GLOBE LIFE AND ACCIDENT INSURANCE COMPANY

A Nebraska Stock Company • P.O. Box 8080 • McKinney, Texas 75070

Benefit Chart of Medicare Supplement Plans Sold on or After January 1, 2020

Benefit Plans A, F, G, HDG, 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 2025[2]					$7,220[2]	$3,610[2]				

* Denotes plans available by Globe Life And Accident Insurance Company

1 Plans F and G also have a high deductible option which requires first paying a plan deductible of $2,870 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 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.

PREMIUM INFORMATION

We, Globe Life And Accident Insurance Company, can only raise your premium if we raise the premium for all policies like yours in this state. Until you are age 100, your premiums will increase on each policy anniversary solely because of your age change. Your premiums may also be increased due to increasing health costs for all policies in your class.

TOBACCO/NON-TOBACCO

Preferred rates are used during Open Enrollment and Guaranteed Issue periods. If the application is underwritten outside of Open Enrollment and Guaranteed Issue periods, preferred rates are used if you answer "NO" to the question, "Have you used tobacco or nicotine in any form in the last 12 months?" If you answer "YES" to this question, standard rates are used.

HOUSEHOLD DISCOUNT PROVISION

In order to be eligible for a household discount, You must (1) have a spouse or civil union partner who has, or is applying for, a Globe Life SilverCare™ policy; OR (2) share an "eligible household" with any person who has, or is applying for, a Globe Life SilverCare™ policy.

For the purpose of this discount, an "eligible household" is defined as a single-family home, a condominium unit, an apartment unit in an apartment complex, or any similar residential facility. An "eligible household" does not include nursing homes, assisted living facilities, progressive care facilities (except in an independent living unit), group homes, adult day care facilities, or any similar residential facility.

If you qualify, the household discount will apply to both policies for as long as you continue to qualify and both policies remain in force. If You cease to be eligible for the household discount, this discount will be removed from your policy and Your premium rates will change accordingly.

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 Globe Life And Accident Insurance Company, P.O. Box 8080, McKinney, Texas 75070. 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 your medical costs.

Neither Globe Life And Accident Insurance Company nor its agents are connected with Medicare.

This Outline of Coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The Company may cancel your policy and refuse to pay 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.

FEMALE PREFERRED (NON-TOBACCO) WITH HOUSEHOLD DISCOUNT

ANNUAL PREMIUM RATES

EFFECTIVE DATE: 03/01/2025

Attained Age	Plan A Policy Form GSMSA	Plan F Policy Form GSMSF	Plan G Policy Form GSMSG	Plan HDG Policy Form GSMSHG	Plan N Policy Form GSMSN
65	$1,614	$2,329	$1,615	$480	$1,378
66	$1,654	$2,385	$1,654	$492	$1,409
67	$1,689	$2,437	$1,690	$501	$1,442
68	$1,730	$2,492	$1,731	$513	$1,475
69	$1,768	$2,553	$1,769	$525	$1,508
70	$1,811	$2,610	$1,812	$538	$1,544
71	$1,877	$2,682	$1,878	$551	$1,601
72	$1,949	$2,757	$1,950	$567	$1,664
73	$2,025	$2,835	$2,026	$584	$1,725
74	$2,100	$2,913	$2,102	$600	$1,792
75	$2,181	$2,993	$2,182	$617	$1,861
76	$2,241	$3,089	$2,242	$636	$1,912
77	$2,305	$3,189	$2,305	$657	$1,966
78	$2,369	$3,291	$2,370	$677	$2,020
79	$2,436	$3,396	$2,437	$698	$2,079
80 +	**Available***	**Available***	**Available***	**Available***	**Available***

These rates include a Household Discount. Your agent will determine if you are eligible.
A Risk Group increase of 10% or 20% may apply based on our height/weight chart.
A one-time $25 Application Fee is not included in these premiums.

To calculate semi-annual, quarterly, or monthly premiums, divide the TOTAL annual premium by 2, 4, and 12, respectively, and round to the high dollar.

***Please contact a company representative for premium rates for ages 80-99.**

FEMALE PREFERRED (NON-TOBACCO) WITHOUT HOUSEHOLD DISCOUNT

ANNUAL PREMIUM RATES

EFFECTIVE DATE: 03/01/2025

Attained Age	Plan A Policy Form GSMSA	Plan F Policy Form GSMSF	Plan G Policy Form GSMSG	Plan HDG Policy Form GSMSHG	Plan N Policy Form GSMSN
65	$1,736	$2,504	$1,737	$516	$1,482
66	$1,778	$2,564	$1,779	$529	$1,515
67	$1,816	$2,620	$1,817	$539	$1,550
68	$1,860	$2,680	$1,861	$552	$1,586
69	$1,901	$2,745	$1,902	$564	$1,622
70	$1,947	$2,806	$1,948	$578	$1,660
71	$2,018	$2,884	$2,019	$593	$1,722
72	$2,096	$2,964	$2,097	$610	$1,789
73	$2,177	$3,048	$2,178	$628	$1,855
74	$2,258	$3,132	$2,260	$645	$1,927
75	$2,345	$3,218	$2,346	$663	$2,001
76	$2,410	$3,322	$2,411	$684	$2,056
77	$2,478	$3,429	$2,479	$706	$2,114
78	$2,547	$3,539	$2,548	$728	$2,172
79	$2,619	$3,652	$2,620	$751	$2,235
80 +	**Available***	**Available***	**Available***	**Available***	**Available***

These rates do not include a Household Discount. Your agent will determine if you are eligible.
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To calculate semi-annual, quarterly, or monthly premiums, divide the TOTAL annual premium by 2, 4, and 12, respectively, and round to the high dollar.

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FEMALE STANDARD (TOBACCO) WITH HOUSEHOLD DISCOUNT

ANNUAL PREMIUM RATES

EFFECTIVE DATE: 03/01/2025

Attained Age	Plan A Policy Form GSMSA	Plan F Policy Form GSMSF	Plan G Policy Form GSMSG	Plan HDG Policy Form GSMSHG	Plan N Policy Form GSMSN
65	$1,857	$2,678	$1,858	$552	$1,585
66	$1,902	$2,742	$1,903	$566	$1,620
67	$1,942	$2,802	$1,943	$576	$1,658
68	$1,989	$2,866	$1,990	$590	$1,696
69	$2,033	$2,936	$2,034	$603	$1,735
70	$2,082	$3,001	$2,083	$618	$1,775
71	$2,158	$3,084	$2,159	$634	$1,842
72	$2,242	$3,170	$2,243	$652	$1,913
73	$2,328	$3,260	$2,329	$672	$1,984
74	$2,415	$3,350	$2,417	$690	$2,061
75	$2,508	$3,442	$2,509	$709	$2,140
76	$2,577	$3,553	$2,579	$732	$2,199
77	$2,650	$3,667	$2,651	$755	$2,261
78	$2,724	$3,785	$2,725	$779	$2,323
79	$2,801	$3,906	$2,802	$803	$2,390
80 +	**Available***	**Available***	**Available***	**Available***	**Available***

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To calculate semi-annual, quarterly, or monthly premiums, divide the TOTAL annual premium by 2, 4, and 12, respectively, and round to the high dollar.

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FEMALE STANDARD (TOBACCO) WITHOUT HOUSEHOLD DISCOUNT

ANNUAL PREMIUM RATES

EFFECTIVE DATE: 03/01/2025

Attained Age	Plan A Policy Form GSMSA	Plan F Policy Form GSMSF	Plan G Policy Form GSMSG	Plan HDG Policy Form GSMSHG	Plan N Policy Form GSMSN
65	$1,996	$2,880	$1,998	$593	$1,704
66	$2,045	$2,949	$2,046	$608	$1,742
67	$2,088	$3,013	$2,090	$620	$1,783
68	$2,139	$3,082	$2,140	$635	$1,824
69	$2,186	$3,157	$2,187	$649	$1,865
70	$2,239	$3,227	$2,240	$665	$1,909
71	$2,321	$3,317	$2,322	$682	$1,980
72	$2,410	$3,409	$2,412	$702	$2,057
73	$2,504	$3,505	$2,505	$722	$2,133
74	$2,597	$3,602	$2,599	$742	$2,216
75	$2,697	$3,701	$2,698	$762	$2,301
76	$2,772	$3,820	$2,773	$787	$2,364
77	$2,850	$3,943	$2,851	$812	$2,431
78	$2,929	$4,070	$2,930	$837	$2,498
79	$3,012	$4,200	$3,013	$864	$2,570
80 +	**Available***	**Available***	**Available***	**Available***	**Available***

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MALE PREFERRED (NON-TOBACCO) WITH HOUSEHOLD DISCOUNT

ANNUAL PREMIUM RATES

EFFECTIVE DATE: 03/01/2025

Attained Age	Plan A Policy Form GSMSA	Plan F Policy Form GSMSF	Plan G Policy Form GSMSG	Plan HDG Policy Form GSMSHG	Plan N Policy Form GSMSN
65	$1,736	$2,503	$1,737	$516	$1,482
66	$1,778	$2,563	$1,779	$529	$1,515
67	$1,816	$2,619	$1,817	$539	$1,550
68	$1,860	$2,679	$1,861	$552	$1,586
69	$1,901	$2,744	$1,902	$564	$1,622
70	$1,947	$2,805	$1,948	$578	$1,660
71	$2,017	$2,883	$2,018	$593	$1,722
72	$2,095	$2,963	$2,096	$610	$1,789
73	$2,176	$3,047	$2,177	$628	$1,855
74	$2,257	$3,131	$2,259	$645	$1,927
75	$2,344	$3,217	$2,345	$663	$2,000
76	$2,409	$3,321	$2,410	$684	$2,055
77	$2,477	$3,428	$2,478	$706	$2,113
78	$2,546	$3,538	$2,547	$728	$2,171
79	$2,618	$3,651	$2,619	$751	$2,234
80 +	**Available***	**Available***	**Available***	**Available***	**Available***

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ANNUAL PREMIUM RATES

EFFECTIVE DATE: 03/01/2025

Attained Age	Plan A Policy Form GSMSA	Plan F Policy Form GSMSF	Plan G Policy Form GSMSG	Plan HDG Policy Form GSMSHG	Plan N Policy Form GSMSN
65	$1,866	$2,692	$1,867	$555	$1,593
66	$1,911	$2,756	$1,912	$569	$1,629
67	$1,952	$2,817	$1,953	$579	$1,666
68	$2,000	$2,881	$2,001	$593	$1,705
69	$2,044	$2,951	$2,045	$606	$1,744
70	$2,093	$3,016	$2,094	$621	$1,785
71	$2,169	$3,100	$2,170	$637	$1,851
72	$2,253	$3,186	$2,254	$656	$1,923
73	$2,340	$3,277	$2,341	$675	$1,994
74	$2,427	$3,367	$2,430	$693	$2,072
75	$2,521	$3,459	$2,522	$713	$2,151
76	$2,591	$3,571	$2,592	$735	$2,210
77	$2,664	$3,686	$2,665	$759	$2,273
78	$2,738	$3,804	$2,739	$783	$2,335
79	$2,815	$3,926	$2,817	$807	$2,403
80 +	**Available***	**Available***	**Available***	**Available***	**Available***

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MALE STANDARD (TOBACCO) WITH HOUSEHOLD DISCOUNT

ANNUAL PREMIUM RATES

EFFECTIVE DATE: 03/01/2025

Attained Age	Plan A Policy Form GSMSA	Plan F Policy Form GSMSF	Plan G Policy Form GSMSG	Plan HDG Policy Form GSMSHG	Plan N Policy Form GSMSN
65	$1,995	$2,878	$1,997	$593	$1,704
66	$2,044	$2,947	$2,045	$608	$1,741
67	$2,087	$3,012	$2,089	$620	$1,782
68	$2,138	$3,081	$2,139	$635	$1,823
69	$2,185	$3,155	$2,186	$648	$1,864
70	$2,238	$3,225	$2,239	$664	$1,908
71	$2,320	$3,315	$2,321	$682	$1,979
72	$2,409	$3,407	$2,410	$701	$2,056
73	$2,502	$3,504	$2,504	$722	$2,132
74	$2,596	$3,600	$2,598	$741	$2,215
75	$2,696	$3,699	$2,697	$762	$2,300
76	$2,770	$3,819	$2,771	$786	$2,363
77	$2,848	$3,942	$2,850	$812	$2,430
78	$2,928	$4,068	$2,929	$837	$2,497
79	$3,010	$4,198	$3,012	$863	$2,569
80 +	**Available***	**Available***	**Available***	**Available***	**Available***

These rates include a Household Discount. Your agent will determine if you are eligible.
A Risk Group increase of 10% or 20% may apply based on our height/weight chart.
A one-time $25 Application Fee is not included in these premiums.

To calculate semi-annual, quarterly, or monthly premiums, divide the TOTAL annual premium by 2, 4, and 12, respectively, and round to the high dollar.

***Please contact a company representative for premium rates for ages 80-99.**

MALE STANDARD (TOBACCO) WITHOUT HOUSEHOLD DISCOUNT

ANNUAL PREMIUM RATES

EFFECTIVE DATE: 03/01/2025

Attained Age	Plan A Policy Form GSMSA	Plan F Policy Form GSMSF	Plan G Policy Form GSMSG	Plan HDG Policy Form GSMSHG	Plan N Policy Form GSMSN
65	$2,146	$3,095	$2,147	$638	$1,832
66	$2,198	$3,169	$2,199	$654	$1,873
67	$2,245	$3,238	$2,246	$666	$1,916
68	$2,299	$3,312	$2,300	$682	$1,960
69	$2,350	$3,393	$2,351	$697	$2,005
70	$2,406	$3,468	$2,408	$714	$2,052
71	$2,494	$3,565	$2,495	$733	$2,128
72	$2,591	$3,664	$2,592	$754	$2,211
73	$2,691	$3,767	$2,692	$776	$2,293
74	$2,791	$3,871	$2,793	$797	$2,382
75	$2,898	$3,977	$2,900	$819	$2,473
76	$2,979	$4,106	$2,980	$845	$2,541
77	$3,063	$4,238	$3,064	$873	$2,613
78	$3,148	$4,374	$3,149	$900	$2,685
79	$3,237	$4,514	$3,238	$928	$2,762
80 +	**Available***	**Available***	**Available***	**Available***	**Available***

These rates do not include a Household Discount. Your agent will determine if you are eligible.
A Risk Group increase of 10% or 20% may apply based on our height/weight chart.
A one-time $25 Application Fee is not included in these premiums.

To calculate semi-annual, quarterly, or monthly premiums, divide the TOTAL annual premium by 2, 4, and 12, respectively, and round to the high dollar.

***Please contact a company representative for premium rates for ages 80-99.**

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 $1676	$0	$1676 (Part A Deductible)
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	$0	Up to $209.50 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 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 $257 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $257 of Medicare-Approved Amounts*	$0	$0	$257 (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 $257 of Medicare-Approved Amounts*	$0	$0	$257 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
– Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $257 of Medicare-Approved Amounts*	$0	$0	$257 (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 PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1676	$1676 (Part A Deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	Up to $209.50 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 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 $257 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $257 of Medicare-Approved Amounts*	$0	$257 (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 $257 of Medicare-Approved Amounts*	$0	$257 (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

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $257 of Medicare-Approved Amounts*	$0	$257 (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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1676	$1676 (Part A Deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	Up to $209.50 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 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 $257 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $257 of Medicare-Approved Amounts*	$0	$0	$257 (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 $257 of Medicare-Approved Amounts*	$0	$0	$257 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
– Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $257 of Medicare-Approved Amounts*	$0	$0	$257 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

HIGH DEDUCTIBLE 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 one has paid a calendar year $2,870 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2,870. 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	AFTER YOU PAY $2870 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2870 DEDUCTIBLE,** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1676	$1676 (Part A Deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	Up to $209.50 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 the balance based on any difference between its billed charges and the amount Medicare would have paid.

HIGH DEDUCTIBLE PLAN G
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $257 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.

** This high deductible plan pays the same benefits as Plan G after one has paid a calendar year $2,870 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2,870. 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	AFTER YOU PAY $2,870 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2,870 DEDUCTIBLE,** 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 $257 of Medicare-Approved Amounts*	$0	$0	$257 (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 $257 of Medicare-Approved Amounts*	$0	$0	$257 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
– Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $257 of Medicare-Approved Amounts*	$0	$0	$257 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1676	$1676 (Part A Deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	Up to $209.50 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 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 $257 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as:			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $257 of Medicare-Approved Amounts*	$0	$0	$257 (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 $257 of Medicare-Approved Amounts*	$0	$0	$257 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
– Tests for diagnostic services	100%	$0	$0

PLAN N (continued)

A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $257 of Medicare-Approved Amounts*	$0	$0	$257 (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