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 N
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed \$203 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 \$203 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. The 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.	\$203 (Part B deductible) 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.
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$203 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$203 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN N (continued)

PARTS A & B

HOME HEALTH CARE – MEDICARE APPROVED SERVICES TREATMENT			
- Medically necessary skilled care services and medical supplies	100%	\$0	\$0
- Durable medical equipment			
First \$203 of Medicare Approved Amounts*	\$0	\$0	\$203 (Part B deductible)
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