GLOBE LIFE AND ACCIDENT INSURANCE COMPANY

A Legal Reserve Stock 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*	К	L	Μ	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%	\checkmark	✓	\checkmark	\checkmark
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	\checkmark	✓	\checkmark	\checkmark
Skilled nursing facility coinsurance			✓	✓	50%	75%	\checkmark	✓	\checkmark	\checkmark
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	\checkmark	\checkmark
Medicare Part B deductible									\checkmark	\checkmark
Medicare Part B excess charges				✓						\checkmark
Foreign travel emergency (up to plan limits)			 ✓ 	✓			\checkmark	\checkmark	\checkmark	\checkmark
Out-of-pocket limit in 2024 ²		•	-		\$7,060 ²	\$3,530 ²				

* Denotes plans available by Globe Life And Accident Insurance Company

¹ Plans F and G also have a high deductible option, which require first paying a plan deductible of \$2,800 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.

DS-GMS2020(21)

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.

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, 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.

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.

RENEWABILITY

This policy is guaranteed renewable for life. We have the right to change the renewal premiums for this policy in accordance with our table of premium rates applicable to all policies of this form and class. This policy provides a 31-day grace period.

Globe Life And Accident Medicare Supplement Rates

PLAN A	Effe	ctive Date: 1	2/01/2024	Plan Cod	e: J72	PLAN C	Effe	ctive Date: 1	2/01/2024	Plan Cod	e: J74
Attained Age	Annual	Semi Annual	Quarterly	Monthly	Monthly Bank Draft	Attained Age	Annual	Semi Annual	Quarterly	Monthly	Monthly Bank Draft
65	1688	861	439	148.50	146.50	65	2797	1426	727	246.00	244.00
66	1810	923	471	159.50	157.50	66	2919	1489	759	257.00	255.00
67	1948	993	506	171.50	169.50	67	3077	1569	800	271.00	269.00
68	2082	1062	541	183.00	181.00	68	3230	1647	840	284.00	282.00
69	2179	1111	567	192.00	190.00	69	3355	1711	872	295.00	293.00
70	2291	1168	596	201.50	199.50	70	3484	1777	906	306.50	304.50
71	2341	1194	609	206.00	204.00	71	3608	1840	938	317.50	315.50
72	2355	1201	612	207.00	205.00	72	3734	1904	971	328.50	326.50
73	2387	1217	621	210.00	208.00	73	3862	1970	1004	340.00	338.00
74	2405	1227	625	211.50	209.50	74	3988	2034	1037	351.00	349.00
75	2433	1241	633	214.00	212.00	75	4115	2099	1070	362.00	360.00
76	2458	1254	639	216.50	214.50	76	4203	2144	1093	370.00	368.00
77	2458	1254	639	216.50	214.50	77	4236	2160	1101	373.00	371.00
78	2458	1254	639	216.50	214.50	78	4277	2181	1112	376.50	374.50
79	2472	1261	643	217.50	215.50	79	4335	2211	1127	381.50	379.50
80+	2472	1261	643	217.50	215.50	80+	4367	2227	1135	384.50	382.50
PLAN B	Effe	ctive Date: 1	2/01/2024	Plan Cod	e: J73	PLAN F	Effe	ctive Date: 1	2/01/2024	Plan Cod	e: J75
Attained Age	Annual	Semi Annual	Quarterly	Monthly	Monthly Bank Draft	Attained Age	Annual	Semi Annual	Quarterly	Monthly	Monthly Bank Draft
Attained Age 65	Annual 2363	Semi Annual	Quarterly 614	Monthly 208.00	Monthly Bank Draft 206.00	Attained Age 65	Annual 2814	Semi Annual 1435	Quarterly 732	Monthly 247.50	Monthly Bank Draft 245.50
				-	Draft					-	Draft
65	2363	1205	614	208.00	Draft 206.00	65	2814	1435	732	247.50	Draft 245.50
65 66	2363 2490	1205 1270	614 647	208.00 219.00	Draft 206.00 217.00	65 66	2814 2939	1435 1499	732 764	247.50 258.50	Draft 245.50 256.50
65 66 67	2363 2490 2632	1205 1270 1342	614 647 684	208.00 219.00 231.50	Draft 206.00 217.00 229.50	65 66 67	2814 2939 3096	1435 1499 1579	732 764 805	247.50 258.50 272.50	Draft 245.50 256.50 270.50
65 66 67 68	2363 2490 2632 2785	1205 1270 1342 1420	614 647 684 724	208.00 219.00 231.50 245.00	Draft 206.00 217.00 229.50 243.00	65 66 67 68	2814 2939 3096 3251	1435 1499 1579 1658	732 764 805 845	247.50 258.50 272.50 286.00	Draft 245.50 256.50 270.50 284.00
65 66 67 68 69	2363 2490 2632 2785 2907	1205 1270 1342 1420 1483	614 647 684 724 756	208.00 219.00 231.50 245.00 256.00	Draft 206.00 217.00 229.50 243.00 254.00	65 66 67 68 69	2814 2939 3096 3251 3377	1435 1499 1579 1658 1722	732 764 805 845 878	247.50 258.50 272.50 286.00 297.00	Draft 245.50 256.50 270.50 284.00 295.00
65 66 67 68 69 70	2363 2490 2632 2785 2907 3032	1205 1270 1342 1420 1483 1546	614 647 684 724 756 788	208.00 219.00 231.50 245.00 256.00 267.00	Draft 206.00 217.00 229.50 243.00 254.00 265.00	65 66 67 68 69 70	2814 2939 3096 3251 3377 3504	1435 1499 1579 1658 1722 1787	732 764 805 845 878 911	247.50 258.50 272.50 286.00 297.00 308.50	Draft 245.50 256.50 270.50 284.00 295.00 306.50
65 66 67 68 69 70 71	2363 2490 2632 2785 2907 3032 3157	1205 1270 1342 1420 1483 1546 1610	614 647 684 724 756 788 821	208.00 219.00 231.50 245.00 256.00 267.00 278.00	Draft 206.00 217.00 229.50 243.00 254.00 265.00 276.00	65 66 67 68 69 70 71	2814 2939 3096 3251 3377 3504 3632	1435 1499 1579 1658 1722 1787 1852	732 764 805 845 878 911 944	247.50 258.50 272.50 286.00 297.00 308.50 319.50	Draft 245.50 256.50 270.50 284.00 295.00 306.50 317.50
65 66 67 68 69 70 71 71 72	2363 2490 2632 2785 2907 3032 3157 3281	1205 1270 1342 1420 1483 1546 1610 1673	614 647 684 724 756 788 821 853	208.00 219.00 231.50 245.00 256.00 267.00 278.00 288.50	Draft 206.00 217.00 229.50 243.00 254.00 265.00 276.00 286.50	65 66 67 68 69 70 71 71 72	2814 2939 3096 3251 3377 3504 3632 3755	1435 1499 1579 1658 1722 1787 1852 1915	732 764 805 845 878 911 944 976	247.50 258.50 272.50 286.00 297.00 308.50 319.50 330.50	Draft 245.50 256.50 270.50 284.00 295.00 306.50 317.50 328.50
65 66 67 68 69 70 71 72 73 73 74 75	2363 2490 2632 2785 2907 3032 3157 3281 3352 3397 3449	1205 1270 1342 1420 1483 1546 1610 1673 1710	614 647 684 724 756 788 821 853 872	208.00 219.00 231.50 245.00 256.00 267.00 278.00 288.50 295.00	Draft 206.00 217.00 229.50 243.00 254.00 265.00 276.00 286.50 293.00 297.00 301.50	65 66 67 68 69 70 71 72 73 73 74 75	2814 2939 3096 3251 3377 3504 3632 3755 3883 4010 4139	1435 1499 1579 1658 1722 1787 1852 1915 1980 2045 2111	732 764 805 845 878 911 944 976 1010	247.50 258.50 272.50 286.00 297.00 308.50 319.50 330.50 341.50	Draft 245.50 256.50 270.50 284.00 295.00 306.50 317.50 328.50 339.50
65 66 67 68 69 70 71 71 72 73 73 74	2363 2490 2632 2785 2907 3032 3157 3281 3352 3397	1205 1270 1342 1420 1483 1546 1610 1673 1710 1732	614 647 684 724 756 788 821 853 872 883	208.00 219.00 231.50 245.00 256.00 267.00 278.00 288.50 295.00 299.00	Draft 206.00 217.00 229.50 243.00 254.00 265.00 276.00 286.50 293.00 297.00	65 66 67 68 69 70 71 71 72 73 73 74	2814 2939 3096 3251 3377 3504 3632 3755 3883 4010	1435 1499 1579 1658 1722 1787 1852 1915 1980 2045	732 764 805 845 878 911 944 976 1010 1043	247.50 258.50 272.50 286.00 297.00 308.50 319.50 330.50 341.50 353.00	Draft 245.50 256.50 270.50 284.00 295.00 306.50 317.50 328.50 339.50 351.00
65 66 67 68 69 70 71 72 73 73 74 75	2363 2490 2632 2785 2907 3032 3157 3281 3352 3397 3449	1205 1270 1342 1420 1483 1546 1610 1673 1710 1732 1759	614 647 684 724 756 788 821 853 872 883 897	208.00 219.00 231.50 245.00 256.00 267.00 267.00 278.00 288.50 295.00 299.00 303.50	Draft 206.00 217.00 229.50 243.00 254.00 265.00 276.00 286.50 293.00 297.00 301.50	65 66 67 68 69 70 71 72 73 73 74 75	2814 2939 3096 3251 3377 3504 3632 3755 3883 4010 4139	1435 1499 1579 1658 1722 1787 1852 1915 1980 2045 2111	732 764 805 845 878 911 944 976 1010 1043 1076	247.50 258.50 272.50 286.00 297.00 308.50 319.50 330.50 341.50 353.00 364.00	Draft 245.50 256.50 270.50 284.00 295.00 306.50 317.50 328.50 339.50 339.50 351.00 362.00
65 66 67 68 69 70 71 72 73 73 74 75 76	2363 2490 2632 2785 2907 3032 3157 3281 3352 3397 3449 3502	1205 1270 1342 1420 1483 1546 1610 1673 1710 1732 1759 1786	614 647 684 724 756 788 821 853 872 883 897 911	208.00 219.00 231.50 245.00 256.00 267.00 278.00 288.50 295.00 299.00 303.50 308.00	Draft 206.00 217.00 229.50 243.00 254.00 265.00 276.00 286.50 293.00 297.00 301.50 306.00	65 66 67 68 69 70 71 72 73 74 75 76	2814 2939 3096 3251 3377 3504 3632 3755 3883 4010 4139 4234	1435 1499 1579 1658 1722 1787 1852 1915 1980 2045 2111 2159	732 764 805 845 878 911 944 976 1010 1043 1076 1101	247.50 258.50 272.50 286.00 297.00 308.50 319.50 330.50 341.50 353.00 364.00 372.50	Draft 245.50 256.50 270.50 284.00 295.00 306.50 317.50 328.50 339.50 351.00 362.00 370.50
65 66 67 68 69 70 71 72 73 74 75 76 77	2363 2490 2632 2785 2907 3032 3157 3281 3352 3397 3449 3502 3502	1205 1270 1342 1420 1483 1546 1610 1673 1710 1732 1759 1786 1786	614 647 684 724 756 788 821 853 872 883 897 911 911	208.00 219.00 231.50 245.00 256.00 267.00 278.00 288.50 295.00 299.00 303.50 308.00 308.00	Draft 206.00 217.00 229.50 243.00 254.00 265.00 276.00 286.50 293.00 297.00 301.50 306.00	65 66 67 68 69 70 71 71 72 73 73 74 75 76 76 77	2814 2939 3096 3251 3377 3504 3632 3755 3883 4010 4139 4234 4267	1435 1499 1579 1658 1722 1787 1852 1915 1980 2045 2111 2159 2176	732 764 805 845 878 911 944 976 1010 1043 1076 1101 1109	247.50 258.50 272.50 286.00 297.00 308.50 319.50 330.50 341.50 353.00 364.00 372.50 375.50	Draft 245.50 256.50 270.50 284.00 295.00 306.50 317.50 328.50 339.50 351.00 362.00 370.50 373.50

Only applicants first eligible for Medicare Part A before 2020 may purchase Plans C, F, and High Deductible F. Page 3

Globe Life And Accident Medicare Supplement Rates

PLAN HD	OF Effe	ective Date: 0	4/01/2020	Plan Cod	e: JB1	PLAN HD	G Effe	ctive Date: 0	4/01/2020	Plan Cod	e: JFO
Attained Age	Annual	Semi Annual	Quarterly	Monthly	Monthly Bank Draft	Attained Age	Annual	Semi Annual	Quarterly	Monthly	Monthly Bank Draft
65	443	226	115	39.00	37.00	65	443	226	115	39.00	37.00
66	479	244	125	42.00	40.00	66	479	244	125	42.00	40.00
67	514	262	134	45.00	43.00	67	514	262	134	45.00	43.00
68	533	272	139	47.00	45.00	68	533	272	139	47.00	45.00
69	557	284	145	49.00	47.00	69	557	284	145	49.00	47.00
70	583	297	152	51.50	49.50	70	583	297	152	51.50	49.50
71	601	307	156	53.00	51.00	71	601	307	156	53.00	51.00
72	633	323	165	55.50	53.50	72	633	323	165	55.50	53.50
73	667	340	173	58.50	56.50	73	667	340	173	58.50	56.50
74	696	355	181	61.00	59.00	74	696	355	181	61.00	59.00
75	726	370	189	64.00	62.00	75	726	370	189	64.00	62.00
76	738	376	192	65.00	63.00	76	738	376	192	65.00	63.00
77	748	381	194	66.00	64.00	77	748	381	194	66.00	64.00
78	762	389	198	67.00	65.00	78	762	389	198	67.00	65.00
79	774	395	201	68.00	66.00	79	774	395	201	68.00	66.00
80+	797	406	207	70.00	68.00	80+	797	406	207	70.00	68.00
PLAN G	Effe	ective Date: 1	2/01/2024	Plan Cod	le: JCO	PLAN N	Effe	ctive Date: 1	2/01/2024	Plan Cod	e: JC8
Attained Age	Annual	Semi Annual	Quarterly	Monthly	Monthly Bank	Attained Age	Annual	Semi Annual	Quarterly	Monthly	Monthly Bank
						Attained Age			Quarterry	wontniy	
65	2514	1282	654	221.00	Draft 219.00	65	1707	871	444	150.00	Draft 148.00
65 66	2514 2638		654 686		Draft						Draft
		1282		221.00	Draft 219.00	65	1707	871	444	150.00	Draft 148.00
66	2638	1282 1345	686	221.00 232.00	Draft 219.00 230.00	65 66	1707 1790	871 913	444 465	150.00 157.50	Draft 148.00 155.50
66 67	2638 2796	1282 1345 1426	686 727	221.00 232.00 246.00	Draft 219.00 230.00 244.00	65 66 67	1707 1790 1895	871 913 966	444 465 493	150.00 157.50 167.00	Draft 148.00 155.50 165.00
66 67 68	2638 2796 2952	1282 1345 1426 1506	686 727 768	221.00 232.00 246.00 260.00	Draft 219.00 230.00 244.00 258.00	65 66 67 68	1707 1790 1895 2003	871 913 966 1022	444 465 493 521	150.00 157.50 167.00 176.50	Draft 148.00 155.50 165.00 174.50
66 67 68 69	2638 2796 2952 3078	1282 1345 1426 1506 1570	686 727 768 800	221.00 232.00 246.00 260.00 271.00	Draft 219.00 230.00 244.00 258.00 269.00	65 66 67 68 69	1707 1790 1895 2003 2092	871 913 966 1022 1067	444 465 493 521 544	150.00 157.50 167.00 176.50 184.00	Draft 148.00 155.50 165.00 174.50 182.00
66 67 68 69 70	2638 2796 2952 3078 3205	1282 1345 1426 1506 1570 1635	686 727 768 800 833	221.00 232.00 246.00 260.00 271.00 282.00	Draft 219.00 230.00 244.00 258.00 269.00 280.00	65 66 67 68 69 70	1707 1790 1895 2003 2092 2179	871 913 966 1022 1067 1111	444 465 493 521 544 567	150.00 157.50 167.00 176.50 184.00 192.00	Draft 148.00 155.50 165.00 174.50 182.00 190.00
66 67 68 69 70 71	2638 2796 2952 3078 3205 3332	1282 1345 1426 1506 1570 1635 1699	686 727 768 800 833 866	221.00 232.00 246.00 260.00 271.00 282.00 293.00	Draft 219.00 230.00 244.00 258.00 269.00 280.00 291.00	65 66 67 68 69 70 71	1707 1790 1895 2003 2092 2179 2272	871 913 966 1022 1067 1111 1159	444 465 493 521 544 567 591	150.00 157.50 167.00 176.50 184.00 192.00 200.00	Draft 148.00 155.50 165.00 174.50 182.00 190.00 198.00
66 67 68 69 70 71 72	2638 2796 2952 3078 3205 3332 3452	1282 1345 1426 1506 1570 1635 1699 1761	686 727 768 800 833 866 898	221.00 232.00 246.00 260.00 271.00 282.00 293.00 304.00	Draft 219.00 230.00 244.00 258.00 269.00 280.00 291.00 302.00	65 66 67 68 69 70 71 71 72	1707 1790 1895 2003 2092 2179 2272 2359	871 913 966 1022 1067 1111 1159 1203	444 465 493 521 544 567 591 613	150.00 157.50 167.00 176.50 184.00 192.00 200.00 207.50	Draft 148.00 155.50 165.00 174.50 182.00 190.00 198.00 205.50
66 67 68 69 70 71 71 72 73	2638 2796 2952 3078 3205 3332 3452 3582	1282 1345 1426 1506 1570 1635 1699 1761 1827	686 727 768 800 833 866 898 931	221.00 232.00 246.00 260.00 271.00 282.00 293.00 304.00 315.00	Draft 219.00 230.00 244.00 258.00 269.00 280.00 291.00 302.00 313.00	65 66 67 68 69 70 71 71 72 73	1707 1790 1895 2003 2092 2179 2272 2359 2452	871 913 966 1022 1067 1111 1159 1203 1251	444 465 493 521 544 567 591 613 638	150.00 157.50 167.00 176.50 184.00 192.00 200.00 207.50 216.00	Draft 148.00 155.50 165.00 174.50 182.00 190.00 198.00 205.50 214.00
66 67 68 69 70 71 72 73 73 74	2638 2796 2952 3078 3205 3332 3452 3582 3709	1282 1345 1426 1506 1570 1635 1699 1761 1827 1892	686 727 768 800 833 866 898 931 964	221.00 232.00 246.00 260.00 271.00 282.00 293.00 304.00 315.00 326.50	Draft 219.00 230.00 244.00 258.00 269.00 280.00 291.00 302.00 313.00 324.50	65 66 67 68 69 70 71 72 73 73 74	1707 1790 1895 2003 2092 2179 2272 2359 2452 2548	871 913 966 1022 1067 1111 1159 1203 1251 1299	444 465 493 521 544 567 591 613 638 662	150.00 157.50 167.00 176.50 184.00 192.00 200.00 207.50 216.00 224.00	Draft 148.00 155.50 165.00 174.50 182.00 190.00 198.00 205.50 214.00 222.00
66 67 68 69 70 71 71 72 73 73 74 75	2638 2796 2952 3078 3205 3332 3452 3582 3582 3709 3837	1282 1345 1426 1506 1570 1635 1699 1761 1827 1892 1957	686 727 768 800 833 866 898 931 964 998	221.00 232.00 246.00 260.00 271.00 282.00 293.00 304.00 315.00 326.50 337.50	Draft 219.00 230.00 244.00 258.00 269.00 280.00 291.00 302.00 313.00 324.50 335.50	65 66 67 68 69 70 71 72 73 73 74 75	1707 1790 1895 2003 2092 2179 2272 2359 2452 2548 2642	871 913 966 1022 1067 1111 1159 1203 1251 1299 1347	444 465 493 521 544 567 591 613 638 662 687	150.00 157.50 167.00 176.50 184.00 192.00 200.00 207.50 216.00 224.00 232.50	Draft 148.00 155.50 165.00 174.50 182.00 190.00 198.00 205.50 214.00 222.00 230.50
66 67 68 69 70 71 72 73 74 75 76	2638 2796 2952 3078 3205 3332 3452 3582 3709 3837 3931	1282 1345 1426 1506 1570 1635 1699 1761 1827 1892 1957 2005	686 727 768 800 833 866 898 931 964 998 1022	221.00 232.00 246.00 260.00 271.00 282.00 293.00 304.00 315.00 326.50 337.50 346.00	Draft 219.00 230.00 244.00 258.00 269.00 280.00 291.00 302.00 313.00 324.50 335.50 344.00	65 66 67 68 69 70 71 72 73 73 74 75 76	1707 1790 1895 2003 2092 2179 2272 2359 2452 2548 2642 2711	871 913 966 1022 1067 1111 1159 1203 1251 1299 1347 1383	444 465 493 521 544 567 591 613 638 662 687 705	150.00 157.50 167.00 176.50 184.00 192.00 200.00 207.50 216.00 224.00 232.50 238.50	Draft 148.00 155.50 165.00 174.50 182.00 190.00 198.00 205.50 214.00 222.00 230.50 236.50
66 67 68 69 70 71 72 73 74 75 76 77	2638 2796 2952 3078 3205 3332 3452 3582 3709 3837 3931 3968	1282 1345 1426 1506 1570 1635 1699 1761 1827 1892 1957 2005 2024	686 727 768 800 833 866 898 931 964 998 1022 1032	221.00 232.00 246.00 260.00 271.00 282.00 293.00 304.00 315.00 326.50 337.50 346.00 349.00	Draft 219.00 230.00 244.00 258.00 269.00 280.00 302.00 313.00 324.50 335.50 344.00 347.00	65 66 67 68 69 70 71 71 72 73 73 74 75 76 76 77	1707 1790 1895 2003 2092 2179 2272 2359 2452 2548 2642 2711 2747	871 913 966 1022 1067 1111 1159 1203 1251 1299 1347 1383 1401	444 465 493 521 544 567 591 613 638 662 687 705 714	150.00 157.50 167.00 176.50 184.00 192.00 200.00 207.50 216.00 224.00 232.50 238.50 241.50	Draft 148.00 155.50 165.00 174.50 182.00 190.00 198.00 205.50 214.00 222.00 230.50 236.50 239.50

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 \$1632	\$0	\$1632 (Part A Deductible)
61st thru 90th day	All but \$408 a day	\$408 a day	\$0
91st day and after:			
 – While using 60 lifetime reserve days 	All but \$816 a day	\$816 a day	\$0
Once lifetime reserve days are used:			
– Additional 365 days	\$0	100% of Medicare-Eligible Expenses	\$0 **
 Beyond the Additional 365 days 	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$204 a day	\$0	Up to \$204 a day
101st day and after	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and	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 \$240 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 \$240 of Medicare-Approved Amounts*	\$0	\$0	\$240 (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare-Approved Amounts)	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$240 of Medicare-Approved Amounts*	\$0	\$0	\$240 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES			
- Tests for diagnostic services	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	\$0	\$0
– Durable medical equipment			
First \$240 of Medicare-Approved Amounts*	\$0	\$0	\$240 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	\$0

PLAN 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 \$1632	\$1632 (Part A Deductible)	\$0
61st thru 90th day	All but \$408 a day	\$408 a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$816 a day	\$816 a day	\$0
Once lifetime reserve days are used:			
– Additional 365 days	\$0	100% of Medicare-Eligible	\$0 **
– Beyond the Additional 365 days	\$0	Expenses \$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$204 a day	\$0	Up to \$204 a day
101st day and after	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you the balance based on any difference between its billed charges and the amount Medicare would have paid. DS-GMS2020(21)

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

* Once you have been billed \$240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$240 of Medicare-Approved Amounts*	\$0	\$0	\$240 (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare-Approved Amounts)	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$240 of Medicare-Approved Amounts*	\$0	\$0	\$240 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES			
– Tests for diagnostic services	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	\$0	\$0
– Durable medical equipment			
First \$240 of Medicare-Approved Amounts*	\$0	\$0	\$240 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	\$0

PLAN 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 \$1632	\$1632 (Part A Deductible)	\$0
61st thru 90th day	All but \$408 a day	\$408 a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$816 a day	\$816 a day	\$0
Once lifetime reserve days are used:			
– Additional 365 days	\$0	100% of Medicare-Eligible Expenses	\$0 **
 Beyond the Additional 365 days 	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$204 a day	Up to \$204 a day	\$0
101st day and after	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$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. DS-GMS2020(21)

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

* Once you have been billed \$240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$240 of Medicare-Approved Amounts*	\$0	\$240 (Part B Deductible)	\$0
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	\$0
	ćo.	ćo.	All Casta
Part B Excess Charges (Above Medicare-Approved Amounts)	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$240 of Medicare-Approved Amounts*	\$0	\$240 (Part B Deductible)	\$0
Remainder of Medicare-Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES			
– Tests for diagnostic services	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	\$0	\$0
– Durable medical equipment			
First \$240 of Medicare-Approved Amounts*	\$0	\$240 (Part B Deductible)	\$0
Remainder of Medicare-Approved Amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year 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 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 \$2800 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$2800. 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 \$2800 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$2800 DEDUCTIBLE,** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1632	\$1632 (Part A Deductible)	\$0
61st thru 90th day	All but \$408 a day	\$408 a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$816 a day	\$816 a day	\$0
Once lifetime reserve days are used:			
– Additional 365 days	\$0	100% of Medicare-Eligible	\$0 ***
Doverned the Additional 26E days	¢0	Expenses	All Casta
 Beyond the Additional 365 days SKILLED NURSING FACILITY CARE* 	\$0	\$0	All Costs
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving			
the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$204 a day	Up to \$204 a day	\$0
101st day and after	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you the balance based on any difference between its billed charges and the amount Medicare would have paid. DS-GMS2020(21)

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

- * Once you have been billed \$240 of Medicare-approved amounts for covered services (which are noted with 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 \$2800 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$2800. 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 \$2800 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$2800 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 \$240 of Medicare-Approved Amounts*	\$0	\$240 (Part B Deductible)	\$0
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare-Approved Amounts)	\$0	100%	\$0
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$240 of Medicare-Approved Amounts*	\$0	\$240 (Part B Deductible)	\$0
Remainder of Medicare-Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES			
– Tests for diagnostic services	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
 Medically necessary skilled care services and medical supplies 	100%	\$0	\$0
– Durable medical equipment			
First \$240 of Medicare-Approved Amounts*	\$0	\$240 (Part B Deductible)	\$0
Remainder of Medicare-Approved Amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN G 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 \$2800 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are \$2800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2800 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$2800 DEDUCTIBLE,** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1632	\$1632 (Part A Deductible)	\$0
61st thru 90th day	All but \$408 a day	\$408 a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$816 a day	\$816 a day	\$0
Once lifetime reserve days are used:			
– Additional 365 days	\$0	100% of Medicare-Eligible	\$0 ***
Devend the Additional 265 days	¢0	Expenses	
 Beyond the Additional 365 days SKILLED NURSING FACILITY CARE* 	\$0	\$0	All Costs
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$204 a day	Up to \$204 a day	\$0
101st day and after	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

 *** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you the balance based on any difference between its billed charges and the amount Medicare would have paid.
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PLAN G or HIGH DEDUCTIBLE PLAN G MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

- * Once you have been billed \$240 of Medicare-approved amounts for covered services (which are noted with 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 \$2800 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are \$2800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2800 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$2800 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 \$240 of Medicare-Approved Amounts*	\$0	\$0	\$240 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare-Approved Amounts)	\$0	100%	\$0
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$240 of Medicare-Approved Amounts*	\$0	\$0	\$240 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES			
– Tests for diagnostic services	100%	\$0	\$0
P/	ARTS A & B		
HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
 Medically necessary skilled care services and medical supplies Durable medical equipment 	100%	\$0	\$0
First \$240 of Medicare-Approved Amounts*	\$0	\$0	\$240 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved Amounts	80%	20%	\$0
OTHER BENEFITS –	NOT COVERED BY M	EDICARE	
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 \$1632	\$1632 (Part A Deductible)	\$0
61st thru 90th day	All but \$408 a day	\$408 a day	\$0
91st day and after:			
 – While using 60 lifetime reserve days 	All but \$816 a day	\$816 a day	\$0
Once lifetime reserve days are used:			
– Additional 365 days	\$0	100% of Medicare-Eligible Expenses	\$0 **
 Beyond the Additional 365 days 	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$204 a day	Up to \$204 a day	\$0
101st day and after	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$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 \$240 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 \$240 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.	\$240 (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	\$0	All Costs	\$0
Next \$240 of Medicare-Approved Amounts*	\$0	\$0	\$240 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES			
– Tests for diagnostic services	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	\$0	\$0
– Durable medical equipment			
First \$240 of Medicare-Approved Amounts*	\$0	\$0	\$240 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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