EXCELLUS HEALTH PLAN, INC.
doing business as

Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2010 Including
Revisions Effective January 1, 2020

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make available Plans "A" & "B" and either "D" or "G". Only applicants first eligible for Medicare before January 1, 2020 may purchase Plans C, F, and high deductible F+. Some plans may not be available in your state. The Plans we sell are A, B, C, D, F, F+, G, G+, and N, these plans are notated below with an asterisk.

	Plans Available to All Applicants								Medicare first eligible before 2020 only	
Benefits	A*	B*	D*	G[1*]	K	L	M	N*	C*	F[1*]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Medicare Part B coinsurance or copayment	✔	✔	✔	✔	50%	75%	✔	✔ copays apply [3]	✔	✔
Blood (first three pints)	✔	✔	✔	✔	50%	75%	✔	✔	✔	✔
Part A hospice care coinsurance or copayment	✔	✔	✔	✔	50%	75%	✔	✔	✔	✔
Skilled nursing facility coinsurance			✔	✔	50%	75%	✔	✔	✔	✔
Medicare Part A deductible		✔	✔	✔	50%	75%	50%	✔	✔	✔
Medicare Part B Deductible									✔	✔
Medicare Part B excess charges				✔						✔
Foreign travel emergency (up to plan limits)			✔	✔			✔	✔	✔	✔
Out-of-Pocket limit in 2026[2]					$8,000[2]	$4,000[2]				

[1] Plans F and G also have a high deductible option which require first paying a plan deductible of $2,950 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 is only available on or after January 1, 2020 and does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

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

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

Medicare Supplement
Plans A, B, C, D, F, F+, G, G+, and N
EFFECTIVE January 1, 2026
MONTHLY SUBSCRIPTION RATES

PLAN A	**$292.43/month**
PLAN B	**$415.53/month**
PLAN C	**$465.34/month**
PLAN D	**$481.14/month**
PLAN F	**$549.18/month**
PLAN F+	**$ 87.21/month**
PLAN G	**$477.04/month**
PLAN G+	**$85.00/month**
PLAN N	**$582.93/month**

PREMIUM INFORMATION

We at Univera Healthcare can only raise your premium if we raise the premium for all policies like yours in this state.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to Univera Healthcare, Attn: Medicare Enrollment Processing, P.O. Box 31790, Rochester, NY 14603-1790. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs.
Neither Univera Healthcare nor its agents are connected with Medicare.
Univera Healthcare 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 *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

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 $1,736	$0	$1,736 (Part A deductible)
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after:	All but $868 a day	$868 a day	$0
- While using 60 lifetime reserve days			
- Once lifetime reserve days are used:			
○ Additional 365 days (lifetime)	$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 $217 a day	$0	Up to $217 a day All
101st day and after	$0	$0	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 out-patient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

*Once you have been billed $283 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 $283 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 Generally 80%	 $0 Generally 20%	 $283 (Part B deductible) $0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD First 3 pints Next $283 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 $0 80%	 All costs $0 20%	 $0 $283 (Part B deductible) $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 • Durable medical equipment First $283 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 $283 (Part B deductible) $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 $1,736	$1,736 (Part A deductible)	$0
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after:	All but $868 a day	$868 a day	$0
- While using 60 lifetime reserve days			
- Once lifetime reserve days are used:			
o Additional 365 days (lifetime)	$0	100% of Medicare eligible expenses	$0
o 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 $217 a day	$0	Up to $217 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 out- patient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

*Once you have been billed $283 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 $283 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 Generally 80%	 $0 Generally 20%	 $283 (Part B deductible) $0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD First 3 pints Next $283 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 $0 80%	 All costs $0 20%	 $0 $283 (Part B deductible) $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 • Durable medical equipment First $283 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 $283 (Part B deductible) $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 $1,736	$1,736 (Part A deductible)	$0
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after:	All but $868 a day	$868 a day	$0
- While using 60 lifetime reserve days			
- Once lifetime reserve days are used:			
o Additional 365 days (lifetime)	$0	100% of Medicare eligible expenses	$0
o 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 $217 a day	Up to $217 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 out-patient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

*Once you have been billed $283 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 $283 of Medicare Approved Amounts*	$0	$283 (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 $283 of Medicare Approved Amounts*	$0	$283 (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 $283 of Medicare Approved Amounts*	$0	$283 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN C
OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL- **NOT COVERED BY MEDICARE** Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

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 $1,736	$1,736 (Part A deductible)	$0
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after:	All but $868 a day	$868 a day	$0
- While using 60 lifetime reserve days			
- Once lifetime reserve days are used:			
○ Additional 365 days (lifetime)	$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 $217 a day	Up to $217 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 out-patient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

*Once you have been billed $283 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 $283 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 Generally 80%	 $0 Generally 20%	 $283 (Part B deductible) $0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD First 3 pints Next $283 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 $0 80%	 All costs $0 20%	 $0 $283 (Part B deductible) $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 • Durable medical equipment First $283 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 $283 (Part B deductible) $0

PLAN D
OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL- **NOT COVERED BY MEDICARE** Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

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 $1,736	$1,736 (Part A deductible)	$0
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after:	All but $868 a day	$868 a day	$0
- While using 60 lifetime reserve days			
- Once lifetime reserve days are used:			
o Additional 365 days (lifetime)	$0	100% of Medicare eligible expenses	$0
o 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 $217 a day	Up to $217 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 out-patient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

*Once you have been billed $283 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 $283 of Medicare Approved Amounts*	$0	$283 (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 $283 of Medicare Approved	$0	$283 (Part B deductible)	$0
Amounts* 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 $283 of Medicare Approved Amounts*	$0	$283 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN F
OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL- **NOT COVERED BY MEDICARE** Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

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 $2,950 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2,950. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,950 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2,950 DEDUCTIBLE,** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,736	$1,736 (Part A deductible)	$0
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after:	All but $868 a day	$868 a day	$0
- While using 60 lifetime reserve days			
- Once lifetime reserve days are used:			
o Additional 365 days (lifetime)	$0	100% of Medicare eligible expenses	$0
o 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 $217 a day	Up to $217 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	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0
You must meet Medicare's requirements, including a doctor's certification of terminal illness			

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

*Once you have been billed $283 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 $2,950 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2,950. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,950 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2,950 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 $283 of Medicare Approved Amounts*	$0	$283 (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 $283 of Medicare approved amounts*	$0	$283 (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

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,950 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2,950 DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES • Medically necessary skilled care services and medical supplies • Durable medical equipment First $283 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $283 (Part B deductible) 20%	 $0 $0 $0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,950 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2,950 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 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 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 $1,736	$1,736 (Part A deductible)	$0
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after:	All but $868 a day	$868 a day	$0
- While using 60 lifetime reserve days			
- Once lifetime reserve days are used:			
o Additional 365 days (lifetime)	$0	100% of Medicare eligible expenses	$0
o 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 $217 a day	Up to $217 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	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0
You must meet Medicare's requirements, including a doctor's certification of terminal illness			

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

*Once you have been billed $283 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 $283 of Medicare Approved Amounts*	$0	$0	$283 (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 Next $283 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 $0 80%	 All costs $0 20%	 $0 $283 (Part B deductible) $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 $283 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 80%	 $0 20%	 $283 (Part B deductible) $0

PLAN G
OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL- **NOT COVERED BY MEDICARE** Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

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

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

**** This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $2,950 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2,950. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,950 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2,950 DEDUCTIBLE,** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,736	$1,736 (Part A deductible)	$0
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after:	All but $868 a day	$868 a day	$0
- While using 60 lifetime reserve days			
- Once lifetime reserve days are used:			
○ Additional 365 days (lifetime)	$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 $217 a day	Up to $217 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 out-patient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

*Once you have been billed $283 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

**** This high deductible plan pays the same benefits as Plan G after one has paid a calendar year $2,950 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2,950. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,950 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2,950 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 $283 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 Generally 80%	 $0 Generally 20%	 $283 (Part B deductible) $0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD First 3 pints Next $283 of Medicare approved amounts* Remainder of Medicare approved amounts	 $0 $0 80%	 All costs $0 20%	 $0 $283 (Part B deductible) $0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

HIGH DEDUCTIBLE PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,950 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2,950 DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES • Medically necessary skilled care services and medical supplies • Durable medical equipment First $283 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 $283 (Part B deductible) $0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,950 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2,950 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 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

MEDICARE SUPPLEMENT 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 $1,736	$1,736 (Part A deductible)	$0
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after:	All but $868 a day	$868 a day	$0
-While using 60 lifetime reserve days			
-Once lifetime reserve days are used:			
o Additional 365 days (lifetime)	$0	100% of Medicare eligible expenses	$0
o 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 $217 a day	Up to $217 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 out-patient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

MEDICARE SUPPLEMENT PLAN N
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $283 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 $283 of Medicare Approved Amounts*	$0	$0	$283 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $283 of Medicare Approved Amounts*	$0	$0	$283 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE SUPPLEMENT PLAN N
MEDICARE PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTHCARE MEDICARE APPROVED SERVICES • Medically necessary skilled care services and medical supplies • Durable medical equipment First $283 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 $283 (Part B deductible) $0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL- **NOT COVERED BY MEDICARE** Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year 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

Notice of Availability of Language Assistance Services

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. To access these services, please call us at 1-877-687-6651 (TTY: 1-800-662-1220).

ATENCIÓN: Si habla español, tiene disponible servicios gratuitos de asistencia lingüística. También hay disponible de manera gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Para acceder a estos servicios, llámenos al 1-877-687-6651 (TTY: 1-800-662-1220).

انتباه: إذا كنت تتحدث العربية فإن خدمات مساعدة اللغة المجانية مُتاحة لك. تتوفر أيضًا المساعدات والخدمات المساعدة المناسبة لتوفير المعلومات بتنسيقات يسهل الوصول إليها مجاناً . للوصول إلى هذه الخدمات، يُرجى الاتصال بنا على الرقم 1-877-687-6651 (الهاتف النصي: 1-800-662-1220)

注意：如果您說中文，我們可以爲您提供免費的語言幫助。我們也可以爲您免費提供適當的輔助工具和服務，以無障礙格式提供資訊。要獲得這些服務，請撥打 1-877-687-6651（TTY：1-800-662-1220）。

ATTENTION : Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et des services supplémentaires appropriés pour fournir des informations dans des formats accessibles sont aussi disponibles gratuitement. Pour accéder à ces services, veuillez nous appeler au 1 877 687 6651 (TTY [*ATS*] : 1 800 662 1220).

দৃষ্টি আকর্ষণ আপনি যদি বাংলাতে কথা বলেন, তাহলে বিনামূল্যে ভাষা সহায়তা পরিষেবা আপনার জন্য উপলব্ধ। অ্যাসিযোগ্য ফরম্যাটে তথ্য দিনের জন্য উপযুক্ত সহায়ক সাহায্য এবং পরিষেবাগুলি ও বিনামূলেয উপলব্ধ। এই পরিষেবাগুলি অযাসেি করার জনয, অনুগ্রহ কের আমাদের 1-877-687-6651 (TTY: 1-800-662-1220) নম্বরে কল করুন।

ВНИМАНИЕ: Если Вы говорите на русском языке, Вам доступны бесплатные услуги языковой поддержки. Также бесплатно доступны соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах. Чтобы воспользоваться этими услугами, позвоните нам по номеру 1-877-687-6651 (TTY: 1-800-662-1220).

ध्यान दिनुहोस्: तपाईं नेपाली बोल्नुहुन्छ भने, निःशुल्क भाषा सहायता सेवाहरू तपाईंका लागि उपलब्ध छन् । सुलभ ढाँचाहरू मा जानकारी दिन गर्न उपयुक्त सहायक सहायताहरू र सेवाहरू पनिर्ी निःशुल्क उपलब्ध छन् । यी सेवाहरू उपयोग गर्न , कृपया हामीलाई 1-877-687-6651 (TTY: 1-800-662-1220) मा फोन गर्नुहोस् ।

УВАГА: Якщо Ви говорите українською, Вам доступні безкоштовні послуги мовної підтримки. Відповідні допоміжні засоби та послуги для надання інформації в доступних форматах також надаються безкоштовно. Щоб скористатися цими послугами, зателефонуйте нам за номером: 1-877-687-6651 (TTY [*Телетайп*]: 1-800-662-1220).

FIIRO-GAAR AH: Haddii aad ku hadashid Soomaali, adeeggyada caawimaada luuqadda oo bilaashka ah ayaad helaysaa. Agabka caawimaada naafada iyo adeeggyo ku habboon oo lagu bixinaayo macluumaadka qaabab la helo karo ayaa sidoo kale lagu heli karaa bilaa lacag. Si loo helo adeegyadaan, fadlan naga soo wac 1-877-687-6651 (TTY: 1-800-662-1220).

ဟ်သျှဉ်ဟ်သး- နမ့်၊ ကတိၤအဲကလံးကျိာ်နှဉ်, တၢ်တိစၢၤမၤစၢၤကျိာ် တၢ်မၤစၢၤတၢ်မၤ အကလီအိဉ်လၢနဂီၢ် လၢနမၤနှၤ်အီၤသ့လီၤ. တၢ်မၤစၢၤတၢ်နၤ်ဟူဝီးလိ ဒီး တၢ်မၤစၢၤတၢ်မၤ လၢအဘဉ်ဘျိုးဘဉ်ဒါတဖဉ် ကဟ့ဉ်ဆီၢ တၢ်ဂ့ၢ် တၢ်ကျိၤ လၢကျိၤကျဲလၢတၢ်ဂ့ၢ်ဘ်လီၤမၤနှၤ်အီၤသ့တဖဉ် စ့ကီၢ အိဉ်လၢနမၤနှၤ်အီၤသ့ လၢတလိဉ်ဟ့ဉ်အပှၤဘဉ်နှဉ်လီၤ. လၢကမၤနှၤ်တၢ်မၤစၢၤတၢ်မၤတဖဉ်အံၤအဂီၢ်, ထံးစူးကိးပှၤဖဲ 1-877-687-6651 (TTY: 1-800-662-1220).

သတိၢ်ပရန်- သင် မြန်မာ ပြောဆိုလ၊်င် ဘာသာစကားအကူအညီ ဝန်ဆောင်မ၊်များကို၊်သင့်အတွက်၊်အခမဲ့ရ၌ို၌၊်င်သည်။ မသန်စွမ်းသူ များ အသုံး၊်ပို၊်င်သည့် ဖောမတ်များဖြင့် အချက်အလက်များ ပံ့ပိုးပေး၌်င်သည့်သင့်လျော်သော ထောက်ကူပစ၊်ည်းများ၌်ှင့် ဝန်ဆောင်မ၊်များကိုလည်း အခမဲ့ရ၌ို၌်ှင်ပါသည်။၊် ဤဝန်ဆောင်မ၊် များကို၊်ရ၌ရန က်၊်၌်ပ်တို၊်ကို၊် 1-877-687-6651 (TTY- 1-800-662-1220)သို့ ဖုန်းခေ၊်ဆိုပါ။

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Các dịch vụ và hỗ trợ bổ sung thích hợp để cung cấp thông tin ở các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Để sử dụng các dịch vụ này, vui lòng gọi cho chúng tôi theo số 1-877-687-6651 (TTY: 1-800-662-1220).

ATANSYON: Si ou pale Kreyòl Ayisyen, sèvis asistans lang gratis disponib pou ou. Èd ak sèvis oksilyè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib tou gratis. Pou jwenn aksè nan sèvis sa yo, tanpri rele nou nan 1-877-687-6651 (TTY: 1-800-662-1220).

توجه: اگر بھ زبان دری صحبت می کنید، خدمات کمک زبان رایگان برای شما قابل دسترس است. کمک امدادی مناسب و خدمات برای دسترسی بھ معلومات در فرمت میسر بصورت مجانی ارائه می‌شود. برای دسترسی بھ این خدامت، با ین شماره ها تماس حاصل کنید 1-877-687-6651 (TTY: 1-800-662-1220).

TAHADHARI: Ikiwa unazungumza Kiswahili, huduma za usaidizi wa lugha bila malipo zinapatikana kwa ajili yako. Misaada ya ziada inayofaa na huduma za kutoa habari katika miundo inayofikika zinapatikana pia bila malipo Ili kupata huduma hizi, tafadhali tupigie simu kwa 1-877-687-6651 (TTY: 1-800-662-1220).