

WMI MUTUAL INSURANCE™ COMPANY
Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020
Benefit Plan(s) **A, C, F, G and N**

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 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 [2023] ²					[\$6940] ²	[\$3470] ²				

¹ Plans F and G also have a high deductible option which require first paying a plan deductible of [\$2490] 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 \$20 for some office visits and a \$50 co-payment for emergency room visits that do not result in an inpatient admission.

PREMIUM INFORMATION

The monthly Preferred rates below are for applicants who are in their open enrollment period (non-smoker only), who qualify for guarantee issue (non-smoker only), or who qualify for a Preferred rate upon completion of underwriting.

2019 Preferred Rates PPPM			Outside of Maricopa County							
Arizona	A		C		F*		G*		N	
Issue Age	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
65	\$92	\$102	\$134	\$148	\$140	\$154	\$133	\$147	\$89	\$99
66	\$96	\$106	\$140	\$154	\$146	\$161	\$138	\$153	\$93	\$103
67	\$100	\$110	\$145	\$161	\$152	\$168	\$144	\$159	\$96	\$106
68	\$104	\$115	\$151	\$167	\$158	\$174	\$150	\$166	\$100	\$110
69	\$108	\$119	\$157	\$173	\$164	\$181	\$155	\$172	\$104	\$114
70	\$112	\$123	\$163	\$180	\$170	\$187	\$161	\$178	\$106	\$118
71	\$116	\$128	\$168	\$186	\$176	\$194	\$167	\$184	\$111	\$123
72	\$120	\$132	\$174	\$193	\$182	\$201	\$172	\$191	\$115	\$127
73	\$124	\$137	\$180	\$199	\$188	\$207	\$178	\$197	\$119	\$131
74	\$127	\$141	\$186	\$205	\$194	\$214	\$184	\$203	\$124	\$137
75	\$131	\$145	\$191	\$212	\$200	\$221	\$190	\$210	\$127	\$141
76	\$135	\$150	\$197	\$218	\$206	\$227	\$195	\$216	\$131	\$145
77	\$139	\$154	\$203	\$224	\$212	\$234	\$201	\$222	\$135	\$149
78	\$143	\$158	\$209	\$231	\$218	\$240	\$207	\$228	\$138	\$152
79	\$147	\$163	\$214	\$237	\$224	\$247	\$212	\$235	\$142	\$156
80	\$151	\$167	\$220	\$243	\$229	\$254	\$218	\$241	\$145	\$161
81	\$155	\$172	\$226	\$250	\$236	\$260	\$224	\$247	\$149	\$165
82	\$159	\$176	\$232	\$257	\$242	\$267	\$230	\$254	\$153	\$169
83	\$164	\$181	\$238	\$263	\$248	\$275	\$236	\$261	\$158	\$174
84	\$168	\$186	\$245	\$270	\$255	\$282	\$242	\$268	\$162	\$179
85+	\$172	\$191	\$251	\$278	\$262	\$289	\$249	\$275	\$165	\$183

*Plans F and G do not include the high deductible option.

2019 Preferred Rates PPM			Maricopa County							
Arizona	A		C		F*		G*		N	
Issue Age	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
65	\$101	\$112	\$147	\$163	\$154	\$170	\$146	\$161	\$98	\$108
66	\$106	\$117	\$154	\$170	\$160	\$177	\$152	\$168	\$102	\$112
67	\$110	\$121	\$160	\$177	\$167	\$184	\$158	\$175	\$105	\$117
68	\$114	\$126	\$166	\$184	\$173	\$192	\$165	\$182	\$109	\$121
69	\$119	\$131	\$173	\$191	\$180	\$199	\$171	\$189	\$113	\$125
70	\$123	\$136	\$179	\$198	\$187	\$206	\$177	\$196	\$117	\$129
71	\$127	\$141	\$185	\$205	\$193	\$214	\$183	\$203	\$122	\$134
72	\$132	\$145	\$192	\$212	\$200	\$221	\$190	\$210	\$126	\$140
73	\$136	\$150	\$198	\$219	\$206	\$228	\$196	\$217	\$131	\$145
74	\$140	\$155	\$204	\$226	\$213	\$235	\$202	\$224	\$135	\$149
75	\$145	\$160	\$211	\$233	\$220	\$243	\$209	\$230	\$140	\$154
76	\$149	\$165	\$217	\$240	\$226	\$250	\$215	\$237	\$143	\$159
77	\$153	\$169	\$223	\$247	\$233	\$257	\$221	\$244	\$147	\$163
78	\$158	\$174	\$230	\$254	\$239	\$264	\$227	\$251	\$151	\$167
79	\$162	\$179	\$236	\$261	\$246	\$272	\$234	\$258	\$156	\$172
80	\$166	\$184	\$242	\$268	\$252	\$279	\$240	\$265	\$160	\$176
81	\$171	\$189	\$249	\$275	\$259	\$286	\$246	\$272	\$164	\$182
82	\$175	\$194	\$255	\$282	\$266	\$294	\$253	\$279	\$168	\$186
83	\$180	\$199	\$262	\$290	\$273	\$302	\$260	\$287	\$173	\$191
84	\$185	\$204	\$269	\$297	\$281	\$310	\$267	\$295	\$177	\$195
85+	\$190	\$210	\$276	\$305	\$288	\$318	\$274	\$302	\$181	\$201

*Plans F and G do not include the high deductible option.

The monthly Standard rates below are for applicants who are in their open enrollment period (smoker only), who qualify for guarantee issue (smoker only), who are not in their open enrollment period, who do not qualify for guarantee issue, who do not qualify for a Preferred rate, but who qualify for a Standard rate upon completion of underwriting.

2019 Standard Rates PPPM			Outside of Maricopa County							
Arizona	A		C		F*		G*		N	
Issue Age	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
65	\$115	\$127	\$167	\$185	\$175	\$193	\$166	\$183	\$112	\$124
66	\$120	\$133	\$175	\$193	\$182	\$201	\$173	\$191	\$116	\$128
67	\$125	\$138	\$182	\$201	\$190	\$210	\$180	\$199	\$120	\$132
68	\$130	\$143	\$189	\$209	\$197	\$218	\$187	\$207	\$124	\$138
69	\$135	\$149	\$196	\$217	\$205	\$226	\$194	\$215	\$129	\$143
70	\$140	\$154	\$203	\$225	\$212	\$234	\$201	\$223	\$133	\$147
71	\$145	\$160	\$211	\$233	\$220	\$243	\$209	\$230	\$139	\$153
72	\$150	\$165	\$218	\$241	\$227	\$251	\$216	\$238	\$143	\$159
73	\$154	\$171	\$225	\$249	\$234	\$259	\$223	\$246	\$148	\$164
74	\$159	\$176	\$232	\$257	\$242	\$267	\$230	\$254	\$154	\$170
75	\$164	\$182	\$239	\$264	\$249	\$276	\$237	\$262	\$160	\$176
76	\$169	\$187	\$246	\$272	\$257	\$284	\$244	\$270	\$163	\$181
77	\$174	\$192	\$254	\$280	\$264	\$292	\$251	\$278	\$168	\$186
78	\$179	\$198	\$261	\$288	\$272	\$301	\$258	\$285	\$172	\$190
79	\$184	\$203	\$268	\$296	\$279	\$309	\$265	\$293	\$177	\$195
80	\$189	\$209	\$275	\$304	\$287	\$317	\$272	\$301	\$181	\$201
81	\$194	\$214	\$283	\$312	\$295	\$326	\$280	\$309	\$186	\$206
82	\$199	\$220	\$290	\$321	\$302	\$334	\$287	\$318	\$191	\$211
83	\$205	\$226	\$298	\$329	\$311	\$343	\$295	\$326	\$197	\$217
84	\$210	\$232	\$306	\$338	\$319	\$352	\$303	\$335	\$201	\$223
85+	\$216	\$238	\$314	\$347	\$327	\$362	\$311	\$344	\$207	\$229

*Plans F and G do not include the high deductible option.

2019 Standard Rates PPPM			Maricopa County							
Arizona	A		C		F*		G*		N	
Issue Age	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
65	\$127	\$140	\$184	\$204	\$192	\$212	\$182	\$202	\$123	\$135
66	\$132	\$146	\$192	\$212	\$200	\$221	\$190	\$210	\$127	\$141
67	\$137	\$152	\$200	\$221	\$209	\$230	\$198	\$219	\$132	\$146
68	\$143	\$158	\$208	\$230	\$217	\$240	\$206	\$228	\$137	\$151
69	\$148	\$164	\$216	\$239	\$225	\$249	\$214	\$236	\$142	\$156
70	\$154	\$170	\$224	\$247	\$233	\$258	\$222	\$245	\$146	\$162
71	\$159	\$176	\$232	\$256	\$241	\$267	\$229	\$254	\$152	\$168
72	\$164	\$182	\$240	\$265	\$250	\$276	\$237	\$262	\$158	\$174
73	\$170	\$188	\$247	\$273	\$258	\$285	\$245	\$271	\$163	\$181
74	\$175	\$194	\$255	\$282	\$266	\$294	\$253	\$279	\$169	\$187
75	\$181	\$200	\$263	\$291	\$274	\$303	\$261	\$288	\$175	\$193
76	\$186	\$206	\$271	\$300	\$283	\$312	\$268	\$297	\$180	\$198
77	\$192	\$212	\$279	\$308	\$291	\$321	\$276	\$305	\$184	\$204
78	\$197	\$218	\$287	\$317	\$299	\$331	\$284	\$314	\$189	\$209
79	\$202	\$224	\$295	\$326	\$307	\$340	\$292	\$323	\$195	\$215
80	\$208	\$230	\$303	\$335	\$316	\$349	\$300	\$331	\$200	\$221
81	\$213	\$236	\$311	\$344	\$324	\$358	\$308	\$340	\$205	\$227
82	\$219	\$242	\$319	\$353	\$333	\$368	\$316	\$349	\$210	\$232
83	\$225	\$249	\$328	\$362	\$342	\$378	\$324	\$359	\$216	\$238
84	\$231	\$255	\$336	\$372	\$351	\$388	\$333	\$368	\$221	\$245
85+	\$237	\$262	\$345	\$382	\$360	\$398	\$342	\$378	\$227	\$251

*Plans F and G do not include the high deductible option.

The monthly Non-Standard rates below are for applicants who are not in their open enrollment period, who do not qualify for guarantee issue, who do not qualify for a Preferred rate or a Standard rate, but who qualify for a Non-Standard rate upon completion of underwriting.

2019 Non-Standard Rates PPPN			Outside of Maricopa County							
Arizona	A		C		F*		G*		N	
Issue Age	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
65	\$155	\$172	\$226	\$250	\$236	\$261	\$224	\$247	\$151	\$167
66	\$162	\$179	\$236	\$261	\$246	\$272	\$234	\$258	\$157	\$173
67	\$169	\$186	\$246	\$271	\$256	\$283	\$243	\$269	\$162	\$179
68	\$175	\$194	\$255	\$282	\$266	\$294	\$253	\$279	\$168	\$186
69	\$182	\$201	\$265	\$293	\$276	\$305	\$262	\$290	\$175	\$193
70	\$189	\$208	\$275	\$303	\$286	\$316	\$272	\$301	\$180	\$198
71	\$195	\$216	\$284	\$314	\$296	\$328	\$281	\$311	\$187	\$207
72	\$202	\$223	\$294	\$325	\$306	\$339	\$291	\$322	\$194	\$214
73	\$208	\$230	\$304	\$336	\$317	\$350	\$301	\$332	\$200	\$222
74	\$215	\$238	\$313	\$346	\$327	\$361	\$310	\$343	\$208	\$230
75	\$222	\$245	\$323	\$357	\$337	\$372	\$320	\$354	\$216	\$238
76	\$228	\$252	\$333	\$368	\$347	\$383	\$329	\$364	\$220	\$244
77	\$235	\$260	\$342	\$378	\$357	\$395	\$339	\$375	\$227	\$251
78	\$242	\$267	\$352	\$389	\$367	\$406	\$349	\$385	\$232	\$256
79	\$248	\$275	\$362	\$400	\$377	\$417	\$358	\$396	\$238	\$264
80	\$255	\$282	\$371	\$411	\$387	\$428	\$368	\$407	\$245	\$271
81	\$262	\$289	\$381	\$422	\$398	\$440	\$378	\$417	\$252	\$278
82	\$269	\$297	\$392	\$433	\$408	\$451	\$388	\$429	\$257	\$285
83	\$276	\$305	\$402	\$444	\$419	\$463	\$398	\$440	\$265	\$293
84	\$283	\$313	\$413	\$456	\$430	\$476	\$409	\$452	\$272	\$300
85+	\$291	\$322	\$424	\$469	\$442	\$489	\$420	\$464	\$279	\$309

*Plans F and G do not include the high deductible option.

2019 Non-Standard Rates PPPM			Maricopa County							
Arizona	A		C		F*		G*		N	
Issue Age	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
65	\$171	\$189	\$249	\$275	\$259	\$287	\$246	\$272	\$165	\$183
66	\$178	\$197	\$259	\$287	\$270	\$299	\$257	\$284	\$172	\$190
67	\$185	\$205	\$270	\$298	\$282	\$311	\$267	\$296	\$179	\$197
68	\$193	\$213	\$281	\$310	\$293	\$323	\$278	\$307	\$184	\$204
69	\$200	\$221	\$291	\$322	\$304	\$336	\$289	\$319	\$191	\$211
70	\$207	\$229	\$302	\$334	\$315	\$348	\$299	\$331	\$198	\$218
71	\$215	\$237	\$313	\$346	\$326	\$360	\$310	\$342	\$205	\$227
72	\$222	\$245	\$323	\$357	\$337	\$373	\$320	\$354	\$213	\$235
73	\$229	\$253	\$334	\$369	\$348	\$385	\$331	\$366	\$220	\$244
74	\$237	\$262	\$345	\$381	\$359	\$397	\$341	\$377	\$228	\$252
75	\$244	\$270	\$355	\$393	\$370	\$409	\$352	\$389	\$236	\$260
76	\$251	\$278	\$366	\$405	\$382	\$422	\$362	\$401	\$242	\$268
77	\$259	\$286	\$377	\$416	\$393	\$434	\$373	\$412	\$249	\$275
78	\$266	\$294	\$387	\$428	\$404	\$446	\$384	\$424	\$256	\$282
79	\$273	\$302	\$398	\$440	\$415	\$459	\$394	\$436	\$263	\$291
80	\$281	\$310	\$409	\$452	\$426	\$471	\$405	\$447	\$270	\$298
81	\$288	\$318	\$420	\$464	\$437	\$483	\$415	\$459	\$277	\$307
82	\$296	\$327	\$431	\$476	\$449	\$496	\$427	\$472	\$283	\$313
83	\$304	\$336	\$442	\$489	\$461	\$510	\$438	\$484	\$291	\$321
84	\$312	\$345	\$454	\$502	\$474	\$523	\$450	\$497	\$299	\$331
85+	\$320	\$354	\$466	\$515	\$486	\$537	\$462	\$510	\$307	\$339

*Plans F and G do not include the high deductible option.

PREMIUM INFORMATION

We, WMI Mutual Insurance Company (“WMI”) can only raise your premium if we raise the premium for all policies like yours in this state.

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 WMI, PO Box 572450, Salt Lake City, UT, 84157-2450. If you send the policy back to us within thirty (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 WMI nor its agents are connected with Medicare.

This outline 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 truthfully and completely answer all questions about your medical and health history. WMI 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 received 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 consecutive days.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1,632]	\$0	\$[1,632] (Part A deductible)
61st through 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 through 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/co-insurance for outpatient drugs and respite care	Medicare copayment/co-insurance	\$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 \$[240] of Medicare-approved amounts for covered services equal to the Part B deductible (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 \$[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

PLAN A

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 C

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 consecutive days.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1,632]	\$[1,632] (Part A Deductible)	\$0
61st through 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 through 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/co-insurance for outpatient drugs and respite care	Medicare copayment/co-insurance	\$0

**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 SERVICE – PER CALENDAR YEAR

* Once you have been billed \$[240] of Medicare-approved amounts for covered services equal to the Part B deductible (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 \$[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	\$0	All costs
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

PLAN C

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 C

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 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 consecutive days.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1,632]	\$[1,632] (Part A Deductible)	\$0
61st through 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 through 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/co-insurance for outpatient drugs and respite care	Medicare copayment/co-insurance	\$0

**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 equal to the Part B deductible (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 \$[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	\$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

PLAN F

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

* 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 consecutive days.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1,632]	\$[1,632] (Part A Deductible)	\$0
61st through 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 through 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/co-insurance for outpatient drugs and respite care	Medicare copayment/co-insurance	\$0

**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 equal to the Part B deductible (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 \$[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

PLAN G

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	\$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 consecutive days.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1,632]	\$[1,632] (Part A Deductible)	\$0
61st through 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 through 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/co-insurance for outpatient drugs and respite care	Medicare copayment/co-insurance	\$0

**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 equal to the Part B deductible (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 \$[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 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.	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.
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] (Part B Deductible)
Remainder of Medicare approved amounts	80%	20%	\$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	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 N

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