NATIONAL HEALTH 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. 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.

NATIONAL HEALTH INSURANCE COMPANY
Medicare Supplement Policy
2010 Standardized Plan A
Attained Age Premium Rates
Rates Effective Upon Approval

Attained Age	Female		Male	
	Preferred	Standard	Preferred	Standard
65	134.52	162.94	152.03	182.25
66	134.52	162.94	152.03	182.25
67	134.52	162.94	152.03	182.25
68	134.52	162.94	152.03	182.25
69	138.73	167.98	156.73	187.85
70	143.05	173.25	161.65	193.81
71	147.38	178.53	166.57	199.64
72	151.81	183.80	171.50	205.59
73	156.37	189.32	176.64	211.77
74	161.03	194.95	181.90	218.08
75	165.81	200.83	187.38	224.61
76	170.82	206.82	192.98	231.38
77	175.94	213.06	198.79	238.38
78	181.18	219.41	204.72	245.38
79	186.64	226.01	210.87	252.85
80	192.22	232.72	217.14	260.31
81	198.02	239.79	223.74	268.25
82	203.94	246.99	230.45	276.30
83	209.85	254.18	237.16	284.35
84	215.77	261.25	243.76	292.28
85	221.58	268.33	250.36	300.10
86	227.38	275.40	256.96	308.04
87	233.07	282.24	263.34	315.74
88	238.87	289.31	269.94	323.67
89	244.79	296.39	276.54	331.49
90	250.94	303.82	283.48	339.89
91	257.20	311.49	290.64	348.41
92	263.68	319.28	297.91	357.16
93	270.28	327.32	305.40	366.14
94	277.00	335.47	313.01	375.24
95	283.94	343.86	320.84	384.69
96	291.00	352.38	328.78	394.14
97	298.28	361.25	337.06	404.06
98	305.79	370.36	345.56	414.33
99+	313.42	379.59	354.18	424.60

Open Enrollment or Guaranteed Issue: *Select the lowest available rate based on age*
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 discount applies)
F - Calculate Monthly Rate (rounded to the nearest penny) F=A*B*C

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

Household Discount: 7%

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

Area Factors:

Nevada Zip Codes	Factor
Area 1: see rate area sheet for zip codes	1.380
Area 2: see rate area sheet for zip codes	1.260

NATIONAL HEALTH INSURANCE COMPANY
Medicare Supplement Policy
2010 Standardized Plan F
Attained Age Premium Rates
Rates Effective Upon Approval

Attained Age	Female		Male	
	Preferred	Standard	Preferred	Standard
65	171.05	207.12	193.26	231.69
66	171.05	207.12	193.26	231.69
67	171.05	207.12	193.26	231.69
68	171.05	207.12	193.26	231.69
69	176.31	213.48	199.18	238.78
70	181.80	220.18	205.43	246.31
71	187.28	226.76	211.58	253.61
72	192.87	233.58	217.94	261.26
73	198.68	240.62	224.51	269.13
74	204.60	247.78	231.20	277.22
75	210.74	255.18	238.09	285.43
76	217.10	262.92	245.31	294.09
77	223.57	270.77	252.64	302.85
78	230.26	278.86	260.19	311.96
79	237.17	287.18	267.95	321.18
80	244.29	295.84	276.03	330.96
81	251.64	304.73	284.33	340.85
82	259.21	313.86	292.85	351.08
83	266.77	323.10	301.47	361.42
84	274.23	332.11	309.88	371.54
85	281.68	341.12	318.28	381.55
86	289.03	350.02	326.58	391.55
87	296.27	358.80	334.77	401.33
88	303.72	367.81	343.18	411.45
89	311.29	376.93	351.70	421.68
90	319.07	386.41	360.54	432.25
91	327.08	396.11	369.59	443.04
92	335.30	406.04	378.86	454.17
93	343.63	416.09	388.24	465.41
94	352.19	426.49	397.94	477.10
95	360.96	437.12	407.85	488.91
96	369.95	447.98	417.98	501.05
97	379.16	459.18	428.44	513.64
98	388.59	470.62	439.11	526.45
99+	398.35	482.40	450.10	539.61

Open Enrollment or Guaranteed Issue: *Select the lowest available rate based on age*
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 discount applies)
F - Calculate Monthly Rate (rounded to the nearest penny) F=A*B*C

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

Household Discount: 7%

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

Area Factors:

Nevada Zip Codes	Factor
Area 1: see rate area sheet for zip codes	1.380
Area 2: see rate area sheet for zip codes	1.260

NATIONAL HEALTH INSURANCE COMPANY
Medicare Supplement Policy
2010 Standardized Plan High F
Attained Age Premium Rates
Rates Effective Upon Approval

Attained Age	Female		Male	
	Preferred	Standard	Preferred	Standard
65	53.57	64.83	60.49	72.51
66	53.57	64.83	60.49	72.51
67	53.57	64.83	60.49	72.51
68	53.57	64.83	60.49	72.51
69	55.23	66.93	62.45	74.89
70	56.89	68.91	64.29	77.05
71	58.55	70.89	66.14	79.32
72	60.32	72.99	68.10	81.70
73	62.09	75.21	70.17	84.08
74	63.97	77.42	72.24	86.58
75	65.85	79.75	74.41	89.19
76	67.84	82.20	76.70	91.91
77	69.83	84.53	78.87	94.52
78	71.94	87.10	81.27	97.47
79	74.15	89.78	83.77	100.42
80	76.36	92.46	86.27	103.37
81	78.69	95.26	88.88	106.55
82	81.01	98.06	91.49	109.72
83	83.34	100.97	94.21	112.90
84	85.66	103.77	96.82	116.08
85	87.98	106.57	99.43	119.26
86	90.31	109.37	102.05	122.32
87	92.52	112.05	104.55	125.38
88	94.85	114.85	107.16	128.45
89	97.17	117.65	109.77	131.62
90	99.61	120.56	112.49	134.91
91	102.15	123.71	115.43	138.43
92	104.70	126.74	118.26	141.72
93	107.35	130.01	121.30	145.47
94	110.01	133.27	124.35	149.10
95	112.78	136.54	127.39	152.73
96	115.54	139.92	130.55	156.47
97	118.42	143.41	133.81	160.44
98	121.41	147.03	137.19	164.42
99+	124.40	150.64	140.56	168.50

Open Enrollment or Guaranteed Issue: *Select the lowest available rate based on age*
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 discount applies)
F - Calculate Monthly Rate (rounded to the nearest penny) F=A*B*C

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

Household Discount: 7%

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

Area Factors:

Nevada Zip Codes	Factor
Area 1: see rate area sheet for zip codes	1.380
Area 2: see rate area sheet for zip codes	1.260

NATIONAL HEALTH INSURANCE COMPANY
Medicare Supplement Policy
2010 Standardized Plan G
Attained Age Premium Rates
Rates Effective Upon Approval

Attained Age	Female		Male	
	Preferred	Standard	Preferred	Standard
65	138.76	168.01	156.76	187.96
66	138.76	168.01	156.76	187.96
67	138.76	168.01	156.76	187.96
68	138.76	168.01	156.76	187.96
69	143.04	173.22	161.63	193.73
70	147.43	178.56	166.60	199.73
71	151.82	183.89	171.58	205.73
72	156.32	189.35	176.67	211.84
73	161.05	195.04	181.98	218.19
74	165.88	200.85	187.40	224.65
75	170.84	206.90	193.04	231.46
76	176.01	213.18	198.91	238.50
77	181.30	219.58	204.88	245.65
78	186.70	226.10	210.97	252.92
79	192.33	232.86	217.27	260.42
80	198.07	239.86	223.80	268.27
81	204.03	247.09	230.54	276.34
82	210.11	254.44	237.40	284.65
83	216.19	261.79	244.26	292.84
84	222.27	269.14	251.12	301.04
85	228.23	276.37	257.87	309.11
86	234.19	283.61	264.62	317.19
87	240.05	290.72	271.26	325.15
88	246.01	297.95	278.00	333.34
89	252.20	305.42	284.97	341.65
90	258.50	313.01	292.05	350.07
91	264.92	320.84	299.36	358.84
92	271.56	328.90	306.88	367.96
93	278.31	337.08	314.51	377.07
94	285.29	345.50	322.37	386.42
95	292.38	354.03	330.33	396.00
96	299.69	362.93	338.63	405.92
97	307.23	372.06	347.15	416.19
98	314.89	381.30	355.78	426.57
99+	322.76	390.91	364.74	437.30

Open Enrollment or Guaranteed Issue: *Select the lowest available rate based on age*
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 discount applies)
F - Calculate Monthly Rate (rounded to the nearest penny) F=A*B*C

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

Household Discount: 7%

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

Area Factors:

Nevada Zip Codes	Factor
Area 1: see rate area sheet for zip codes	1.380
Area 2: see rate area sheet for zip codes	1.260

NATIONAL HEALTH INSURANCE COMPANY
Medicare Supplement Policy
2010 Standardized Plan N
Attained Age Premium Rates
Rates Effective Upon Approval

Attained Age	Female		Male	
	Preferred	Standard	Preferred	Standard
65	115.10	139.33	130.01	155.91
66	115.10	139.33	130.01	155.91
67	115.10	139.33	130.01	155.91
68	115.10	139.33	130.01	155.91
69	118.64	143.65	134.03	160.67
70	122.29	148.08	138.16	165.66
71	125.94	152.51	142.30	170.54
72	129.71	157.06	146.54	175.65
73	133.58	161.72	150.89	180.87
74	137.57	166.62	155.46	186.43
75	141.66	171.51	160.03	191.88
76	145.87	176.64	164.82	197.55
77	150.29	182.01	169.82	203.56
78	154.83	187.49	174.94	209.69
79	159.48	193.08	180.16	215.93
80	164.24	198.91	185.60	222.51
81	169.22	204.86	191.15	229.21
82	174.31	211.04	196.91	236.02
83	179.40	217.22	202.68	242.94
84	184.38	223.28	208.33	249.74
85	189.36	229.35	213.99	256.55
86	194.23	235.18	219.43	263.02
87	199.10	241.12	224.98	269.72
88	204.08	247.19	230.64	276.52
89	209.17	253.25	236.29	283.33
90	214.37	259.54	242.17	290.37
91	219.68	266.07	248.26	297.63
92	225.22	272.72	254.46	305.12
93	230.86	279.60	260.88	312.72
94	236.62	286.48	267.30	320.44
95	242.48	293.59	273.93	328.38
96	248.57	301.05	280.90	336.77
97	254.77	308.51	287.86	345.06
98	261.19	316.33	295.15	353.80
99+	267.72	324.14	302.44	362.53

Open Enrollment or Guaranteed Issue: *Select the lowest available rate based on age*
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 discount applies)		
F - Calculate Monthly Rate (rounded to the nearest penny)		F=A*B*C

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

Household Discount: 7%

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

Area Factors:

Nevada Zip Codes	Factor
Area 1: see rate area sheet for zip codes	1.380
Area 2: see rate area sheet for zip codes	1.260

Rate Areas by Zip Code

Area 1:	89001	89003	89007	89008	89010	89013	89017	89020
89021	89022	89023	89024	89025	89027	89034	89040	89041
89042	89043	89045	89047	89048	89049	89060	89061	89067
89301	89310	89311	89314	89315	89316	89317	89318	89319
89404	89405	89406	89407	89409	89412	89414	89415	89418
89419	89420	89421	89422	89425	89426	89427	89430	89437
89438	89444	89445	89446	89447	89496	89820	89821	89834

Area 2: All Other Zip Codes

PREMIUM INFORMATION

We, National Health 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. Thereafter your premium will increase each year based on your age at that time. 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.

DISCLOSURES

Use this outline to compare benefits and premiums among policies, certificates and contracts.

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: PO Box 1070, Winston-Salem, NC 27102-1070. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued, and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs. Neither National Health 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 "The Medicare Handbook″ for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

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

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

SERVICES	MEDICARE PAYS	PLAN 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 and 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	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		$816 a day	
-While using 60 lifetime reserve days	All but $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 and 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.*

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%	$240 (Part B Deductible) Generally 20%	$0 $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	$240 (Part B Deductible)	$0
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	$240 (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 service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

*** This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $2800 deductible. Benefits from the high deductible plan G will not begin until out-of-pocket expenses are $2800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.*

SERVICES	MEDICARE PAYS	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 Additional	$0 100%	3 pints	$0
amounts		$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.*

*** This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $2800 deductible. Benefits from the high deductible plan G will not begin until out-of-pocket expenses are $2800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.*

SERVICES	MEDICARE PAYS	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,	$0	$0	$240 (Unless Part B Deductible has been met)
First $240 of Medicare Approved Amounts **			
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
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 (Unless Part B Deductible has been met)
Remainder of Medicare Approved Amounts	80%	20%	$0
Other Benefits - Not Covered by Medicare			
FOREIGN TRAVEL- NOTCOVERED BYMEDICARE, 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 All but $204 a day	$0 Up to $204 a day	$0 $0
21st thru 100th day	$0	$0	All costs
101st day and after			
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 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 **	$0	$0	$240 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
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
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