2014
Benefit Chart of Medicare Supplement Plans
Outline of Coverage

Members
HEALTH
INSURANCE

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MH-ING-LG-FL12-032

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Outline of Medicare Supplement Coverage-Cover Page:

Benefit Plans A, B, C, D, F, G, M and N

These charts show the benefits included in each of the standard Medicare Supplement Insurance plans. Every company must make available Plan A. Some of the other plans may not be available from every company.

Plans E, H, I, and J are no longer available for sale.

BASIC BENEFITS
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare approved expenses) or copayments 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 coinsurance.

PLAN A	PLAN B	PLAN C	PLAN D	PLAN F/F*	PLAN G
Basic Benefits, including 100% of Part B Coinsurance	Basic Benefits, including 100% of Part B Coinsurance	Basic Benefits, including 100% of Part B Coinsurance	Basic Benefits, including 100% of Part B Coinsurance	Basic Benefits, including 100% of Part B Coinsurance*	Basic Benefits, including 100% of Part B 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 B Deductible		Part B Deductible	
				Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency

Outline of Medicare Supplement Coverage-Cover Page (continued)

PLAN K	PLAN L	PLAN M	PLAN 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 Benefits, including 100% of Part B Coinsurance	Basic Benefits, including 100% of 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 $4940; paid at 100% after limit reached	Out-of-pocket limit $2470; paid at 100% after limit reached		

*Plan F also has an option called a High Deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2140 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses exceed $2140. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

Outline of Medicare Supplement Coverage-Cover Page (continued)

Basic Benefits for Plans K and L include cost-sharing for the basic benefits at different levels.

PLAN K**	**PLAN L****
100% of Part A Hospitalization coinsurance plus coverage for 365 days after Medicare benefits end, 50% hospice cost-sharing, 50% of Medicare-eligible expenses for the first three pints of blood, 50% Part B coinsurance, except 100% coinsurance for Part B Preventive Services	100% of Part A Hospitalization coinsurance plus coverage for 365 days after Medicare benefits; 75% hospice cost-sharing; 75% of Medicare-eligible expenses for the first three pints of blood; 75% Part B coinsurance, except 100% coinsurance for Part B Preventive Services
50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
50% Part A Deductible	75% Part A Deductible
$4940 Out-of-Pocket Annual Limit***	$2470 Out-of-Pocket Annual Limit***

**Plans K and L provide for different cost-sharing for items and services than Plans A, B, C, D, F, and G.

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.

PREMIUM INFORMATION

We, Members Health Insurance Company, can raise your premium at any time. However, we can only raise your premium if we raise the premium for all persons of the same class and benefit plan insured under the group policy who reside in your state. Any premium increase must be approved by Indiana Department of Insurance. The Medicare Supplement Insurance coverage is age-rated. Your premium will be based on your current age and adjusted annually each birthday. Refer to the following premium chart for the premium applicable to the Medicare Supplement Insurance plans offered under the group policy.

Indiana Farm Bureau Group Medicare Supplement Insurance Policy
Group Medicare Supplement Insurance - Monthly Premiums*

AGE	PLAN A	PLAN B	PLAN C	PLAN D	PLAN F	PLAN G	PLAN M	PLAN N
65	$81.00	$94.00	$107.00	$99.00	$110.00	$99.00	$81.00	$80.00
66	$87.50	$102.00	$116.25	$107.25	$119.75	$107.25	$88.50	$87.50
67	$95.25	$108.75	$125.25	$115.25	$128.50	$115.12	$94.00	$94.00
68	$100.75	$116.25	$134.00	$124.00	$137.50	$123.00	$102.00	$100.75
69	$106.25	$124.00	$143.00	$132.00	$146.25	$130.75	$107.25	$107.25
70	$111.75	$128.50	$151.75	$139.50	$155.25	$138.50	$114.25	$112.75
71	$117.25	$134.00	$159.50	$148.50	$164.00	$146.25	$121.75	$120.75
72	$123.00	$138.50	$168.25	$156.25	$172.75	$154.00	$127.50	$126.25
73	$127.50	$146.25	$177.25	$164.00	$181.50	$161.75	$134.00	$133.00
74	$133.00	$154.00	$184.00	$170.50	$189.50	$169.50	$139.50	$138.50
75	$138.50	$166.25	$193.75	$177.25	$199.25	$177.25	$145.00	$144.00
76	$144.00	$172.75	$201.75	$185.00	$208.25	$186.00	$150.75	$149.50
77	$148.50	$179.50	$209.25	$191.75	$216.00	$192.75	$156.25	$155.25
78	$152.75	$185.00	$216.00	$197.25	$223.75	$199.25	$161.75	$160.75
79	$157.25	$190.50	$222.50	$203.75	$230.50	$204.75	$166.25	$165.00
80	$160.75	$195.00	$228.00	$208.25	$236.00	$210.50	$170.50	$169.50
81	$164.00	$199.25	$233.75	$213.75	$242.75	$216.00	$175.00	$174.00
82	$167.25	$203.75	$239.25	$218.25	$248.25	$220.50	$178.50	$177.25
83	$170.50	$208.25	$243.75	$222.50	$253.75	$225.00	$181.50	$180.50
84	$172.75	$212.75	$248.25	$227.00	$258.00	$229.50	$186.00	$184.00
85	$177.25	$216.00	$252.75	$231.50	$262.50	$232.50	$189.50	$187.25
86	$177.25	$219.50	$257.00	$234.75	$267.00	$237.00	$191.75	$190.50
87	$177.25	$222.50	$261.50	$238.25	$270.50	$240.25	$195.00	$193.75
88	$177.25	$226.00	$264.75	$241.50	$274.75	$243.75	$197.25	$196.00
89	$177.25	$229.50	$268.00	$244.75	$278.00	$248.25	$200.50	$198.25
90	$177.25	$232.50	$271.50	$248.25	$281.25	$250.25	$202.75	$201.75
91+	$177.25	$234.75	$274.75	$251.25	$285.75	$253.75	$204.75	$203.75

* Your Premium is effective on your Certificate Effective Date and is based on your attained age as of your Certificate Effective Date. After the Certificate Effective Date, your Premium will be adjusted each year on your birthday to the Premium indicated above for your newly attained age for that year.

DISCLOSURE

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your Certificate's most important features. The Certificate is your insurance contract. You must read the Certificate 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 Certificate for any reason, you may return it to

Members Health Insurance Company
P.O. Box 1424
Columbia, Tennessee 38402-1424

If you send the Certificate back to us within 30 days after you receive it, we will treat the Certificate 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 Certificate and are sure you want to keep it.

NOTICE

The Certificate may not fully cover all of your medical costs. Members Health Insurance Company is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult The Medicare Handbook (*Medicare and You*) for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

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

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 $1216	$0	$1216 (Part A deductible)
61st thru 90th day	All but $304 a day	$304 a day	$0
91st day and after: -While using 60 lifetime reserve days	All but $608 a day	$608 a day	$0
Once lifetime reserve days are used: -Additional 365 days	$0	100% of Medicare eligible expenses	$0**
-Beyond 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 hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $152 a day	$0	Up to $152 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 Plan 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 for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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Medicare (Part B) - Medical Services - Per Calendar Year

* Once you have been billed $147 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 $147 of Medicare Approved Amounts	$0	$0	$147 (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 $147 of Medicare Approved Amounts*	$0	$0	$147 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - 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 $147 of Medicare Approved Amounts	$0	$0	$147 (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 $1216	$1216 (Part A deductible)	$0
61st thru 90th day	All but $304 a day	$304 a day	$0
91st day and after: -While using 60 lifetime reserve days	All but $608 a day	$608 a day	$0
Once lifetime reserve days are used: -Additional 365 days	$0	100% of Medicare eligible expenses	$0**
-Beyond 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 hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $152 a day	$0	Up to $152 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 Plan 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 for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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Medicare (Part B) - Medical Services - Per Calendar Year

* Once you have been billed $147 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 $147 of Medicare Approved Amounts	$0	$0	$147 (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 $147 of Medicare Approved Amounts*	$0	$0	$147 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - 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 $147 of Medicare Approved Amounts	$0	$0	$147 (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 $1216	$1216 (Part A deductible)	$0
61st thru 90th day	All but $304 a day	$304 a day	$0
91st day and after: -While using 60 lifetime reserve days	All but $608 a day	$608 a day	$0
Once lifetime reserve days are used: -Additional 365 days	$0	100% of Medicare eligible expenses	$0**
-Beyond 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 hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $152 a day	Up to $152 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 Plan 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 for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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Medicare (Part B) - Medical Services - Per Calendar Year

* Once you have been billed $147 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 $147 of Medicare Approved Amounts*	$0	$147 (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 $147 of Medicare Approved Amounts*	$0	$147 (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

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 $147 of Medicare Approved Amounts*	$0	$147 (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 first 60 days of each trip outside US			
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 $50,000 lifetime maximum

PLAN D

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 $1216	$1216 (Part A deductible)	$0
61st thru 90th day	All but $304 a day	$304 a day	$0
91st day and after: -While using 60 lifetime reserve days	All but $608 a day	$608 a day	$0
Once lifetime reserve days are used: -Additional 365 days	$0	100% of Medicare eligible expenses	$0**
-Beyond 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 hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $152 a day	Up to $152 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 Plan 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 for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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Medicare (Part B) - Medical Services - Per Calendar Year

* Once you have been billed $147 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 $147 of Medicare Approved Amounts*	$0	$0	$147 (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 $147 of Medicare Approved Amounts*	$0	$0	$147 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - 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 $147 of Medicare Approved Amounts*	$0	$0	$147 (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 first 60 days of each trip outside US			
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 $50,000 lifetime maximum

PLAN F

Medicare (Part A) - Hospital Services - Per Benefit Period

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1216	$1216 (Part A deductible)	$0
61st thru 90th day	All but $304 a day	$304 a day	$0
91st day and after: -While using 60 lifetime reserve days	All but $608 a day	$608 a day	$0
Once lifetime reserve days are used: -Additional 365 days	$0	100% of Medicare eligible expenses	$0**
-Beyond 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 hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $152 a day	Up to $152 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 Plan 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 for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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PLAN F *(continued)*

Medicare (Part B) - Medical Services - Per Calendar Year

* Once you have been billed $147 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 $147 of Medicare Approved Amounts*	$0	$147 (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 $147 of Medicare Approved Amounts*	$0	$147 (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

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 $147 of Medicare Approved Amounts*	$0	$147 (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 first 60 days of each trip outside US			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

Medicare (Part A) - Hospital Services - Per Benefit Period

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1216	$1216 (Part A deductible)	$0
61st thru 90th day	All but $304 a day	$304 a day	$0
91st day and after: -While using 60 lifetime reserve days	All but $608 a day	$608 a day	$0
Once lifetime reserve days are used: -Additional 365 days	$0	100% of Medicare eligible expenses	$0**
-Beyond 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 hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $152 a day	Up to $152 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 Plan 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 for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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Medicare (Part B) - Medical Services - Per Calendar Year

* Once you have been billed $147 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 $147 of Medicare Approved Amounts*	$0	$0	$147 (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 $147 of Medicare Approved Amounts*	$0	$0	$147 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - 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 $147 of Medicare Approved Amounts*	$0	$0	$147 (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 first 60 days of each trip outside US			
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 M

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 $1216	$608 (50% of Part A deductible)	$608 (50% of Part A deductible)
61st thru 90th day	All but $304 a day	$304 a day	$0
91st day and after: -While using 60 lifetime reserve days	All but $608 a day	$608 a day	$0
Once lifetime reserve days are used: -Additional 365 days	$0	100% of Medicare eligible expenses	$0**
-Beyond 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 hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $152 a day	Up to $152 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 Plan 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 for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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Medicare (Part B) - Medical Services - Per Calendar Year

* Once you have been billed $147 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 $147 of Medicare Approved Amounts*	$0	$0	$147 (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 $147 of Medicare Approved Amounts*	$0	$0	$147 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - 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 $147 of Medicare Approved Amounts*	$0	$0	$147 (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 first 60 days of each trip outside US			
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 $1216	$1216 (Part A deductible)	$0
61st thru 90th day	All but $304 a day	$304 a day	$0
91st day and after: -While using 60 lifetime reserve days	All but $608 a day	$608 a day	$0
Once lifetime reserve days are used: -Additional 365 days	$0	100% of Medicare eligible expenses	$0**
-Beyond 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 hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $152 a day	Up to $152 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 Plan 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 for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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Medicare (Part B) - Medical Services - Per Calendar Year

* Once you have been billed $147 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 $147 of Medicare Approved Amounts*	$0	$0	$147 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per ER 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 ER 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 $147 of Medicare Approved Amounts*	$0	$0	$147 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

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PLAN N *(continued)*

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 $147 of Medicare Approved Amounts*	$0	$0	$147 (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 first 60 days of each trip outside US			
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

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