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 \$1,600	\$0	\$1,600 (Part A Deductible)
61st thru 90th day 91st day and after:	All but \$400 a day	\$400 a day	\$0
 While using 60 lifetime reserve days Once lifetime reserve days are used: 	All but \$800 a day	\$800 a day	\$0
■ 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
21 st thru 100 th day	All but \$200 a day	\$0	Up to \$200 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 for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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Plan A MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed \$226 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	Φ0	00	#000 /D / D
First \$226 of Medicare Approved	\$0	\$0	\$226 (Part B
amounts*	Caparally 900/	Conorally 200/	Deductible) \$0
Remainder of Medicare Approved amounts	Generally 80%	Generally 20%	φυ
PART B EXCESS CHARGES			
(Above Medicare Approved	\$0	\$0	All costs
amounts)	ΨΟ	Ψ	7111 00313
BLOOD			
First 3 pints	\$0	All costs	\$ 0
Next \$226 of Medicare Approved	\$0	\$0	\$226 (Part B
amounts*			Deductible)
Remainder of Medicare Approved	80%	20%	\$0
amounts			
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 \$226 of Medicare Approved amounts* 	\$0	\$0	\$226 (Part B Deductible)
 Remainder of Medicare Approved amounts 	80%	20%	\$0

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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 \$1,600	\$1,600 (Part A Deductible)	\$0
61st thru 90th day	All but \$400 a day	\$400 a day	\$ 0
91st day and after:			
 While using 60 lifetime reserve days 	All but \$800 a day	\$800 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 \$200 a day	\$0	Up to \$200 a day
101st day and after	\$0	\$0	All costs
BLOOD	77	+ -	000.0
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's	All but very limited	Medicare copayment/	\$0
requirements, including a	copayment/coinsurance	coinsurance	
doctor's certification of	for outpatient drugs and		
terminal illness.	inpatient respite care.		

^{**} 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 for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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

* Once you have been billed \$226 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	00	00	# 000
First \$226 of Medicare Approved	\$0	\$0	\$226
amounts*			(Part B
D : 1 (M !: A	0 11 000/	0 11 000/	Deductible)
Remainder of Medicare Approved	Generally 80%	Generally 20%	\$0
amounts			
PART B EXCESS CHARGES	00	00	A.II. (
(Above Medicare-approved amounts)	\$0	\$0	All costs
BLOOD First 2 pints	\$0	All costs	\$0
First 3 pints	· ·		\$226
Next \$226 of Medicare Approved amounts*	\$0	\$0	
amounts			(Part B Deductible)
D : 1 (M): A	000/	000/	,
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 	100%	\$0	\$0
services and medical supplies			
 Durable medical equipment: 			
■ First \$226 of Medicare Approved	\$0	\$0	\$226
amounts*			(Part B
			Deductible)
■ Pomainder of Medicare Approved	000/	200/	CO
■ Remainder of Medicare Approved	80%	20%	\$0

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amounts

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*			100.100
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,600	\$1,600 (Part A Deductible)	\$0
61 st thru 90 th day	All but \$400 a day	\$400 a day	\$0
91st day and after:			
 While using 60 lifetime reserve days 	All but \$800 a day	\$800 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 \$200 a day	Up to \$200 a day	\$0
101st day and after	\$0	\$0	All costs
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 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 for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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

* Once you have been billed \$226 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.

an asterisk), your Part B Deductible wil		endar year.	1
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 \$226 of Medicare Approved	\$0	\$226 (Part B	\$0
amounts*		Deductible)	4 0
Remainder of Medicare Approved	Generally 80%	Generally 20%	\$0
amounts	Octionally 0070	Octionally 2070	ΨΟ
PART B EXCESS CHARGES			
(Above Medicare-approved amounts)	\$0	\$0	All costs
BLOOD	Ψ	Ψ Φ	7 111 00010
First 3 pints	\$0	All costs	\$0
Next \$226 of Medicare Approved	\$0	\$226 (Part B	\$0
amounts*	ΨΟ	Deductible)	ΨΟ
Remainder of Medicare Approved	80%	20%	\$0
amounts	00 70	20 /0	ΨΟ
CLINICAL LABORATORY			
SERVICES-			
Tests For Diagnostic Services	100%	\$0	\$0
10313 FOI Diagnostic Oct vices	PARTS A & B	Ψ	ΨΟ
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
Medically necessary skilled care	100%	\$0	\$0
services and medical supplies	10070	ΨΟ	ΨΟ
Durable medical equipment:			
■ First \$226 of Medicare Approved	\$0	\$226 (Part B	\$0
amounts*	ΨΟ	Deductible)	Ψ
■ Remainder of Medicare Approved	80%	20%	\$0
amounts	0070	20%	ΦΟ
	NEFITS - NOT COVERED	BY MEDICARE	1
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 \$0	80% to a lifetime	\$250 20% and
Tremainder of Onlarges	ΨΟ	maximum benefit of	amounts over
		\$50,000	the \$50,000
		, , -,	lifetime
			maximum

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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	AUL (\$4.000	\$4.000 (D. (A.D.) (III.)	
First 60 days	All but \$1,600	\$1,600 (Part A Deductible)	\$0
61st thru 90th day 91st day and after:	All but \$400 a day	\$400 a day	\$0
 – While using 60 lifetime reserve days – Once lifetime reserve days are used: 	All but \$800 a day	\$800 a day	\$0
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			
	All approved amounts	\$0	\$0
First 20 days		,	
21 st thru 100 th day	All but \$200 a day	Up to \$200 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	All but very limited	Medicare copayment/	\$0
requirements, including a doctor's	copayment/	coinsurance	
certification of terminal illness.	coinsurance for outpatient		
	drugs and		
	inpatient respite care.		

^{**}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 for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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Plan F

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

* Once you have been billed \$226 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.

(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 \$226 of Medicare Approved	\$0	\$226 (Part B	\$0	
amounts*		Deductible)		
Remainder of Medicare Approved	Generally 80%	Generally 20%	\$0	
amounts		,	·	
PART B EXCESS CHARGES				
(Above Medicare-approved amounts)	\$0	100%	\$0	
BLOOD	7.7		**	
First 3 pints	\$0	All costs	\$0	
Next \$226 of Medicare Approved	\$0	\$226 (Part B	\$0	
amounts*		Deductible)		
Remainder of Medicare Approved	80%	20%	\$0	
amounts				
CLINICAL LABORATORY				
SERVICES -				
Tests For Diagnostic Services	100%	\$0	\$0	
	PARTS A & B			
HOME HEALTH CARE				
MEDICARE APPROVED SERVICES				
 Medically necessary skilled care 	100%	\$0	\$0	
services and medical supplies				
 Durable medical equipment: 				
■ First \$226 of Medicare Approved	\$0	\$226 (Part B	\$0	
amounts*		Deductible)	, , , , , , , , , , , , , , , , , , ,	
 Remainder of Medicare Approved 	80%	20%	\$0	
amounts			T T	
	NEFITS - NOT COVERED B	Y MEDICARE	-	
FOREIGN TRAVEL - NOT				
COVERED BY MEDICARE				
Medically necessary emergency care				
services beginning during the first 60				
days of each trip outside the USA			4	
First \$250 each calendar year	\$0	\$0	\$250	
Remainder of Charges	\$0	80% to a lifetime	20% and amounts	
		maximum benefit	over the \$50,000	
		of \$50,000	lifetime maximum	

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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 \$1,600	\$1,600 (Part A Deductible)	\$0
61st thru 90th day 91st day and after:	All but \$400 a day	\$400 a day	\$0
While using 60 lifetime reserve days Once lifetime reserve days	All but \$800 a day	\$800 a day	\$0
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			
	All approved amounts	\$0	\$0
First 20 days			
21st thru 100th day	All but \$200 a day	Up to \$200 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	All but very limited	Medicare copayment/	\$0
requirements, including a doctor's	copayment/	coinsurance	
certification of terminal illness.	coinsurance for outpatient		
	drugs and		
	inpatient respite care.		

^{**}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 for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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Plan G

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

Once you have been billed \$226 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.

(which are noted with an asterisk),	(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 \$226 of Medicare Approved	\$0	\$0	\$226 (Part B		
amounts*			Deductible)		
Remainder of Medicare Approved	Generally 80%	Generally 20%	\$0		
amounts					
PART B EXCESS CHARGES					
(Above Medicare-approved amounts)	\$0	100%	\$0		
BLOOD					
First 3 pints	\$0	All costs	\$0		
Next \$226 of Medicare Approved	\$0	\$0	\$226 (Part B		
amounts*			Deductible)		
Remainder of Medicare Approved	80%	20%	\$0		
amounts					
CLINICAL LABORATORY					
SERVICES –					
Tests For Diagnostic Services	100%	\$0	\$0		
	PARTS A & B				
HOME HEALTH CARE					
MEDICARE APPROVED SERVICES					
 Medically necessary skilled care 	100%	\$0	\$0		
services and medical supplies					
 Durable medical equipment: 					
First \$226 of Medicare Approved	\$0	\$0	\$226 (Part B		
amounts*			Deductible)		
Remainder of Medicare Approved	80%	20%	\$0		
amounts					
	FITS - NOT COVERED	BY MEDICARE	1		
FOREIGN TRAVEL – NOT					
COVERED BY MEDICARE					
Medically necessary emergency care					
services beginning during the first 60					
days of each trip outside the USA	4				
First \$250 each calendar year	\$0	\$0	\$250		

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80% to a lifetime

maximum benefit

of \$50,000

20% and amounts

over the \$50,000

lifetime maximum

\$0

Remainder of Charges

Plan K

* You will pay half of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$6940 each calendar year. The amounts that count toward your annual limit are noted with diamonds (◆) in the chart below. Once you reach the annual limit, the plan pays 100% of the 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.

,	but \$1,600 but \$400 a day	\$800 (50% of Part A Deductible)	\$800 (50% of Part A Deductible)♦
nursing and miscellaneous services and supplies First 60 days All I		Deductible)	· · · · · · · · · · · · · · · · · · ·
and supplies First 60 days All I		Deductible)	· · · · · · · · · · · · · · · · · · ·
First 60 days All I		Deductible)	· · · · · · · · · · · · · · · · · · ·
		Deductible)	· · · · · · · · · · · · · · · · · · ·
61st thru 90th day	but \$400 a day	\$400 a day	/ L DOGGOGDIO /▼
91st day and after:		\$400 a day	\$0
	but \$800 a day	\$800 a day	\$0
Once lifetime reserve days are used:			
Additional 365 days (lifetime) \$0		100% of Medicare Eligible Expenses	\$0***
 Beyond the additional 365 \$0 days 		\$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			
	approved amounts	\$0	\$0
•	but \$200 a day	Up to \$100 a day	\$100 a day◆
101 st day and after \$0		\$0	All costs
BLOOD –			
First 3 Pints \$0		50%	50%◆
Additional amounts 100	0%	\$0	\$0
HOSPICE CARE		====	
You must meet Medicare's All I	but very limited	50% of copayment/	50% of
requirements, including a doctor's copertification of terminal illness.	payment/	coinsurance	copayment/
	nsurance for tpatient drugs and		coinsurance◆
	atient respite care.		

*** 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 for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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Plan K MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

**** Once you have been billed \$226 of Medicare Approved amounts for covered services (which are noted with asterisks), 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 \$226 of Medicare Approved Amounts**** Preventive Benefits for Medicare Covered Services Remainder of Medicare Approved Amounts	\$0 Generally 80% or more of Medicare Approved amounts Generally 80%	\$0 Remainder of Medicare Approved amounts Generally 10%	\$226 (Part B Deductible)**** All costs above Medicare Approved amounts 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 \$6940)*
BLOOD First 3 Pints Next \$226 of Medicare Approved Amounts*** Remainder of Medicare Approved Amounts	\$0 \$0 Generally 80%	50% \$0 Generally 10%	50% • \$226 (Part B Deductible)**** • Generally 10% •
CLINICAL LABORATORY SERVICES – Tests For Diagnostic Services	100%	\$0	\$0

^{*} This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$6940 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.

PARTS A & B

HOME HEALTH CARE			
MEDICARE APPROVED			
SERVICES			
- Medically necessary skilled	100%	\$0	\$0
care services and medical			
supplies			
- Durable medical equipment:			
 First \$226 of Medicare 	\$0	\$0	\$226 (Part B
Approved Amounts*****			Deductible)◆
 Remainder of Medicare 	80%	10%	10%◆
Approved Amounts			

^{*****} Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

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Plan L

* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$3470 each calendar year. The amounts that count toward your annual limit are noted with 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.

Services	Medicare Pays	Plan Pays	You Pay*
HOSPITALIZATION**	_		
Semiprivate room and board, general nursing and			
miscellaneous services and			
supplies	AUL (04 000	04 000 /750/ CD +A	0400 (050)
First 60 days	All but \$1,600	\$1,200 (75% of Part A Deductible)	\$400 (25% of Part A Deductible)◆
61st thru 90th day	All but \$400 a day	\$400 a day	\$0
91st day and after:	•		
While using 60 lifetime	All but \$800 a day	\$800 a day	\$0
reserve days - Once lifetime reserve days			
are used:			
 Additional 365 days 	\$0	100% of Medicare	\$0***
(lifetime) Beyond the additional	\$0	Eligible Expenses	All costs
365 days	ΨΟ	ΨΟ	All COSIS
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 \$200 a day	Up to \$150 a day	\$50 a day ♦
101 st day and after	\$0	\$0	All costs
BLOOD -			
First 3 Pints	\$0	75%	25%♦
Additional amounts	100%	\$0	\$ 0
HOSPICE CARE You must meet Medicare's	All but york limited	75% of concument	25% of
requirements, including a	All but very limited copayment/	75% of copayment/ coinsurance	copayment/
doctor's certification of terminal	coinsurance for	33/110di di 1100	coinsurance◆
illness.	outpatient drugs and		
	inpatient respite care.		

^{***} 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 for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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Plan L MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

**** Once you have been billed \$226 of Medicare Approved amounts for covered services (which are noted with asterisks), 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 \$226 of Medicare Approved Amounts**** Preventive Benefits for Medicare Covered Services	\$0 Generally 80% or more of Medicare Approved amounts	\$0 Remainder of Medicare Approved amounts	\$226 (Part B Deductible)****◆ All costs above Medicare Approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5%◆
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of \$3470)*
BLOOD First 3 Pints Next \$226 of Medicare Approved Amounts**** Remainder of Medicare Approved Amounts	\$0 \$0 Generally 80%	75% \$0 Generally 15%	25% \$ \$226 (Part B Deductible)**** \$ Generally 5% \$
CLINICAL LABORATORY SERVICES – Tests For Diagnostic Services	100%	\$0	\$0

^{*} This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$3470 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.

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED			
SERVICES			
- Medically necessary skilled	100%	\$0	\$0
care services and medical			
supplies - Durable medical equipment:			
First \$226 of Medicare	\$0	\$0	\$226 (Part B
Approved Amounts*****			Deductible)◆
 Remainder of Medicare 	80%	15%	5%◆
Approved Amounts			

^{*****} Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

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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 \$1,600	\$1,600 (Part A Deductible)	\$0
61st thru 90th day 91st day and after:	All but \$400 a day	\$400 a day	\$0
While using 60 lifetime reserve days	All but \$800 a day	\$800 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 21st thru 100th day 101st day and after	All approved amounts All but \$200 a day \$0	\$0 Up to \$200 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	\$0 100% All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care.	3 pints \$0 Medicare copayment/ coinsurance	\$0 \$0 \$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 for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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Plan N

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

Once you have been billed \$226 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	Wedicale Pays	Fiail Fays	Tou Fay	
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 \$226 of Medicare Approved amounts* Remainder of Medicare Approved amounts	\$0 Generally 80%	\$0 Balance other than up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	\$226 (Part B Deductible) Up to \$20 per office visit and up to \$50 per emergency room visit. The co-payment 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 Next \$226 of Medicare Approved	\$0 \$0	All costs \$0	\$0 \$226 (Part B	
amounts*	Ψ	Ψ	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 suppliesDurable medical equipment:	100%	\$0	\$0	
 First \$226 of Medicare Approved amounts* 	\$0	\$0	\$226 (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 Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
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