

Benefit Chart of Medicare Supplement Plans sold on or after June 15, 2017

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.

Basic Benefits:

- **Hospitalization** – Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses** – Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.
- **Blood** – First three pints of blood each year.
- **Hospice** – Part A coinsurance.

A	B	C	D	F	F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER						
		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance				
	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible					
		Part B Deductible		Part B Deductible						
				Part B Excess (100%)	Part B Excess (100%)					
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency				Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket limit \$5120; paid at 100% after limit reached	Out-of-pocket limit \$2560; paid at 100% after limit reached		

* Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2200 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed \$2200. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

MEDICARE SUPPLEMENT PREMIUM RATES

AGE	PLAN A		PLAN F		PLAN G		PLAN N		ZIP CODE AREA FACTORS	
	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	ZIP REGION	AREA FACTOR
65	\$1,632.07	\$1,444.32	\$2,445.42	\$2,164.08	\$1,561.64	\$1,381.98	\$1,313.76	\$1,162.62	894, 973-979, 993	1.000
66	\$1,655.69	\$1,465.23	\$2,514.23	\$2,224.98	\$1,561.64	\$1,381.98	\$1,350.75	\$1,195.34		
67	\$1,679.34	\$1,486.12	\$2,585.04	\$2,287.64	\$1,561.64	\$1,381.98	\$1,388.66	\$1,228.90		
68	\$1,766.32	\$1,563.13	\$2,686.46	\$2,377.40	\$1,561.64	\$1,381.98	\$1,447.25	\$1,280.76		
69	\$1,853.31	\$1,640.11	\$2,787.90	\$2,467.16	\$1,609.89	\$1,424.68	\$1,505.88	\$1,332.64		
70	\$1,940.35	\$1,717.11	\$2,889.35	\$2,556.95	\$1,656.33	\$1,465.78	\$1,564.49	\$1,384.50		
71	\$2,027.34	\$1,794.10	\$2,990.78	\$2,646.71	\$1,703.20	\$1,507.26	\$1,623.11	\$1,436.38	970-972	1.043
72	\$2,114.34	\$1,871.10	\$3,092.23	\$2,736.49	\$1,755.92	\$1,553.91	\$1,681.72	\$1,488.25		
73	\$2,175.00	\$1,924.79	\$3,202.35	\$2,833.94	\$1,811.93	\$1,603.48	\$1,748.59	\$1,547.42		
74	\$2,236.33	\$1,979.06	\$3,312.48	\$2,931.39	\$1,866.66	\$1,651.91	\$1,815.47	\$1,606.61		
75	\$2,299.30	\$2,034.77	\$3,422.62	\$3,028.88	\$1,916.22	\$1,695.77	\$1,882.33	\$1,665.78		
76	\$2,364.04	\$2,092.07	\$3,532.77	\$3,126.34	\$1,970.64	\$1,743.93	\$1,949.20	\$1,724.95		
77	\$2,424.89	\$2,145.92	\$3,642.89	\$3,223.79	\$2,023.05	\$1,790.31	\$2,016.07	\$1,784.14		
78	\$2,454.87	\$2,172.45	\$3,745.67	\$3,314.75	\$2,071.01	\$1,832.75	\$2,082.46	\$1,842.89		
79	\$2,484.87	\$2,199.00	\$3,851.26	\$3,408.19	\$2,119.98	\$1,876.09	\$2,148.82	\$1,901.61		
80	\$2,514.86	\$2,225.52	\$3,959.87	\$3,504.31	\$2,189.19	\$1,937.34	\$2,215.21	\$1,960.37		
81	\$2,544.83	\$2,252.06	\$4,060.79	\$3,593.62	\$2,248.30	\$1,989.65	\$2,281.59	\$2,019.10		
82	\$2,574.83	\$2,278.61	\$4,161.71	\$3,682.92	\$2,309.01	\$2,043.37	\$2,347.98	\$2,077.84		
83	\$2,618.09	\$2,316.91	\$4,286.47	\$3,793.33	\$2,373.67	\$2,100.59	\$2,436.87	\$2,156.53		
84	\$2,620.30	\$2,318.84	\$4,411.18	\$3,903.70	\$2,437.75	\$2,157.30	\$2,525.81	\$2,235.24		
85	\$2,622.49	\$2,320.79	\$4,535.94	\$4,014.10	\$2,498.70	\$2,211.24	\$2,614.77	\$2,313.95		
86	\$2,624.70	\$2,322.73	\$4,660.71	\$4,124.53	\$2,546.17	\$2,253.25	\$2,703.67	\$2,392.63		
87	\$2,626.91	\$2,324.69	\$4,785.45	\$4,234.91	\$2,594.55	\$2,296.06	\$2,792.63	\$2,471.34		
88	\$2,634.76	\$2,331.64	\$4,837.09	\$4,280.61	\$2,643.85	\$2,339.69	\$2,871.26	\$2,540.94		
89	\$2,642.63	\$2,338.61	\$4,888.72	\$4,326.31	\$2,691.43	\$2,381.80	\$2,925.25	\$2,588.71		
90	\$2,650.49	\$2,345.57	\$4,992.15	\$4,417.83	\$2,739.88	\$2,424.67	\$2,980.34	\$2,637.46		
91	\$2,658.37	\$2,352.53	\$5,132.54	\$4,542.08	\$2,764.53	\$2,446.49	\$3,036.24	\$2,686.94		
92	\$2,666.24	\$2,359.50	\$5,277.32	\$4,670.20	\$2,789.42	\$2,468.51	\$3,093.23	\$2,737.36		
93	\$2,673.79	\$2,366.18	\$5,425.82	\$4,801.61	\$2,811.73	\$2,488.26	\$3,151.30	\$2,788.77		
94	\$2,681.35	\$2,372.88	\$5,578.75	\$4,936.94	\$2,834.23	\$2,508.17	\$3,210.49	\$2,841.15		
95	\$2,688.93	\$2,379.59	\$5,735.67	\$5,075.82	\$2,859.74	\$2,530.74	\$3,270.86	\$2,894.57		
96	\$2,696.48	\$2,386.27	\$5,897.19	\$5,218.73	\$2,879.76	\$2,548.46	\$3,332.42	\$2,949.04		
97	\$2,704.06	\$2,392.98	\$6,063.30	\$5,365.77	\$2,899.92	\$2,566.30	\$3,394.85	\$3,004.29		
98	\$2,711.63	\$2,399.68	\$6,234.16	\$5,516.94	\$2,920.21	\$2,584.26	\$3,458.49	\$3,060.62		
99	\$2,719.20	\$2,406.38	\$6,409.79	\$5,672.37	\$2,940.66	\$2,602.35	\$3,523.35	\$3,118.01		
100+	\$2,726.79	\$2,413.10	\$6,468.19	\$5,724.07	\$2,961.24	\$2,620.57	\$3,589.46	\$3,176.51		

ZIP CODE AREA FACTORS	
ZIP REGION	AREA FACTOR
894, 973-979, 993	1.000
970-972	1.043

MODAL FACTORS	
MODE	FACTOR
Annual	1.000
Semi-Annual	0.510
Quarterly	0.260
Monthly	0.086

TOBACCO FACTOR	
Non-Tobacco	1.00
Tobacco	1.15

There is a one-time application fee of \$15.00.

HOW TO CALCULATE A MODAL PREMIUM

(Annual Rate x Area Factor x Tobacco Factor x Modal Factor) + \$0.25 = Modal Premium

Disability Rates				
<65	\$1,511.18	\$1,337.33	\$1,882.54	\$1,665.96

\$1,313.76	\$1,162.62
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PREMIUM INFORMATION

We (Oxford Life Insurance Company) can only raise your premium if we raise the premium for all policies like yours in this State. The premium will increase annually based on your age.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

This outline shows benefits and premiums of policies sold for effective dates on or after June 15, 2017.

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 PO Box 46518, Madison, WI 53744-6518. 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 Oxford 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 Medicare and You for more details.

LIMITATIONS AND EXCLUSIONS

No benefits are available under this policy for 1) medical care of the kinds not covered by Medicare; 2) medical care which Medicare does not consider to be medically necessary; 3) medical care which is not eligible for payment under Medicare; or 4) expenses to the extent of any benefit available to the insured under Medicare.

REFUND OF PREMIUM

We will refund your premium if you return the policy to us within 30 days after you receive it. We will refund any unearned premium at the time of your death upon proper notice by your survivor, or upon your written request to cancel.

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. The company 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.

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 61st thru 90th day 91st 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 \$1316.00 All but \$329.00 a day All but \$658.00 a day \$0.00 \$0.00	\$0.00 \$329.00 a day \$658.00 a day 100% of Medicare eligible expenses \$0.00	\$1316.00 (Part A deductible) \$0.00 \$0.00 \$0.00** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$164.50 a day \$0.00	\$0.00 \$0.00 \$0.00	\$0.00 Up to \$164.50 a day All costs
BLOOD First 3 pints Additional amounts	\$0.00 100%	3 pints \$0.00	\$0.00 \$0.00
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	\$0.00

** **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, continued

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

* Once you have been billed \$183.00 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 \$183.00 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0.00 Generally 80%	 \$0.00 Generally 20%	 \$183.00 (Part B deductible) \$0.00
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0.00	\$0.00	All costs
BLOOD First 3 pints Next \$183.00 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0.00 \$0.00 80%	 All costs \$0.00 20%	 \$0.00 \$183.00 (Part B deductible) \$0.00
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	\$0.00	\$0.00

PLAN A, continued

MEDICARE (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%	\$0.00	\$0.00
Durable medical equipment			
First \$183.00 of Medicare Approved Amounts*	\$0.00	\$0.00	\$183.00 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0.00

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 61st thru 90th day 91st 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 \$1316.00 All but \$329.00 a day All but \$658.00 a day \$0.00 \$0.00	\$1316.00 (Part A deductible) \$329.00 a day \$658.00 a day 100% of Medicare eligible expenses \$0.00	\$0.00 \$0.00 \$0.00 \$0.00** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$164.50 a day \$0.00	\$0.00 Up to \$164.50 a day \$0.00	\$0.00 \$0.00 All costs
BLOOD First 3 pints Additional amounts	\$0.00 100%	3 pints \$0.00	\$0.00 \$0.00
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	\$0.00

** **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, continued

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

* Once you have been billed \$183.00 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 \$183.00 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0.00 Generally 80%	 \$183.00 (Part B deductible) Generally 20%	 \$0.00 \$0.00
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0.00	100%	\$0.00
BLOOD First 3 pints Next \$183.00 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0.00 \$0.00 80%	 All costs \$183.00 (Part B deductible) 20%	 \$0.00 \$0.00 \$0.00
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	\$0.00	\$0.00

PLAN F, continued

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0.00	\$0.00
Durable medical equipment			
First \$183.00 of Medicare Approved Amounts*	\$0.00	\$183.00 (Part B deductible)	\$0.00
Remainder of Medicare Approved Amounts	80%	20%	\$0.00

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	\$0.00	\$0.00	\$250.00
Remainder of charges	\$0.00	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st 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 \$1316.00 All but \$329.00 a day All but \$658.00 a day \$0.00 \$0.00	\$1316.00 (Part A deductible) \$329.00 a day \$658.00 a day 100% of Medicare eligible expenses \$0.00	\$0.00 \$0.00 \$0.00 \$0.00** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$164.50 a day \$0.00	\$0.00 Up to \$164.50 a day \$0.00	\$0.00 \$0.00 All costs
BLOOD First 3 pints Additional amounts	\$0.00 100%	3 pints \$0.00	\$0.00 \$0.00
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	\$0.00

** **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, continued

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

* Once you have been billed \$183.00 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 \$183.00 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0.00 Generally 80%	 \$0.00 Generally 20%	 \$183.00 (Part B deductible) \$0.00
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0.00	100%	\$0.00
BLOOD First 3 pints Next \$183.00 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0.00 \$0.00 80%	All costs \$0.00 20%	\$0.00 \$183.00 (Part B deductible) \$0.00
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	\$0.00	\$0.00

PLAN G, continued

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	\$0.00	\$0.00
Durable medical equipment			
First \$183.00 of Medicare Approved Amounts*	\$0.00	\$0.00	\$183.00 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0.00

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	\$0.00	\$0.00	\$250.00
Remainder of charges	\$0.00	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st 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 \$1316.00 All but \$329.00 a day All but \$658.00 a day \$0.00 \$0.00	\$1316.00 (Part A deductible) \$329.00 a day \$658.00 a day 100% of Medicare eligible expenses \$0.00	\$0.00 \$0.00 \$0.00 \$0.00** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$164.50 a day \$0.00	\$0.00 Up to \$164.50 a day \$0.00	\$0.00 \$0.00 All costs
BLOOD First 3 pints Additional amounts	\$0.00 100%	3 pints \$0.00	\$0.00 \$0.00
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	\$0.00

** **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, continued

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

* Once you have been billed \$183.00 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
<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</p> <p>First \$183.00 of Medicare Approved Amounts*</p> <p>Remainder of Medicare Approved Amounts</p>	<p align="center">\$0.00</p> <p align="center">Generally 80%</p>	<p align="center">\$0.00</p> <p align="center">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.</p>	<p align="center">\$183.00 (Part B deductible)</p> <p align="center">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.</p>
<p>PART B EXCESS CHARGES (Above Medicare Approved Amounts)</p>	<p align="center">\$0.00</p>	<p align="center">\$0.00</p>	<p align="center">All costs</p>
<p>BLOOD First 3 pints Next \$183.00 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts</p>	<p align="center">\$0.00</p> <p align="center">\$0.00</p> <p align="center">80%</p>	<p align="center">All costs</p> <p align="center">\$0.00</p> <p align="center">20%</p>	<p align="center">\$0.00</p> <p align="center">\$183.00 (Part B deductible)</p> <p align="center">\$0.00</p>
<p>CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES</p>	<p align="center">100%</p>	<p align="center">\$0.00</p>	<p align="center">\$0.00</p>

PLAN N, continued

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0.00	\$0.00
Durable medical equipment			
First \$183.00 of Medicare Approved Amounts*	\$0.00	\$0.00	\$183.00 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0.00

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	\$0.00	\$0.00	\$250.00
Remainder of charges	\$0.00	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum