GLOBE LIFE AND ACCIDENT INSURANCE COMPANY

A Nebraska Company • Globe Life Center • Oklahoma City, Oklahoma 73184

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

Benefit Plans A, B, C, F, HDF, G, HDG, 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. 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 2026[2]					$8,000[2]	$4,000[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 $2,950 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.

[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 81, 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.

The renewal premiums for this policy may change on the renewal date following the effective date of any such applicable change. Any such premium change will be based on the actuarial computations which We then use to determine the renewal premium and must receive prior approval from the Texas Department of Insurance before becoming effective.

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 Globe Life And Accident 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, Globe Life Center, Oklahoma City, Oklahoma 73184. 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.

LIMITATIONS AND EXCLUSIONS

We will not pay benefits under this policy for:

1) Any portion of any expense for which payment is made by Medicare; or

2) Any type of expense not eligible for coverage under Medicare, except as provided under MEDICALLY NECESSARY EMERGENCY CARE IN A FOREIGN COUNTRY; or

3) Services, treatment, or care provided by You, or furnished at Your direction, in Your role as a Physician; or

4) Services, treatment, or care provided by, or furnished at the direction of, any member of Your Immediate Family in his or her role as a Physician.

5) Loss due to a pre-existing condition is not covered unless the loss is incurred more than 60 days after the policy effective date. If you have a pre-existing condition and qualify for open enrollment and have had continuous period of creditable coverage for at least 60 days, we cannot exclude coverage based on the pre-existing condition. If the period of creditable coverage is less than 60 days, we will give credit for the amount of time of creditable coverage you have had towards fulfilling the pre-existing condition exclusion period.

REFUND OF PREMIUM

In the event of cancellation or Your death, we will promptly refund the unearned portion of any premium paid on Your behalf.

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.

Globe Life And Accident Medicare Supplement Rates

PLAN A Effective Date: 01/01/2025 Plan Code: J72

Attained Age	Annual	Semi Annual	Quarterly	Monthly	Monthly Bank Draft
65	2070	1056	538	182.00	180.00
66	2209	1127	574	194.50	192.50
67	2347	1197	610	206.50	204.50
68	2487	1268	647	219.00	217.00
69	2623	1338	682	231.00	229.00
70	2761	1408	718	243.00	241.00
71	2814	1435	732	247.50	245.50
72	2837	1447	738	249.50	247.50
73	2874	1466	747	253.00	251.00
74	2898	1478	753	255.00	253.00
75	2932	1495	762	258.00	256.00
76	2954	1507	768	260.00	258.00
77	2954	1507	768	260.00	258.00
78	2954	1507	768	260.00	258.00
79	2954	1507	768	260.00	258.00
80+	2954	1507	768	260.00	258.00

PLAN B Effective Date: 01/01/2025 Plan Code: J73

Attained Age	Annual	Semi Annual	Quarterly	Monthly	Monthly Bank Draft
65	2824	1440	734	248.50	246.50
66	2964	1512	771	261.00	259.00
67	3093	1577	804	272.00	270.00
68	3226	1645	839	284.00	282.00
69	3366	1717	875	296.00	294.00
70	3500	1785	910	308.00	306.00
71	3632	1852	944	319.50	317.50
72	3769	1922	980	331.50	329.50
73	3907	1993	1016	344.00	342.00
74	3992	2036	1038	351.50	349.50
75	4057	2069	1055	357.00	355.00
76	4095	2088	1065	360.50	358.50
77	4095	2088	1065	360.50	358.50
78	4095	2088	1065	360.50	358.50
79	4095	2088	1065	360.50	358.50
80+	4095	2088	1065	360.50	358.50

PLAN C Effective Date: 01/01/2025 Plan Code: J74

Attained Age	Annual	Semi Annual	Quarterly	Monthly	Monthly Bank Draft
65	3183	1623	828	280.00	278.00
66	3317	1692	862	292.00	290.00
67	3450	1760	897	303.50	301.50
68	3592	1832	934	316.00	314.00
69	3728	1901	969	328.00	326.00
70	3867	1972	1005	340.50	338.50
71	4008	2044	1042	352.50	350.50
72	4143	2113	1077	364.50	362.50
73	4278	2182	1112	376.50	374.50
74	4420	2254	1149	389.00	387.00
75	4554	2323	1184	401.00	399.00
76	4647	2370	1208	409.00	407.00
77	4680	2387	1217	412.00	410.00
78	4722	2408	1228	415.50	413.50
79	4759	2427	1237	419.00	417.00
80+	4788	2442	1245	421.50	419.50

PLAN F Effective Date: 01/01/2025 Plan Code: J75

Attained Age	Annual	Semi Annual	Quarterly	Monthly	Monthly Bank Draft
65	3214	1639	836	283.00	281.00
66	3352	1710	872	295.00	293.00
67	3486	1778	906	307.00	305.00
68	3629	1851	944	319.50	317.50
69	3762	1919	978	331.00	329.00
70	3903	1991	1015	343.50	341.50
71	4038	2059	1050	355.50	353.50
72	4171	2127	1084	367.00	365.00
73	4313	2200	1121	379.50	377.50
74	4450	2270	1157	391.50	389.50
75	4586	2339	1192	403.50	401.50
76	4695	2394	1221	413.00	411.00
77	4732	2413	1230	416.50	414.50
78	4775	2435	1242	420.00	418.00
79	4809	2453	1250	423.00	421.00
80+	4842	2469	1259	426.00	424.00

Only applicants first eligible for Medicare Part A before 2020 may purchase Plans C, F, and High Deductible F.

Globe Life And Accident Medicare Supplement Rates

PLAN HDF Effective Date: 06/01/2020 Plan Code: JB1

Attained Age	Annual	Semi Annual	Quarterly	Monthly	Monthly Bank Draft
65	468	239	122	41.00	39.00
66	506	258	132	44.50	42.50
67	546	278	142	48.00	46.00
68	566	289	147	50.00	48.00
69	595	303	155	52.50	50.50
70	621	317	161	54.50	52.50
71	642	327	167	56.50	54.50
72	675	344	176	59.50	57.50
73	713	364	185	62.50	60.50
74	749	382	195	66.00	64.00
75	787	401	205	69.50	67.50
76	825	421	215	72.50	70.50
77	868	443	226	76.50	74.50
78	912	465	237	80.50	78.50
79	956	488	249	84.00	82.00
80+	1030	525	268	90.50	88.50

PLAN HDG Effective Date: 06/01/2020 Plan Code: JF0

Attained Age	Annual	Semi Annual	Quarterly	Monthly	Monthly Bank Draft
65	468	239	122	41.00	39.00
66	506	258	132	44.50	42.50
67	546	278	142	48.00	46.00
68	566	289	147	50.00	48.00
69	595	303	155	52.50	50.50
70	621	317	161	54.50	52.50
71	642	327	167	56.50	54.50
72	675	344	176	59.50	57.50
73	713	364	185	62.50	60.50
74	749	382	195	66.00	64.00
75	787	401	205	69.50	67.50
76	825	421	215	72.50	70.50
77	868	443	226	76.50	74.50
78	912	465	237	80.50	78.50
79	956	488	249	84.00	82.00
80+	1030	525	268	90.50	88.50

PLAN G Effective Date: 01/01/2025 Plan Code: JC0

Attained Age	Annual	Semi Annual	Quarterly	Monthly	Monthly Bank Draft
65	2911	1485	757	256.00	254.00
66	3051	1556	793	268.50	266.50
67	3187	1625	829	280.50	278.50
68	3326	1696	865	292.50	290.50
69	3462	1766	900	304.50	302.50
70	3602	1837	937	317.00	315.00
71	3738	1906	972	329.00	327.00
72	3871	1974	1006	340.50	338.50
73	4013	2047	1043	353.00	351.00
74	4149	2116	1079	365.00	363.00
75	4283	2184	1114	377.00	375.00
76	4394	2241	1142	386.50	384.50
77	4431	2260	1152	390.00	388.00
78	4474	2282	1163	393.50	391.50
79	4509	2300	1172	397.00	395.00
80+	4541	2316	1181	399.50	397.50

PLAN N Effective Date: 01/01/2025 Plan Code: JC8

Attained Age	Annual	Semi Annual	Quarterly	Monthly	Monthly Bank Draft
65	1938	988	504	170.50	168.50
66	2026	1033	527	178.50	176.50
67	2119	1081	551	186.50	184.50
68	2216	1130	576	195.00	193.00
69	2310	1178	601	203.50	201.50
70	2409	1229	626	212.00	210.00
71	2505	1278	651	220.50	218.50
72	2603	1328	677	229.00	227.00
73	2706	1380	704	238.00	236.00
74	2804	1430	729	247.00	245.00
75	2909	1484	756	256.00	254.00
76	2994	1527	778	263.50	261.50
77	3036	1548	789	267.00	265.00
78	3078	1570	800	271.00	269.00
79	3114	1588	810	274.00	272.00
80+	3161	1612	822	278.00	276.00

Only applicants first eligible for Medicare Part A before 2020 may purchase Plans C, F, and High Deductible F.

Globe Life And Accident Medicare Supplement Rates

UNDER AGE 65 DURING OPEN ENROLLMENT (O/E)

Plan	A	SA	Q	M	MBD	Plan Code	Effective Date
A	9364	4776	2435	824.00	822.00	J88	01/01/2025

UNDER AGE 65 GUARANTEED ISSUE PERIOD (G/I)

Plan	A	SA	Q	M	MBD	Plan Code	Effective Date
A	9364	4776	2435	824.00	822.00	J88	01/01/2025

UNDER AGE 65 ELIGIBLE END STAGE RENAL DISEASE OR AMYOTROPHIC LATERAL SCLEROSIS DURING OPEN ENROLLMENT PERIOD (O/E)

Plan	A	SA	Q	M	MBD	Plan Code	Effective Date
A	2070	1056	538	182.00	180.00	JA7	09/01/2025
B	2824	1440	734	248.50	246.50	JA8	09/01/2025
C	6366	3247	1655	560.00	558.00	JA9	09/01/2025
F	6428	3278	1671	565.50	563.50	JB0	09/01/2025
HDF	936	477	243	82.50	80.50	JB5	09/01/2025
G	5822	2969	1514	512.50	510.50	JC4	09/01/2025
HDG	936	477	243	82.50	80.50	JF4	09/01/2025
N	3876	1977	1008	341.00	339.00	JD1	09/01/2025

Only applicants first eligible for Medicare Part A before 2020 may purchase Plans C, F, and High Deductible F.

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 $1736	$0	$1736 (Part A Deductible)
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $868 a day	$868 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 $217 a day	$0	Up to $217 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	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 $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 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

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 B
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 $1736	$1736 (Part A Deductible)	$0
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $868 a day	$868 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 $217 a day	$0	Up to $217 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 B
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 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

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 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 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 $1736	$1736 (Part A Deductible)	$0
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $868 a day	$868 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 $217 a day	Up to $217 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 C
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 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	$0	All Costs
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

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

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 F or HIGH DEDUCTIBLE 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.

** This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2950 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2950. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2950 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2950 DEDUCTIBLE,** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1736	$1736 (Part A Deductible)	$0
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $868 a day	$868 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 $217 a day	Up to $217 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 or HIGH DEDUCTIBLE 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.

** This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2950 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2950. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2950 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2950 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 $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

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

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 or 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 $2950 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2950. 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 $2950 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2950 DEDUCTIBLE,** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1736	$1736 (Part A Deductible)	$0
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $868 a day	$868 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 $217 a day	Up to $217 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 or HIGH DEDUCTIBLE 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.

** This high deductible plan pays the same benefits as Plan G after one has paid a calendar year $2950 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2950. 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 $2950 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2950 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 $283 of Medicare-Approved Amounts*	$0	$0	$283 (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 $283 of Medicare-Approved Amounts*	$0	$0	$283 (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 $283 of Medicare-Approved Amounts*	$0	$0	$283 (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 $1736	$1736 (Part A Deductible)	$0
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $868 a day	$868 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 $217 a day	Up to $217 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 $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 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%	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 $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

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

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