HealthSpring℠ Medicare Supplement Insurance
Loyal American Life Insurance Company

Outline of Coverage and Rates for District of Columbia Residents

Medicare Supplement benefit plans A, F, G, and N

HealthSpring℠

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LOYAL AMERICAN LIFE INSURANCE COMPANY
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Outline of Medicare Supplement Coverage – Benefit Plans A, F, G, and N

This chart shows the benefits included in each of the standard Medicare Supplement plans. Every company must make Plan A available. Some plans may not be available in your state. Only Applicants first eligible for Medicare before 2020 may purchase Plans C, F, and high-deductible F.

Benefits	Note: A ✓ means 100% of the benefit is paid Plans available								Plans available only if first Medicare eligible before 2020		
	A	B	D	G[1]	HDG[1]	K	L	M	N	C	F[1]	HDF[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 2026[2]						$8,000[2]	$4,000[2]					

[1]Plans F and G also have a high-deductible option which requires first paying a plan deductible of $2,950 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. These expenses include the Medicare deductibles for Part A and Part B, but do not include the Plan's separate foreign travel emergency 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 copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that do not result in an inpatient admission.

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Locate appropriate Area according to the Applicant's ZIP Code in the ZIP Code chart below.

DISTRICT OF COLUMBIA ZIP CODES

Area	**3-digit ZIP Codes**
Area I	200–205

Loyal American Life Insurance Company

MEDICARE SUPPLEMENT

DISTRICT OF COLUMBIA

Attained Age Rates -- Effective 11/1/2026 -- Area I (200-205)

PREFERRED ANNUAL & MONTHLY BANK DRAFT RATES

FEMALE RATES									MALE RATES							
Plan A		Plan F		Plan G		Plan N		Attained	Plan A		Plan F		Plan G		Plan N	
Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly	Age	Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly
2,849.01	237.32	3,510.90	292.46	2,362.73	196.82	1,805.62	150.41	**65**	3,276.37	272.92	4,037.52	336.33	2,717.14	226.34	2,076.46	172.97
2,849.01	237.32	3,510.90	292.46	2,362.73	196.82	1,805.62	150.41	**66**	3,276.37	272.92	4,037.52	336.33	2,717.14	226.34	2,076.46	172.97
2,977.25	248.00	3,663.89	305.20	2,477.70	206.39	1,890.35	157.47	**67**	3,423.84	285.21	4,213.46	350.98	2,849.36	237.35	2,173.88	181.08
3,104.01	258.56	3,809.95	317.37	2,587.49	215.54	1,972.47	164.31	**68**	3,569.59	297.35	4,381.47	364.98	2,975.61	247.87	2,268.33	188.95
3,228.50	268.93	3,959.43	329.82	2,699.83	224.90	2,054.60	171.15	**69**	3,712.78	309.27	4,553.35	379.29	3,104.78	258.63	2,362.79	196.82
3,349.04	278.98	4,098.36	341.39	2,804.22	233.59	2,131.94	177.59	**70**	3,851.39	320.82	4,713.11	392.60	3,224.84	268.63	2,451.73	204.23
3,449.14	287.31	4,232.55	352.57	2,905.06	241.99	2,209.65	184.06	**71**	3,966.50	330.41	4,867.42	405.46	3,340.82	278.29	2,541.10	211.67
3,549.25	295.65	4,366.71	363.75	3,005.90	250.39	2,287.34	190.54	**72**	4,081.62	340.00	5,021.74	418.31	3,456.79	287.95	2,630.44	219.12
3,649.35	303.99	4,500.90	374.92	3,106.73	258.79	2,365.02	197.01	**73**	4,196.75	349.59	5,176.05	431.16	3,572.74	297.61	2,719.78	226.56
3,749.45	312.33	4,635.09	386.10	3,207.57	267.19	2,442.73	203.48	**74**	4,311.87	359.18	5,330.34	444.02	3,688.71	307.27	2,809.12	234.00
3,853.40	320.99	4,774.04	397.68	3,311.72	275.87	2,522.94	210.16	**75**	4,431.40	369.14	5,490.15	457.33	3,808.49	317.25	2,901.37	241.68
3,943.10	328.46	4,917.67	409.64	3,416.91	284.63	2,607.44	217.20	**76**	4,534.58	377.73	5,655.33	471.09	3,929.44	327.32	2,998.54	249.78
4,034.23	336.05	5,063.68	421.80	3,523.85	293.54	2,693.35	224.36	**77**	4,639.35	386.46	5,823.24	485.08	4,052.43	337.57	3,097.36	258.01
4,130.85	344.10	5,217.30	434.60	3,636.19	302.89	2,783.49	231.86	**78**	4,750.48	395.71	5,999.88	499.79	4,181.62	348.33	3,201.01	266.64
4,229.11	352.28	5,373.67	447.63	3,750.58	312.42	2,875.28	239.51	**79**	4,863.48	405.13	6,179.72	514.77	4,313.17	359.29	3,306.58	275.44
4,329.05	360.61	5,532.85	460.89	3,867.04	322.12	2,968.77	247.30	**80**	4,978.41	414.70	6,362.77	530.02	4,447.09	370.44	3,414.08	284.39
4,441.29	369.96	5,728.70	477.20	4,009.25	333.97	3,086.30	257.09	**81**	5,107.49	425.45	6,588.01	548.78	4,610.65	384.07	3,549.25	295.65
4,555.62	379.48	5,928.47	493.84	4,154.34	346.06	3,206.24	267.08	**82**	5,238.97	436.41	6,817.73	567.92	4,777.49	397.96	3,687.18	307.14
4,676.67	389.57	6,138.23	511.31	4,306.56	358.74	3,331.91	277.55	**83**	5,378.19	448.00	7,058.97	588.01	4,952.56	412.55	3,831.70	319.18
4,800.10	399.85	6,352.46	529.16	4,462.06	371.69	3,460.29	288.24	**84**	5,520.12	459.83	7,305.35	608.54	5,131.37	427.44	3,979.34	331.48
4,925.94	410.33	6,571.25	547.39	4,620.86	384.92	3,591.46	299.17	**85**	5,664.83	471.88	7,556.94	629.49	5,313.99	442.66	4,130.17	344.04
5,060.42	421.53	6,802.03	566.61	4,787.01	398.76	3,727.99	310.54	**86**	5,819.46	484.76	7,822.34	651.60	5,505.05	458.57	4,287.20	357.12
5,198.11	433.00	7,038.98	586.35	4,957.64	412.97	3,868.28	322.23	**87**	5,977.82	497.95	8,094.83	674.30	5,701.28	474.92	4,448.53	370.56
5,339.12	444.75	7,282.27	606.61	5,132.86	427.57	4,012.42	334.23	**88**	6,139.99	511.46	8,374.62	697.61	5,902.78	491.70	4,614.27	384.37
5,478.15	456.33	7,524.65	626.80	5,307.56	442.12	4,156.39	346.23	**89**	6,299.87	524.78	8,653.33	720.82	6,103.68	508.44	4,779.85	398.16
5,614.83	467.72	7,765.49	646.87	5,481.33	456.59	4,299.87	358.18	**90**	6,457.07	537.87	8,930.32	743.90	6,303.52	525.08	4,944.86	411.91
5,747.76	478.79	8,012.56	667.45	5,658.96	471.39	4,447.89	370.51	**91**	6,609.93	550.61	9,214.44	767.56	6,507.80	542.10	5,115.07	426.09
5,883.21	490.07	8,264.75	688.45	5,840.29	486.50	4,599.02	383.10	**92**	6,765.67	563.58	9,504.45	791.72	6,716.35	559.47	5,288.87	440.56
6,009.29	500.57	8,505.28	708.49	6,013.49	500.92	4,743.95	395.17	**93**	6,910.70	575.66	9,781.07	814.76	6,915.52	576.06	5,455.54	454.45
6,137.45	511.25	8,750.14	728.89	6,189.80	515.61	4,891.50	407.46	**94**	7,058.07	587.94	10,062.66	838.22	7,118.26	592.95	5,625.22	468.58
6,267.70	522.10	8,999.34	749.65	6,369.24	530.56	5,041.74	419.98	**95**	7,207.86	600.41	10,349.22	862.09	7,324.62	610.14	5,797.99	482.97
6,393.06	532.54	9,179.32	764.64	6,496.62	541.17	5,142.58	428.38	**96**	7,352.02	612.42	10,556.23	879.33	7,471.11	622.34	5,913.95	492.63
6,520.93	543.19	9,362.90	779.93	6,626.56	551.99	5,245.43	436.94	**97**	7,499.05	624.67	10,767.34	896.92	7,620.55	634.79	6,032.23	502.48
6,651.35	554.06	9,550.17	795.53	6,759.08	563.03	5,350.33	445.68	**98**	7,649.04	637.17	10,982.69	914.86	7,772.96	647.49	6,152.87	512.53
6,784.37	565.14	9,741.18	811.44	6,894.28	574.29	5,457.34	454.60	**99**	7,802.02	649.91	11,202.35	933.16	7,928.42	660.44	6,275.93	522.78

Policies may be issued on an annual, semi-annual, quarterly or monthly mode. To obtain semi-annual premiums, multiply the above-quoted annual premium by 0.52. To obtain quarterly premiums, multiply the above quoted annual premium by 0.265. Applicants who qualify for Household Discount multiply above rates by 0.93. Add one-time enrollment fee of $20.00 to the first premium.

Loyal American Life Insurance Company

MEDICARE SUPPLEMENT

DISTRICT OF COLUMBIA

Attained Age Rates -- Effective 11/1/2026 -- Area I (200-205)

STANDARD ANNUAL & MONTHLY BANK DRAFT RATES

FEMALE RATES									MALE RATES							
Plan A		Plan F		Plan G		Plan N		Attained	Plan A		Plan F		Plan G		Plan N	
Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly	Age	Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly
3,133.91	261.05	3,861.99	321.70	2,599.01	216.50	1,986.17	165.45	**65**	3,604.02	300.21	4,441.27	369.96	2,988.85	248.97	2,284.10	190.27
3,133.91	261.05	3,861.99	321.70	2,599.01	216.50	1,986.17	165.45	**66**	3,604.02	300.21	4,441.27	369.96	2,988.85	248.97	2,284.10	190.27
3,274.99	272.81	4,030.26	335.72	2,725.48	227.03	2,079.38	173.21	**67**	3,766.24	313.73	4,634.82	386.08	3,134.30	261.09	2,391.28	199.19
3,414.41	284.42	4,190.96	349.11	2,846.24	237.09	2,169.71	180.74	**68**	3,926.56	327.08	4,819.60	401.47	3,273.16	272.65	2,495.16	207.85
3,551.35	295.83	4,355.39	362.80	2,969.80	247.38	2,260.05	188.26	**69**	4,084.06	340.20	5,008.70	417.22	3,415.28	284.49	2,599.07	216.50
3,683.94	306.87	4,508.18	375.53	3,084.64	256.95	2,345.14	195.35	**70**	4,236.52	352.90	5,184.42	431.86	3,547.33	295.49	2,696.91	224.65
3,794.04	316.04	4,655.80	387.83	3,195.56	266.19	2,430.60	202.47	**71**	4,363.16	363.45	5,354.17	446.00	3,674.90	306.12	2,795.20	232.84
3,904.16	325.22	4,803.39	400.12	3,306.48	275.43	2,516.08	209.59	**72**	4,489.80	374.00	5,523.90	460.14	3,802.45	316.74	2,893.47	241.03
4,014.27	334.39	4,951.00	412.42	3,417.42	284.67	2,601.53	216.71	**73**	4,616.41	384.55	5,693.64	474.28	3,930.02	327.37	2,991.77	249.21
4,124.39	343.56	5,098.59	424.71	3,528.34	293.91	2,686.99	223.83	**74**	4,743.05	395.10	5,863.39	488.42	4,057.59	338.00	3,090.04	257.40
4,238.74	353.09	5,251.45	437.45	3,642.89	303.45	2,775.23	231.18	**75**	4,874.56	406.05	6,039.17	503.06	4,189.34	348.97	3,191.52	265.85
4,337.42	361.31	5,409.42	450.60	3,758.60	313.09	2,868.17	238.92	**76**	4,988.04	415.50	6,220.84	518.20	4,322.38	360.05	3,298.40	274.76
4,437.64	369.66	5,570.05	463.99	3,876.24	322.89	2,962.68	246.79	**77**	5,103.28	425.10	6,405.56	533.58	4,457.67	371.32	3,407.09	283.81
4,543.94	378.51	5,739.03	478.06	3,999.81	333.18	3,061.85	255.05	**78**	5,225.52	435.29	6,599.87	549.77	4,599.79	383.16	3,521.11	293.31
4,652.02	387.51	5,911.03	492.39	4,125.64	343.67	3,162.81	263.46	**79**	5,349.84	445.64	6,797.70	566.25	4,744.48	395.22	3,637.23	302.98
4,761.95	396.67	6,086.15	506.98	4,253.74	354.34	3,265.64	272.03	**80**	5,476.24	456.17	6,999.07	583.02	4,891.80	407.49	3,755.50	312.83
4,885.44	406.96	6,301.57	524.92	4,410.18	367.37	3,394.95	282.80	**81**	5,618.24	468.00	7,246.81	603.66	5,071.72	422.47	3,904.19	325.22
5,011.19	417.43	6,521.29	543.22	4,569.78	380.66	3,526.87	293.79	**82**	5,762.88	480.05	7,499.49	624.71	5,255.23	437.76	4,055.90	337.86
5,144.34	428.52	6,752.05	562.45	4,737.23	394.61	3,665.10	305.30	**83**	5,916.01	492.80	7,764.86	646.81	5,447.80	453.80	4,214.87	351.10
5,280.12	439.83	6,987.72	582.08	4,908.26	408.86	3,806.33	317.07	**84**	6,072.14	505.81	8,035.88	669.39	5,644.50	470.19	4,377.27	364.63
5,418.54	451.36	7,228.38	602.12	5,082.95	423.41	3,950.60	329.08	**85**	6,231.32	519.07	8,312.62	692.44	5,845.40	486.92	4,543.19	378.45
5,566.45	463.69	7,482.24	623.27	5,265.71	438.63	4,100.80	341.60	**86**	6,401.40	533.24	8,604.56	716.76	6,055.57	504.43	4,715.90	392.83
5,717.93	476.30	7,742.87	644.98	5,453.40	454.27	4,255.12	354.45	**87**	6,575.60	547.75	8,904.31	741.73	6,271.41	522.41	4,893.37	407.62
5,873.05	489.23	8,010.50	667.27	5,646.15	470.32	4,413.65	367.66	**88**	6,753.99	562.61	9,212.07	767.37	6,493.07	540.87	5,075.71	422.81
6,025.98	501.96	8,277.11	689.48	5,838.31	486.33	4,572.04	380.85	**89**	6,929.86	577.26	9,518.67	792.91	6,714.06	559.28	5,257.84	437.98
6,176.33	514.49	8,542.05	711.55	6,029.44	502.25	4,729.87	394.00	**90**	7,102.78	591.66	9,823.36	818.29	6,933.87	577.59	5,439.35	453.10
6,322.54	526.67	8,813.81	734.19	6,224.85	518.53	4,892.68	407.56	**91**	7,270.93	605.67	10,135.88	844.32	7,158.59	596.31	5,626.58	468.69
6,471.53	539.08	9,091.21	757.30	6,424.32	535.15	5,058.92	421.41	**92**	7,442.25	619.94	10,454.89	870.89	7,387.96	615.42	5,817.76	484.62
6,610.22	550.63	9,355.82	779.34	6,614.85	551.02	5,218.34	434.69	**93**	7,601.77	633.23	10,759.19	896.24	7,607.06	633.67	6,001.09	499.89
6,751.21	562.38	9,625.14	801.77	6,808.76	567.17	5,380.65	448.21	**94**	7,763.90	646.73	11,068.91	922.04	7,830.08	652.25	6,187.75	515.44
6,894.49	574.31	9,899.27	824.61	7,006.16	583.61	5,545.90	461.97	**95**	7,928.66	660.46	11,384.17	948.30	8,057.08	671.15	6,377.80	531.27
7,032.38	585.80	10,097.25	841.10	7,146.29	595.29	5,656.83	471.21	**96**	8,087.23	673.67	11,611.83	967.27	8,218.23	684.58	6,505.34	541.89
7,173.03	597.51	10,299.20	857.92	7,289.21	607.19	5,769.96	480.64	**97**	8,248.98	687.14	11,844.09	986.61	8,382.60	698.27	6,635.46	552.73
7,316.48	609.46	10,505.18	875.08	7,435.00	619.34	5,885.35	490.25	**98**	8,413.96	700.88	12,080.97	1,006.34	8,550.24	712.23	6,768.16	563.79
7,462.81	621.65	10,715.28	892.58	7,583.70	631.72	6,003.07	500.06	**99**	8,582.23	714.90	12,322.59	1,026.47	8,721.25	726.48	6,903.53	575.06

Policies may be issued on an annual, semi-annual, quarterly or monthly mode. To obtain semi-annual premiums, multiply the above-quoted annual premium by 0.52. To obtain quarterly premiums, multiply the above quoted annual premium by 0.265. Applicants who qualify for Household Discount multiply above rates by 0.93. Add one-time enrollment fee of $20.00 to the first premium.

PREMIUM INFORMATION
Your premium will increase each year because of the increase in your attained age. We, Loyal American Life Insurance Company, can also raise your premium if (a) we change the rates which apply to all policies of this form issued by us and in-force in your state; (b) coverage under Medicare changes; or (c) you move to a different ZIP Code location. We will send you a written notice at least thirty (30) days in advance when we change the premium rates for all policies of this form issued by us and in-force in your state.

There will be a one-time enrollment fee of $20 added to the first premium.

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 Loyal American Life Insurance Company.

30-DAY RIGHT TO RETURN POLICY
If you find that you are not satisfied with your policy, you may return it to Loyal American Life Insurance Company, PO Box 5700, Scranton, PA 18505. 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 premiums.

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

NOTICE
The policy may not fully cover all of your medical costs. Neither Loyal American 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 the *Medicare and You* for more details.

EXCLUSIONS AND LIMITATIONS
The benefits of a policy will not duplicate any benefits paid by Medicare. The combined benefits of a policy and the benefits paid by Medicare may not exceed one hundred percent (100%) of the Medicare Eligible Expenses incurred. A policy will not pay benefits for the following:

1. the Medicare Part B deductible (not applicable for Plans F and C);
2. any expense which you are not legally obligated to pay or services for which no charge is normally made in the absence of insurance;
3. any services that are not medically necessary as determined by Medicare;
4. any portion of any expense for which payment is made by Medicare or other government programs (except Medicaid) or for which payment would have been made by Medicare if you were enrolled in Parts A and B of Medicare;
5. any type of expense not a Medicare Eligible Expense except as provided previously in the policy;
6. any deductible, coinsurance, or copayment not covered by Medicare, unless such coverage is listed as a benefit in the policy; or
7. Pre-Existing Conditions: We will not pay for any expenses incurred for care or treatment of a Pre-Existing Condition for the first six (6) months from the effective date of coverage. This exclusion does not apply if you applied for and were issued a policy under guaranteed issue status; if on the date of

application for a policy you had at least six (6) months of prior Creditable Coverage; or if the policy is replacing another Medicare Supplement policy and a six (6) month waiting period has already been satisfied. Evidence of prior coverage or replacement must have been disclosed on the application for a policy.

If you had less than six (6) months prior Creditable Coverage, the Pre-Existing Conditions limitation will be reduced by the aggregate amount of Creditable Coverage. If the policy is replacing another Medicare Supplement policy, credit will be given for any portion of the waiting period that has been satisfied.

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. We 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.

RENEWABILITY
The policy is guaranteed renewable for life.

HOUSEHOLD DISCOUNT
Affiliate means an insurance company that is under common ownership or control with Loyal American Life Insurance Company and that is a member of the same insurance holding company system.

Household Discount is a discount that is available when more than one member of your household enrolls or is enrolled in a Medicare Supplement policy provided by or through an Affiliate of Loyal American Life Insurance Company. Household is defined as a condominium unit, a single-family home, or an apartment unit within an apartment complex. Assisted Living facilities, Group Homes, Adult Day Care facilities and Nursing Homes, or any other health residential facility are not included in the definition of "Household."

The household premium discount will be removed if the other Medicare Supplement policyholder whose policy status entitles you to the discount no longer resides with you or no longer has a Medicare Supplement policy through Loyal American Life Insurance Company or an Affiliate of Loyal American Life Insurance Company. However, if that person becomes deceased, your discount will still apply. The addition or removal of the discount will occur on the billing cycle following the date we learn your eligibility has changed.

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 A PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,736	$0	$1,736 (Part A deductible)
61st through 90th day	All but $434 per day	$434 per day	$0
91st day and after:			
– while using 60 lifetime reserve days	All but $868 per day	$868 per 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 entering 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 $217 per day	$0	Up to $217 per day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0
You must meet Medicare's requirements, including a doctor's certification of terminal illness			

****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 $283 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN A 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 $283 of Medicare-approved amounts*	$0	$0	$283 (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 $283 of Medicare-approved amounts*	$0	$0	$283 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Tests for diagnostic services	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically-necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $283 of Medicare-approved amounts*	$0	$0	$283 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

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 days in a row.

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,736	$1,736 (Part A deductible)	$0
61st through 90th day	All but $434 per day	$434 per day	$0
91st day and after:			
– while using 60 lifetime reserve days	All but $868 per day	$868 per 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 entering 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 $217 per day	Up to $217 per 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

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $283 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN F 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 $283 of Medicare-approved amounts*	$0	$283 (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 $283 of Medicare-approved amounts*	$0	$283 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Tests for diagnostic services	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically-necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $283 of Medicare-approved amounts*	$0	$283 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN F
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR (cont'd.)

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN 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.

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,736	$1,736 (Part A deductible)	$0
61st through 90th day	All but $434 per day	$434 per day	$0
91st day and after:			
– while using 60 lifetime reserve days	All but $868 per day	$868 per 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 entering 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 $217 per day	Up to $217 per 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	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0
You must meet Medicare's requirements, including a doctor's certification of terminal illness			

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

PLAN G

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $283 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN G 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 $283 of Medicare-approved amounts*	$0	$0	$283 (Part B deductible)
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 $283 of Medicare-approved amounts*	$0	$0	$283 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Tests for diagnostic services	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically-necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $283 of Medicare-approved amounts*	$0	$0	$283 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN G
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR (cont'd.)

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN N

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

*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 N PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,736	$1,736 (Part A deductible)	$0
61st through 90th day	All but $434 per day	$434 per day	$0
91st day and after:			
– while using 60 lifetime reserve days	All but $868 per day	$868 per 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 entering 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 $217 per day	Up to $217 per 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	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0
You must meet Medicare's requirements, including a doctor's certification of terminal illness			

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

PLAN N
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $283 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN N 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 $283 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.	 $283 (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 $283 of Medicare-approved amounts* Remainder of Medicare-approved amounts	$0 $0 80%	All costs $0 20%	$0 $283 (Part B deductible) $0
CLINICAL LABORATORY SERVICES Tests for diagnostic services	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically-necessary skilled care services and medical supplies Durable medical equipment First $283 of Medicare-approved amounts* Remainder of Medicare-approved amounts	 100% $0 80%	 $0 $0 20%	 $0 $283 (Part B deductible) $0

PLAN N
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR (cont'd.)

OTHER BENEFITS – NOT COVERED BY MEDICARE

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