Home Office: 1932 Wynnton Road, Columbus, GA 31999 Administrative Office: 1021 Reams Fleming Blvd., Franklin, TN 37064 Telephone Number: 1-833-504-0336 Website: www.Aflac.com

OUTLINE OF MEDICARE SUPPLEMENT PLANS SOLD FOR EFFECTIVE DATE 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.

Medicare Supplement Benefit Plans A, F, G, and N are offered by Tier One Insurance Company.

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

	Plans Available to All Applicants							
Benefits	A	В	D	G¹	К	L	M	N
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 ³
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 2024 ²				•	\$7,060 ²	\$3,530 ²		

Medicare first eligible before 2020 only			
С	F ¹		
✓	√		
✓	✓		
✓	✓		
✓	✓		
✓	✓		
✓	✓		
✓	✓		
	✓		
✓	✓		

¹Plans F and G also have a high deductible option which require first paying a plan deductible of \$2,800 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.

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

³ 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.

Tier One Insurance Company

Annual Attained Age Premiums ZIP Codes: 820-831

Female Rates

Rates Effective: 03/01/2024

	Prefe	erred		Attained		Stan	dard	
Plan A	Plan F	Plan G	Plan N	Age	Plan A	Plan F	Plan G	Plan N
1,589.06	1,653.11	1,468.49	1,024.78	65	1,765.63	1,836.78	1,631.66	1,138.64
1,589.06	1,653.11	1,468.49	1,024.78	66	1,765.63	1,836.78	1,631.66	1,138.64
1,589.06	1,653.11	1,468.49	1,024.78	67	1,765.63	1,836.78	1,631.66	1,138.64
1,623.57	1,670.93	1,472.03	1,073.28	68	1,803.96	1,856.59	1,635.60	1,192.53
1,680.21	1,696.56	1,484.99	1,106.16	69	1,866.91	1,885.07	1,649.99	1,229.06
1,739.52	1,751.65	1,530.41	1,142.87	70	1,932.79	1,946.27	1,700.46	1,269.85
1,791.39	1,817.82	1,575.14	1,192.52	71	1,990.44	2,019.80	1,750.16	1,325.02
1,843.27	1,884.72	1,629.04	1,243.59	72	2,048.08	2,094.14	1,810.04	1,381.76
1,895.16	1,952.37	1,691.37	1,297.54	73	2,105.73	2,169.29	1,879.29	1,441.72
1,966.51	2,028.79	1,754.27	1,358.73	74	2,185.01	2,254.21	1,949.19	1,509.70
2,049.19	2,106.54	1,835.85	1,428.06	75	2,276.88	2,340.60	2,039.83	1,586.72
2,107.07	2,199.93	1,911.54	1,494.74	76	2,341.19	2,444.37	2,123.93	1,660.82
2,166.23	2,296.68	2,018.78	1,571.18	77	2,406.92	2,551.87	2,243.08	1,745.77
2,226.68	2,396.89	2,145.60	1,650.52	78	2,474.09	2,663.21	2,384.00	1,833.92
2,288.45	2,500.67	2,279.52	1,732.84	79	2,542.73	2,778.52	2,532.79	1,925.39
2,351.58	2,608.14	2,420.90	1,818.26	80	2,612.88	2,897.94	2,689.89	2,020.28
2,407.04	2,731.60	2,569.01	1,905.95	81	2,674.49	3,035.12	2,854.45	2,117.73
2,463.63	2,860.12	2,725.29	1,996.90	82	2,737.37	3,177.91	3,028.11	2,218.77
2,521.37	2,993.89	2,890.17	2,101.40	83	2,801.52	3,326.55	3,211.31	2,334.89
2,580.29	3,133.12	3,064.10	2,210.37	84	2,866.99	3,481.24	3,404.55	2,455.98
2,640.42	3,278.00	3,247.53	2,324.00	85	2,933.79	3,642.22	3,608.37	2,582.22
2,691.00	3,414.19	3,425.13	2,428.92	86	2,989.99	3,793.55	3,805.69	2,698.79
2,742.50	3,555.61	3,611.91	2,538.03	87	3,047.22	3,950.68	4,013.23	2,820.03
2,794.95	3,702.44	3,808.34	2,651.50	88	3,105.49	4,113.82	4,231.49	2,946.11
2,848.35	3,854.87	4,014.89	2,769.51	89	3,164.83	4,283.20	4,460.99	3,077.23
2,902.72	4,013.13	4,232.08	2,892.20	90	3,225.25	4,459.04	4,702.32	3,213.56
2,948.96	4,167.99	4,449.57	3,011.15	91	3,276.63	4,631.10	4,943.97	3,345.72
2,995.95	4,328.53	4,677.87	3,134.62	92	3,328.82	4,809.47	5,197.63	3,482.91
3,043.67	4,494.95	4,917.49	3,262.80	93	3,381.85	4,994.39	5,463.88	3,625.33
3,092.15	4,667.46	5,168.99	3,395.84	94	3,435.72	5,186.07	5,743.32	3,773.16
3,141.40	4,846.27	5,432.94	3,533.93	95	3,490.45	5,384.75	6,036.60	3,926.59
3,188.52	4,991.66	5,661.13	3,639.94	96	3,542.81	5,546.29	6,290.14	4,044.39
3,236.35	5,141.41	5,898.89	3,749.15	97	3,595.95	5,712.68	6,554.32	4,165.72
3,284.90	5,295.65	6,146.65	3,861.62	98	3,649.88	5,884.06	6,829.60	4,290.69
3,334.17	5,454.52	6,404.80	3,977.47	99	3,704.64	6,060.58	7,116.44	4,419.41

Modal Factors: Semi-Annual - 0.5200, Quarterly - 0.2650, Monthly - 0.08333

Add a One-Time Policy Fee \$20

To calculate a Household discount:

Annual premium x modal factor = modal premium (round to nearest whole cent)

Modal premium x.90 = discounted premium

Tier One Insurance Company

Annual Attained Age Premiums ZIP Codes: 820-831

Male Rates

Rates Effective: 03/01/2024

	Prefe	erred		Attained		Stan	dard	
Plan A	Plan F	Plan G	Plan N	Age	Plan A	Plan F	Plan G	Plan N
1,820.23	1,893.59	1,682.12	1,173.86	65	2,022.49	2,103.99	1,869.03	1,304.29
1,820.23	1,893.59	1,682.12	1,173.86	66	2,022.49	2,103.99	1,869.03	1,304.29
1,820.23	1,893.59	1,682.12	1,173.86	67	2,022.49	2,103.99	1,869.03	1,304.29
1,859.75	1,914.01	1,686.19	1,229.42	68	2,066.40	2,126.68	1,873.54	1,366.02
1,924.65	1,943.38	1,701.02	1,267.07	69	2,138.50	2,159.31	1,890.02	1,407.86
1,992.57	2,006.47	1,753.05	1,309.13	70	2,213.97	2,229.41	1,947.84	1,454.59
2,052.00	2,082.26	1,804.28	1,366.00	71	2,280.00	2,313.63	2,004.75	1,517.77
2,111.42	2,158.90	1,866.03	1,424.51	72	2,346.03	2,398.78	2,073.37	1,582.78
2,170.86	2,236.39	1,937.41	1,486.30	73	2,412.06	2,484.88	2,152.69	1,651.45
2,252.58	2,323.92	2,009.47	1,556.39	74	2,502.88	2,582.14	2,232.74	1,729.33
2,347.30	2,412.99	2,102.91	1,635.80	75	2,608.10	2,681.11	2,336.57	1,817.56
2,413.59	2,519.97	2,189.62	1,712.19	76	2,681.77	2,799.96	2,432.91	1,902.43
2,481.36	2,630.78	2,312.46	1,799.75	77	2,757.06	2,923.10	2,569.41	1,999.73
2,550.60	2,745.58	2,457.74	1,890.63	78	2,834.00	3,050.63	2,730.81	2,100.71
2,621.37	2,864.45	2,611.13	1,984.93	79	2,912.63	3,182.73	2,901.26	2,205.49
2,693.69	2,987.56	2,773.08	2,082.77	80	2,992.98	3,319.51	3,081.20	2,314.19
2,757.21	3,128.98	2,942.74	2,183.22	81	3,063.56	3,476.65	3,269.71	2,425.80
2,822.03	3,276.19	3,121.76	2,287.39	82	3,135.59	3,640.22	3,468.62	2,541.55
2,888.17	3,429.43	3,310.63	2,407.10	83	3,209.08	3,810.48	3,678.48	2,674.56
2,955.66	3,588.91	3,509.85	2,531.93	84	3,284.07	3,987.68	3,899.84	2,813.26
3,024.53	3,754.86	3,719.97	2,662.08	85	3,360.59	4,172.07	4,133.30	2,957.87
3,082.47	3,910.87	3,923.40	2,782.26	86	3,424.97	4,345.41	4,359.33	3,091.40
3,141.47	4,072.87	4,137.36	2,907.25	87	3,490.52	4,525.40	4,597.06	3,230.28
3,201.54	4,241.05	4,362.36	3,037.24	88	3,557.27	4,712.28	4,847.07	3,374.70
3,262.71	4,415.67	4,598.96	3,172.40	89	3,625.23	4,906.29	5,109.95	3,524.90
3,324.99	4,596.94	4,847.75	3,312.95	90	3,694.44	5,107.71	5,386.39	3,681.05
3,377.97	4,774.33	5,096.88	3,449.19	91	3,753.30	5,304.81	5,663.20	3,832.44
3,431.78	4,958.23	5,358.38	3,590.63	92	3,813.09	5,509.14	5,953.76	3,989.59
3,486.45	5,148.85	5,632.86	3,737.45	93	3,873.83	5,720.95	6,258.74	4,152.72
3,541.99	5,346.46	5,920.95	3,889.85	94	3,935.53	5,940.50	6,578.84	4,322.05
3,598.40	5,551.29	6,223.30	4,048.03	95	3,998.22	6,168.10	6,914.77	4,497.81
3,652.37	5,717.82	6,484.68	4,169.47	96	4,058.20	6,353.14	7,205.20	4,632.75
3,707.17	5,889.36	6,757.04	4,294.55	97	4,119.07	6,543.73	7,507.81	4,771.73
3,762.77	6,066.04	7,040.83	4,423.39	98	4,180.86	6,740.05	7,823.14	4,914.88
3,819.21	6,248.02	7,336.55	4,556.09	99	4,243.56	6,942.24	8,151.71	5,062.33

Modal Factors: Semi-Annual - 0.5200, Quarterly - 0.2650, Monthly - 0.08333

Add a One-Time Policy Fee \$20

To calculate a Household discount:

Annual premium x modal factor = modal premium (round to nearest whole cent)

Modal premium x.90 = discounted premium

PREMIUM INFORMATION

Tier One Insurance Company can only raise your premium if we raise the premium for all policies like yours in this state. Premiums for this policy will increase due to the increase in your age. Upon attainment of an age requiring a rate increase, the renewal premium for the policy will be the renewal premium then in effect for your attained age.

HOUSEHOLD DISCOUNT

You are eligible for a Household Premium Discount if: (1) you reside with your spouse (including civil union/domestic partner) or (2) for the past year you have resided with a family member who is 50 years old or older. For the purpose of this discount, a civil union partner or domestic partner will be considered a legal spouse when such partnerships are valid and recognized in your state of residence. We may request additional documentation to determine eligibility. The discounted rate will be 10 percent lower than the individual rate and will be removed if the other adult or spouse no longer resides with you (other than in the case of his/her death).

DISCLOSURES

Use this outline to compare benefits and premium 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 Tier One Insurance Company's administrative office, 1021 Reams Fleming Boulevard, Franklin, TN 37064. 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

The policy may not cover all of your medical costs.

Neither Tier One Insurance Company 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 & 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 any 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.

THE FOLLOWING CHARTS DESCRIBE PLANS A, F, G and N OFFERED BY TIER ONE INSURANCE COMPANY.

PLAN A

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board,			
general nursing and miscellaneous			
services and supplies			
First 60 days	All but \$1,632	\$0	\$1,632 (Part A Deductible)
61st thru 90th day	All but \$408 a day	\$408 a day	\$0
91st day and after	·		
While using 60 lifetime reserve days	All but \$816 a day	\$816 a day	\$0
Once lifetime reserve days are used:			
Additional 365 days	\$0	100% of Medicare	\$0**
		Eligible Expenses	
Beyond the Additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's			
requirements, including having been			
in a hospital for at least 3 days and			
entered a Medicare-Approved facility			
within 30 days after leaving the			
hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$204 a day	\$0	Up to \$204 a day
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE		, ,	
You must meet Medicare's	All but very limited	Medicare copayment/	\$0
requirements, including a doctor's	copayment/coinsurance	coinsurance	
certification of terminal illness.	for outpatient drugs and		
	inpatient respite care		

^{**}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 \$240 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 test, durable medical equipment			
First \$240 of Medicare-Approved amounts*	\$0	\$0	\$240 (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above			
Medicare-Approved	\$0	\$0	All costs
BLOOD First 3 pints Next \$240 of Medicare-Approved amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$240 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE — MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
First \$240 of Medicare Approved amounts*	\$0	\$0	\$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	\$0

PLAN F

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general			
nursing and miscellaneous services			
and supplies			
First 60 days	All but \$1,632	\$1,632	\$0
		(Part A Deductible)	
61st thru 90th day	All but \$408 a day	\$408 a day	\$0
91st day and after			
While using 60 lifetime reserve days	All but \$816 a day	\$816 a day	\$0
Once lifetime reserve days are used:	40		40**
Additional 365 days	\$0	100% of Medicare	\$0**
		Eligible Expenses	
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		¢0	ćo
First 20 days	All approved	\$0	\$0
21st thru 100th day	amounts	Un to \$204 a day	\$0
·	All but \$204 a day	Up to \$204 a day	'
101st day and after	\$0	\$0	All costs
BLOOD	\$0	2 mints	\$0
First 3 pints Additional amounts	100%	3 pints \$0	\$0
HOSPICE CARE	100/0	70	70
You must meet Medicare's	All but very limited	Medicare	\$0
requirements, including a doctor's	copayment/	copayment/	T -
certification of terminal illness.	coinsurance for	coinsurance	
certification of terminal liness.	outpatient drugs and	3334141100	
	inpatient respite care		
	p. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2.		

^{**}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 \$240 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 test, durable medical equipment First \$240 of Medicare-Approved amounts*	\$0	\$240 (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 Next \$240 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs \$240 (Part B Deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES –			
TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
First \$240 of Medicare Approved amounts*	\$0	\$240 (Part B Deductible)	\$0
Remainder of Medicare-Approved amounts	80%	20%	\$0

PLAN F
OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN G

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general			
nursing and miscellaneous services			
and supplies			
First 60 days	All but \$1,632	\$1,632	\$0
		(Part A Deductible)	
61st thru 90th day	All but \$408 a day	\$408 a day	\$0
91st day and after			
While using 60 lifetime reserve days	All but \$816 a day	\$816 a day	\$0
Once lifetime reserve days are used:			
Additional 365 days	\$0	100% of Medicare	\$0**
		Eligible Expenses	
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	Allonguessad	\$0	\$0
First 20 days	All approved amounts	, ŞU	, ŞU
21st thru 100th day	All but \$204 a day	Up to \$204 a day	\$0
	7.11. Sut 7204 a day	- ορ το γ2οπ α ααγ	
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			40
You must meet Medicare's	All but very limited	Medicare	\$0
requirements, including a doctor's	copayment/	copayment/	
certification of terminal illness.	coinsurance for	coinsurance	
	outpatient drugs and		
	inpatient respite care		

^{**}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 \$240 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 test, durable medical equipment			
First \$240 of Medicare-Approved amounts*	\$0	\$0	\$240 (Unless Part B Deductible has been met)
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 Next \$240 of Medicare-Approved amounts*	\$0 \$0	All costs \$0	\$0 \$240 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES –			
TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment First \$240 of Medicare-Approved amounts*	\$0	\$0	\$240 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved amounts	80%	20%	\$0

PLAN G

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

PLAN N

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general			
nursing and miscellaneous services			
and supplies			
First 60 days	All but \$1,632	\$1,632	\$0
		(Part A Deductible)	
61st thru 90th day	All but \$408 a day	\$408 a day	\$0
91st day and after		4	4
While using 60 lifetime reserve days	All but \$816 a day	\$816 a day	\$0
Once lifetime reserve days are used:	1.0		A a strate
Additional 365 days	\$0	100% of Medicare	\$0**
		Eligible Expenses	
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		ćo	ćo
First 20 days	All approved	\$0	\$0
21st thru 100th day	amounts All but \$204 a day	Up to \$204 a day	\$0
•		1 '	
101st day and after	\$0	\$0	All costs
BLOOD First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE	10070	70	70
You must meet Medicare's	All but very limited	Medicare co-payment/	\$0
requirements, including a doctor's	copayment/	coinsurance	1 -
certification of terminal illness.	coinsurance for		
codation of co	outpatient drugs		
	and inpatient		
	respite care		

^{**}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 \$240 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 test, durable medical equipment First \$240 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 co-payment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	\$240 (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 \$240 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$240 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN N PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment	100%	\$0	\$0
First \$240 of Medicare-Approved amounts*	\$0	\$0	\$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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