

ACTUARIAL SERVICES

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[COMPANY NAME]

Outline of Medicare Supplement Coverage—Cover Page: 1 of 2
Benefit Plans _____ [insert letters of plans being offered]

These charts show the benefits included in each of the standard 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	
		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 B deductible			Part B deductible					Part B deductible	
					Part B Excess (100%)		Part B Excess (80%)		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	
			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 benefits as Plans F and J after one has paid a calendar year [***] deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses exceed [***]. 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.

[COMPANY NAME]
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 50% of Medicare-eligible expenses for the first three pints of blood 50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 75% Hospice cost-sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services
Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT covered by Medicare		
	[\$***] Out of Pocket Annual Limit****	[\$***] Out of Pocket 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 plan pays 100% of the Medicare copayments, coinsurance, 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.**

***** Deductible amounts and out-of-pocket limits announced annually by CMS.**

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

See Outlines of Coverage for details and exceptions.

HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	Generally, most Medicare eligible expenses for outpatient drugs and inpatient respite care	50% of coinsurance or copayments	50% of coinsurance or copayments ♦
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**** **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 K
MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

****Once you have been billed \$[***] 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 \$[***] of Medicare Approved Amounts****	\$0	\$0	\$[***] (Part B deductible)**** ♦
Preventive Benefits for Medicare Covered Services Remainder of Medicare Approved Amounts	Generally 75% or more of Medicare approved amounts Generally 80%	Remainder of Medicare approved amounts Generally 10%	All costs above Medicare approved amounts Generally 10%. ♦
Part 8 Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of \$[***])*
BLOOD First 3 pints Next \$[***] of Medicare Approved Amounts***	\$0 \$0	50% \$0	50%. ♦ \$[***] (Part B deductible)**** ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10%. ♦
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

* **This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[***] per year.** However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PARTS A & B

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 \$[100] of Medicare Approved Amounts****	100% \$0	\$0 \$0	\$0 \$[***] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	80%	1%	10% ♦

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

*** Deductible amounts and out-of-pocket limits announced annually by CMS.

PLAN L

* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[***] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies 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 \$[***] All but \$[***] a day All but \$[***] a day \$0 \$0	\$[***] (75% of Part A deductible) \$[***] a day \$[***] a day 100% of Medicare eligible expenses \$0	\$[***] (25% of 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 21st thru 100th day 101st day and after	All approved amounts All but \$[***] a day \$0	\$0 Up to \$[***] a day \$0	\$0 Up to \$[***] a day ♦ All costs
BLOOD First 3 pints Additional amounts	\$0 100%	75% \$0	25%. ♦ \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	Generally, most Medicare eligible expenses for outpatient drugs and inpatient respite care	75% of coinsurance or copayments	25% of coinsurance or copayments ♦

**** 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.