

# **MEDICARE SUPPLEMENT OUTLINE OF COVERAGE**

## **UTAH**

**Benefit Plans A, B, C, D, E, F, G  
& High Deductible F**

**Genworth Life and Annuity Insurance Company**

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Telephone Number: (877) 825-9337

**GENWORTH LIFE AND ANNUITY INSURANCE COMPANY**  
**OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE: Page 1 of 2**  
**BENEFIT PLANS AVAILABLE: A, B, C, D, E, F, G and High Deductible F**

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: Included in All Plans:** 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, co-payments 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 Co-insurance	Skilled Nursing Co-insurance	Skilled Nursing Co-insurance	Skilled Nursing Co-insurance	Skilled Nursing Co-insurance	Skilled Nursing Co-insurance	Skilled Nursing Co-insurance	Skilled Nursing Co-insurance
	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 [\$1790] deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses exceed [\$1790]. 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.

**GENWORTH LIFE AND ANNUITY INSURANCE COMPANY**  
**Outline of Medicare Supplement Coverage-Cover Page: 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.**

<b>J</b>	<b>K**</b>	<b>L**</b>
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 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		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT covered by Medicare		
	<b>[\$4000] Out of Pocket Annual Limit***</b>	<b>[\$2000] Out of Pocket Annual Limit***</b>

\*\*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.

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

See Outlines of Coverage for details and exceptions.

**GENWORTH LIFE & ANNUITY INSURANCE COMPANY  
 OUTLINE OF MEDICARE SUPPLEMENT COVERAGE RATE SHEET  
 STATE OF UTAH**

<b>Medicare Supplement Plan A ZIP CODES: All of State</b>				
<b>AGE</b>	<b>FEMALE PREFERRED</b>	<b>MALE PREFERRED</b>	<b>FEMALE STANDARD</b>	<b>MALE STANDARD</b>
65	\$ 671.00	\$ 772.00	\$ 746.00	\$ 858.00
66	\$ 704.00	\$ 809.00	\$ 781.00	\$ 899.00
67	\$ 736.00	\$ 846.00	\$ 817.00	\$ 940.00
68	\$ 767.00	\$ 883.00	\$ 853.00	\$ 980.00
69	\$ 798.00	\$ 918.00	\$ 888.00	\$ 1,020.00
70	\$ 830.00	\$ 953.00	\$ 921.00	\$ 1,059.00
71	\$ 858.00	\$ 987.00	\$ 954.00	\$ 1,097.00
72	\$ 888.00	\$ 1,020.00	\$ 986.00	\$ 1,133.00
73	\$ 914.00	\$ 1,052.00	\$ 1,016.00	\$ 1,168.00
74	\$ 941.00	\$ 1,082.00	\$ 1,044.00	\$ 1,201.00
75	\$ 965.00	\$ 1,109.00	\$ 1,071.00	\$ 1,233.00
76	\$ 987.00	\$ 1,135.00	\$ 1,096.00	\$ 1,261.00
77	\$ 1,008.00	\$ 1,159.00	\$ 1,120.00	\$ 1,288.00
78	\$ 1,026.00	\$ 1,180.00	\$ 1,141.00	\$ 1,311.00
79	\$ 1,043.00	\$ 1,199.00	\$ 1,159.00	\$ 1,332.00
80	\$ 1,057.00	\$ 1,215.00	\$ 1,175.00	\$ 1,350.00
81	\$ 1,069.00	\$ 1,229.00	\$ 1,187.00	\$ 1,365.00
82	\$ 1,080.00	\$ 1,243.00	\$ 1,201.00	\$ 1,381.00
83	\$ 1,092.00	\$ 1,256.00	\$ 1,214.00	\$ 1,396.00
84	\$ 1,104.00	\$ 1,270.00	\$ 1,227.00	\$ 1,411.00
85	\$ 1,116.00	\$ 1,283.00	\$ 1,240.00	\$ 1,426.00
86	\$ 1,127.00	\$ 1,296.00	\$ 1,253.00	\$ 1,441.00
87	\$ 1,139.00	\$ 1,310.00	\$ 1,266.00	\$ 1,456.00
88	\$ 1,151.00	\$ 1,324.00	\$ 1,279.00	\$ 1,471.00
89	\$ 1,163.00	\$ 1,337.00	\$ 1,292.00	\$ 1,485.00
90	\$ 1,175.00	\$ 1,350.00	\$ 1,305.00	\$ 1,501.00
91	\$ 1,186.00	\$ 1,364.00	\$ 1,317.00	\$ 1,516.00
92	\$ 1,198.00	\$ 1,377.00	\$ 1,330.00	\$ 1,530.00
93	\$ 1,209.00	\$ 1,390.00	\$ 1,343.00	\$ 1,545.00
94	\$ 1,220.00	\$ 1,404.00	\$ 1,356.00	\$ 1,560.00
95	\$ 1,232.00	\$ 1,417.00	\$ 1,368.00	\$ 1,574.00
96	\$ 1,243.00	\$ 1,430.00	\$ 1,382.00	\$ 1,588.00
97	\$ 1,254.00	\$ 1,443.00	\$ 1,395.00	\$ 1,603.00
98	\$ 1,266.00	\$ 1,457.00	\$ 1,407.00	\$ 1,619.00
99	\$ 1,278.00	\$ 1,470.00	\$ 1,420.00	\$ 1,634.00

<b>Medicare Supplement Plan B ZIP CODES: All of State</b>				
<b>AGE</b>	<b>FEMALE PREFERRED</b>	<b>MALE PREFERRED</b>	<b>FEMALE STANDARD</b>	<b>MALE STANDARD</b>
65	\$ 806.00	\$ 927.00	\$ 896.00	\$ 1,030.00
66	\$ 846.00	\$ 974.00	\$ 941.00	\$ 1,082.00
67	\$ 887.00	\$ 1,019.00	\$ 985.00	\$ 1,133.00
68	\$ 926.00	\$ 1,066.00	\$ 1,030.00	\$ 1,184.00
69	\$ 966.00	\$ 1,111.00	\$ 1,074.00	\$ 1,236.00
70	\$ 1,006.00	\$ 1,156.00	\$ 1,117.00	\$ 1,285.00
71	\$ 1,044.00	\$ 1,201.00	\$ 1,160.00	\$ 1,334.00
72	\$ 1,082.00	\$ 1,243.00	\$ 1,201.00	\$ 1,382.00
73	\$ 1,117.00	\$ 1,285.00	\$ 1,240.00	\$ 1,427.00
74	\$ 1,152.00	\$ 1,324.00	\$ 1,280.00	\$ 1,472.00
75	\$ 1,185.00	\$ 1,363.00	\$ 1,316.00	\$ 1,514.00
76	\$ 1,216.00	\$ 1,399.00	\$ 1,351.00	\$ 1,553.00
77	\$ 1,245.00	\$ 1,432.00	\$ 1,383.00	\$ 1,592.00
78	\$ 1,273.00	\$ 1,464.00	\$ 1,414.00	\$ 1,626.00
79	\$ 1,297.00	\$ 1,492.00	\$ 1,441.00	\$ 1,657.00
80	\$ 1,320.00	\$ 1,517.00	\$ 1,466.00	\$ 1,686.00
81	\$ 1,339.00	\$ 1,540.00	\$ 1,488.00	\$ 1,712.00
82	\$ 1,358.00	\$ 1,562.00	\$ 1,509.00	\$ 1,735.00
83	\$ 1,377.00	\$ 1,584.00	\$ 1,530.00	\$ 1,760.00
84	\$ 1,396.00	\$ 1,604.00	\$ 1,550.00	\$ 1,783.00
85	\$ 1,413.00	\$ 1,625.00	\$ 1,569.00	\$ 1,805.00
86	\$ 1,431.00	\$ 1,645.00	\$ 1,589.00	\$ 1,828.00
87	\$ 1,447.00	\$ 1,664.00	\$ 1,608.00	\$ 1,849.00
88	\$ 1,463.00	\$ 1,682.00	\$ 1,625.00	\$ 1,870.00
89	\$ 1,478.00	\$ 1,700.00	\$ 1,643.00	\$ 1,889.00
90	\$ 1,493.00	\$ 1,718.00	\$ 1,659.00	\$ 1,908.00
91	\$ 1,508.00	\$ 1,733.00	\$ 1,676.00	\$ 1,926.00
92	\$ 1,520.00	\$ 1,749.00	\$ 1,690.00	\$ 1,943.00
93	\$ 1,533.00	\$ 1,763.00	\$ 1,704.00	\$ 1,959.00
94	\$ 1,546.00	\$ 1,777.00	\$ 1,717.00	\$ 1,975.00
95	\$ 1,557.00	\$ 1,790.00	\$ 1,730.00	\$ 1,989.00
96	\$ 1,567.00	\$ 1,803.00	\$ 1,742.00	\$ 2,003.00
97	\$ 1,579.00	\$ 1,816.00	\$ 1,754.00	\$ 2,018.00
98	\$ 1,590.00	\$ 1,829.00	\$ 1,767.00	\$ 2,033.00
99	\$ 1,602.00	\$ 1,842.00	\$ 1,780.00	\$ 2,047.00

Some Plans may not be available in your state

Premiums payable other than annual may be determined by the following factors:

Semi-annual:      0.5200              Quarterly:              0.2650              Monthly EFT              0.0867

**GENWORTH LIFE & ANNUITY INSURANCE COMPANY  
 OUTLINE OF MEDICARE SUPPLEMENT COVERAGE RATE SHEET  
 STATE OF UTAH**

**Medicare Supplement Plan C  
 ZIP CODES: All of State**

AGE	FEMALE PREFERRED	MALE PREFERRED	FEMALE STANDARD	MALE STANDARD
65	\$ 976.00	\$ 1,122.00	\$ 1,084.00	\$ 1,247.00
66	\$ 1,019.00	\$ 1,172.00	\$ 1,133.00	\$ 1,303.00
67	\$ 1,063.00	\$ 1,222.00	\$ 1,181.00	\$ 1,359.00
68	\$ 1,107.00	\$ 1,273.00	\$ 1,230.00	\$ 1,415.00
69	\$ 1,150.00	\$ 1,323.00	\$ 1,278.00	\$ 1,470.00
70	\$ 1,194.00	\$ 1,372.00	\$ 1,326.00	\$ 1,525.00
71	\$ 1,236.00	\$ 1,420.00	\$ 1,373.00	\$ 1,579.00
72	\$ 1,275.00	\$ 1,468.00	\$ 1,418.00	\$ 1,630.00
73	\$ 1,316.00	\$ 1,513.00	\$ 1,462.00	\$ 1,681.00
74	\$ 1,355.00	\$ 1,558.00	\$ 1,506.00	\$ 1,730.00
75	\$ 1,391.00	\$ 1,600.00	\$ 1,546.00	\$ 1,778.00
76	\$ 1,426.00	\$ 1,639.00	\$ 1,584.00	\$ 1,822.00
77	\$ 1,459.00	\$ 1,677.00	\$ 1,621.00	\$ 1,864.00
78	\$ 1,490.00	\$ 1,712.00	\$ 1,655.00	\$ 1,903.00
79	\$ 1,518.00	\$ 1,745.00	\$ 1,686.00	\$ 1,939.00
80	\$ 1,543.00	\$ 1,774.00	\$ 1,714.00	\$ 1,971.00
81	\$ 1,566.00	\$ 1,800.00	\$ 1,739.00	\$ 2,001.00
82	\$ 1,587.00	\$ 1,825.00	\$ 1,764.00	\$ 2,028.00
83	\$ 1,609.00	\$ 1,850.00	\$ 1,787.00	\$ 2,055.00
84	\$ 1,630.00	\$ 1,875.00	\$ 1,811.00	\$ 2,083.00
85	\$ 1,651.00	\$ 1,898.00	\$ 1,833.00	\$ 2,108.00
86	\$ 1,670.00	\$ 1,919.00	\$ 1,856.00	\$ 2,134.00
87	\$ 1,688.00	\$ 1,942.00	\$ 1,876.00	\$ 2,157.00
88	\$ 1,706.00	\$ 1,962.00	\$ 1,896.00	\$ 2,180.00
89	\$ 1,723.00	\$ 1,982.00	\$ 1,915.00	\$ 2,202.00
90	\$ 1,740.00	\$ 2,001.00	\$ 1,933.00	\$ 2,223.00
91	\$ 1,755.00	\$ 2,018.00	\$ 1,950.00	\$ 2,243.00
92	\$ 1,769.00	\$ 2,034.00	\$ 1,966.00	\$ 2,261.00
93	\$ 1,782.00	\$ 2,050.00	\$ 1,980.00	\$ 2,278.00
94	\$ 1,795.00	\$ 2,063.00	\$ 1,994.00	\$ 2,293.00
95	\$ 1,805.00	\$ 2,077.00	\$ 2,006.00	\$ 2,307.00
96	\$ 1,817.00	\$ 2,090.00	\$ 2,020.00	\$ 2,322.00
97	\$ 1,829.00	\$ 2,103.00	\$ 2,032.00	\$ 2,337.00
98	\$ 1,840.00	\$ 2,116.00	\$ 2,045.00	\$ 2,351.00
99	\$ 1,853.00	\$ 2,130.00	\$ 2,058.00	\$ 2,367.00

**Medicare Supplement Plan D  
 ZIP CODES: All of State**

AGE	FEMALE PREFERRED	MALE PREFERRED	FEMALE STANDARD	MALE STANDARD
65	\$ 807.00	\$ 929.00	\$ 897.00	\$ 1,033.00
66	\$ 848.00	\$ 976.00	\$ 943.00	\$ 1,084.00
67	\$ 888.00	\$ 1,022.00	\$ 987.00	\$ 1,136.00
68	\$ 930.00	\$ 1,069.00	\$ 1,033.00	\$ 1,187.00
69	\$ 970.00	\$ 1,114.00	\$ 1,077.00	\$ 1,238.00
70	\$ 1,009.00	\$ 1,161.00	\$ 1,121.00	\$ 1,290.00
71	\$ 1,049.00	\$ 1,205.00	\$ 1,164.00	\$ 1,340.00
72	\$ 1,086.00	\$ 1,250.00	\$ 1,207.00	\$ 1,388.00
73	\$ 1,123.00	\$ 1,291.00	\$ 1,248.00	\$ 1,435.00
74	\$ 1,159.00	\$ 1,332.00	\$ 1,288.00	\$ 1,481.00
75	\$ 1,193.00	\$ 1,372.00	\$ 1,325.00	\$ 1,525.00
76	\$ 1,224.00	\$ 1,408.00	\$ 1,362.00	\$ 1,566.00
77	\$ 1,255.00	\$ 1,443.00	\$ 1,395.00	\$ 1,604.00
78	\$ 1,283.00	\$ 1,476.00	\$ 1,426.00	\$ 1,639.00
79	\$ 1,309.00	\$ 1,506.00	\$ 1,455.00	\$ 1,673.00
80	\$ 1,332.00	\$ 1,532.00	\$ 1,481.00	\$ 1,703.00
81	\$ 1,354.00	\$ 1,557.00	\$ 1,504.00	\$ 1,730.00
82	\$ 1,373.00	\$ 1,580.00	\$ 1,527.00	\$ 1,755.00
83	\$ 1,393.00	\$ 1,602.00	\$ 1,548.00	\$ 1,781.00
84	\$ 1,413.00	\$ 1,625.00	\$ 1,569.00	\$ 1,805.00
85	\$ 1,432.00	\$ 1,646.00	\$ 1,590.00	\$ 1,829.00
86	\$ 1,450.00	\$ 1,667.00	\$ 1,611.00	\$ 1,853.00
87	\$ 1,467.00	\$ 1,687.00	\$ 1,630.00	\$ 1,875.00
88	\$ 1,483.00	\$ 1,706.00	\$ 1,648.00	\$ 1,896.00
89	\$ 1,499.00	\$ 1,724.00	\$ 1,665.00	\$ 1,915.00
90	\$ 1,514.00	\$ 1,741.00	\$ 1,682.00	\$ 1,934.00
91	\$ 1,529.00	\$ 1,758.00	\$ 1,698.00	\$ 1,952.00
92	\$ 1,542.00	\$ 1,772.00	\$ 1,713.00	\$ 1,969.00
93	\$ 1,554.00	\$ 1,787.00	\$ 1,727.00	\$ 1,986.00
94	\$ 1,566.00	\$ 1,800.00	\$ 1,740.00	\$ 2,001.00
95	\$ 1,576.00	\$ 1,813.00	\$ 1,751.00	\$ 2,014.00
96	\$ 1,586.00	\$ 1,824.00	\$ 1,763.00	\$ 2,027.00
97	\$ 1,597.00	\$ 1,838.00	\$ 1,775.00	\$ 2,042.00
98	\$ 1,609.00	\$ 1,849.00	\$ 1,787.00	\$ 2,055.00
99	\$ 1,620.00	\$ 1,863.00	\$ 1,800.00	\$ 2,069.00

Some Plans may not be available in your state

Premiums payable other than annual may be determined by the following factors:

Semi-annual: 0.5200      Quarterly: 0.2650      Monthly EFT 0.0867

**GENWORTH LIFE & ANNUITY INSURANCE COMPANY  
 OUTLINE OF MEDICARE SUPPLEMENT COVERAGE RATE SHEET  
 STATE OF UTAH**

<b>Medicare Supplement Plan E ZIP CODES: All of State</b>				
<b>AGE</b>	<b>FEMALE PREFERRED</b>	<b>MALE PREFERRED</b>	<b>FEMALE STANDARD</b>	<b>MALE STANDARD</b>
65	\$ 813.00	\$ 934.00	\$ 902.00	\$ 1,037.00
66	\$ 853.00	\$ 981.00	\$ 948.00	\$ 1,090.00
67	\$ 893.00	\$ 1,028.00	\$ 993.00	\$ 1,142.00
68	\$ 935.00	\$ 1,075.00	\$ 1,038.00	\$ 1,194.00
69	\$ 975.00	\$ 1,121.00	\$ 1,084.00	\$ 1,246.00
70	\$ 1,015.00	\$ 1,167.00	\$ 1,127.00	\$ 1,296.00
71	\$ 1,054.00	\$ 1,212.00	\$ 1,171.00	\$ 1,347.00
72	\$ 1,092.00	\$ 1,256.00	\$ 1,214.00	\$ 1,396.00
73	\$ 1,129.00	\$ 1,299.00	\$ 1,254.00	\$ 1,443.00
74	\$ 1,165.00	\$ 1,340.00	\$ 1,294.00	\$ 1,489.00
75	\$ 1,199.00	\$ 1,380.00	\$ 1,332.00	\$ 1,532.00
76	\$ 1,231.00	\$ 1,417.00	\$ 1,368.00	\$ 1,574.00
77	\$ 1,262.00	\$ 1,451.00	\$ 1,401.00	\$ 1,613.00
78	\$ 1,291.00	\$ 1,484.00	\$ 1,434.00	\$ 1,649.00
79	\$ 1,316.00	\$ 1,514.00	\$ 1,463.00	\$ 1,681.00
80	\$ 1,340.00	\$ 1,541.00	\$ 1,489.00	\$ 1,712.00
81	\$ 1,360.00	\$ 1,565.00	\$ 1,511.00	\$ 1,738.00
82	\$ 1,381.00	\$ 1,588.00	\$ 1,534.00	\$ 1,765.00
83	\$ 1,401.00	\$ 1,611.00	\$ 1,557.00	\$ 1,790.00
84	\$ 1,420.00	\$ 1,634.00	\$ 1,578.00	\$ 1,814.00
85	\$ 1,439.00	\$ 1,655.00	\$ 1,600.00	\$ 1,839.00
86	\$ 1,457.00	\$ 1,676.00	\$ 1,619.00	\$ 1,862.00
87	\$ 1,474.00	\$ 1,695.00	\$ 1,639.00	\$ 1,884.00
88	\$ 1,492.00	\$ 1,714.00	\$ 1,657.00	\$ 1,905.00
89	\$ 1,507.00	\$ 1,733.00	\$ 1,675.00	\$ 1,926.00
90	\$ 1,523.00	\$ 1,750.00	\$ 1,692.00	\$ 1,945.00
91	\$ 1,536.00	\$ 1,767.00	\$ 1,707.00	\$ 1,964.00
92	\$ 1,550.00	\$ 1,782.00	\$ 1,722.00	\$ 1,980.00
93	\$ 1,562.00	\$ 1,796.00	\$ 1,736.00	\$ 1,996.00
94	\$ 1,574.00	\$ 1,810.00	\$ 1,749.00	\$ 2,010.00
95	\$ 1,584.00	\$ 1,822.00	\$ 1,761.00	\$ 2,024.00
96	\$ 1,595.00	\$ 1,834.00	\$ 1,772.00	\$ 2,038.00
97	\$ 1,605.00	\$ 1,847.00	\$ 1,785.00	\$ 2,052.00
98	\$ 1,617.00	\$ 1,859.00	\$ 1,797.00	\$ 2,066.00
99	\$ 1,628.00	\$ 1,873.00	\$ 1,809.00	\$ 2,080.00

<b>Medicare Supplement Plan F ZIP CODES: All of State</b>				
<b>AGE</b>	<b>FEMALE PREFERRED</b>	<b>MALE PREFERRED</b>	<b>FEMALE STANDARD</b>	<b>MALE STANDARD</b>
65	\$ 1,006.00	\$ 1,156.00	\$ 1,117.00	\$ 1,285.00
66	\$ 1,051.00	\$ 1,208.00	\$ 1,168.00	\$ 1,343.00
67	\$ 1,096.00	\$ 1,260.00	\$ 1,218.00	\$ 1,401.00
68	\$ 1,142.00	\$ 1,312.00	\$ 1,268.00	\$ 1,457.00
69	\$ 1,186.00	\$ 1,364.00	\$ 1,317.00	\$ 1,515.00
70	\$ 1,230.00	\$ 1,415.00	\$ 1,366.00	\$ 1,571.00
71	\$ 1,273.00	\$ 1,464.00	\$ 1,415.00	\$ 1,627.00
72	\$ 1,315.00	\$ 1,512.00	\$ 1,462.00	\$ 1,681.00
73	\$ 1,357.00	\$ 1,560.00	\$ 1,508.00	\$ 1,733.00
74	\$ 1,397.00	\$ 1,605.00	\$ 1,551.00	\$ 1,784.00
75	\$ 1,434.00	\$ 1,649.00	\$ 1,593.00	\$ 1,832.00
76	\$ 1,469.00	\$ 1,690.00	\$ 1,633.00	\$ 1,877.00
77	\$ 1,503.00	\$ 1,729.00	\$ 1,670.00	\$ 1,921.00
78	\$ 1,534.00	\$ 1,765.00	\$ 1,705.00	\$ 1,961.00
79	\$ 1,563.00	\$ 1,798.00	\$ 1,737.00	\$ 1,998.00
80	\$ 1,589.00	\$ 1,828.00	\$ 1,766.00	\$ 2,030.00
81	\$ 1,612.00	\$ 1,854.00	\$ 1,791.00	\$ 2,060.00
82	\$ 1,635.00	\$ 1,880.00	\$ 1,817.00	\$ 2,089.00
83	\$ 1,657.00	\$ 1,905.00	\$ 1,840.00	\$ 2,117.00
84	\$ 1,678.00	\$ 1,931.00	\$ 1,865.00	\$ 2,144.00
85	\$ 1,698.00	\$ 1,953.00	\$ 1,888.00	\$ 2,171.00
86	\$ 1,719.00	\$ 1,977.00	\$ 1,910.00	\$ 2,196.00
87	\$ 1,738.00	\$ 1,999.00	\$ 1,932.00	\$ 2,221.00
88	\$ 1,756.00	\$ 2,020.00	\$ 1,952.00	\$ 2,244.00
89	\$ 1,774.00	\$ 2,041.00	\$ 1,971.00	\$ 2,267.00
90	\$ 1,791.00	\$ 2,060.00	\$ 1,989.00	\$ 2,288.00
91	\$ 1,806.00	\$ 2,078.00	\$ 2,007.00	\$ 2,308.00
92	\$ 1,822.00	\$ 2,094.00	\$ 2,024.00	\$ 2,328.00
93	\$ 1,835.00	\$ 2,111.00	\$ 2,040.00	\$ 2,345.00
94	\$ 1,848.00	\$ 2,125.00	\$ 2,053.00	\$ 2,362.00
95	\$ 1,859.00	\$ 2,139.00	\$ 2,066.00	\$ 2,376.00
96	\$ 1,872.00	\$ 2,153.00	\$ 2,079.00	\$ 2,391.00
97	\$ 1,884.00	\$ 2,167.00	\$ 2,094.00	\$ 2,407.00
98	\$ 1,896.00	\$ 2,181.00	\$ 2,106.00	\$ 2,423.00
99	\$ 1,908.00	\$ 2,195.00	\$ 2,120.00	\$ 2,439.00

Some Plans may not be available in your state

Premiums payable other than annual may be determined by the following factors:

Semi-annual:      0.5200              Quarterly:              0.2650              Monthly EFT              0.0867

**GENWORTH LIFE & ANNUITY INSURANCE COMPANY  
 OUTLINE OF MEDICARE SUPPLEMENT COVERAGE RATE SHEET  
 STATE OF UTAH**

<b>Medicare Supplement Plan High Deductible F ZIP CODES: All of State</b>				
<b>AGE</b>	<b>FEMALE PREFERRED</b>	<b>MALE PREFERRED</b>	<b>FEMALE STANDARD</b>	<b>MALE STANDARD</b>
65	\$ 396.00	\$ 455.00	\$ 440.00	\$ 505.00
66	\$ 413.00	\$ 475.00	\$ 459.00	\$ 528.00
67	\$ 431.00	\$ 496.00	\$ 480.00	\$ 551.00
68	\$ 449.00	\$ 517.00	\$ 499.00	\$ 574.00
69	\$ 467.00	\$ 536.00	\$ 518.00	\$ 596.00
70	\$ 484.00	\$ 557.00	\$ 538.00	\$ 618.00
71	\$ 501.00	\$ 576.00	\$ 557.00	\$ 641.00
72	\$ 517.00	\$ 595.00	\$ 575.00	\$ 662.00
73	\$ 533.00	\$ 613.00	\$ 593.00	\$ 682.00
74	\$ 550.00	\$ 632.00	\$ 610.00	\$ 702.00
75	\$ 564.00	\$ 649.00	\$ 627.00	\$ 721.00
76	\$ 578.00	\$ 665.00	\$ 643.00	\$ 739.00
77	\$ 592.00	\$ 680.00	\$ 657.00	\$ 756.00
78	\$ 603.00	\$ 694.00	\$ 671.00	\$ 771.00
79	\$ 614.00	\$ 706.00	\$ 684.00	\$ 786.00
80	\$ 625.00	\$ 719.00	\$ 694.00	\$ 798.00
81	\$ 634.00	\$ 729.00	\$ 705.00	\$ 811.00
82	\$ 643.00	\$ 740.00	\$ 714.00	\$ 822.00
83	\$ 652.00	\$ 749.00	\$ 724.00	\$ 833.00
84	\$ 660.00	\$ 760.00	\$ 733.00	\$ 844.00
85	\$ 669.00	\$ 769.00	\$ 743.00	\$ 854.00
86	\$ 676.00	\$ 778.00	\$ 752.00	\$ 864.00
87	\$ 684.00	\$ 786.00	\$ 760.00	\$ 874.00
88	\$ 690.00	\$ 795.00	\$ 768.00	\$ 883.00
89	\$ 698.00	\$ 803.00	\$ 776.00	\$ 891.00
90	\$ 705.00	\$ 811.00	\$ 783.00	\$ 900.00
91	\$ 711.00	\$ 817.00	\$ 790.00	\$ 908.00
92	\$ 717.00	\$ 824.00	\$ 797.00	\$ 916.00
93	\$ 722.00	\$ 830.00	\$ 802.00	\$ 923.00
94	\$ 727.00	\$ 836.00	\$ 808.00	\$ 929.00
95	\$ 732.00	\$ 841.00	\$ 813.00	\$ 935.00
96	\$ 736.00	\$ 847.00	\$ 818.00	\$ 941.00
97	\$ 741.00	\$ 851.00	\$ 823.00	\$ 947.00
98	\$ 746.00	\$ 858.00	\$ 829.00	\$ 953.00
99	\$ 751.00	\$ 863.00	\$ 834.00	\$ 959.00

<b>Medicare Supplement Plan G ZIP CODES: All of State</b>				
<b>AGE</b>	<b>FEMALE PREFERRED</b>	<b>MALE PREFERRED</b>	<b>FEMALE STANDARD</b>	<b>MALE STANDARD</b>
65	\$ 830.00	\$ 953.00	\$ 921.00	\$ 1,059.00
66	\$ 870.00	\$ 1,001.00	\$ 967.00	\$ 1,112.00
67	\$ 912.00	\$ 1,049.00	\$ 1,014.00	\$ 1,165.00
68	\$ 954.00	\$ 1,096.00	\$ 1,060.00	\$ 1,219.00
69	\$ 995.00	\$ 1,145.00	\$ 1,105.00	\$ 1,272.00
70	\$ 1,035.00	\$ 1,191.00	\$ 1,151.00	\$ 1,323.00
71	\$ 1,075.00	\$ 1,236.00	\$ 1,195.00	\$ 1,374.00
72	\$ 1,114.00	\$ 1,282.00	\$ 1,238.00	\$ 1,424.00
73	\$ 1,152.00	\$ 1,325.00	\$ 1,280.00	\$ 1,473.00
74	\$ 1,188.00	\$ 1,366.00	\$ 1,321.00	\$ 1,518.00
75	\$ 1,223.00	\$ 1,406.00	\$ 1,359.00	\$ 1,563.00
76	\$ 1,256.00	\$ 1,444.00	\$ 1,396.00	\$ 1,604.00
77	\$ 1,287.00	\$ 1,481.00	\$ 1,430.00	\$ 1,644.00
78	\$ 1,315.00	\$ 1,513.00	\$ 1,462.00	\$ 1,681.00
79	\$ 1,342.00	\$ 1,544.00	\$ 1,492.00	\$ 1,714.00
80	\$ 1,366.00	\$ 1,570.00	\$ 1,518.00	\$ 1,746.00
81	\$ 1,387.00	\$ 1,595.00	\$ 1,541.00	\$ 1,772.00
82	\$ 1,408.00	\$ 1,619.00	\$ 1,565.00	\$ 1,798.00
83	\$ 1,427.00	\$ 1,642.00	\$ 1,586.00	\$ 1,824.00
84	\$ 1,448.00	\$ 1,664.00	\$ 1,608.00	\$ 1,849.00
85	\$ 1,467.00	\$ 1,686.00	\$ 1,629.00	\$ 1,874.00
86	\$ 1,485.00	\$ 1,707.00	\$ 1,650.00	\$ 1,897.00
87	\$ 1,502.00	\$ 1,728.00	\$ 1,670.00	\$ 1,919.00
88	\$ 1,519.00	\$ 1,747.00	\$ 1,688.00	\$ 1,941.00
89	\$ 1,535.00	\$ 1,766.00	\$ 1,706.00	\$ 1,962.00
90	\$ 1,551.00	\$ 1,784.00	\$ 1,723.00	\$ 1,982.00
91	\$ 1,566.00	\$ 1,800.00	\$ 1,739.00	\$ 2,001.00
92	\$ 1,579.00	\$ 1,816.00	\$ 1,754.00	\$ 2,017.00
93	\$ 1,592.00	\$ 1,831.00	\$ 1,769.00	\$ 2,034.00
94	\$ 1,603.00	\$ 1,845.00	\$ 1,782.00	\$ 2,049.00
95	\$ 1,614.00	\$ 1,857.00	\$ 1,794.00	\$ 2,063.00
96	\$ 1,625.00	\$ 1,870.00	\$ 1,806.00	\$ 2,078.00
97	\$ 1,637.00	\$ 1,882.00	\$ 1,819.00	\$ 2,092.00
98	\$ 1,648.00	\$ 1,896.00	\$ 1,831.00	\$ 2,106.00
99	\$ 1,660.00	\$ 1,909.00	\$ 1,843.00	\$ 2,120.00

Some Plans may not be available in your state

Premiums payable other than annual may be determined by the following factors:

Semi-annual:      0.5200              Quarterly:              0.2650                      Monthly EFT              0.0867

## PREMIUM INFORMATION

Genworth Life and Annuity Insurance Company can only raise your premium if we raise the premium for all policies like yours in this state. Premiums for this policy will increase due to the increase in your age. Upon attainment of an age requiring a rate increase, the renewal premium for the policy will be the renewal premium then in effect for your attained age. Other policies may be provided with Issue Age rating and do not increase with age. You should compare Issue Age with Attained Age policies.

Premiums payable other than annual will be determined according to the following factors:

Semi-annual: 0.5200 Quarterly: 0.2650 Monthly EFT: 0.0867

## DISCLOSURES

Use this outline to compare benefits and premium 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 Genworth Life and Annuity Insurance Company, PO Box 10824, Clearwater, FL 33757-8824. 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 cover all of your medical costs.

Neither Genworth Life and Annuity 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 & 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 any 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.

**THE FOLLOWING CHARTS DESCRIBE PLANS A, B, C, D, E, F, G and High Deductible F OFFERED BY GENWORTH LIFE AND ANNUITY INSURANCE COMPANY.**

**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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<p><b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days</p> <p>61st thru 90th day</p> <p>91st day and after</p> <ul style="list-style-type: none"> <li>•While using 60 lifetime reserve days</li> <li>•Once lifetime reserve days are used:                             <ul style="list-style-type: none"> <li>•Additional 365 days</li> <li>•Beyond the Additional 365 days</li> </ul> </li> </ul>	<p>All but \$952.00</p> <p>All but \$238.00 a day</p> <p>All but \$476.00 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>\$238.00 a day</p> <p>\$476.00 a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$952.00 (Part A Deductible)</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p><b>SKILLED NURSING FACILITY CARE*</b> 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</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$119.00 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$119.00 a day</p> <p>All costs</p>
<p><b>BLOOD</b> First 3 pints Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p><b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited coinsurance for outpatient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance</p>

\*\*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 \$124 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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES –</b> 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 test, durable medical equipment First \$124 of Medicare-Approved amounts*  Remainder of Medicare-Approved amounts	\$0  Generally 80%	\$0  Generally 20%	\$124 (Part B Deductible)  \$0
<b>Part B Excess Charges</b> (Above Medicare-Approved amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints  Next \$124 of Medicare-Approved amounts*  Remainder of Medicare-Approved amounts	\$0  \$0  80%	All costs  \$0  20%	\$0  \$124 (Part B Deductible)  \$0
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE –</b> MEDICARE- APPROVED SERVICES •Medically necessary skilled care services and medical supplies  •Durable medical equipment •First \$124 of Medicare-Approved amounts*  •Remainder of Medicare-Approved amounts	100%  \$0  80%	\$0  \$0  20%	\$0  \$124 (Part B Deductible)  \$0
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**PLAN B**

**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
<p><b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies</p> <p>First 60 days</p> <p>61st thru 90th day</p> <p>91st day and after</p> <ul style="list-style-type: none"> <li>•While using 60 lifetime reserve days</li> <li>•Once lifetime reserve days are used:               <ul style="list-style-type: none"> <li>•Additional 365 days</li> <li>•Beyond the Additional 365 days</li> </ul> </li> </ul>	<p>All but \$952.00</p> <p>All but \$238.00 a day</p> <p>All but \$476.00 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$952.00 (Part A Deductible)</p> <p>\$238.00 a day</p> <p>\$476.00 a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p><b>SKILLED NURSING FACILITY CARE*</b> 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</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$119.00 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$119.00 a day</p> <p>All costs</p>
<p><b>BLOOD</b> First 3 pints</p> <p>Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p><b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited coinsurance for outpatient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance</p>

\*\*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 B**

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

\* Once you have been billed \$124 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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES –</b> 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 test, durable medical equipment First \$124 of Medicare-Approved amounts*  Remainder of Medicare-Approved amounts	\$0  Generally 80%	\$0  Generally 20%	\$124 (Part B Deductible)  \$0
<b>Part B Excess Charges</b> (Above Medicare-Approved amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints  Next \$124 of Medicare-Approved amounts*  Remainder of Medicare-Approved amounts	\$0  \$0  80%	All costs  \$0  20%	\$0  \$124 (Part B Deductible)  \$0
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE –</b> MEDICARE- APPROVED SERVICES •Medically necessary skilled care services and medical supplies  •Durable medical equipment •First \$124 of Medicare-Approved amounts*  •Remainder of Medicare-Approved amounts	100%  \$0  80%	\$0  \$0  20%	\$0  \$124 (Part B Deductible)  \$0
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**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 days in a row.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> 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 \$952.00 All but \$238.00 a day All but \$476.00 a day \$0 \$0	\$952.00 (Part A Deductible) \$238.00 a day \$476.00 a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0** All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 \$119.00 a day \$0	\$0 Up to \$119.00 a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

\*\*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 C**

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

\*Once you have been billed \$124 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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment First \$124 of Medicare-Approved amounts*	\$0	\$124 (Part B Deductible)	\$0
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare-Approved amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints	\$0	All costs	\$0
Next \$124 of Medicare-Approved amounts*	\$0	\$124 (Part B Deductible)	\$0
Remainder of Medicare-Approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE – MEDICARE- APPROVED SERVICES</b> •Medically necessary skilled care services and medical supplies	100%	\$0	\$0
•Durable medical equipment •First \$124 of Medicare-Approved amounts*	\$0	\$124 (Part B Deductible)	\$0
•Remainder of Medicare-Approved amounts	80%	20%	\$0

**PLAN C  
OTHER BENEFITS - NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> 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

**PLAN D**

**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
<p><b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies</p> <p>First 60 days</p> <p>61st thru 90th day</p> <p>91st day and after</p> <ul style="list-style-type: none"> <li>•While using 60 lifetime reserve days</li> <li>•Once lifetime reserve days are used:                             <ul style="list-style-type: none"> <li>•Additional 365 days</li> <li>•Beyond the Additional 365 days</li> </ul> </li> </ul>	<p>All but \$952.00</p> <p>All but \$238.00 a day</p> <p>All but \$476.00 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$952.00 (Part A Deductible)</p> <p>\$238.00 a day</p> <p>\$476.00 a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p><b>SKILLED NURSING FACILITY CARE*</b> 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</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$119.00 a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$119.00 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p><b>BLOOD</b> First 3 pints Additional amounts</p>	<p>\$0 100%</p>	<p>3 pints \$0</p>	<p>\$0 \$0</p>
<p><b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited coinsurance for outpatient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance</p>

\*\*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 D**

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

\*Once you have been billed \$124 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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES –</b> 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 test, durable medical equipment First \$124 of Medicare-Approved amounts*  Remainder of Medicare-Approved amounts	\$0  Generally 80%	\$0  Generally 20%	\$124 (Part B Deductible)  \$0
<b>Part B Excess Charges</b> (Above Medicare-Approved amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints  Next \$124 of Medicare-Approved amounts*  Remainder of Medicare-Approved amounts	\$0  \$0  80%	All costs  \$0  20%	\$0  \$124 (Part B Deductible)  \$0
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE –</b> MEDICARE- APPROVED SERVICES •Medically necessary skilled care services and medical supplies  •Durable medical equipment •First \$124 of Medicare-Approved amounts*  •Remainder of Medicare-Approved amounts	100%  \$0  80%	\$0  \$0  20%	\$0  \$124 (Part B Deductible)  \$0
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SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p><b>HOME HEALTH CARE (cont'd)</b>  <b>AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE</b>  Home care certified by your doctor, for personal care beginning during recovery from an Injury or sickness for which Medicare approved a Home Care Treatment Plan</p> <ul style="list-style-type: none"> <li>•Benefit for each visit</li> <li>•Number of visits covered (must be received within 8 weeks of last Medicare-Approved visit)</li> <li>•Calendar year maximum</li> </ul>	<p>\$0</p> <p>\$0</p> <p>\$0</p>	<p>Actual Charges to \$40 a visit</p> <p>Up to the number of Medicare-Approved visits, not to exceed 7 each week</p> <p>\$1,600</p>	<p>Balance</p>

**PLAN D**  
**OTHER BENEFITS – NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p><b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b>  Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA</p> <p>First \$250 each calendar year</p> <p>Remainder of charges</p>	<p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>80% to a lifetime maximum benefit of \$50,000</p>	<p>\$250</p> <p>20% and amounts over the \$50,000 lifetime maximum</p>

**PLAN E**

**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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<p><b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies</p> <p>First 60 days</p> <p>61st thru 90th day</p> <p>91st day and after</p> <ul style="list-style-type: none"> <li>•While using 60 lifetime reserve days</li> <li>•Once lifetime reserve days are used:                             <ul style="list-style-type: none"> <li>•Additional 365 days</li> <li>•Beyond the Additional 365 days</li> </ul> </li> </ul>	<p>All but \$952.00</p> <p>All but \$238.00 a day</p> <p>All but \$476.00 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$952.00 (Part A Deductible)</p> <p>\$238.00 a day</p> <p>\$476.00 a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p><b>SKILLED NURSING FACILITY CARE*</b> 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</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$119.00 a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$119.00 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p><b>BLOOD</b> First 3 pints Additional amounts</p>	<p>\$0 100%</p>	<p>3 pints \$0</p>	<p>\$0 \$0</p>
<p><b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited coinsurance for outpatient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance</p>

\*\*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 E**

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

\*Once you have been billed \$124 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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES –</b> 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 test, durable medical equipment First \$124 of Medicare-Approved amounts*  Remainder of Medicare-Approved amounts	\$0  Generally 80%	\$0  Generally 20%	\$124 (Part B Deductible)  \$0
<b>Part B Excess Charges</b> (Above Medicare-Approved amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints  Next \$124 of Medicare-Approved amounts*  Remainder of Medicare-Approved amounts	\$0  \$0  80%	All costs  \$0  20%	\$0  \$124 (Part B Deductible)  \$0
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE –</b> MEDICARE- APPROVED SERVICES •Medically necessary skilled care services and medical supplies	100%	\$0	\$0
•Durable medical equipment •First \$124 of Medicare-Approved amounts*	\$0	\$0	\$124 (Part B Deductible)
•Remainder of Medicare-Approved amounts	80%	20%	\$0

**PLAN E**  
**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<p><b>PREVENTIVE MEDICAL CARE BENEFIT – NOT COVERED BY MEDICARE</b>  Annual physical and preventive tests and services such as: digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare  First \$120 each calendar year  Additional charges</p>	<p>\$0 \$0</p>	<p>\$120 \$0</p>	<p>\$0 All costs</p>
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SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p><b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b>  Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA  First \$250 each calendar year  Remainder of charges</p>	<p>\$0 \$0</p>	<p>\$0 80% to a lifetime maximum benefit of \$50,000</p>	<p>\$250 20% and amounts over the \$50,000 lifetime maximum</p>

**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
<p><b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies</p> <p>First 60 days</p> <p>61st thru 90th day</p> <p>91st day and after</p> <ul style="list-style-type: none"> <li>•While using 60 lifetime reserve days</li> <li>•Once lifetime reserve days are used:                             <ul style="list-style-type: none"> <li>•Additional 365 days</li> <li>•Beyond the Additional 365 days</li> </ul> </li> </ul>	<p>All but \$952.00</p> <p>All but \$238.00 a day</p> <p>All but \$476.00 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$952.00 (Part A Deductible)</p> <p>\$238.00 a day</p> <p>\$476.00 a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p><b>SKILLED NURSING FACILITY CARE*</b> 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</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$119.00 a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$119.00 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p><b>BLOOD</b> First 3 pints Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p><b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited coinsurance for outpatient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance</p>

\*\*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**

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

\*Once you have been billed \$124 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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES –</b> 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 test, durable medical equipment First \$124 of Medicare-Approved amounts*	\$0	\$124 (Part B Deductible)	\$0
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare-Approved amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints	\$0	All costs	\$0
Next \$124 of Medicare-Approved amounts*	\$0	\$124 (Part B Deductible)	\$0
Remainder of Medicare-Approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE –</b> MEDICARE- APPROVED SERVICES •Medically necessary skilled care services and medical supplies	100%	\$0	\$0
•Durable medical equipment •First \$124 of Medicare-Approved amounts*	\$0	\$124 (Part B Deductible)	\$0
•Remainder of Medicare-Approved amounts	80%	20%	\$0

**PLAN F**  
**OTHER BENEFITS - NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> 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

## HIGH DEDUCTIBLE 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.

**\*\*This high deductible plan pays the same or offers the same benefits as Plan F after you have paid a calendar year [\$1790] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [\$1790]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's foreign emergency travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY [\$1790] DEDUCTIBLE** PLAN PAYS	IN ADDITION TO [\$1790] DEDUCTIBLE** YOU PAY
<b>HOSPITALIZATION*</b> 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 \$952.00  All but \$238.00 a day  All but \$476.00 a day  \$0  \$0	\$952.00 (Part A Deductible) \$238.00 a day  \$476.00 a day  100% of Medicare Eligible Expenses \$0	\$0  \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY                      CARE*</b> 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 \$119.00 a day \$0	\$0  Up to \$119.00 a day \$0	\$0  \$0  All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0

<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance
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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.

**HIGH DEDUCTIBLE PLAN F**

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

\*Once you have been billed \$124 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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>AFTER YOU PAY [\$1790] DEDUCTIBLE** PLAN PAYS</b>	<b>IN ADDITION TO [\$1790] DEDUCTIBLE** YOU PAY</b>
<b>MEDICAL EXPENSES –</b> 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 test, durable medical equipment First \$124 of Medicare-Approved amounts*  Remainder of Medicare-Approved amounts	\$0  Generally 80%	\$124 (Part B Deductible)  Generally 20%	\$0  \$0
<b>Part B Excess Charges</b> (Above Medicare-Approved amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints  Next \$124 of Medicare-Approved amounts*  Remainder of Medicare-Approved amounts	\$0  \$0  80%	All costs  \$124 (Part B Deductible)  20%	\$0  \$0  \$0
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE –</b> MEDICARE- APPROVED SERVICES •Medically necessary skilled care services and medical supplies	100%	\$0	\$0
•Durable medical equipment •First \$124 of Medicare-Approved amounts*	\$0	\$124 (Part B Deductible)	\$0
•Remainder of Medicare-Approved amounts	80%	20%	\$0

**HIGH DEDUCTIBLE PLAN F  
OTHER BENEFITS - NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>AFTER YOU PAY [\$1790] DEDUCTIBLE** PLAN PAYS</b>	<b>IN ADDITION TO [\$1790] DEDUCTIBLE** YOU PAY</b>
<p><b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges</p>	<p>\$0 \$0</p>	<p>\$0 80% to a lifetime maximum benefit of \$50,000</p>	<p>\$250 20% and amounts over the \$50,000 lifetime maximum</p>

**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
<p><b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies</p> <p>First 60 days</p> <p>61st thru 90th day</p> <p>91st day and after</p> <ul style="list-style-type: none"> <li>•While using 60 lifetime reserve days</li> <li>•Once lifetime reserve days are used:               <ul style="list-style-type: none"> <li>•Additional 365 days</li> <li>•Beyond the Additional 365 days</li> </ul> </li> </ul>	<p>All but \$952.00</p> <p>All but \$238.00 a day</p> <p>All but \$476.00 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$952.00 (Part A Deductible)</p> <p>\$238.00 a day</p> <p>\$476.00 a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p><b>SKILLED NURSING FACILITY CARE*</b> 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</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$119.00 a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$119.00 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p><b>BLOOD</b> First 3 pints Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p><b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited coinsurance for outpatient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance</p>

\*\*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**

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

\*Once you have been billed \$124 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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES –</b> 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 test, durable medical equipment First \$124 of Medicare-Approved amounts*  Remainder of Medicare-Approved amounts	\$0  Generally 80%	\$0  Generally 20%	\$124 (Part B Deductible)  \$0
<b>Part B Excess Charges</b> (Above Medicare-Approved amounts)	\$0	80%	20%
<b>BLOOD</b> First 3 pints  Next \$124 of Medicare-Approved amounts*  Remainder of Medicare-Approved amounts	\$0  \$0  80%	All costs  \$0  20%	\$0  \$124 (Part B Deductible)  \$0
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE –</b> MEDICARE- APPROVED SERVICES •Medically necessary skilled care services and medical supplies  •Durable medical equipment •First \$124 of Medicare-Approved amounts*  •Remainder of Medicare-Approved amounts	100%  \$0  80%	\$0  \$0  20%	\$0  \$124 (Part B Deductible)  \$0
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**PLAN G  
PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTH CARE (cont'd)</b> <b>AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE</b> Home care certified by your doctor, for personal care beginning during recovery from an Injury or sickness for which Medicare approved a Home Care Treatment Plan •Benefit for each visit  •Number of visits covered (must be received within 8 weeks of last Medicare-Approved visit)  •Calendar year maximum	\$0  \$0  \$0	Actual Charges to \$40 a visit Up to the number of Medicare-Approved visits, not to exceed 7 each week \$1,600	Balance

**PLAN G  
OTHER BENEFITS - NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> 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