AMERICAN HERITAGE LIFE INSURANCE COMPANY

Outline of Medicare Supplement Plans A, F, High Deductible F, G, N

This chart shows the benefit 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. We offer plans A, F, High Deductible F, G and N.

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

	Plans Available to All Applicants								Medicare first eligible before 2020 only	
Benefits	**A**	**B**	**D**	**G[1]**	**K**	**L**	**M**	**N**	**C**	**F[1]**
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]					$7060[2]	$3530[2]				

[1] Plans F and G also have a high deductible option which require first paying a plan deductible of $2800 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.

[2] 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.

[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.

AMERICAN HERITAGE LIFE INSURANCE COMPANY
Medicare Supplement Policy
2010 Standardized Plan A
Attained Age Premium Rates
Rates Effective Upon Approval

Attained	Female			Male		
Age	Preferred Select	Preferred	Standard	Preferred Select	Preferred	Standard
0-64	103.43		118.92	116.90		134.36
65	103.43		118.92	116.90		134.36
66	103.43		118.92	116.90		134.36
67	103.43	109.69	126.11	116.90	123.97	142.49
68	103.43	115.23	132.48	116.90	130.23	149.68
69	103.43	121.06	139.13	116.90	136.77	157.17
70	104.52	126.64	145.58	118.13	143.11	164.50
71	109.97	131.71	151.44	124.28	148.87	171.06
72	113.23	136.96	157.39	127.98	154.71	177.82
73	117.66	142.38	163.63	132.92	160.84	184.88
74	122.33	147.99	170.06	138.18	167.17	192.15
75	127.15	153.78	176.79	143.69	173.78	199.72
76	132.21	158.42	182.07	149.36	178.97	205.74
77	137.44	163.17	187.55	155.29	184.37	211.96
78	142.82	168.03	193.15	161.39	189.86	218.19
79	148.47	173.09	198.95	167.75	195.57	224.83
80	154.28	178.27	204.86	174.29	201.38	231.47
81	159.37	183.65	211.09	180.07	207.50	238.52
82	164.93	189.14	217.42	186.37	213.73	245.68
83	170.39	194.63	223.76	192.56	219.95	252.84
84	175.01	200.11	229.98	197.71	226.07	259.90
85	179.25	205.50	236.21	202.54	232.19	266.85
86	183.94	210.88	242.44	207.88	238.32	273.90
87	188.55	216.16	248.45	213.03	244.23	280.75
88	193.24	221.54	254.68	218.37	250.35	287.80
89	198.03	227.03	260.91	223.71	256.47	294.76
90	203.00	232.73	267.45	229.32	262.90	302.23
91	208.07	238.53	274.21	235.12	269.54	309.80
92	213.31	244.55	281.07	241.00	276.29	317.58
93	218.65	250.67	288.14	247.06	283.24	325.57
94	224.08	256.90	295.31	253.22	290.29	333.66
95	229.70	263.34	302.70	259.55	297.56	342.07
96	235.41	269.88	310.20	265.98	304.92	350.47
97	241.30	276.63	318.01	272.67	312.60	359.29
98	247.38	283.60	326.03	279.55	320.49	368.42
99+	253.54	290.67	334.16	286.52	328.48	377.55

Open Enrollment or Guaranteed Issue: *Determine Underwriting Class based on Tobacco and HT/WT*
Underwritten: *Determine Underwriting Class based on Tobacco, HT/WT, and Preferred Select Medical Question*
See UW Guide for detailed instructions

Rate Calculator

Monthly Rate

A - Monthly Rate (use table above)		
B - Area Factor (see area factors below)		
C - Input Household Discount (1.0 if not applicable, 0.93 if roommate HHD applies, 0.9 if dual HHD applies)		
D - Input Activity Tracker Discount (1.0 if not applicable, 0.95 if discount applies)		
E - Input Annual Pay Discount (1.0 if not applicable, 0.9 if discount applies)		
F - Calculate Monthly Rate (rounded to the nearest penny)		F=A*B*C*D*E

Quarterly, Semi-Annual, or Annual Rate

G - Input Modal Factor (Quarterly - multiply by 3, Semi-Annual - multiply by 6, Annual - multiply by 12)		
H - Calculate Final Modal Billing Rate (rounded to the nearest penny)		H=F*G

Roommate Household Discount:	7%
Dual Household Discount (applies if multiple people in the same Household have or are applying for National General Medicare Supplement policies):	10%
Annual Pay Discount:	10%
Activity Tracker "Wearable" Discount:	5%

The rates above do not include a one time $25 policy fee.

Area Factors:

Kansas Zip Codes	Factor
Area 1: 660-662, 672	1.100
Area 2: All Other Zip Codes	1.060

AMERICAN HERITAGE LIFE INSURANCE COMPANY
Medicare Supplement Policy
2010 Standardized Plan F
Attained Age Premium Rates
Rates Effective Upon Approval

Attained	Female			Male		
Age	Preferred Select	Preferred	Standard	Preferred Select	Preferred	Standard
0-64	129.41		148.74	146.21		168.06
65	129.41		148.74	146.21		168.06
66	129.41		148.74	146.21		168.06
67	129.41	137.23	157.73	146.21	155.05	178.22
68	129.41	144.17	165.70	146.21	162.88	187.23
69	129.41	151.38	173.98	146.21	171.02	196.56
70	130.77	158.35	182.04	147.75	178.94	205.70
71	137.58	164.68	189.27	155.44	186.05	213.82
72	141.67	171.20	196.79	160.06	193.45	222.34
73	147.10	178.00	204.62	166.22	201.15	231.18
74	152.93	185.00	212.67	172.80	209.05	240.34
75	159.00	192.30	221.02	179.64	217.26	249.72
76	165.33	198.11	227.72	186.82	223.85	257.29
77	171.83	204.01	234.53	194.18	230.54	264.96
78	178.60	210.11	241.53	201.81	237.43	272.93
79	185.63	216.42	248.74	209.72	244.51	281.00
80	192.93	222.92	256.24	217.99	251.88	289.55
81	199.27	229.62	263.94	225.16	259.46	298.21
82	206.25	236.53	271.85	233.02	267.23	307.16
83	213.11	243.43	279.85	240.83	275.09	316.21
84	218.84	250.24	287.66	247.29	282.77	325.06
85	224.21	257.04	295.46	253.34	290.44	333.81
86	230.06	263.74	303.17	259.95	298.01	342.57
87	235.82	270.35	310.77	266.47	305.49	351.12
88	241.75	277.15	318.57	273.16	313.16	359.97
89	247.77	284.05	326.48	279.94	320.93	368.93
90	253.97	291.16	334.68	286.97	328.99	378.17
91	260.34	298.46	343.09	294.18	337.25	387.61
92	266.89	305.97	351.69	301.56	345.71	397.35
93	273.52	313.57	360.40	309.02	354.27	407.18
94	280.33	321.38	369.40	316.74	363.12	417.41
95	287.31	329.38	378.61	324.63	372.17	427.74
96	294.47	337.58	388.01	332.70	381.42	438.36
97	301.80	345.99	397.72	341.02	390.96	449.38
98	309.30	354.59	407.62	349.51	400.69	460.59
99+	317.07	363.50	417.83	358.26	410.72	472.10

Open Enrollment or Guaranteed Issue: *Determine Underwriting Class based on Tobacco and HT/WT*
Underwritten: *Determine Underwriting Class based on Tobacco, HT/WT, and Preferred Select Medical Question*
See UW Guide for detailed instructions

Rate Calculator

Monthly Rate

A - Monthly Rate (use table above)		
B - Area Factor (see area factors below)		
C - Input Household Discount (1.0 if not applicable, 0.93 if roommate HHD applies, 0.9 if dual HHD applies)		
D - Input Activity Tracker Discount (1.0 if not applicable, 0.95 if discount applies)		
E - Input Annual Pay Discount (1.0 if not applicable, 0.9 if discount applies)		
F - Calculate Monthly Rate (rounded to the nearest penny)		F=A*B*C*D*E

Quarterly, Semi-Annual, or Annual Rate

G - Input Modal Factor (Quarterly - multiply by 3, Semi-Annual - multiply by 6, Annual - multiply by 12)		
H - Calculate Final Modal Billing Rate (rounded to the nearest penny)		H=F*G

Roommate Household Discount:	7%
Dual Household Discount (applies if multiple people in the same Household have or are applying for National General Medicare Supplement policies):	10%
Annual Pay Discount:	10%
Activity Tracker "Wearable" Discount:	5%

The rates above do not include a one time $25 policy fee.

Area Factors:

Kansas Zip Codes	Factor
Area 1: 660-662, 672	1.100
Area 2: All Other Zip Codes	1.060

AMERICAN HERITAGE LIFE INSURANCE COMPANY
Medicare Supplement Policy
2010 Standardized Plan High F
Attained Age Premium Rates
Rates Effective Upon Approval

Attained	Female			Male		
Age	Preferred Select	Preferred	Standard	Preferred Select	Preferred	Standard
0-64	40.41		46.42	45.63		52.45
65	40.41		46.42	45.63		52.45
66	40.41		46.42	45.63		52.45
67	40.41	42.85	49.23	45.63	48.39	55.62
68	40.41	45.02	51.72	45.63	50.84	58.43
69	40.41	47.28	54.39	45.63	53.46	61.47
70	40.84	49.41	56.81	46.11	55.85	64.16
71	42.96	51.34	59.00	48.52	58.00	66.68
72	44.24	53.39	61.32	49.96	60.28	69.33
73	45.84	55.47	63.77	51.81	62.69	72.02
74	47.68	57.68	66.26	53.84	65.13	74.84
75	49.54	59.92	68.88	55.98	67.71	77.81
76	51.52	61.73	71.00	58.24	69.79	80.18
77	53.52	63.54	73.01	60.45	71.77	82.46
78	55.64	65.46	75.23	62.85	73.95	85.03
79	57.87	67.47	77.54	65.38	76.22	87.61
80	60.14	69.49	79.86	67.94	78.50	90.18
81	62.14	71.60	82.28	70.19	80.88	92.95
82	64.28	73.72	84.69	72.60	83.25	95.73
83	66.39	75.83	87.21	75.05	85.73	98.50
84	68.17	77.94	89.63	77.05	88.10	101.27
85	69.83	80.06	92.04	78.92	90.48	104.04
86	71.68	82.17	94.46	81.00	92.86	106.71
87	73.44	84.19	96.78	82.98	95.13	109.39
88	75.28	86.30	99.19	85.05	97.51	112.06
89	77.12	88.42	101.61	87.13	99.88	114.83
90	79.06	90.63	104.13	89.28	102.36	117.70
91	81.08	92.95	106.85	91.61	105.03	120.77
92	83.10	95.27	109.47	93.86	107.60	123.64
93	85.21	97.68	112.28	96.28	110.38	126.91
94	87.31	100.10	115.10	98.70	113.15	130.08
95	89.51	102.62	117.92	101.11	115.92	133.24
96	91.71	105.13	120.84	103.62	118.79	136.51
97	93.99	107.75	123.87	106.21	121.76	139.97
98	96.36	110.47	126.99	108.89	124.83	143.44
99+	98.73	113.19	130.11	111.56	127.90	147.00

Open Enrollment or Guaranteed Issue: *Determine Underwriting Class based on Tobacco and HT/WT*
Underwritten: *Determine Underwriting Class based on Tobacco, HT/WT, and Preferred Select Medical Question*
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Rate Calculator

Monthly Rate

A - Monthly Rate (use table above)		
B - Area Factor (see area factors below)		
C - Input Household Discount (1.0 if not applicable, 0.93 if roommate HHD applies, 0.9 if dual HHD applies)		
D - Input Activity Tracker Discount (1.0 if not applicable, 0.95 if discount applies)		
E - Input Annual Pay Discount (1.0 if not applicable, 0.9 if discount applies)		
F - Calculate Monthly Rate (rounded to the nearest penny)		F=A*B*C*D*E

Quarterly, Semi-Annual, or Annual Rate

G - Input Modal Factor (Quarterly - multiply by 3, Semi-Annual - multiply by 6, Annual - multiply by 12)		
H - Calculate Final Modal Billing Rate (rounded to the nearest penny)		H=F*G

Roommate Household Discount:	7%
Dual Household Discount (applies if multiple people in the same Household have or are applying for National General Medicare Supplement policies):	10%
Annual Pay Discount:	10%
Activity Tracker "Wearable" Discount:	5%

The rates above do not include a one time $25 policy fee.

Area Factors:

Kansas Zip Codes	Factor
Area 1: 660-662, 672	1.100
Area 2: All Other Zip Codes	1.060

AMERICAN HERITAGE LIFE INSURANCE COMPANY
Medicare Supplement Policy
2010 Standardized Plan G
Attained Age Premium Rates
Rates Effective Upon Approval

Attained	Female			Male		
Age	Preferred Select	Preferred	Standard	Preferred Select	Preferred	Standard
0-64	107.90		124.00	121.89		140.13
65	107.90		124.00	121.89		140.13
66	107.90		124.00	121.89		140.13
67	107.90	114.42	131.49	121.89	129.26	148.60
68	107.90	120.20	138.14	121.89	135.79	156.10
69	107.90	126.22	145.09	121.89	142.62	163.90
70	109.03	131.98	151.73	123.17	149.15	171.43
71	114.71	137.20	157.75	129.59	155.07	178.26
72	118.12	142.60	163.96	133.44	161.17	185.29
73	122.54	148.29	170.47	138.48	167.57	192.63
74	127.43	154.16	177.17	143.96	174.16	200.17
75	132.47	160.22	184.18	149.69	181.05	208.12
76	137.76	165.07	189.77	155.68	186.54	214.45
77	143.21	170.03	195.47	161.84	192.15	220.89
78	148.83	175.10	201.27	168.18	197.85	227.42
79	154.71	180.38	207.29	174.78	203.77	234.17
80	160.77	185.76	213.52	181.65	209.89	241.22
81	166.06	191.35	219.96	187.64	216.22	248.48
82	171.83	197.05	226.50	194.15	222.65	255.95
83	177.50	202.75	233.04	200.55	229.08	263.32
84	182.30	208.45	239.59	205.97	235.51	270.69
85	186.71	214.05	246.03	210.95	241.84	277.95
86	191.59	219.64	252.46	216.47	248.17	285.21
87	196.37	225.13	258.80	221.90	254.40	292.37
88	201.25	230.72	265.24	227.42	260.73	299.74
89	206.32	236.53	271.88	233.13	267.26	307.21
90	211.47	242.44	278.64	238.92	273.90	314.78
91	216.72	248.45	285.60	244.89	280.75	322.67
92	222.15	254.68	292.78	251.04	287.80	330.86
93	227.67	261.01	300.06	257.29	294.96	339.06
94	233.38	267.56	307.56	263.71	302.33	347.46
95	239.18	274.21	315.16	270.23	309.80	356.07
96	245.17	281.07	323.07	277.02	317.58	365.00
97	251.33	288.14	331.20	283.99	325.57	374.23
98	257.60	295.31	339.43	291.04	333.66	383.57
99+	264.04	302.70	347.98	298.38	342.07	393.22

Open Enrollment or Guaranteed Issue: *Determine Underwriting Class based on Tobacco and HT/WT*
Underwritten: *Determine Underwriting Class based on Tobacco, HT/WT, and Preferred Select Medical Question*
See UW Guide for detailed instructions

Rate Calculator

Monthly Rate

A - Monthly Rate (use table above)		
B - Area Factor (see area factors below)		
C - Input Household Discount (1.0 if not applicable, 0.93 if roommate HHD applies, 0.9 if dual HHD applies)		
D - Input Activity Tracker Discount (1.0 if not applicable, 0.95 if discount applies)		
E - Input Annual Pay Discount (1.0 if not applicable, 0.9 if discount applies)		
F - Calculate Monthly Rate (rounded to the nearest penny)		F=A*B*C*D*E

Quarterly, Semi-Annual, or Annual Rate

G - Input Modal Factor (Quarterly - multiply by 3, Semi-Annual - multiply by 6, Annual - multiply by 12)		
H - Calculate Final Modal Billing Rate (rounded to the nearest penny)		H=F*G

Roommate Household Discount:	7%
Dual Household Discount (applies if multiple people in the same Household have or are applying for National General Medicare Supplement policies):	10%
Annual Pay Discount:	10%
Activity Tracker "Wearable" Discount:	5%

The rates above do not include a one time $25 policy fee.

Area Factors:

Kansas Zip Codes	Factor
Area 1: 660-662, 672	1.100
Area 2: All Other Zip Codes	1.060

AMERICAN HERITAGE LIFE INSURANCE COMPANY
Medicare Supplement Policy
2010 Standardized Plan N
Attained Age Premium Rates
Rates Effective Upon Approval

Attained	Female			Male		
Age	Preferred Select	Preferred	Standard	Preferred Select	Preferred	Standard
0-64	79.69		91.56	90.01		103.49
65	79.69		91.56	90.01		103.49
66	79.69		91.56	90.01		103.49
67	79.69	84.51	97.10	90.01	95.45	109.75
68	79.69	88.77	102.01	90.01	100.27	115.29
69	79.69	93.22	107.13	90.01	105.31	121.04
70	80.53	97.48	112.03	90.95	110.13	126.61
71	84.72	101.35	116.49	95.69	114.51	131.58
72	87.24	105.36	121.09	98.53	119.03	136.79
73	90.51	109.52	125.85	102.24	123.71	142.18
74	94.09	113.83	130.86	106.33	128.64	147.90
75	97.81	118.29	135.95	110.49	133.63	153.62
76	101.65	121.81	140.01	114.86	137.63	158.16
77	105.71	125.50	144.26	119.44	141.81	162.98
78	109.90	129.29	148.61	124.17	146.08	167.88
79	114.23	133.17	153.04	129.04	150.44	172.88
80	118.70	137.15	157.66	134.13	154.98	178.15
81	122.63	141.31	162.38	138.52	159.62	183.51
82	126.93	145.56	167.28	143.39	164.43	188.96
83	131.15	149.81	172.17	148.17	169.25	194.50
84	134.65	153.97	176.98	152.14	173.97	199.95
85	137.93	158.13	181.78	155.87	178.69	205.40
86	141.48	162.19	186.40	159.83	183.24	210.58
87	145.02	166.26	191.12	163.87	187.87	215.94
88	148.65	170.42	195.92	167.99	192.59	221.39
89	152.36	174.67	200.73	172.11	197.32	226.84
90	156.15	179.01	205.72	176.39	202.22	232.48
91	160.02	183.45	210.90	180.83	207.31	238.29
92	164.05	188.07	216.16	185.35	212.49	244.28
93	168.16	192.78	221.62	190.02	217.85	250.37
94	172.35	197.59	227.07	194.70	223.21	256.55
95	176.62	202.49	232.71	199.53	228.75	262.91
96	181.06	207.57	238.62	204.60	234.56	269.63
97	185.57	212.74	244.54	209.68	240.38	276.26
98	190.25	218.10	250.73	214.98	246.47	283.26
99+	195.00	223.56	256.92	220.29	252.55	290.25

Open Enrollment or Guaranteed Issue: *Determine Underwriting Class based on Tobacco and HT/WT*
Underwritten: *Determine Underwriting Class based on Tobacco, HT/WT, and Preferred Select Medical Question*
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Rate Calculator

Monthly Rate

A - Monthly Rate (use table above)		
B - Area Factor (see area factors below)		
C - Input Household Discount (1.0 if not applicable, 0.93 if roommate HHD applies, 0.9 if dual HHD applies)		
D - Input Activity Tracker Discount (1.0 if not applicable, 0.95 if discount applies)		
E - Input Annual Pay Discount (1.0 if not applicable, 0.9 if discount applies)		
F - Calculate Monthly Rate (rounded to the nearest penny)		F=A*B*C*D*E

Quarterly, Semi-Annual, or Annual Rate

G - Input Modal Factor (Quarterly - multiply by 3, Semi-Annual - multiply by 6, Annual - multiply by 12)		
H - Calculate Final Modal Billing Rate (rounded to the nearest penny)		H=F*G

Roommate Household Discount:	7%
Dual Household Discount (applies if multiple people in the same Household have or are applying for National General Medicare Supplement policies):	10%
Annual Pay Discount:	10%
Activity Tracker "Wearable" Discount:	5%

The rates above do not include a one time $25 policy fee.

Area Factors:

Kansas Zip Codes	Factor
Area 1: 660-662, 672	1.100
Area 2: All Other Zip Codes	1.060

PREMIUM INFORMATION
We, American Heritage Life Insurance Company, can only raise your premium if we raise the premium for all policies like yours in this State. We will not change the premiums for this policy during your first year of coverage. No rate adjustment may be made on an individual basis. Also, your renewal premiums may change on a renewal date following the Effective Date of any change in the deductible and/or coinsurance amounts which you are required to pay under Medicare. Any such premium change will be based on the actuarial computations that we then use to determine the renewal premium.

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 us at: 1776 American Heritage Life Drive, Jacksonville, Florida 32224. 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.

RENEWAL CONDITIONS
You may renew this Policy as long as You live by paying the premium on time. We cannot cancel or refuse to renew Your Policy, or place any restrictions on it, other than for non-payment or for fraudulent misstatements made by You in Your application for this Policy.

CANCELLATION BY YOU
You may cancel this Policy at any time by giving Us written notice. It will be effective when We receive notice or on a later date that you may specify. Upon cancellation or upon death, We will promptly return any unearned premium which will be based on a pro rata cancellation. Cancellation will not affect an existing claim.

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 American Heritage Life 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 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.

You have selected Plan _____ and the premium for the plan is $_____ monthly.

There is a $25 one-time policy fee.

Agents Name: (Print)_____

Agent's Address:_____

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1632	$0	$1632 (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 eligible expenses	$0***
-Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $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 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, 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 (continued)
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 a double 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 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 $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 Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare Approved Amounts**	$0	$0	$240 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
Part A & B			
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 or HIGH DEDUCTIBLE F
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2800 DEDUCTIBLE,** PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1632	$1632 (Part A deductible)	$0
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 eligible expenses	$0***
-Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient 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 or High Deductible F (continued)
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 a double 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 you have paid a calendar year $2800 deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $2800. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductible for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.*

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2800 DEDUCTIBLE** PLAN PAYS	YOU PAY
MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT 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 $240 of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	$0 Generally 80%	$240 (Part B Deductible) Generally 20%	$0 $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
Part A & B			
HOME HEALTH CARE - MEDICARE APPROVED SERVICES -Medically necessary skilled care services and medical supplies -Durable medical equipment First $240 of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	100% $0 80%	$0 $240 (Part B Deductible) 20%	$0 $0 $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 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 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 hot not received skilled care in any other facility for 60 days in a row..*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1632	$1632 (Part A deductible)	$0
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 eligible expenses	$0***
-Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient 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 (continued)

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 a double 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 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 $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	$0	All costs	$0
Next $240 of Medicare Approved Amounts**	$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			
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
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 N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1632	$1632 (Part A deductible)	$0
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 eligible expenses	$0***
-Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient 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 (continued)

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 a double 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 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 $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 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	$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
Part A & B			
HOME HEALTH CARE – MEDICARE APPROVED SERVICES -Medically necessary skilled care services and medical supplies -Durable medical equipment First $240 of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 $240 (Part B Deductible) $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 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