WMI MUTUAL INSURANCE™ COMPANY
Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020
Benefit Plan(s) **A, C, F, G and N**

This chart shows the benefits included in each of the Standard Medicare Supplement Plans. Some plans may not be available. Only applicants' **first** eligible for Medicare before 2020 may purchase Plans C, F and high deductible F.

Note: A √ means 100% of the benefit is paid.

| Benefits | Plans Available to All Applicants | | | | | | | | Medicare first eligible before 2020 only | |
|---|---|---|---|---|---|---|---|---|---|---|
| | **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] | | | | | [$8000][2] | [$4000][2] | | | | |

[1] Plans F and G also have a high deductible option which require first paying a plan deductible of [$2950] before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.
[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 $20 for some office visits and a $50 co-payment for emergency room visits that do not result in an inpatient admission.

## PREMIUM INFORMATION

**The monthly Preferred rates below are for applicants who are in their open enrollment period (non-smoker only), who qualify for guarantee issue (non-smoker only), or who qualify for a Preferred rate upon completion of underwriting.**

| 2026 Preferred Rates PPPM | Outside of Maricopa County | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Arizona | A | | C | | F* | | G* | | N | |
| Issue Age | Female | Male | Female | Male | Female | Male | Female | Male | Female | Male |
| 65 | $100 | $111 | $146 | $161 | $153 | $168 | $145 | $160 | $97 | $108 |
| 66 | $105 | $116 | $152 | $168 | $159 | $175 | $150 | $167 | $101 | $112 |
| 67 | $109 | $120 | $159 | $175 | $166 | $183 | $157 | $173 | $105 | $116 |
| 68 | $113 | $125 | $165 | $182 | $172 | $190 | $164 | $181 | $109 | $120 |
| 69 | $118 | $130 | $171 | $189 | $179 | $197 | $169 | $187 | $113 | $124 |
| 70 | $122 | $134 | $177 | $196 | $185 | $204 | $175 | $194 | $116 | $129 |
| 71 | $126 | $140 | $184 | $203 | $192 | $211 | $182 | $201 | $121 | $134 |
| 72 | $131 | $144 | $190 | $210 | $198 | $219 | $187 | $208 | $125 | $138 |
| 73 | $135 | $149 | $196 | $217 | $205 | $226 | $194 | $215 | $130 | $143 |
| 74 | $138 | $154 | $202 | $224 | $211 | $233 | $201 | $221 | $135 | $149 |
| 75 | $143 | $158 | $209 | $231 | $218 | $241 | $207 | $229 | $138 | $154 |
| 76 | $147 | $164 | $215 | $238 | $225 | $247 | $213 | $235 | $143 | $158 |
| 77 | $152 | $168 | $221 | $244 | $231 | $255 | $219 | $242 | $147 | $162 |
| 78 | $156 | $172 | $227 | $251 | $238 | $262 | $226 | $249 | $150 | $166 |
| 79 | $160 | $178 | $234 | $258 | $244 | $269 | $231 | $256 | $155 | $170 |
| 80 | $165 | $182 | $240 | $265 | $250 | $277 | $238 | $263 | $158 | $175 |
| 81 | $169 | $187 | $246 | $272 | $257 | $283 | $244 | $269 | $162 | $180 |
| 82 | $173 | $192 | $253 | $280 | $264 | $291 | $251 | $277 | $167 | $184 |
| 83 | $179 | $197 | $260 | $287 | $270 | $300 | $257 | $284 | $172 | $190 |
| 84 | $183 | $203 | $267 | $295 | $278 | $307 | $264 | $292 | $177 | $195 |
| 85+ | $187 | $208 | $274 | $303 | $286 | $315 | $271 | $300 | $180 | $199 |

*Plans F and G do not include the high deductible option.

| 2026 Preferred Rates PPPM | Maricopa County | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Arizona | A | | C | | F* | | G* | | N | |
| Issue Age | Female | Male | Female | Male | Female | Male | Female | Male | Female | Male |
| 65 | $110 | $122 | $161 | $178 | $168 | $185 | $159 | $175 | $107 | $118 |
| 66 | $116 | $128 | $168 | $185 | $174 | $193 | $166 | $183 | $111 | $122 |
| 67 | $120 | $132 | $174 | $193 | $182 | $201 | $172 | $191 | $114 | $128 |
| 68 | $124 | $137 | $181 | $200 | $189 | $209 | $180 | $198 | $119 | $132 |
| 69 | $130 | $143 | $188 | $208 | $196 | $217 | $186 | $206 | $123 | $136 |
| 70 | $134 | $148 | $195 | $216 | $204 | $225 | $193 | $214 | $128 | $141 |
| 71 | $138 | $154 | $202 | $223 | $210 | $233 | $199 | $221 | $133 | $146 |
| 72 | $144 | $158 | $209 | $231 | $218 | $241 | $207 | $229 | $137 | $153 |
| 73 | $148 | $164 | $216 | $238 | $225 | $249 | $214 | $237 | $143 | $158 |
| 74 | $153 | $169 | $223 | $246 | $232 | $256 | $220 | $244 | $147 | $162 |
| 75 | $158 | $174 | $230 | $254 | $240 | $265 | $228 | $251 | $153 | $168 |
| 76 | $162 | $180 | $236 | $261 | $246 | $273 | $234 | $258 | $156 | $173 |
| 77 | $167 | $184 | $243 | $269 | $254 | $280 | $241 | $266 | $160 | $178 |
| 78 | $172 | $190 | $250 | $277 | $261 | $288 | $247 | $274 | $165 | $182 |
| 79 | $177 | $195 | $257 | $284 | $268 | $296 | $255 | $281 | $170 | $187 |
| 80 | $181 | $201 | $264 | $292 | $275 | $304 | $262 | $289 | $174 | $192 |
| 81 | $186 | $206 | $271 | $300 | $282 | $312 | $268 | $296 | $179 | $198 |
| 82 | $191 | $211 | $278 | $308 | $290 | $320 | $276 | $304 | $183 | $203 |
| 83 | $196 | $217 | $286 | $316 | $298 | $329 | $283 | $313 | $189 | $208 |
| 84 | $202 | $222 | $293 | $324 | $306 | $338 | $291 | $322 | $193 | $213 |
| 85+ | $207 | $229 | $301 | $333 | $314 | $347 | $299 | $329 | $197 | $219 |

*Plans F and G do not include the high deductible option.

**The monthly Standard rates below are for applicants who are in their open enrollment period (smoker only), who qualify for guarantee issue (smoker only), who are not in their open enrollment period, who do not qualify for guarantee issue, who do not qualify for a Preferred rate, but who qualify for a Standard rate upon completion of underwriting.**

| 2026 Standard Rates PPPM | Outside of Maricopa County | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Arizona | A | | C | | F* | | G* | | N | |
| Issue Age | Female | Male | Female | Male | Female | Male | Female | Male | Female | Male |
| 65 | $125 | $139 | $183 | $201 | $191 | $210 | $181 | $200 | $121 | $135 |
| 66 | $131 | $145 | $190 | $210 | $199 | $219 | $188 | $209 | $127 | $140 |
| 67 | $136 | $150 | $199 | $219 | $208 | $229 | $196 | $216 | $131 | $144 |
| 68 | $141 | $156 | $206 | $228 | $215 | $238 | $205 | $226 | $136 | $150 |
| 69 | $148 | $163 | $214 | $236 | $224 | $246 | $211 | $234 | $142 | $155 |
| 70 | $153 | $168 | $221 | $245 | $231 | $255 | $219 | $243 | $144 | $161 |
| 71 | $158 | $175 | $230 | $254 | $240 | $264 | $228 | $251 | $151 | $168 |
| 72 | $164 | $180 | $238 | $263 | $248 | $274 | $234 | $260 | $157 | $173 |
| 73 | $169 | $186 | $245 | $271 | $256 | $283 | $243 | $269 | $162 | $178 |
| 74 | $173 | $193 | $253 | $280 | $264 | $291 | $251 | $276 | $169 | $187 |
| 75 | $179 | $198 | $261 | $289 | $273 | $301 | $259 | $286 | $173 | $192 |
| 76 | $184 | $205 | $269 | $298 | $281 | $309 | $266 | $294 | $178 | $198 |
| 77 | $190 | $210 | $276 | $305 | $289 | $319 | $274 | $303 | $184 | $203 |
| 78 | $195 | $215 | $284 | $314 | $298 | $328 | $283 | $311 | $188 | $207 |
| 79 | $200 | $223 | $293 | $323 | $305 | $336 | $289 | $320 | $193 | $213 |
| 80 | $206 | $228 | $300 | $331 | $313 | $346 | $298 | $329 | $198 | $219 |
| 81 | $211 | $234 | $308 | $340 | $321 | $354 | $305 | $336 | $203 | $225 |
| 82 | $216 | $240 | $316 | $350 | $330 | $364 | $314 | $346 | $208 | $230 |
| 83 | $224 | $246 | $325 | $359 | $338 | $375 | $321 | $355 | $215 | $237 |
| 84 | $229 | $254 | $334 | $369 | $348 | $384 | $330 | $365 | $221 | $244 |
| 85+ | $234 | $260 | $343 | $379 | $358 | $394 | $339 | $375 | $225 | $249 |

*Plans F and G do not include the high deductible option.

| 2026 Standard Rates PPPM | | | Maricopa County | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Arizona | A | | C | | F* | | G* | | N | |
| Issue Age | Female | Male | Female | Male | Female | Male | Female | Male | Female | Male |
| 65 | $138 | $153 | $201 | $223 | $210 | $231 | $199 | $219 | $134 | $147 |
| 66 | $145 | $160 | $210 | $231 | $218 | $241 | $208 | $229 | $139 | $153 |
| 67 | $150 | $165 | $218 | $241 | $228 | $251 | $215 | $239 | $143 | $159 |
| 68 | $155 | $171 | $226 | $250 | $236 | $261 | $225 | $248 | $149 | $165 |
| 69 | $163 | $179 | $235 | $260 | $245 | $271 | $233 | $258 | $154 | $170 |
| 70 | $168 | $185 | $244 | $270 | $255 | $281 | $241 | $268 | $159 | $176 |
| 71 | $173 | $193 | $253 | $279 | $263 | $291 | $249 | $276 | $166 | $183 |
| 72 | $180 | $198 | $261 | $289 | $273 | $301 | $259 | $286 | $172 | $191 |
| 73 | $185 | $205 | $270 | $298 | $281 | $311 | $268 | $296 | $178 | $198 |
| 74 | $191 | $211 | $279 | $308 | $290 | $320 | $275 | $305 | $184 | $203 |
| 75 | $198 | $218 | $288 | $318 | $300 | $331 | $285 | $314 | $191 | $210 |
| 76 | $203 | $225 | $295 | $326 | $308 | $341 | $293 | $323 | $195 | $217 |
| 77 | $209 | $230 | $304 | $336 | $318 | $350 | $301 | $333 | $200 | $222 |
| 78 | $215 | $238 | $313 | $346 | $326 | $360 | $309 | $343 | $206 | $228 |
| 79 | $221 | $244 | $321 | $355 | $335 | $370 | $319 | $351 | $213 | $234 |
| 80 | $226 | $251 | $330 | $365 | $344 | $380 | $328 | $361 | $218 | $240 |
| 81 | $233 | $258 | $339 | $375 | $353 | $390 | $335 | $370 | $223 | $248 |
| 82 | $239 | $264 | $348 | $385 | $363 | $400 | $345 | $380 | $229 | $253 |
| 83 | $245 | $271 | $358 | $395 | $373 | $411 | $354 | $391 | $236 | $260 |
| 84 | $253 | $278 | $366 | $405 | $383 | $423 | $364 | $403 | $241 | $266 |
| 85+ | $259 | $286 | $376 | $416 | $393 | $434 | $374 | $411 | $247 | $274 |

*Plans F and G do not include the high deductible option.

**The monthly Non-Standard rates below are for applicants who are not in their open enrollment period, who do not qualify for guarantee issue, who do not qualify for a Preferred rate or a Standard rate, but who qualify for a Non-Standard rate upon completion of underwriting.**

| 2026 Non-Standard Rates PPPM Outside of Maricopa County | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Arizona | A | | C | | F* | | G* | | N | |
| Issue Age | Female | Male | Female | Male | Female | Male | Female | Male | Female | Male |
| 65 | $169 | $187 | $246 | $272 | $258 | $284 | $245 | $270 | $164 | $182 |
| 66 | $177 | $196 | $257 | $284 | $268 | $295 | $253 | $282 | $171 | $189 |
| 67 | $184 | $203 | $268 | $295 | $280 | $309 | $265 | $292 | $177 | $195 |
| 68 | $191 | $211 | $278 | $307 | $290 | $321 | $277 | $305 | $184 | $202 |
| 69 | $199 | $219 | $289 | $319 | $302 | $332 | $285 | $316 | $191 | $210 |
| 70 | $206 | $226 | $299 | $331 | $312 | $344 | $295 | $327 | $195 | $217 |
| 71 | $213 | $236 | $311 | $343 | $324 | $356 | $307 | $339 | $204 | $226 |
| 72 | $221 | $243 | $321 | $354 | $334 | $370 | $316 | $351 | $212 | $234 |
| 73 | $228 | $251 | $331 | $366 | $346 | $381 | $327 | $363 | $219 | $241 |
| 74 | $233 | $260 | $341 | $378 | $356 | $393 | $339 | $373 | $228 | $252 |
| 75 | $241 | $267 | $353 | $390 | $368 | $407 | $349 | $386 | $234 | $259 |
| 76 | $248 | $277 | $363 | $402 | $380 | $417 | $359 | $397 | $241 | $267 |
| 77 | $257 | $284 | $373 | $412 | $390 | $430 | $370 | $408 | $248 | $274 |
| 78 | $263 | $290 | $383 | $424 | $402 | $442 | $381 | $420 | $254 | $280 |
| 79 | $270 | $300 | $395 | $435 | $412 | $454 | $390 | $432 | $261 | $287 |
| 80 | $278 | $307 | $405 | $447 | $422 | $467 | $402 | $444 | $267 | $296 |
| 81 | $285 | $316 | $415 | $459 | $434 | $478 | $412 | $454 | $274 | $303 |
| 82 | $292 | $324 | $427 | $473 | $446 | $491 | $424 | $467 | $281 | $311 |
| 83 | $302 | $332 | $439 | $484 | $456 | $506 | $434 | $479 | $291 | $320 |
| 84 | $309 | $343 | $451 | $498 | $469 | $518 | $446 | $493 | $298 | $329 |
| 85+ | $316 | $351 | $462 | $511 | $483 | $532 | $457 | $506 | $303 | $337 |

*Plans F and G do not include the high deductible option.

| 2026 Non-Standard Rates PPPM | Maricopa County | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Arizona | A | | C | | F* | | G* | | N | |
| Issue Age | Female | Male | Female | Male | Female | Male | Female | Male | Female | Male |
| 65 | $186 | $206 | $272 | $300 | $284 | $312 | $268 | $295 | $180 | $199 |
| 66 | $196 | $216 | $284 | $312 | $294 | $326 | $280 | $309 | $188 | $206 |
| 67 | $203 | $223 | $294 | $326 | $307 | $339 | $290 | $322 | $193 | $215 |
| 68 | $209 | $231 | $305 | $338 | $319 | $353 | $304 | $334 | $200 | $223 |
| 69 | $219 | $241 | $317 | $351 | $331 | $366 | $314 | $348 | $208 | $230 |
| 70 | $226 | $250 | $329 | $365 | $344 | $380 | $326 | $361 | $215 | $237 |
| 71 | $233 | $260 | $341 | $376 | $354 | $393 | $336 | $373 | $224 | $246 |
| 72 | $243 | $267 | $353 | $390 | $368 | $407 | $349 | $386 | $232 | $258 |
| 73 | $250 | $277 | $365 | $402 | $380 | $420 | $361 | $400 | $241 | $267 |
| 74 | $258 | $285 | $376 | $415 | $392 | $432 | $371 | $412 | $248 | $274 |
| 75 | $267 | $294 | $388 | $429 | $405 | $447 | $385 | $424 | $258 | $283 |
| 76 | $273 | $304 | $398 | $440 | $415 | $461 | $395 | $435 | $263 | $292 |
| 77 | $282 | $311 | $410 | $454 | $429 | $473 | $407 | $449 | $270 | $300 |
| 78 | $290 | $321 | $422 | $467 | $440 | $486 | $417 | $462 | $278 | $307 |
| 79 | $299 | $329 | $434 | $479 | $452 | $500 | $430 | $474 | $287 | $316 |
| 80 | $305 | $339 | $446 | $493 | $464 | $513 | $442 | $488 | $294 | $324 |
| 81 | $314 | $348 | $457 | $506 | $476 | $527 | $452 | $500 | $302 | $335 |
| 82 | $322 | $356 | $469 | $520 | $489 | $540 | $466 | $513 | $309 | $342 |
| 83 | $331 | $366 | $483 | $533 | $503 | $555 | $478 | $528 | $318 | $351 |
| 84 | $341 | $375 | $494 | $547 | $516 | $570 | $491 | $543 | $326 | $359 |
| 85+ | $349 | $386 | $508 | $562 | $530 | $586 | $505 | $555 | $333 | $370 |

*Plans F and G do not include the high deductible option.

**PREMIUM INFORMATION**

We, WMI Mutual Insurance Company ("WMI") 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 WMI, PO Box 572450, Salt Lake City, UT, 84157-2450. If you send the policy back to us within thirty (30) days after you receive it, we will treat the policy as if it had never been issued and return all of your 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 WMI nor its agents are connected with Medicare.

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

**COMPLETE ANSWERS ARE VERY IMPORTANT**

When you fill out the application for the new policy, be sure to truthfully and completely answer all questions about your medical and health history. WMI 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 received 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 consecutive days.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** | | | |
| Semi-private room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $[1,736] | $0 | $[1,736] (Part A deductible) |
| 61st through 90th day | All but $[434] a day | $[434] a day | $0 |
| 91st day and after | | | |
| --While using 60 lifetime reserve days | All but $[868] a day | $[868] a day | $0 |
| --Once lifetime reserve days are used: Additional 365 days | $0 | 100% of Medicare eligible expenses | $0** |
| --Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** | | | |
| You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st through 100th day | All but $[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/co-insurance for outpatient drugs and respite care | Medicare copayment/co-insurance | $0 |

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

**PLAN A**

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

* Once you have been billed $[283] of Medicare-approved amounts for covered services equal to the Part B deductible (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 | $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 |

**PLAN A**

**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 | $0 | $[283] (Part B Deductible) |
| Remainder of Medicare approved amounts | 80% | 20% | $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 consecutive days.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** | | | |
| Semi-private room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $[1,736] | $[1,736] (Part A Deductible) | $0 |
| 61st through 90th day | All but $[434] a day | $[434] a day | $0 |
| 91st day and after: | | | |
| --While using 60 lifetime reserve days | All but $[868] a day | $[868] a day | $0 |
| --Once lifetime reserve days are used: Additional 365 days | $0 | 100% of Medicare eligible expenses | $0** |
| --Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** | | | |
| You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st through 100th day | All but $[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/co-insurance for outpatient drugs and respite care | Medicare copayment/co-insurance | $0 |

**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 C

## MEDICARE (PART B) – MEDICAL SERVICE – PER CALENDAR YEAR

* Once you have been billed $[283] of Medicare-approved amounts for covered services equal to the Part B deductible (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 |

## PLAN C

## 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 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 consecutive days.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** | | | |
| Semi-private room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $[1,736] | $[1,736] (Part A Deductible) | $0 |
| 61st through 90th day | All but $[434] a day | $[434] a day | $0 |
| 91st day and after | | | |
| While using 60 lifetime reserve days | All but $[868] a day | $[868] a day | $0 |
| Once lifetime reserve days are used: Additional 365 days | $0 | 100% of Medicare eligible expenses | $0** |
| Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** | | | |
| You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st through 100th day | All but $[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/co-insurance for outpatient drugs and respite care | Medicare copayment/co-insurance | $0 |

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

**PLAN F**

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

* Once you have been billed $[283] of Medicare-approved amounts for covered services equal to the Part B deductible (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 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 |

**PLAN F**

**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 |

## 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 consecutive days.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** | | | |
| Semi-private room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $[1,736] | $[1,736] (Part A Deductible) | $0 |
| 61st through 90th day | All but $[434] a day | $[434] a day | $0 |
| 91st day and after | | | |
| While using 60 lifetime reserve days | All but $[868] a day | $[868] a day | $0 |
| Once lifetime reserve days are used: Additional 365 days | $0 | 100% of Medicare eligible expenses | $0** |
| Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** | | | |
| You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st through 100th day | All but $[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/co-insurance for outpatient drugs and respite care | Medicare copayment/co-insurance | $0 |

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

## PLAN G

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

* Once you have been billed $[283] of Medicare-approved amounts for covered services equal to the Part B deductible (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] (Unless Part B Deductible has been met) |
| 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 | $0 | $[283] (Unless Part B Deductible has been met) |
| Remainder of Medicare approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES --** TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

## PLAN G

## 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 | $0 | $[283] (Unless Part B |

| | | | |
|---|---|---|---|
| | | | Deductible has been met) |
| Remainder of Medicare approved amounts | 80% | 20% | $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 |

## 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 consecutive days.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** | | | |
| Semi-private room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $[1,736] | $[1,736] (Part A Deductible) | $0 |
| 61st through 90th day | All but $[434] a day | $[434] a day | $0 |
| 91st day and after | | | |
| While using 60 lifetime reserve days | All but $[868] a day | $[868] a day | $0 |
| Once lifetime reserve days are used: Additional 365 days | $0 | 100% of Medicare eligible expenses | $0** |
| Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** | | | |
| You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st through 100th day | All but $[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/co-insurance for outpatient drugs and respite care | Medicare copayment/co-insurance | $0 |

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

**PLAN N**

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

* Once you have been billed $[283] of Medicare-approved amounts for covered services equal to the Part B deductible (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 co-payment 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 co-payment 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 | 100% | $0 |
| **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 |

**PLAN N**

**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 | $0 | $[283] (Part B Deductible) |
| Remainder of Medicare approved amounts | 80% | 20% | $0 |

**PLAN N**

**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 |