GLOBE LIFE AND ACCIDENT INSURANCE COMPANY

A Nebraska 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, 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 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 requires 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.

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. Your premiums may also be increased due to increasing health costs for all policies in your class. We will not change our table of premium rates more often than once in a 12-month period.

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.

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	2497	1273	649	219.50	217.50	J88	01/01/2024
B	3787	1931	985	333.50	331.50	J89	01/01/2024
F	5426	2767	1411	477.50	475.50	J91	01/01/2024
HDF	1051	536	273	92.50	90.50	JB4	07/01/2021
G	5094	2598	1324	448.50	446.50	JC3	01/01/2024
HDG	1051	536	273	92.50	90.50	JF3	07/01/2021
N	3277	1671	852	288.50	286.50	JD0	01/01/2024

UNDER AGE 65 GUARANTEED ISSUE PERIOD (G/I)

Plan	A	SA	Q	M	MBD	Plan Code	Effective Date
A	2497	1273	649	219.50	217.50	J88	01/01/2024
B	3787	1931	985	333.50	331.50	J89	01/01/2024
F	5426	2767	1411	477.50	475.50	J91	01/01/2024
HDF	1051	536	273	92.50	90.50	JB4	07/01/2021
G	5094	2598	1324	448.50	446.50	JC3	01/01/2024
HDG	1051	536	273	92.50	90.50	JF3	07/01/2021

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 A **Effective Date: 01/01/2024** **Plan Code: J68**

Issue Age	Annual	Semi Annual	Quarterly	Monthly	Monthly Bank Draft
65	1775	905	462	156.00	154.00
66	1857	947	483	163.50	161.50
67	1857	947	483	163.50	161.50
68	1857	947	483	163.50	161.50
69	1857	947	483	163.50	161.50
70	1972	1006	513	173.50	171.50
71	1972	1006	513	173.50	171.50
72	1972	1006	513	173.50	171.50
73	1972	1006	513	173.50	171.50
74	1972	1006	513	173.50	171.50
75	2032	1036	528	179.00	177.00
76	2032	1036	528	179.00	177.00
77	2032	1036	528	179.00	177.00
78	2032	1036	528	179.00	177.00
79	2032	1036	528	179.00	177.00
80	2082	1062	541	183.00	181.00
81	2082	1062	541	183.00	181.00
82	2082	1062	541	183.00	181.00
83	2082	1062	541	183.00	181.00
84	2082	1062	541	183.00	181.00
85	2288	1167	595	201.50	199.50
86	2288	1167	595	201.50	199.50
87	2288	1167	595	201.50	199.50
88	2288	1167	595	201.50	199.50
89	2288	1167	595	201.50	199.50
90+	2497	1273	649	219.50	217.50

PLAN B **Effective Date: 01/01/2024** **Plan Code: J69**

Issue Age	Annual	Semi Annual	Quarterly	Monthly	Monthly Bank Draft
65	2520	1285	655	222.00	220.00
66	2668	1361	694	235.00	233.00
67	2668	1361	694	235.00	233.00
68	2668	1361	694	235.00	233.00
69	2668	1361	694	235.00	233.00
70	2916	1487	758	256.50	254.50
71	2916	1487	758	256.50	254.50
72	2916	1487	758	256.50	254.50
73	2916	1487	758	256.50	254.50
74	2916	1487	758	256.50	254.50
75	3082	1572	801	271.00	269.00
76	3082	1572	801	271.00	269.00
77	3082	1572	801	271.00	269.00
78	3082	1572	801	271.00	269.00
79	3082	1572	801	271.00	269.00
80	3157	1610	821	278.00	276.00
81	3157	1610	821	278.00	276.00
82	3157	1610	821	278.00	276.00
83	3157	1610	821	278.00	276.00
84	3157	1610	821	278.00	276.00
85	3473	1771	903	305.50	303.50
86	3473	1771	903	305.50	303.50
87	3473	1771	903	305.50	303.50
88	3473	1771	903	305.50	303.50
89	3473	1771	903	305.50	303.50
90+	3787	1931	985	333.50	331.50

Globe Life And Accident Medicare Supplement Rates

PLAN F **Effective Date: 01/01/2024** **Plan Code: J71**

Issue Age	Annual	Semi Annual	Quarterly	Monthly	Monthly Bank Draft
65	3161	1612	822	278.00	276.00
66	3373	1720	877	297.00	295.00
67	3373	1720	877	297.00	295.00
68	3373	1720	877	297.00	295.00
69	3373	1720	877	297.00	295.00
70	3826	1951	995	336.50	334.50
71	3826	1951	995	336.50	334.50
72	3826	1951	995	336.50	334.50
73	3826	1951	995	336.50	334.50
74	3826	1951	995	336.50	334.50
75	4195	2139	1091	369.00	367.00
76	4195	2139	1091	369.00	367.00
77	4195	2139	1091	369.00	367.00
78	4195	2139	1091	369.00	367.00
79	4195	2139	1091	369.00	367.00
80	4522	2306	1176	398.00	396.00
81	4522	2306	1176	398.00	396.00
82	4522	2306	1176	398.00	396.00
83	4522	2306	1176	398.00	396.00
84	4522	2306	1176	398.00	396.00
85	4973	2536	1293	437.50	435.50
86	4973	2536	1293	437.50	435.50
87	4973	2536	1293	437.50	435.50
88	4973	2536	1293	437.50	435.50
89	4973	2536	1293	437.50	435.50
90+	5426	2767	1411	477.50	475.50

PLAN HDF **Effective Date: 01/01/2021** **Plan Code: JA6**

Issue Age	Annual	Semi Annual	Quarterly	Monthly	Monthly Bank Draft
65	652	333	170	57.50	55.50
66	692	353	180	61.00	59.00
67	692	353	180	61.00	59.00
68	692	353	180	61.00	59.00
69	692	353	180	61.00	59.00
70	753	384	196	66.50	64.50
71	753	384	196	66.50	64.50
72	753	384	196	66.50	64.50
73	753	384	196	66.50	64.50
74	753	384	196	66.50	64.50
75	815	416	212	71.50	69.50
76	815	416	212	71.50	69.50
77	815	416	212	71.50	69.50
78	815	416	212	71.50	69.50
79	815	416	212	71.50	69.50
80	875	446	228	77.00	75.00
81	875	446	228	77.00	75.00
82	875	446	228	77.00	75.00
83	875	446	228	77.00	75.00
84	875	446	228	77.00	75.00
85	964	492	251	85.00	83.00
86	964	492	251	85.00	83.00
87	964	492	251	85.00	83.00
88	964	492	251	85.00	83.00
89	964	492	251	85.00	83.00
90+	1051	536	273	92.50	90.50

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 G Effective Date: 01/01/2024 Plan Code: JB9

Issue Age	Annual	Semi Annual	Quarterly	Monthly	Monthly Bank Draft
65	2885	1471	750	254.00	252.00
66	3097	1579	805	272.50	270.50
67	3097	1579	805	272.50	270.50
68	3097	1579	805	272.50	270.50
69	3097	1579	805	272.50	270.50
70	3549	1810	923	312.50	310.50
71	3549	1810	923	312.50	310.50
72	3549	1810	923	312.50	310.50
73	3549	1810	923	312.50	310.50
74	3549	1810	923	312.50	310.50
75	3917	1998	1018	344.50	342.50
76	3917	1998	1018	344.50	342.50
77	3917	1998	1018	344.50	342.50
78	3917	1998	1018	344.50	342.50
79	3917	1998	1018	344.50	342.50
80	4246	2165	1104	373.50	371.50
81	4246	2165	1104	373.50	371.50
82	4246	2165	1104	373.50	371.50
83	4246	2165	1104	373.50	371.50
84	4246	2165	1104	373.50	371.50
85	4671	2382	1214	411.00	409.00
86	4671	2382	1214	411.00	409.00
87	4671	2382	1214	411.00	409.00
88	4671	2382	1214	411.00	409.00
89	4671	2382	1214	411.00	409.00
90+	5094	2598	1324	448.50	446.50

PLAN HDG Effective Date: 01/01/2021 Plan Code: JE9

Issue Age	Annual	Semi Annual	Quarterly	Monthly	Monthly Bank Draft
65	652	333	170	57.50	55.50
66	692	353	180	61.00	59.00
67	692	353	180	61.00	59.00
68	692	353	180	61.00	59.00
69	692	353	180	61.00	59.00
70	753	384	196	66.50	64.50
71	753	384	196	66.50	64.50
72	753	384	196	66.50	64.50
73	753	384	196	66.50	64.50
74	753	384	196	66.50	64.50
75	815	416	212	71.50	69.50
76	815	416	212	71.50	69.50
77	815	416	212	71.50	69.50
78	815	416	212	71.50	69.50
79	815	416	212	71.50	69.50
80	875	446	228	77.00	75.00
81	875	446	228	77.00	75.00
82	875	446	228	77.00	75.00
83	875	446	228	77.00	75.00
84	875	446	228	77.00	75.00
85	964	492	251	85.00	83.00
86	964	492	251	85.00	83.00
87	964	492	251	85.00	83.00
88	964	492	251	85.00	83.00
89	964	492	251	85.00	83.00
90+	1051	536	273	92.50	90.50

Globe Life And Accident Medicare Supplement Rates

PLAN N **Effective Date: 01/01/2024** **Plan Code: JA4**

Issue Age	Annual	Semi Annual	Quarterly	Monthly	Monthly Bank Draft
65	1825	931	475	160.50	158.50
66	1958	999	509	172.50	170.50
67	1958	999	509	172.50	170.50
68	1958	999	509	172.50	170.50
69	1958	999	509	172.50	170.50
70	2257	1151	587	198.50	196.50
71	2257	1151	587	198.50	196.50
72	2257	1151	587	198.50	196.50
73	2257	1151	587	198.50	196.50
74	2257	1151	587	198.50	196.50
75	2504	1277	651	220.50	218.50
76	2504	1277	651	220.50	218.50
77	2504	1277	651	220.50	218.50
78	2504	1277	651	220.50	218.50
79	2504	1277	651	220.50	218.50
80	2731	1393	710	240.50	238.50
81	2731	1393	710	240.50	238.50
82	2731	1393	710	240.50	238.50
83	2731	1393	710	240.50	238.50
84	2731	1393	710	240.50	238.50
85	3006	1533	782	264.50	262.50
86	3006	1533	782	264.50	262.50
87	3006	1533	782	264.50	262.50
88	3006	1533	782	264.50	262.50
89	3006	1533	782	264.50	262.50
90+	3277	1671	852	288.50	286.50

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 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 $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 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 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 $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 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 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 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 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 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

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 (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 $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*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The 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 $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 benefit of $50,000	20% and amounts over the $50,000 lifetime maximum