Outline of Coverage
Medicare Supplement Benefit Plans A, F, G, HDG and N
Benefit Chart of Medicare Supplement Plans Sold On or After January 1, 2020

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.

✦Only Medicare Supplement Benefit Plans A, F, G, and N are offered by Montana Health Co-Op.

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

Benefits	Plans Available to All Applicants								Plans Available ONLY to those first eligible before 01/01/2020	
	✦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 2024[2]					$7,060[2]	$3,530[2]				

[1] Plans F and G also have a high deductible option which require first paying a plan deductible of $2,800 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 up to $20 for some office visits and up to a $50 co-payment for emergency room visits that do not result in an inpatient admission.

Montana Health Co-op
Annual Premium Rates – FEMALE
ZIP Codes starting with: All Montana Zip Codes

Rates Effective: 05-01-2024

Non-Tobacco					Attained Age	Tobacco				
Plan A	Plan F	Plan G	Plan HDG	Plan N		Plan A	Plan F	Plan G	Plan HDG	Plan N
5,296.78	6,333.50	6,274.54	2,368.17	4,582.50	0-64	5,296.78	6,333.50	6,274.54	2,722.05	4,582.50
1,501.36	1,929.01	1,507.22	526.26	1,152.40	65	1,726.56	2,218.37	1,733.32	604.90	1,325.26
1,501.36	1,929.01	1,507.22	544.22	1,152.40	66	1,726.56	2,218.37	1,733.32	625.54	1,325.26
1,501.36	1,937.54	1,507.22	561.83	1,157.36	67	1,726.56	2,228.14	1,733.32	645.78	1,330.95
1,565.29	1,961.29	1,507.22	578.98	1,182.54	68	1,800.08	2,255.48	1,733.32	665.49	1,359.92
1,628.08	2,022.85	1,634.11	595.58	1,224.58	69	1,872.29	2,326.30	1,879.21	684.57	1,408.27
1,688.87	2,097.46	1,697.60	618.58	1,319.41	70	1,942.21	2,412.09	1,952.22	711.00	1,517.32
1,739.34	2,169.16	1,758.18	640.19	1,375.67	71	2,000.27	2,494.54	2,021.92	735.86	1,582.03
1,789.86	2,236.67	1,818.79	661.82	1,429.08	72	2,058.33	2,572.16	2,091.62	760.71	1,643.45
1,840.35	2,304.18	1,879.40	683.44	1,485.24	73	2,116.40	2,649.80	2,161.32	785.57	1,708.02
1,890.85	2,371.68	1,940.01	705.07	1,541.42	74	2,174.48	2,727.43	2,231.01	810.42	1,772.62
1,941.34	2,439.18	2,001.63	726.69	1,597.56	75	2,232.54	2,805.05	2,301.86	835.27	1,837.20
1,966.87	2,486.38	2,045.04	741.46	1,639.68	76	2,261.90	2,859.33	2,351.79	852.25	1,885.63
1,992.43	2,533.58	2,087.87	756.23	1,681.79	77	2,291.29	2,913.62	2,401.07	869.23	1,934.07
2,017.96	2,580.78	2,130.74	771.00	1,723.91	78	2,320.66	2,967.89	2,450.35	886.21	1,982.50
2,043.50	2,627.98	2,173.18	785.77	1,766.02	79	2,350.03	3,022.17	2,499.14	903.19	2,030.92
2,069.05	2,675.19	2,215.61	800.55	1,808.13	80	2,379.40	3,076.46	2,547.95	920.16	2,079.36
2,086.74	2,721.40	2,257.17	817.77	1,849.50	81	2,399.77	3,129.63	2,595.76	939.96	2,126.92
2,104.46	2,767.64	2,298.74	834.99	1,890.85	82	2,420.14	3,182.80	2,643.56	959.76	2,174.50
2,122.17	2,813.87	2,340.54	852.21	1,932.22	83	2,440.49	3,235.96	2,691.64	979.56	2,222.06
2,139.89	2,860.09	2,382.12	869.44	1,973.58	84	2,460.86	3,289.12	2,739.45	999.35	2,269.62
2,157.59	2,906.34	2,425.38	886.66	2,014.94	85	2,481.25	3,342.28	2,789.19	1,019.16	2,317.21
2,166.56	2,939.72	2,457.13	900.62	2,045.65	86	2,491.55	3,380.67	2,825.72	1,035.19	2,352.49
2,175.53	2,973.11	2,489.21	914.57	2,076.33	87	2,501.85	3,419.07	2,862.58	1,051.23	2,387.78
2,184.50	3,006.49	2,521.55	928.53	2,107.01	88	2,512.17	3,457.48	2,899.78	1,067.28	2,423.06
2,193.47	3,039.88	2,553.96	942.48	2,137.71	89	2,522.47	3,495.87	2,937.06	1,083.32	2,458.35
2,202.43	3,073.27	2,586.43	956.44	2,168.39	90	2,532.80	3,534.26	2,974.39	1,099.35	2,493.64
2,204.56	3,099.57	2,612.54	968.58	2,192.68	91	2,535.26	3,564.49	3,004.43	1,113.31	2,521.57
2,206.72	3,125.86	2,638.70	980.72	2,216.96	92	2,537.72	3,594.74	3,034.50	1,127.27	2,549.51
2,208.85	3,152.16	2,664.90	992.86	2,241.25	93	2,540.17	3,624.99	3,064.63	1,141.21	2,577.42
2,210.97	3,178.45	2,691.16	1,005.00	2,265.52	94	2,542.62	3,655.23	3,094.81	1,155.17	2,605.36
2,213.11	3,204.74	2,717.45	1,017.13	2,289.81	95	2,545.09	3,685.46	3,125.04	1,169.11	2,633.29
2,237.46	3,240.00	2,749.80	1,017.13	2,315.00	96	2,573.08	3,726.02	3,162.27	1,169.11	2,662.26
2,262.07	3,275.63	2,782.54	1,017.13	2,340.47	97	2,601.39	3,767.00	3,199.92	1,169.11	2,691.54
2,286.96	3,311.66	2,815.69	1,017.13	2,366.22	98	2,630.00	3,808.42	3,238.05	1,169.11	2,721.14
2,312.13	3,348.09	2,849.23	1,017.13	2,392.24	99	2,658.93	3,850.32	3,276.60	1,169.11	2,751.08

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833
The above rates do not include the $25 one-time policy fee.

To calculate a Household discount:
Annual premium x modal factor = modal premium (round to nearest whole cent)
Modal premium x .93 = discounted premium

Montana Health Co-op
Annual Premium Rates – MALE
ZIP Codes starting with: All Montana Zip Codes

Rates Effective: 05-01-2024

Non-Tobacco					Attained Age	Tobacco				
Plan A	Plan F	Plan G	Plan HDG	Plan N		Plan A	Plan F	Plan G	Plan HDG	Plan N
5,296.78	6,333.50	6,274.54	2,712.65	4,582.50	0-64	5,296.78	6,333.50	6,274.54	3,118.01	4,582.50
1,640.84	2,108.20	1,647.24	602.81	1,259.45	65	1,886.95	2,424.45	1,894.35	692.89	1,448.37
1,640.84	2,108.20	1,647.24	623.39	1,259.45	66	1,886.95	2,424.45	1,894.35	716.54	1,448.37
1,640.84	2,117.53	1,647.24	643.56	1,264.87	67	1,886.95	2,435.13	1,894.35	739.72	1,454.60
1,710.70	2,143.48	1,647.24	663.20	1,292.40	68	1,967.31	2,465.01	1,894.35	762.30	1,486.25
1,779.32	2,210.77	1,785.91	682.22	1,338.34	69	2,046.22	2,542.40	2,053.78	784.16	1,539.09
1,845.75	2,292.31	1,855.30	708.56	1,441.97	70	2,122.63	2,636.17	2,133.58	814.44	1,658.27
1,900.93	2,370.67	1,921.52	733.33	1,503.46	71	2,186.09	2,726.28	2,209.74	842.91	1,728.99
1,956.13	2,444.46	1,987.75	758.10	1,561.84	72	2,249.54	2,811.11	2,285.92	871.38	1,796.12
2,011.31	2,518.22	2,053.98	782.86	1,623.21	73	2,313.00	2,895.96	2,362.10	899.84	1,866.69
2,066.50	2,591.99	2,120.23	807.63	1,684.61	74	2,376.48	2,980.80	2,438.27	928.31	1,937.29
2,121.69	2,665.77	2,187.58	832.40	1,745.96	75	2,439.93	3,065.63	2,515.70	956.79	2,007.87
2,149.58	2,717.35	2,235.02	849.32	1,792.00	76	2,472.03	3,124.94	2,570.27	976.23	2,060.80
2,177.52	2,768.94	2,281.83	866.24	1,838.02	77	2,504.14	3,184.29	2,624.11	995.68	2,113.74
2,205.43	2,820.52	2,328.68	883.16	1,884.05	78	2,536.24	3,243.60	2,677.97	1,015.13	2,166.66
2,233.34	2,872.11	2,375.06	900.08	1,930.07	79	2,568.34	3,302.92	2,731.30	1,034.58	2,219.59
2,261.26	2,923.70	2,421.43	917.00	1,976.10	80	2,600.45	3,362.25	2,784.65	1,054.03	2,272.52
2,280.59	2,974.20	2,466.85	936.73	2,021.31	81	2,622.69	3,420.37	2,836.90	1,076.70	2,324.50
2,299.97	3,024.74	2,512.28	956.47	2,066.50	82	2,644.95	3,478.46	2,889.14	1,099.38	2,376.50
2,319.31	3,075.26	2,557.97	976.19	2,111.71	83	2,667.20	3,536.56	2,941.68	1,122.06	2,428.48
2,338.67	3,125.78	2,603.41	995.92	2,156.92	84	2,689.47	3,594.66	2,993.94	1,144.74	2,480.46
2,358.02	3,176.32	2,650.69	1,015.65	2,202.12	85	2,711.75	3,652.76	3,048.30	1,167.41	2,532.47
2,367.83	3,212.81	2,685.39	1,031.63	2,235.68	86	2,723.00	3,694.73	3,088.20	1,185.79	2,571.03
2,377.63	3,249.30	2,720.44	1,047.62	2,269.21	87	2,734.27	3,736.70	3,128.51	1,204.16	2,609.59
2,387.43	3,285.79	2,755.79	1,063.61	2,302.75	88	2,745.54	3,778.66	3,169.16	1,222.54	2,648.15
2,397.23	3,322.27	2,791.21	1,079.60	2,336.29	89	2,756.81	3,820.62	3,209.90	1,240.91	2,686.72
2,407.03	3,358.76	2,826.70	1,095.58	2,369.83	90	2,768.08	3,862.59	3,250.70	1,259.29	2,725.29
2,409.36	3,387.50	2,855.24	1,109.48	2,396.37	91	2,770.78	3,895.63	3,283.53	1,275.27	2,755.82
2,411.71	3,416.24	2,883.83	1,123.38	2,422.91	92	2,773.47	3,928.68	3,316.39	1,291.25	2,786.35
2,414.04	3,444.99	2,912.46	1,137.30	2,449.46	93	2,776.14	3,961.73	3,349.32	1,307.23	2,816.86
2,416.37	3,473.73	2,941.15	1,151.20	2,475.98	94	2,778.82	3,994.78	3,382.31	1,323.22	2,847.39
2,418.70	3,502.45	2,969.89	1,165.10	2,502.53	95	2,781.52	4,027.82	3,415.35	1,339.19	2,877.91
2,445.31	3,540.98	3,005.24	1,165.10	2,530.05	96	2,812.10	4,072.15	3,456.03	1,339.19	2,909.57
2,472.21	3,579.93	3,041.03	1,165.10	2,557.89	97	2,843.05	4,116.94	3,497.18	1,339.19	2,941.57
2,499.41	3,619.31	3,077.25	1,165.10	2,586.03	98	2,874.32	4,162.21	3,538.84	1,339.19	2,973.93
2,526.91	3,659.12	3,113.91	1,165.10	2,614.47	99	2,905.93	4,208.01	3,580.99	1,339.19	3,006.64

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833
The above rates do not include the $25 one-time policy fee.

To calculate a Household discount:
Annual premium x modal factor = modal premium (round to nearest whole cent)
Modal premium x .93 = discounted premium

Outline of Coverage
Medicare Supplement Benefit Plans A, F, G, HDG and N

Disclosures. Use this outline to compare benefits and premiums among policies.

Premium Information. Montana Health Co-Op can only raise your premium if we raise the premium for all policies like yours in the same geographic area of the state where you live. Premiums for this policy will increase due to the increase in your age.

Household Premium Discount. You are eligible for a Household Premium Discount if for the past year you have resided with: (1) your spouse (including civil union/domestic partner) or (2) at least one, but not more than three, other adults. For the purpose of this discount, a civil union partner or domestic partner will be considered a legal spouse when such partnerships are valid and recognized in your state of residence. We may request additional documentation to determine eligibility. The discounted rate will be 7 percent lower than the individual rate and will be removed if the other adult or spouse no longer resides with you (other than in the case of his/her death).

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 us.

Right to Return Policy. If you find that you are not satisfied with your policy, you may return it to us at our Medicare Supplement Administrative Office P.O. Box 410035, Salt Lake City, UT 84141-0035. 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. The policy may not fully cover all of your medical costs. Neither we nor our 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 answer truthfully and completely all questions about your medical and health history. We 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.**

PLEASE REFER TO YOUR POLICY FOR DETAILS.

Outline of Coverage
Medicare Supplement Benefit Plans A, F, G, HDG and N

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 A Pays	You Pay
Hospitalization Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but $1,632	$0	$1,632 Part A Deductible
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after			
- While using 60 lifetime reserve days	All but $816 a day	$816 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 thru 100th days	All but $204 a day	$0	Up to $204 a day
101st day and after	$0	$0	All Costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	$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.

Outline of Coverage
Medicare Supplement Benefit Plans A, F, G, HDG and N

Plan A

Medicare Part B – Medical Services per Calendar Year

*Once you have been billed $240 of Medicare Eligible Expenses for covered services (which are noted with an asterisk), your Medicare Part B Deductible will have been met for the calendar year.

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 $240 of Medicare approved amounts* Remainder of Medicare approved amounts	 $0 Generally 80%	 $0 Generally 20%	 $240 Part B Deductible $0
Part B Excess Charges (above Medicare approved amounts)	$0	$0	All costs
Blood First 3 pints Next $240 of Medicare approved amounts* Remainder of Medicare approved amounts	 $0 $0 80%	 All costs $0 20%	 $0 $240 Part B Deductible $0
Clinical Laboratory Services – Tests for diagnostic services	100%	$0	$0

Parts A & B

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 $240 of Medicare approved amounts* ▪ Remainder of Medicare approved amounts	 100% $0 80%	 $0 $0 20%	 $0 $240 Part B Deductible $0

Outline of Coverage
Medicare Supplement Benefit Plans A, F, G, HDG and N

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 F Pays	You Pay
Hospitalization Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but $1,632	$1,632 Part A Deductible	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after			
- While using 60 lifetime reserve days	All but $816 a day	$816 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 thru 100th days	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All Costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	$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.

Outline of Coverage
Medicare Supplement Benefit Plans A, F, G, HDG and N

Plan F

Medicare Part B – Medical Services per Calendar Year

*Once you have been billed $240 of Medicare Approved amounts for covered services (which are noted with an asterisk), your Medicare Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan F 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 $240 of Medicare approved amounts* Remainder of Medicare approved amounts	 $0 Generally 80%	 $240 Part B Deductible Generally 20%	 $0 $0
Part B Excess Charges (above Medicare approved amounts)	$0	100%	$0
Blood First 3 pints Next $240 of Medicare approved amounts* Remainder of Medicare approved amounts	 $0 $0 80%	 All costs $240 Part B Deductible $20%	 $0 $0 $0
Clinical Laboratory Services – Tests for Diagnostic services	100%	$0	$0

Parts A & B

Services	Medicare Pays	Plan F Pays	You Pay
Home Health Care Medicare Approved Services - Medically necessary skilled care services and medical supplies - Durable medical equipment ▪ First $240 of Medicare approved amounts* ▪ Remainder of Medicare approved amounts	 100% $0 80%	 $0 $240 Part B Deductible 20%	 $0 $0 $0

Other Benefits Not Covered by Medicare

Services	Medicare Pays	Plan F Pays	You Pay
Foreign Travel Not Covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA. First $250 each calendar year Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000.	 $250 20% and amounts over the $50,000 lifetime maximum.

Outline of Coverage
Medicare Supplement Benefit Plans A, F, G, HDG and N

Plan G or HIGH DEDUCTIBLE PLAN G

Medicare Part A – Hospital Services Per Benefit Period

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

****This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $2,800 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2,800. Out-of-pocket expenses for this deductible are expenses that would normally be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.**

Services	Medicare Pays	AFTER YOU PAY $2,800 DEDUCTIBLE,** Plan G Pays	IN ADDITION TO $2,800 DEDUCTIBLE,** You Pay
Hospitalization Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but $1,632	$1,632 Part A Deductible	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after			
- While using 60 lifetime reserve days	All but $816 a day	$816 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 thru 100 days	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All Costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	$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 or HIGH DEDUCTIBLE PLAN G
Medicare Part B – Medical Services per Calendar Year

*Once you have been billed $240 of Medicare approved amounts for covered services (which are noted with an asterisk), your Medicare Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	AFTER YOU PAY $2,800 DEDUCTIBLE,** Plan G Pays	IN ADDITION TO $2,800 DEDUCTIBLE,** You Pay
Medical Expenses In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First $240 of Medicare approved amounts* Remainder of Medicare approved amounts	 $0 Generally 80%	 $0 Generally 20%	 $240 (Unless Part B Deductible has been met) $0
Part B Excess Charges (above Medicare approved amounts)	$0	100%	$0
Blood First 3 pints Next $240 of Medicare approved amounts* Remainder of Medicare approved amounts	 $0 $0 80%	 All costs $0 $20%	 $0 $240 (Unless Part B Deductible has been met) $0
Clinical Laboratory Services – Tests for Diagnostic services	100%	$0	$0

Outline of Coverage
Medicare Supplement Benefit Plans A, F, G, HDG and N

Parts A & B

Services	Medicare Pays	AFTER YOU PAY $2,800 DEDUCTIBLE,** Plan G Pays	IN ADDITION TO $2,800 DEDUCTIBLE,** You Pay
Home Health Care Medicare Approved Services - Medically necessary skilled care services and medical supplies - Durable medical equipment ▪ First $240 of Medicare approved amounts* ▪ Remainder of Medicare approved amounts	 100% $0 80%	 $0 $0 20%	 $0 $240 (Unless Part B Deductible has been met) $0

Plan G or HIGH DEDUCTIBLE PLAN G

Other Benefits Not Covered by Medicare

Services	Medicare Pays	AFTER YOU PAY $2,800 DEDUCTIBLE,** Plan G Pays	IN ADDITION TO $2,800 DEDUCTIBLE,** You Pay
Foreign Travel Not Covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA. First $250 each calendar year Remainder of Charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000.	 $250 20% and amounts over the $50,000 lifetime maximum.

Outline of Coverage
Medicare Supplement Benefit Plans A, F, G, HDG and N

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 N Pays	You Pay
Hospitalization Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but $1,632	$1,632 Part A Deductible	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after			
- While using 60 lifetime reserve days	All but $816 a day	$816 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 thru 100 days	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All Costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	$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.

Outline of Coverage
Medicare Supplement Benefit Plans A, F, G, HDG and N

Plan N

Medicare Part B – Medical Services per Calendar Year

*Once you have been billed $240 of Medicare Approved amounts for covered services (which are noted with an asterisk), your Medicare Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan N 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 $240 of Medicare approved amounts*	$0	$0	$240 Part B Deductible
Remainder of Medicare approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (above Medicare approved amounts)	$0	$0	All costs
Blood			
First 3 pints	$0	All costs	$0
Next $240 of Medicare approved amounts*	$0	$0	$240 Part B Deductible
Remainder of Medicare approved amounts	80%	$20%	$0
Clinical Laboratory Services – Tests for diagnostic services	100%	$0	$0

Parts A & B

Services	Medicare Pays	Plan N Pays	You Pay
Home Health Care			
Medicare Approved Services			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
▪ First $240 of Medicare approved amounts*	$0	$0	$240 Part B Deductible
▪ Remainder of Medicare approved amounts	80%	20%	$0

Outline of Coverage
Medicare Supplement Benefit Plans A, F, G, HDG and N

Plan N

Other Benefits Not Covered by Medicare

Services	Medicare Pays	Plan N Pays	You Pay
Foreign Travel Not Covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA. First $250 each calendar year Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000.	 $250 20% and amounts over the $50,000 lifetime maximum.