STERLING LIFE INSURANCE COMPANY

Medicare Supplement Administrative Offices/Customer Service P.O. Box 5348, Bellingham, WA 98227-5348

Outline of Medicare SELECT and Medicare Supplement Coverage - Cover Page 1 of 2

Benefit Chart of Medicare Supplement Plans Sold with Effective Dates on or after June 1, 2010

Standard Medicare Supplement Plans A, B, C, F, Innovative F, G, K and N are Available.

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Standard Plan "A". Some plans may not be available in Your state.

The starred (*) plans (A, B, C, F, Innovative F, G, K and N) are Medicare SELECT Plans. Medicare SELECT plans contain restrictions on Your use of hospitals and providers. **See Outlines of Coverage sections for details about ALL plans.**

BASIC BENEFITS for Plans A-N.

- **Hospitalization:** Part A coinsurance plus coverage for 365 additional days in Your lifetime after Medicare benefits end.
- **Medical Expenses:** Part B coinsurance (generally 20% of Medicare approved expenses), or co-payments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.
- **Blood:** First three pints of blood each year.
- **Hospice –** Part A cost sharing.

*A	*B	*C	D	*F	F*	*Innovative F	*G
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance*		+Basic Benefits	Basic, including 100% Part B coinsurance
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible		Part B Deductible	
				Part B Excess (100%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency	Foreign Travel Emergency
						+Innovative Benefits+	

 # Plans F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plans F after the policyholder has paid a calendar year $2,000 deductible. Benefits from high deductible Plans F will not begin until out-of-pocket expenses exceed $2,000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. The expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

+Innovative F includes innovative benefits not contained in other standardized Medicare Supplement Plans. They include, subject to plan limitations: (a) access to nurse advice telephone service, (b) annual physical examination, (c) preventive dental care, (d) routing vision care, and (e) routing hearing exam. You are also charged a co-pay of the lesser of a five dollar ($5) copayment or actual Part B coinsurance for provider office visits.

STERLING LIFE INSURANCE COMPANY

Outline of Medicare Supplement Coverage – Cover Page 2

Basic Benefits for Plans K and L include <u>similar</u> services as Plans A-G, but cost sharing for the basic benefits is at different levels.

*K**	L**	M	*N
Hospitalization and preventative care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventative care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
50% Part A deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Foreign Travel Emergency	Foreign Travel Emergency
Out-of-pocket limit $4,640; benefits paid at 100% after limit reached	Out-of -pocket limit $2,320; benefits paid at 100% after limit reached		

Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges". You will be responsible for paying excess charges. **The out-of-pocket annual limit will increase each year for inflation.

See Outlines of Coverage for details and exceptions.

PREMIUM INFORMATION

Sterling Life Insurance Company may raise Your premium if it raises the premium for all policies in Your class. Premiums are issue age rated and based on the mode of the premium payment selected. **Premium in the chart below is subject to change.**

(INSERT PAGES 3, 3A, 3B, 3C and 3D)

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE DISCLOSURES

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 are not satisfied with Your policy, You may return it to us within thirty (30) days after You receive it. You may return it to us or to the agent who sold it. We will refund to You any premium paid and this policy will be void.

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 of Your medical costs. This Outline of Coverage does not give all the details of Medicare coverage. Contact Your local Social Security Office or consult "Medicare & You" for more details. Neither Sterling Life Insurance Company nor its agents are connected with Medicare.

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 any claims if you leave out or falsify important medical information. Review the application carefully before You sign it. Be certain that all information has been properly recorded.

REFUND OF PREMIUM

If termination is due to You ceasing to be eligible for this plan or We receive written notice that You wish to terminate Your coverage, the date of termination will be the first day of the month following the event. Any premium paid beyond the termination date will be refunded to You.

LIMITATIONS AND EXCLUSIONS

This is a Medicare supplement policy. With the exception of Innovative Benefits Exceeding Standardized Medicare Supplement Plans, as described above, Your coverage is conditional on Medicare's approval of Medicare Eligible Expenses. With the exception of Innovative Benefits Exceeding Standardized Medicare Supplement Plans, as described above, services eligible for coverage must therefore be deemed as medically necessary by Medicare. With the exception of Innovative Benefits Exceeding Standardized Medicare Supplement Plans, as described above, if Medicare does not consider services rendered or expenses incurred as medically necessary, no benefits will be paid. We will not place any limitations on benefits that are more restrictive than Medicare's limitations and restrictions, except as noted in the Network Hospital Restrictions.

No benefits will be paid under Medicare Part A which duplicates payments under Medicare Part B. No benefits will be paid under Medicare Part B which duplicates payments under Medicare Part A. No benefits will duplicate payment made directly by Medicare.

NETWORK HOSPITAL RESTRICTIONS – MEDICARE SELECT PRODUCTS ONLY

Except as specified below, Part A and Part B (hospital or facility) benefits will not be paid for services provided at a Hospital which is not a Network Hospital and Part B (hospital or facility) benefits for outpatient surgery will only be provided if performed at a doctor's office, Network Hospital, or outpatient surgery clinic which is owned, operated by or has a written agreement with a Network Hospital to provide services.

Full benefits of Your coverage will be paid when:

1. Services are provided in the following places: a Physician's office; in another office setting (other than an outpatient surgery clinic); in a Skilled Nursing Facility;
2. The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, Injury or a condition, and it is not reasonable to obtain such services through the Network Hospital;
3. While Traveling outside the Service Area, services will be covered from the 1st day through the 90th day of each trip, travel must be for purposes other than the receipt of medical care; or
4. Required services are not available at a Network Hospital in Your Service Area.

Network Hospitals

A Network Hospital is one that has a written agreement with Sterling and has been designated by Sterling to provide hospital services insured under this policy. You may use any Network Hospital, which is listed, on Your current Sterling Medicare SELECT Supplement Insurance **Network Hospital Directory.** This directory is updated periodically. To verify the status of a hospital please call 1-800-688-0010 between the hours of 5AM and 8PM Pacific Time, Monday through Friday.

Non-Network Hospital Admission Procedures

Prior to admission to a non-Network Hospital, You, either directly or through Your physician, should contact Sterling's Customer Service Center. The Customer Service Center will confirm whether the required services are available from a Network Hospital, and if not available, will assist You in locating a hospital that provides the necessary service. **Utilizing Sterling's Customer Service Center prior to use of a non-Network Hospital eliminates the need for retrospective inquiry as to the legitimacy of the filed claim**.

These non-Network Hospital Admission Procedures do not apply in emergency situations or while You are traveling outside of the service area during the 1st through 90th day of travel. Travel must be for purposes other than the receipt of medical care.

CONTINUATION OF COVERAGE

Any claim for a continuous loss that begins while this policy is in force will not be affected by the ending of this policy. However, benefits for such continuous loss may be conditioned upon Your continuous total disability, and are limited to the duration of the Medicare Benefit Period, if any, or the maximum benefits payable.

If the authority to issue Medicare SELECT policies is discontinued for whatever reason or the Service Area no longer exists, Your coverage can continue. Coverage will be continued under any other Medicare Supplement policy We have available containing comparable or lesser benefits and which does not contain Restricted Network Provisions. You will not need to provide evidence of insurability.

CONVERSION PRIVILEGE – MEDICARE SELECT PRODUCTS ONLY

You may request to convert this policy to a policy that does not contain Restricted Network Provisions without submission of evidence of insurance at anytime. Your request must be received by Sterling on or before the 20th day of the month, and will be effective the 1st day of the following month. The conversion will be to a Medicare Supplement policy with comparable or lesser benefits which is offered by Sterling. Conversion is subject to the availability of a Sterling Medicare Supplement policy for sale in Your state.

COMPLAINT PROCEDURE – MEDICARE SELECT PRODUCTS ONLY

Complaints While Staying At A Network Hospital.

If, while confined at a Network Hospital, You have a complaint regarding the hospital's services being provided, You may contact Sterling's Customer Service Center by phone 1-800-688-0010 5AM to 8PM Pacific Time, Monday through Friday, to express the complaint. Sterling's Customer Service representatives will relay the complaint within twenty-four (24) hours, to the hospital's Administrator for response within twenty (20) days. Calls received between 8PM and 5AM, weekends and holidays, will be transferred to automated voice-mail, where You may leave Your name, policyholder identification number, telephone number and comment, request or complaint. Return phone calls will be placed the following business day.

Other Complaints. If You have questions or are dissatisfied with the quality of care received from a Network Hospital, have a complaint, or want to contest the disposition of a claim, You may direct such inquiries to the Customer Service Center, P.O. Box 5348, Bellingham, WA 98227-5348, 1-800-688-0010 without initiating a formal grievance.

Questions or complaints regarding any of these areas which are presented shall receive acknowledgment within three (3) business days of receipt. A response will be sent to You within thirty (30) business days of the complaint. If after thirty (30) business days a response is unavailable, we will provide a status update to You every ten (10) business days.

GRIEVANCE PROCEDURE – MEDICARE SELECT PRODUCTS ONLY

In the event You are dissatisfied with the response received to a complaint or with the disposition of a claim, You may submit a formal grievance by writing to the Claims Administrator at P.O. Box 5348, Bellingham, WA 98227-5348. Formal grievances in all other areas should be submitted to Us in writing at the same address. A grievance must clearly state "This is a grievance", or other words that clearly state that the intention of the written communication is to serve as a written grievance to be handled according to this procedure. Acknowledgment of receipt of the grievance will be mailed within three (3) business days and the grievance will be investigated. A response will be sent within thirty (30) days following the date the grievance is received and shall explain in detail the reasons for the determination.

If Sterling upholds the grievance, corrective action will be taken promptly to remedy the situation.

Grievance Appeal Committee. In the event You are not satisfied with the results of Our determination, You have the right to file an appeal by written request with Sterling. The appeal should be submitted to the Grievance Appeal Committee of Sterling within sixty (60) days from the date You are notified of the complaint procedure results. The Grievance Appeal Committee shall be made up of individuals not involved in the decision making process of the original grievance or request for determination. The Grievance Appeal Committee shall schedule a hearing on the grievance within sixty (60) days of its receipt. Both You and the person or organization against whom the complaint has been made shall be notified of the time and place of the Grievance Appeal Committee hearing at which time such individuals shall have the right to appear in person or by telephone and present any information which supports their position. At the close of the hearing, the Grievance Appeal Committee shall make findings and issue a written decision within fifteen (15) business days after the hearing is held unless additional information is needed.

If You are dissatisfied with the decision, You should submit a written complaint to Arizona Department of Insurance, 2910 North 44th Street, Suite 210, Phoenix, AZ 85018-7256, or call (602) 912-8444 or 1 (800) 325-2548.

PLAN A - BENEFITS CHART

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.

** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY**
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,132	$0	$1,132 (Part A Deductible)
61st thru 90th day	All but $283 a day	$283 a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but $566 a day	$566 a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare Eligible Expenses	$0 ➢See NOTICE below
(➢**See your policy, page 5 or 6 for details of coverage**.)			
-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 $141.50 a day	$0	Up to $141.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare cost sharing	$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 "Basic Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A - BENEFITS CHART

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

* Once you have been billed $162 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.

** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

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 $162 of Medicare-Approved Amounts*	$0	$0	$162 (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 $162 of Medicare-Approved Amounts*	$0	$0	$162 (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 $162 of Medicare-Approved Amounts*	$0	$0	$162 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

PLAN B - BENEFITS CHART

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.

** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY**
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,132	$1,132 (Part A Deductible)	$0
61st thru 90th day	All but $283 a day	$283 a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but $566 a day	$566 a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare Eligible Expenses	$0 ➘See NOTICE below
(➘**See your policy, page 5 or 6 for details of coverage**.)			
-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 $141.50 a day	$0	Up to $141.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare cost sharing	$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 "Basic Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B - BENEFITS CHART

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

* Once you have been billed $162 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.

** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

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 $162 of Medicare-Approved Amounts*	$0	$0	$162 (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 $162 of Medicare-Approved Amounts*	$0	$0	$162 (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	$0	$0	$162 (Part B Deductible)
First $162 of Medicare-Approved Amounts*	80%	20%	$0
Remainder of Medicare-Approved Amounts			

PLAN C - BENEFITS CHART

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.

** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY**
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,132	$1,132 (Part A Deductible)	$0
61st thru 90th day	All but $283 a day	$283 a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but $566 a day	$566 a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare Eligible Expenses	$0 ⩛See NOTICE below
(⩛**See your policy, page 5 or 6 for details of coverage**.)			
-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 $141.50 a day	Up to $141.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare cost sharing	$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 "Basic Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN C - BENEFITS CHART

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

* Once you have been billed $162 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.

** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

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 $162 of Medicare-Approved Amounts*	$0	$162 (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 $162 of Medicare-Approved Amounts*	$0	$162 (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 $162 of Medicare-Approved Amounts*	$0	$162 (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0

PLAN C - BENEFITS CHART

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically Necessary Emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each Calendar Year	$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 Benefit

PLAN F - BENEFITS CHART

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.

** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY**
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,132	$1,132 (Part A Deductible)	$0
61st thru 90th day	All but $283 a day	$283 a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but $566 a day	$566 a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare Eligible Expenses	$0 ➘See NOTICE below
(➘**See your policy, page 5 or 6 for details of coverage**.)			All costs
-Beyond the Additional 365 days	$0	$0	
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 $141.50 a day	Up to $141.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare cost sharing	$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 "Basic Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F - BENEFITS CHART

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

* Once you have been billed $162 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.

** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

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 $162 of Medicare-Approved Amounts*	$0	$162 (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 $162 of Medicare-Approved Amounts*	$0	$162 (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 $162 of Medicare-Approved Amounts*	$0	$162 (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0

PLAN F - BENEFITS CHART

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically Necessary Emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each Calendar Year	$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 Benefit

INNOVATIVE BENEFIT PLAN F - BENEFITS CHART

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.

** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY**
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,132	$1,132 (Part A Deductible)	$0
61st thru 90th day	All but $283 a day	$283 a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but $566 a day	$566 a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare Eligible Expenses	$0 ⮟See NOTICE below
(⮟**See your policy, page 5 or 6 for details of coverage**.)			
-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 $141.50 a day	Up to $141.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness. Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare cost sharing	$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 "Basic Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

INNOVATIVE BENEFIT PLAN F - BENEFITS CHART

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

* Once you have been billed $162 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.

** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY**
PROVIDER OFFICE VISIT – **You pay the lesser of $5 co-pay or Part B coinsurance prior to plan coverage for provider office visits only**		**After you pay the lesser of $5 co-pay or Part B coinsurance, the plan pays:**	**Lesser of $5 co-pay or Part B coinsurance, then:**
First $162 of Medicare-Approved Amounts*	$0	$162 (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
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, **OTHER THAN PROVIDER OFFICE VISIT** such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $162 of Medicare-Approved Amounts*	$0	$162 (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $162 of Medicare-Approved Amounts*	$0	$162 (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Tests For Diagnostic Services	100%	$0	$0

INNOVATIVE BENEFIT PLAN F - BENEFITS CHART

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY**
HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES			
-Medically Necessary skilled care services and medical supplies	100%	$0	$0
-Durable medical equipment			
First $162 of Medicare-Approved Amounts*	$0	$162 (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically Necessary Emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each Calendar Year	$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 Benefit

INNOVATIVE BENEFITS - NOT COVERED BY MEDICARE OR STANDARDIZED MEDICARE SUPPLEMENT PLANS

** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY**
NURSE ADVICE TELEPHONE LINE Coverage for access to our telephone Nurse Advice Line for answers to health-related questions.	$0	All costs	$0
ANNUAL PHYSICAL EXAMINATION Coverage for up to $100 dollars for one (1) routine physical examination every year, including routine lab tests billed as part of the routine physical exam. You are responsible for any charges above the $100 routine physical exam allowance, including lab tests. This benefit is separate from the one-time physical examination covered by Medicare within the first 12 months of Part B enrollment.	$0	All costs	$0
PREVENTIVE DENTAL BENEFIT Coverage for up to $500 dollars per calendar year for preventive dental care, limited to American Dental Association codes 0100-1550. Coverage is limited to:			
A. Oral Examinations – Limited to one time every six months	$0	All costs	$0
B. Bite Wing Radiographs, limited to 1 series of films per calendar year	$0	All costs	$0
C. Complete Series of Panorex Radiographs – Limited to one time per 36 months	$0	All costs	$0
D. Dental Prophylaxis – Limited to one time every six months	$0	All costs	$0
E. Diagnostic Casts – Limited to one time per 24 months	$0	All costs	$0
F. Extraoral Radiographs – Limited to 2 films per calendar year	$0	All costs	$0
ROUTINE VISION CARE Coverage for up to $100 dollars for one (1) routine eye examination every year. This is separate from diagnostic eye examinations and related charges as covered by Medicare.	$0	All costs	$0
ROUTING HEARING EXAMINATIONS Coverage for up to $100 dollars for one (1) routine hearing test every year. This is separate from diagnostic hearing examinations and related charges as covered by Medicare.	$0	All costs	$0

PLAN G - BENEFITS CHART

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.

** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY**
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,132	$1,132 (Part A Deductible)	$0
61st thru 90th day	All but $283 a day	$283 a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but $566 a day	$566 a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare Eligible Expenses	$0 ↘See NOTICE below
(↘**See your policy, page 5 or 6 for details of coverage**.)			
-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 $141.50 a day	Up to $141.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirement, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare cost sharing	$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 "Basic Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G - BENEFITS CHART

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

* Once you have been billed $162 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.

** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

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 $162 of Medicare-Approved Amounts*	$0	$0	$162 (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $162 of Medicare-Approved Amounts*	$0	$0	$162 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Blood Tests For Diagnostic Services	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY**
HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES			
-Medically Necessary skilled care services and medical supplies	100%	$0	$0
-Durable medical equipment			
First $162 of Medicare-Approved Amounts*	$0	$0	$162 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

PLAN G - BENEFITS CHART

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically Necessary Emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each Calendar Year	$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 Benefit

PLAN K - BENEFITS CHART

You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $4,640 each calendar year. The amounts that count toward your annual limit are noted with the diamonds (◆) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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. ** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY**
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,132	$566 (50% of Part A Deductible)	$566 (50% of Part A Deductible)◆
61st thru 90th day	All but $283 a day	$283 a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but $566 a day	$566 a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare Eligible Expenses	$0 ➘See NOTICE below
(➘**See your policy, page 5 or 6 for details of coverage**.)			
-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 $141.50 a day	Up to $70.75 a day	Up to $70.75 a day◆
101st day and after	$0	$0	All costs

PLAN K - BENEFITS CHART

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.

** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY**
BLOOD First 3 pints Additional amounts	 $0 100%	 50% $0	 50%◆ $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	50% of cost sharing	50% of cost sharing◆

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 "Basic Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN K - BENEFITS CHART

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

* Once you have been billed $162 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.

** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

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 $162 of Medicare-Approved Amounts*	$0	$0	$162 (Part B Deductible)*◆
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 10%	Generally 10%◆
PART B EXCESS CHARGES (Above Medicare-Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $4,640)***
BLOOD			
First 3 pints	$0	50%	50%◆
Next $162 of Medicare-Approved Amounts*	$0	$0	$162 (Part B Deductible)*◆
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 10%	Generally 10%◆
CLINICAL LABORATORY SERVICES			
Tests For Diagnostic Services	100%	$0	$0

PLAN K - BENEFITS CHART

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY**
HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES			
-Medically Necessary skilled care services and medical supplies	100%	$0	$0
-Durable medical equipment			
First $162 of Medicare-Approved Amounts***	$0	$0	$162 (Part B Deductible)*◆
Remainder of Medicare-Approved Amounts	80%	10%	10%◆

***__This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $4,640 per year.__ However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People With Medicare*.

PLAN N - BENEFITS CHART

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.

** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY**
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,132	$1,132 (Part A Deductible)	$0
61st thru 90th day	All but $283 a day	$283 a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but $566 a day	$566 a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare Eligible Expenses	$0 ↘See NOTICE below
(↘**See your policy, page 5 or 6 for details of coverage**.)			
-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 $141.50 a day	Up to $141.50 a day	$0
101st day and after	$0	$0	All costs

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 "Basic Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N - BENEFITS CHART

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.

** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY**
BLOOD First 3 pints Additional amounts	 $0 100%	 3 pints $0	 $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 cost sharing	$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 "Basic Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N - BENEFITS CHART

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

* Once you have been billed $162 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.

** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

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 $162 of Medicare-Approved Amounts*	$0	$0	$162 (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 visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency room 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 $162 of Medicare-Approved Amounts*	$0	$0	$162 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Tests For Diagnostic Services	100%	$0	$0

PLAN N - BENEFITS CHART

PARTS A & B

* Once you have been billed $162 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.

** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY**
HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES			
-Medically Necessary skilled care services and medical supplies	100%	$0	$0
-Durable medical equipment			
First $162 of Medicare-Approved Amounts*	$0	$0	$162 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY**
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically Necessary Emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each Calendar Year	$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 Benefit