



Home Office:
 The Order of United Commercial Travelers of America
 632 N. Park St., P.O. Box 159019, Columbus, OH 43215
 (614) 228-3276 • Toll-free: (800) 848-0123 • Fax: (614) 228-1898
 Visit our web site at www.ucit.org

Outline of Medicare Supplement Coverage -- Cover Page: 1 of 2

Benefit Plans A, B, C, D and F

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

See Outlines of Coverage sections for details about ALL plans.

Basic Benefits for Plans A-J:

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
 Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services.
 Blood: First three pints of blood each year.

A	B	C	D	E	F	F*	G	H	I	J	J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible	Part B Deductible				Part B Deductible	Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)	Part B Excess (100%)		Part B Excess (100%)	Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery			At-Home Recovery		At-Home Recovery
				Preventive Care NOT covered by Medicare						Preventive Care NOT covered by Medicare	

*Plans F and J also have an option called a high deductible Plan F and a high deductible Plan J. These high deductible plans pay the same or offer the same benefits as Plans F and J after one has paid a calendar year \$1,860 deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses are \$1,860. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare Deductibles for Part A and Part B, but does not include, in Plan J, the plan's separate prescription drug deductible or, in Plans F and J, the plan's separate foreign emergency deductible.



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Outline of Medicare Supplement Coverage – Cover Page 2

Basic Benefits for Plans K and L include similar services as plans A-J, but cost-sharing for the basic benefits is at different levels.

	J	K**	L**
Basic Benefits	100% of Part A Hospitalization Coinsurance plus coverage for 365 days after Medicare Benefits End 50% Hospice cost-sharing	100% of Part A Hospitalization Coinsurance plus coverage for 365 days after Medicare Benefits End 75% Hospice cost-sharing	100% of Part A Hospitalization Coinsurance plus coverage for 365 days after Medicare Benefits End 75% Hospice cost-sharing
50% of Medicare-eligible expenses for the first three pints of blood		75% of Medicare-eligible expenses for the first three pints of blood	75% of Medicare-eligible expenses for the first three pints of blood
50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services		75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services
Skilled Nursing Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible	75% Part A Deductible
Part B Excess (100%)			
Foreign Travel Emergency			
At-Home Recovery			
Preventative Care NOT covered by Medicare			
	\$4,140 Out of Pocket Annual Limit ***	\$2,070 Out of Policy Annual Limit ***	

** Plans K and L provide for different cost-sharing for items and services than Plans A-J. Once you reach the annual limit, the plans pay 100% of the Medicare copayments, coinsurances, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges". You will be responsible for paying excess charges.

*** The out-of-pocket annual limit will increase each year for inflation.

See Outlines of Coverage for details and exceptions.

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

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

COMPLETE ANSWERS ARE VERY IMPORTANT

This outline of coverage does not give all of the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare & You* for more details.

Neither The Order of United Commercial Travelers of America nor its agents are connected with Medicare.

This policy may not fully cover all of your medical costs.

NOTICE

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.

POLICY REPLACEMENT

If you find that you are not satisfied with your policy, you may return it to: The Order of United Commercial Travelers of America, 632 North Park Street, P.O. Box 159019, Columbus, Ohio 43215-8619, or to the representative through whom the policy was purchased. 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.

RIGHT TO RETURN POLICY

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.

READ YOUR POLICY VERY CAREFULLY

Use this outline to compare benefits and premiums among policies.

DISCLOSURES

You should compare other Medicare Supplement policies that are issue age bases to policies of attained age bases. While the cost of the policy at the covered individuals present age may be lower than the cost of a Medicare supplement policy based on issue age or community rating, it is important to compare the potential cost of these policies over the life of the policy.

Premiums for other Medicare supplement policies that are issue age or community rated do not increase due to changes in the policyholder's age.

Age	65	66	67	68	69	70	71	72	73	74	75
Premium	\$1105.0	\$1162.8	\$1220.6	\$1271.6	\$1329.4	\$1381.2	\$1434.8	\$1484.1	\$1530.8	\$1575.9	\$1615.0

Premiums are based on your attained age and will change on Your Policy Anniversary Date. The following illustration reflects the increase in premium due to age over a period of 10 years. (This information is based on the annual rates in the outline for Plan B and the individual being a 65 year old Male Non Smoker at the time of issue. Rate increases can also be applied in the future).

The Order of United Commercial Travelers of America may change your premium if a new table of rates is applicable. The change in the table of rates will apply to all covered persons in the same class on the date of change, and premiums are guaranteed for twelve months after each premium increase. Class is defined as attained age, underwriting class, state and zip code of residence.

PREMIUM INFORMATION



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**Annual Non-Smoker Premium Rates
 For Use In All North Carolina Zip Codes**

Attained Age	Plan A		Plan B		Plan C		Plan D		Plan F	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
0-64	\$1,274.15	\$1,466.25	N/A	N/A	\$1,701.70	\$1,957.55	N/A	N/A	N/A	N/A
65	\$742.05	\$853.40	\$961.35	\$1,105.00	\$1,034.45	\$1,190.00	\$935.85	\$1,076.10	\$1,055.70	\$1,214.65
66	\$780.30	\$897.60	\$1,010.65	\$1,162.80	\$1,085.45	\$1,248.65	\$983.45	\$1,130.50	\$1,099.90	\$1,264.80
67	\$820.25	\$942.65	\$1,061.65	\$1,220.60	\$1,139.85	\$1,310.70	\$1,032.75	\$1,187.45	\$1,145.80	\$1,317.50
68	\$855.10	\$983.45	\$1,105.85	\$1,271.60	\$1,193.40	\$1,371.05	\$1,076.10	\$1,237.60	\$1,194.25	\$1,372.75
69	\$892.50	\$1,026.80	\$1,156.00	\$1,329.40	\$1,243.55	\$1,430.55	\$1,125.40	\$1,293.70	\$1,241.00	\$1,426.30
70	\$929.05	\$1,067.60	\$1,201.90	\$1,381.25	\$1,288.60	\$1,482.40	\$1,169.60	\$1,345.55	\$1,286.05	\$1,478.15
71	\$963.90	\$1,108.40	\$1,247.80	\$1,434.80	\$1,333.65	\$1,535.10	\$1,213.80	\$1,396.55	\$1,330.25	\$1,530.85
72	\$997.05	\$1,147.50	\$1,290.30	\$1,484.10	\$1,375.30	\$1,581.85	\$1,257.15	\$1,445.00	\$1,371.90	\$1,577.60
73	\$1,029.35	\$1,183.20	\$1,331.10	\$1,530.85	\$1,412.70	\$1,625.20	\$1,296.25	\$1,490.05	\$1,409.30	\$1,620.95
74	\$1,058.25	\$1,216.35	\$1,370.20	\$1,575.90	\$1,449.25	\$1,666.85	\$1,333.65	\$1,533.40	\$1,445.85	\$1,662.60
75	\$1,085.45	\$1,247.80	\$1,404.20	\$1,615.00	\$1,482.40	\$1,704.25	\$1,367.65	\$1,571.65	\$1,478.15	\$1,700.00
76	\$1,109.25	\$1,276.70	\$1,436.50	\$1,651.55	\$1,509.60	\$1,737.40	\$1,398.25	\$1,608.20	\$1,506.20	\$1,732.30
77	\$1,133.90	\$1,303.90	\$1,467.95	\$1,688.95	\$1,536.80	\$1,767.15	\$1,428.00	\$1,642.20	\$1,533.40	\$1,762.05
78	\$1,156.00	\$1,329.40	\$1,496.00	\$1,720.40	\$1,560.60	\$1,795.20	\$1,456.05	\$1,674.50	\$1,556.35	\$1,790.10
79	\$1,176.40	\$1,353.20	\$1,522.35	\$1,750.15	\$1,581.85	\$1,819.85	\$1,480.70	\$1,703.40	\$1,578.45	\$1,815.60
80	\$1,195.10	\$1,373.60	\$1,547.00	\$1,779.05	\$1,602.25	\$1,843.65	\$1,505.35	\$1,731.45	\$1,598.85	\$1,838.55
81	\$1,212.10	\$1,394.00	\$1,569.10	\$1,804.55	\$1,622.65	\$1,867.45	\$1,527.45	\$1,755.25	\$1,619.25	\$1,862.35
82	\$1,229.10	\$1,413.55	\$1,590.35	\$1,829.20	\$1,643.90	\$1,891.25	\$1,547.85	\$1,780.75	\$1,640.50	\$1,886.15
83	\$1,244.40	\$1,430.55	\$1,611.60	\$1,852.15	\$1,664.30	\$1,915.05	\$1,568.25	\$1,802.85	\$1,660.90	\$1,909.95
84	\$1,260.55	\$1,448.40	\$1,631.15	\$1,875.10	\$1,682.15	\$1,936.30	\$1,586.95	\$1,825.80	\$1,678.75	\$1,930.35
85	\$1,288.60	\$1,466.25	\$1,649.85	\$1,898.05	\$1,701.70	\$1,957.55	\$1,605.65	\$1,847.05	\$1,697.45	\$1,951.60
86	\$1,288.60	\$1,481.55	\$1,668.55	\$1,918.45	\$1,719.55	\$1,977.95	\$1,624.35	\$1,867.45	\$1,715.30	\$1,972.00
87	\$1,303.05	\$1,497.70	\$1,686.40	\$1,939.70	\$1,736.55	\$1,998.35	\$1,641.35	\$1,887.85	\$1,732.30	\$1,992.40
88	\$1,314.95	\$1,513.00	\$1,701.70	\$1,957.55	\$1,751.85	\$2,015.35	\$1,657.50	\$1,905.70	\$1,747.60	\$2,009.40
89	\$1,326.85	\$1,526.60	\$1,718.70	\$1,976.25	\$1,766.30	\$2,032.35	\$1,672.80	\$1,923.55	\$1,762.05	\$2,026.40
90	\$1,339.60	\$1,540.20	\$1,734.00	\$1,994.10	\$1,780.75	\$2,049.35	\$1,688.10	\$1,940.55	\$1,777.35	\$2,043.40
91	\$1,350.65	\$1,553.80	\$1,748.45	\$2,011.10	\$1,795.20	\$2,064.65	\$1,701.70	\$1,956.70	\$1,790.95	\$2,059.55
92	\$1,360.85	\$1,564.85	\$1,761.20	\$2,025.55	\$1,806.25	\$2,078.25	\$1,714.45	\$1,971.15	\$1,802.00	\$2,073.15
93	\$1,370.20	\$1,576.75	\$1,773.95	\$2,040.00	\$1,818.15	\$2,091.85	\$1,727.20	\$1,986.45	\$1,813.90	\$2,085.90
94	\$1,379.55	\$1,586.10	\$1,785.85	\$2,053.60	\$1,828.35	\$2,103.75	\$1,739.10	\$2,000.05	\$1,824.10	\$2,098.65
95	\$1,387.20	\$1,595.45	\$1,796.05	\$2,064.65	\$1,838.55	\$2,115.65	\$1,748.45	\$2,011.10	\$1,834.30	\$2,109.70
96	\$1,395.70	\$1,604.80	\$1,806.25	\$2,077.40	\$1,847.05	\$2,126.05	\$1,758.65	\$2,022.15	\$1,842.80	\$2,119.05
97	\$1,404.20	\$1,615.00	\$1,817.30	\$2,090.15	\$1,857.25	\$2,135.05	\$1,768.85	\$2,033.20	\$1,853.00	\$2,130.10
98	\$1,412.70	\$1,625.20	\$1,828.35	\$2,102.90	\$1,866.60	\$2,147.10	\$1,779.05	\$2,046.80	\$1,862.35	\$2,141.15
99	\$1,421.20	\$1,633.70	\$1,838.55	\$2,113.95	\$1,875.95	\$2,158.15	\$1,789.25	\$2,057.85	\$1,871.70	\$2,152.20

Semi Annual
0.51500

Quarterly
0.26250

MODAL FACTORS

Direct Monthly
0.10000

Monthly EFT
0.08333

Effective 11-1-07



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Attained Age	Plan A		Plan B		Plan C		Plan D		Plan F	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
0-64	\$1,592.90	\$1,832.60	N/A	N/A	\$2,127.55	\$2,446.30	N/A	N/A	N/A	N/A
65	\$928.20	\$1,066.75	\$1,201.90	\$1,381.25	\$1,292.85	\$1,486.65	\$1,169.60	\$1,345.55	\$1,320.05	\$1,517.25
66	\$975.80	\$1,122.00	\$1,263.10	\$1,453.50	\$1,357.45	\$1,560.60	\$1,229.10	\$1,413.55	\$1,374.45	\$1,581.00
67	\$1,025.10	\$1,178.95	\$1,326.85	\$1,526.60	\$1,424.60	\$1,637.95	\$1,291.15	\$1,484.10	\$1,432.25	\$1,647.30
68	\$1,068.45	\$1,229.10	\$1,382.10	\$1,589.50	\$1,490.90	\$1,714.45	\$1,345.55	\$1,547.00	\$1,492.60	\$1,716.15
69	\$1,116.05	\$1,283.50	\$1,445.00	\$1,661.75	\$1,555.50	\$1,788.40	\$1,406.75	\$1,617.55	\$1,551.25	\$1,783.30
70	\$1,160.25	\$1,334.50	\$1,501.95	\$1,727.20	\$1,611.60	\$1,853.00	\$1,462.85	\$1,682.15	\$1,607.35	\$1,847.90
71	\$1,205.30	\$1,385.50	\$1,559.75	\$1,794.35	\$1,667.70	\$1,917.60	\$1,518.10	\$1,745.05	\$1,663.45	\$1,912.50
72	\$1,246.95	\$1,433.95	\$1,613.30	\$1,854.70	\$1,719.55	\$1,977.95	\$1,570.80	\$1,806.25	\$1,715.30	\$1,972.00
73	\$1,286.05	\$1,479.00	\$1,664.30	\$1,913.35	\$1,766.30	\$2,031.50	\$1,620.10	\$1,862.35	\$1,761.20	\$2,025.55
74	\$1,322.60	\$1,521.50	\$1,712.75	\$1,969.45	\$1,812.20	\$2,083.35	\$1,666.85	\$1,916.75	\$1,807.10	\$2,078.25
75	\$1,356.60	\$1,559.75	\$1,755.25	\$2,018.75	\$1,855.00	\$2,130.95	\$1,708.50	\$1,964.35	\$1,847.90	\$2,125.00
76	\$1,387.20	\$1,595.45	\$1,796.05	\$2,064.65	\$1,887.85	\$2,170.90	\$1,747.60	\$2,010.25	\$1,882.75	\$2,164.95
77	\$1,417.80	\$1,630.30	\$1,835.15	\$2,110.55	\$1,921.00	\$2,209.15	\$1,785.85	\$2,053.60	\$1,915.90	\$2,203.20
78	\$1,445.00	\$1,661.75	\$1,870.00	\$2,150.50	\$1,950.75	\$2,243.15	\$1,819.85	\$2,092.70	\$1,945.65	\$2,237.20
79	\$1,470.50	\$1,690.65	\$1,903.15	\$2,187.90	\$1,978.80	\$2,275.45	\$1,851.30	\$2,129.25	\$1,972.85	\$2,268.65
80	\$1,493.45	\$1,717.85	\$1,933.75	\$2,224.45	\$2,003.45	\$2,304.35	\$1,881.90	\$2,164.10	\$1,998.35	\$2,298.40
81	\$1,515.55	\$1,743.35	\$1,960.95	\$2,255.90	\$2,029.80	\$2,334.10	\$1,908.25	\$2,194.70	\$2,023.85	\$2,327.30
82	\$1,535.95	\$1,766.30	\$1,988.15	\$2,285.65	\$2,056.15	\$2,363.85	\$1,935.45	\$2,226.15	\$2,050.20	\$2,357.90
83	\$1,555.50	\$1,789.25	\$2,013.65	\$2,316.25	\$2,080.80	\$2,393.60	\$1,960.10	\$2,254.20	\$2,075.70	\$2,386.80
84	\$1,575.05	\$1,810.50	\$2,038.30	\$2,343.45	\$2,103.75	\$2,419.95	\$1,983.90	\$2,281.40	\$2,098.65	\$2,413.15
85	\$1,592.90	\$1,832.60	\$2,062.95	\$2,372.35	\$2,127.55	\$2,446.30	\$2,007.70	\$2,308.60	\$2,121.60	\$2,439.50
86	\$1,610.75	\$1,852.15	\$2,085.05	\$2,397.85	\$2,149.65	\$2,471.80	\$2,029.80	\$2,334.10	\$2,143.70	\$2,465.00
87	\$1,628.60	\$1,872.55	\$2,108.00	\$2,424.20	\$2,171.75	\$2,497.30	\$2,051.90	\$2,359.60	\$2,165.80	\$2,490.50
88	\$1,643.90	\$1,891.25	\$2,127.55	\$2,446.30	\$2,190.45	\$2,519.40	\$2,071.45	\$2,382.55	\$2,184.50	\$2,512.60
89	\$1,659.20	\$1,907.40	\$2,147.95	\$2,470.10	\$2,209.15	\$2,540.65	\$2,091.00	\$2,404.65	\$2,203.20	\$2,533.00
90	\$1,674.50	\$1,925.25	\$2,167.50	\$2,493.05	\$2,227.00	\$2,561.05	\$2,109.70	\$2,425.90	\$2,221.05	\$2,554.25
91	\$1,688.95	\$1,942.25	\$2,185.35	\$2,513.45	\$2,244.00	\$2,580.60	\$2,126.70	\$2,445.45	\$2,238.05	\$2,573.80
92	\$1,700.85	\$1,956.70	\$2,201.50	\$2,532.15	\$2,259.30	\$2,598.45	\$2,142.85	\$2,464.15	\$2,252.50	\$2,590.80
93	\$1,713.60	\$1,970.30	\$2,217.65	\$2,550.00	\$2,273.75	\$2,614.60	\$2,159.00	\$2,482.85	\$2,267.80	\$2,607.80
94	\$1,724.65	\$1,983.05	\$2,232.10	\$2,567.00	\$2,286.50	\$2,629.90	\$2,172.60	\$2,499.00	\$2,280.55	\$2,623.10
95	\$1,734.85	\$1,994.95	\$2,244.85	\$2,581.45	\$2,299.25	\$2,643.50	\$2,183.35	\$2,513.45	\$2,292.45	\$2,639.45
96	\$1,744.20	\$2,006.85	\$2,258.45	\$2,597.60	\$2,310.30	\$2,657.10	\$2,198.10	\$2,527.90	\$2,304.35	\$2,649.50
97	\$1,754.45	\$2,017.90	\$2,272.05	\$2,612.05	\$2,321.35	\$2,669.85	\$2,210.85	\$2,542.35	\$2,315.40	\$2,663.05
98	\$1,765.45	\$2,030.65	\$2,284.80	\$2,628.20	\$2,334.10	\$2,683.45	\$2,224.45	\$2,557.65	\$2,327.30	\$2,676.65
99	\$1,775.65	\$2,041.70	\$2,297.55	\$2,642.65	\$2,345.15	\$2,697.05	\$2,236.35	\$2,572.10	\$2,339.20	\$2,689.40

MODAL FACTORS

Semi Annual	Quarterly	Direct Monthly	Monthly EFT
0.51500	0.26250	0.10000	0.08333

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, we stand 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.

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
HOSPITALIZATION* Semi-private room and board, general nursing and miscellaneous services and supplies: First 60 days 61 st - 90 th day 91 st day and after: - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$992 All but \$248 a day All but \$496 a day \$0	\$0 \$248 a day \$496 a day 100% of Medicare Eligible Expenses \$0	\$992 (Part A Deductible) \$0 \$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 21 st - 100 th day 101 st day and after	All approved amounts All but \$124 a day \$0	\$0 \$0 \$0 \$0	\$0 Up to \$124 a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies that you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

* 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.

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

PLAN A

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First \$131 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100%	\$0	\$0
	80%	\$0	\$131 (Part B Deductible)

MEDICARE (PARTS A & B)

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 \$131 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$131 (Part B Deductible)
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$131 of Medicare Approved Amounts*	80%	20%	\$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

*Once you have been billed \$131 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.

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

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, we stand 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.

SERVICES	MEDICARE PAYS	PLAN B PAYS	YOU PAY
HOSPITALIZATION* Semi-private room and board, general nursing and miscellaneous services and supplies: First 60 days 61 st - 90 th day 91 st day and after: - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$992 All but \$248 a day All but \$496 a day \$0	\$992 (Part A Deductible) \$248 a day \$496 a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 All costs \$0**
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21 st - 100 th day 101 st day and after	All approved amounts All but \$124 a day \$0	\$0 \$0 \$0 All costs Up to \$124 a day All costs \$0	\$0 \$0 \$0 All costs \$0
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0 \$0
HOSPICE CARE Available as long as your doctor certifies that you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

* 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.

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

PLAN B

SERVICES	MEDICARE PAYS	PLAN B PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First \$131 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100%	\$0	\$0
		\$0	\$131 (Part B Deductible)
		20%	\$0

MEDICARE (PARTS A & B)

SERVICES	MEDICARE PAYS	PLAN B 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 \$131 of Medicare Approved Amounts*	Generally 80%	\$0	\$131 (Part B Deductible)
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$131 of Medicare Approved Amounts*	\$0	All costs	\$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PLAN B
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**
 *Once you have been billed \$131 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.

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, we stand 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.

SERVICES	MEDICARE PAYS	PLAN C PAYS	YOU PAY
HOSPITALIZATION* Semi-private room and board, general nursing and miscellaneous services and supplies: First 60 days 61 st - 90 th day 91 st day and after: - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$992 All but \$248 a day All but \$496 a day \$0	\$992 (Part A Deductible) \$248 a day \$496 a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$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 21 st - 100 th day 101 st day and after	All approved amounts All but \$124 a day \$0	\$0 Up to \$124 a day \$0	\$0 \$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies that you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

* 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.

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

PLAN C

PLAN C			
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR			
*Once you have been billed \$131 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 C 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 \$131 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	Generally 80%	\$131 (Part B Deductible) Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$131 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	80%	All costs \$131 (Part B Deductible) 20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0
MEDICARE (PARTS A & B)			
SERVICES	MEDICARE PAYS	PLAN C PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First \$131 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100%	\$0	\$0
OTHER BENEFITS – NOT COVERED BY MEDICARE	80%	20%	\$0
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	\$250 20% and amounts over the \$50,000 lifetime maximum

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, we stand 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.

SERVICES	MEDICARE PAYS	PLAN D PAYS	YOU PAY
HOSPITALIZATION* Semi-private room and board, general nursing and miscellaneous services and supplies: First 60 days 61 st - 90 th day 91 st day and after: - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$992 All but \$248 a day All but \$496 a day \$0 \$0	\$992 (Part A Deductible) \$248 a day \$496 a day 100% of Medicare Eligible Expenses \$0	\$0 \$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 21 st - 100 th day 101 st day and after	All approved amounts All but \$124 a day \$0	\$0 Up to \$124 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies that you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

* 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.

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

PLAN D

YOU PAY	PLAN D PAYS	MEDICARE PAYS	SERVICES
\$0	\$0	Generally 80%	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 \$131 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts
All costs	\$0	\$0	Part B Excess Charges (Above Medicare Approved Amounts)
\$0	All costs	80%	BLOOD First 3 pints Next \$131 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts
\$0	\$0	100%	CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES

PLAN D MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR
 *Once you have been billed \$131 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.

MEDICARE (PARTS A & B)			
SERVICES	MEDICARE PAYS	PLAN D PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First \$131 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan - Benefit for each visit - Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit) \$0	100% \$0 80% \$0 20% \$0	Actual charges to \$40 a visit Up to the number of Medicare Approved visits, not to exceed 7 each week. \$1,600	\$0 \$0 Balance \$0 \$131 (Part B Deductible) \$0
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 \$0	80% to a lifetime maximum benefit of \$50,000 \$250 20% and amounts over the \$50,000 lifetime maximum	\$0 \$0
OTHER BENEFITS - NOT COVERED BY MEDICARE			

PLAN D

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, we stand 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.

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
HOSPITALIZATION* Semi-private room and board, general nursing and miscellaneous services and supplies: First 60 days 61 st - 90 th day 91 st day and after: - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$992 All but \$248 a day All but \$496 a day \$0	\$992 (Part A Deductible) \$248 a day \$496 a day 100% of Medicare Eligible Expenses \$0	\$0 \$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 21 st - 100 th day 101 st day and after	All approved amounts All but \$124 a day \$0	\$0 Up to \$124 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies that you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

* 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.

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

PLAN F

<p>NOT COVERED BY MEDICARE - FOREIGN TRAVEL - 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</p>	<p>\$0 \$0</p>	<p>\$0 \$0 80% to a lifetime maximum benefit of \$50,000</p>	<p>\$250 20% and amounts over the \$50,000 lifetime maximum</p>
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OTHER BENEFITS - NOT COVERED BY MEDICARE

<p>HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First \$131 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts</p>	<p>100% \$0 80%</p>	<p>\$0 \$131 (Part B Deductible) 20%</p>	<p>\$0 \$0 \$0</p>
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SERVICES MEDICARE PAYS PLAN F PAYS YOU PAY

MEDICARE (PARTS A & B)

<p>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 \$131 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts</p>	<p>Generally 80%</p>	<p>\$131 (Part B Deductible) Generally 20%</p>	<p>\$0 \$0</p>
<p>Part B Excess Charges (Above Medicare Approved Amounts)</p>	<p>\$0</p>	<p>100%</p>	<p>\$0</p>
<p>BLOOD First 3 pints Next \$131 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts</p>	<p>\$0 \$0 80%</p>	<p>All costs \$131 (Part B Deductible) 20%</p>	<p>\$0 \$0 \$0</p>
<p>CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES</p>	<p>100%</p>	<p>\$0</p>	<p>\$0</p>

PLAN F MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR
 *Once you have been billed \$131 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.