Cigna Healthcare Medicare Supplement Insurance
Medco Containment Life Insurance Company

Outline of Coverage and Rates for Vermont Residents

Medicare Supplement benefit plans A, F, High-Deductible F, G, and N

MCLIC-OC-2020-VT

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MEDCO CONTAINMENT LIFE INSURANCE COMPANY

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Outline of Medicare Supplement Coverage – Benefit Plans A, F, High-Deductible F, G, and N

This chart shows the benefits included in each of the standard Medicare Supplement plans. Every company must make Plan A available. Some plans may not be available in your state. Only Applicants first eligible for Medicare before 2020 may purchase Plans C, F, and high-deductible F.

Benefits	Note: A ✓ means 100% of the benefit is paid Plans available									Plans available only if first Medicare eligible before 2020		
	A	B	D	G[1]	HDG[1]	K	L	M	N	C	F[1]	HDF[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓
Medicare Part B coinsurance or copayment	✓	✓	✓		✓	50%	75%	✓	✓ copays apply[3]	✓		✓
Blood (first three pints)	✓	✓	✓		✓	50%	75%	✓	✓	✓		✓
Part A hospice care coinsurance or copayment	✓	✓	✓		✓	50%	75%	✓	✓	✓		✓
Skilled nursing facility coinsurance			✓		✓	50%	75%	✓	✓	✓		✓
Medicare Part A deductible		✓	✓		✓	50%	75%	50%	✓	✓		✓
Medicare Part B deductible										✓		✓
Medicare Part B excess charges[4]					✓							✓
Foreign travel emergency (up to plan limits)			✓		✓			✓	✓	✓		✓
Out-of-pocket limit in 2025[2]						$7,220[2]	$3,610[2]					

[1]Plans F and G also have a high-deductible option which requires first paying a plan deductible of $2,870 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High-deductible Plan G does not cover the Medicare Part B deductible. However, high-deductible Plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible. These expenses include the Medicare deductibles for Part A and Part B, but do not include the Plan's separate foreign travel emergency deductible.

[2]Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

[3]Plan N pays 100% of the Part B coinsurance except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that do not result in an inpatient admission.

[4]A physician who agrees to treat a Medicare or General Assistance beneficiary shall not charge or collect from a Medicare or General Assistance beneficiary any amount in excess of the reasonable charge for that service, as determined by the U.S. Secretary of Health and Human Services or the Commissioner of Vermont Health Access.

Medco Containment Life Insurance Company

MEDICARE SUPPLEMENT

VERMONT

AGE 65+ COMMUNITY RATES -- Effective 11/1/2025

	Annual Direct Bill/Bank Draft	Semi-Annual Direct Bill/Bank Draft	Quarterly Direct Bill/Bank Draft	Monthly Bank Draft
Plan A	1,666.04	866.34	441.50	138.78
Plan F	3,241.43	1,685.55	858.98	270.01
Plan HDF	766.69	398.68	203.17	63.86
Plan G	2,596.11	1,349.98	687.97	216.26
Plan N	2,203.58	1,145.86	583.95	183.56

Medco Containment Life Insurance Company

MEDICARE SUPPLEMENT

VERMONT

UNDER AGE 65 RATES -- Effective 11/1/2025

	Annual Direct Bill/Bank Draft	Semi-Annual Direct Bill/Bank Draft	Quarterly Direct Bill/Bank Draft	Monthly Bank Draft
Plan A	5,831.13	3,032.19	1,545.25	485.73
Plan F	11,345.02	5,899.41	3,006.43	945.04
Plan HDF	2,683.40	1,395.37	711.10	223.53
Plan G	9,086.37	4,724.91	2,407.89	756.89
Plan N	7,712.53	4,010.52	2,043.82	642.45

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PREMIUM INFORMATION
We, Medco Containment Life Insurance Company, can raise your premium if (a) we change the rates which apply to all policies of this form issued by us and in force in the state where your policy was issued; or (b) coverage under Medicare changes. We will send you a written notice at least thirty (30) days in advance when we change the premium rates for all policies of this form issued by us and in force in the state where your policy was issued.

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 Medco Containment Life Insurance Company.

30-DAY RIGHT TO RETURN POLICY
If you find that you are not satisfied with your policy, you may return it to Medco Containment Life Insurance Company, One Express Way, Saint Louis, Missouri 63121. If you send the policy back to us within thirty (30) days after you receive it, we will treat the policy as if it had never been issued and return all of your premiums.

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
The policy may not fully cover all of your medical costs. Neither Medco Containment Life Insurance Company nor its agents are connected with Medicare. This Outline of Coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the *Medicare and You* for more details.

EXCLUSIONS AND LIMITATIONS
The benefits of a policy will not duplicate any benefits paid by Medicare. The combined benefits of a policy and the benefits paid by Medicare may not exceed one hundred percent (100%) of the Medicare Eligible Expenses incurred. A policy will not pay benefits for the following:

1. the Medicare Part B deductible (not applicable for Plans F and C);
2. any expense which you are not legally obligated to pay or services for which no charge is normally made in the absence of insurance;
3. any services that are not medically necessary as determined by Medicare;
4. any portion of any expense for which payment is made by Medicare or other government programs (except Medicaid) or for which payment would have been made by Medicare if you were enrolled in Parts A and B of Medicare;
5. any type of expense not a Medicare Eligible Expense except as provided previously in the policy;
6. any deductible, coinsurance, or copayment not covered by Medicare, unless such coverage is listed as a benefit in the policy; or
7. Pre-Existing Conditions: We will not pay for any expenses incurred for care or treatment of a Pre-Existing Condition for the first six (6) months from the effective date of coverage. This exclusion does not apply if you applied for and were issued a policy under guaranteed issue status; if on the date of application for a policy you had at least six (6) months of prior Creditable Coverage; or if the policy is replacing another Medicare Supplement policy and a six (6) month waiting period has already been satisfied. Evidence of prior coverage or replacement must have been disclosed on the application for a policy.

   If you had less than six (6) months prior Creditable Coverage, the Pre-Existing Conditions limitation will be reduced by the aggregate amount of Creditable Coverage. If the policy is replacing another Medicare Supplement policy, credit will be given for any portion of the waiting period that has been satisfied.

If you had less than six (6) months prior Creditable Coverage, the Pre-Existing Conditions limitation will be reduced by the aggregate amount of Creditable Coverage. If the policy is replacing another Medicare Supplement policy, credit will be given for any portion of the waiting period that has been satisfied.

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. We 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.

RENEWABILITY

The policy is guaranteed renewable for life.

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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 A PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,676	$0	$1,676 (Part A deductible)
61st through 90th day	All but $419 per day	$419 per day	$0
91st day and after:			
– while using 60 lifetime reserve days	All but $838 per day	$838 per 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 entering a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $209.50 per day	$0	Up to $209.50 per 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.

PLAN A

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

*Once you have been billed $257 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 A 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 $257 of Medicare-approved amounts*	$0	$0	$257 (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 $257 of Medicare-approved amounts*	$0	$0	$257 (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 A PAYS	YOU PAY
HOME HEALTH CARE MEDICARE- APPROVED SERVICES			
Medically-necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $257 of Medicare-approved amounts*	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

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 F PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,676	$1,676 (Part A deductible)	$0
61st through 90th day	All but $419 per day	$419 per day	$0
91st day and after:			
– while using 60 lifetime reserve days	All but $838 per day	$838 per 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 entering a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $209.50 per day	Up to $209.50 per day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

PLAN F

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

*Once you have been billed $257 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 F 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 $257 of Medicare-approved amounts*	$0	$257 (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 $257 of Medicare-approved amounts*	$0	$257 (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 F PAYS	YOU PAY
HOME HEALTH CARE MEDICARE- APPROVED SERVICES Medically-necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $257 of Medicare-approved amounts*	$0	$257 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN F
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR (cont'd.)

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN F 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 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

HIGH-DEDUCTIBLE PLAN F
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

**This high-deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,870 deductible. Benefits from the high- deductible Plan F will not begin until out-of-pocket expenses are $2,870. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductible for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,870 DEDUCTIBLE, ** PLAN PAYS	IN ADDITION TO $2,870 DEDUCTIBLE, **YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,676	$1,676 (Part A deductible)	$0
61st through the 90th day	All but $419 per day	$419 per day	$0
91st day and after:			
– while using 60 lifetime reserve days	All but $838 per day	$838 per 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 entering a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through the 100th day	All but $209.50 per day	Up to $209.50 per day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

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

*Once You have been billed $257 of Medicare-approved amounts for covered services (which are noted with an asterisk), Your Part B deductible will have been met for the calendar year.

**This high-deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,870 deductible. Benefits from the high- deductible Plan F will not begin until out-of-pocket expenses are $2,870. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductible for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,870 DEDUCTIBLE, ** PLAN PAYS	IN ADDITION TO $2,870 DEDUCTIBLE, ** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL **TREATMENT** such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $257 of Medicare-approved amounts*	$0	$257 (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 $257 of Medicare-approved amounts*	$0	$257 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Tests for diagnostic services	100%	$0	$0

HIGH-DEDUCTIBLE PLAN F
PARTS A & B

*Once You have been billed $257 of Medicare-approved amounts for covered services (which are noted with an asterisk), Your Part B deductible will have been met for the calendar year.

**This high-deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,870 deductible. Benefits from the high- deductible Plan F will not begin until out-of-pocket expenses are $2,870. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductible for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,870 DEDUCTIBLE, ** PLAN PAYS	IN ADDITION TO $2,870 DEDUCTIBLE, ** YOU PAY
HOME HEALTH CARE MEDICARE- APPROVED SERVICES			
Medically-necessary skilled care services and medical supplies			
– Durable medical equipment	100%	$0	$0
First $257 of Medicare-approved amounts*	$0	$257 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,870 DEDUCTIBLE, ** PLAN PAYS	IN ADDITION TO $2,870 DEDUCTIBLE, ** 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

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 G PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,676	$1,676 (Part A deductible)	$0
61st through 90th day	All but $419 per day	$419 per day	$0
91st day and after:			
– while using 60 lifetime reserve days	All but $838 per day	$838 per 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 entering a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $209.50 per day	Up to $209.50 per day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

PLAN G

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

*Once you have been billed $257 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 G 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 $257 of Medicare-approved amounts*	$0	$0	$257 (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 $257 of Medicare-approved amounts*	$0	$0	$257 (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 G PAYS	YOU PAY
HOME HEALTH CARE MEDICARE- APPROVED SERVICES Medically-necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $257 of Medicare-approved amounts*	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN G

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR (cont'd.)

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN G 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 Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000	 $250 20% and amounts over the $50,000 lifetime maximum

PLAN 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 N PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,676	$1,676 (Part A deductible)	$0
61st through 90th day	All but $419 per day	$419 per day	$0
91st day and after:			
– while using 60 lifetime reserve days	All but $838 per day	$838 per 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 entering a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $209.50 per day	Up to $209.50 per day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

PLAN N

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

*Once you have been billed $257 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 N 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 $257 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.	 $257 (Part B deductible) Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the Insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
PART B EXCESS CHARGES (above Medicare-approved amounts)	$0	$0	All costs
BLOOD First 3 pints Next $257 of Medicare-approved amounts* Remainder of Medicare-approved amounts	$0 $0 80%	All costs $0 20%	$0 $257 (Part B deductible) $0
CLINICAL LABORATORY SERVICES Tests for diagnostic services	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
HOME HEALTH CARE MEDICARE- APPROVED SERVICES Medically-necessary skilled care services and medical supplies Durable medical equipment First $257 of Medicare-approved amounts* Remainder of Medicare-approved amounts	 100% $0 80%	 $0 $0 20%	 $0 $257 (Part B deductible) $0

PLAN N

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR (cont'd.)

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN N 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 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