

MediGap

Plans A, C, F, G and N

2020 OHIO

OUTLINE OF MEDICARE
SUPPLEMENT COVERAGE

BENEFIT CHART OF MEDICARE SUPPLEMENT PLANS SOLD FOR EFFECTIVE DATES ON OR AFTER JUNE 1, 2010

This chart shows the benefits included in each of the standard Medicare supplement plans with an effective date for coverage on or after June 1, 2010. Every company must make available Plan "A". Some plans may not be available in your state.

Basic Benefits:

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

A	B	C	D	F	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out-of-Pocket Limit \$5,880; paid at 100% after limit reached	Out-of-Pocket Limit \$2,940; paid at 100% after limit reached		

*Plan F has an option called a high deductible plan F. This high deductible plan pays the same benefits as plan F after one has paid a calendar year \$2,340 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed \$2,340 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.

Paramount determines premiums for its Medicare Supplement policies based upon attained age. This means your premium will increase automatically as you get older. Your premium may also change if premiums for these policies change.

If you choose to pay directly by check, you will be billed monthly for the applicable premium listed below. If you choose to pay your premium through our automated bank deduction program, premiums will be withdrawn from your bank monthly.

To find the amount of premium you will pay, find your age as of December 31 of the previous year in the first column then choose the plan in which you are interested from one of the next five columns.

OHIO 2020 MONTHLY MEDICARE SUPPLEMENT RATES

Age	MediGap Plan A without discount	MediGap Plan A with discount	MediGap Plan C without discount	MediGap Plan C with discount	MediGap Plan F without discount	MediGap Plan F with discount
65*	\$106.74	\$101.40	\$139.36	\$132.39	\$145.94	\$138.94
66	\$111.66	\$106.08	\$145.79	\$138.50	\$152.68	\$145.05
67	\$116.59	\$110.76	\$152.23	\$144.62	\$159.42	\$151.45
68	\$122.67	\$116.54	\$160.16	\$152.15	\$167.72	\$159.33
69	\$128.74	\$122.30	\$168.09	\$159.69	\$176.03	\$167.23
70	\$134.82	\$128.08	\$176.03	\$167.23	\$184.34	\$175.12
71	\$140.89	\$133.85	\$183.96	\$174.76	\$192.65	\$183.02
72	\$146.97	\$139.62	\$191.89	\$182.30	\$200.95	\$190.90
73	\$153.04	\$145.39	\$199.82	\$189.83	\$209.26	\$198.80
74	\$159.28	\$151.32	\$207.97	\$197.57	\$217.79	\$206.90
75	\$165.52	\$157.24	\$216.12	\$205.31	\$226.33	\$215.01
76	\$171.93	\$163.33	\$224.48	\$213.26	\$235.08	\$223.33
77	\$178.33	\$169.41	\$232.84	\$221.20	\$243.84	\$231.65
78	\$184.74	\$175.50	\$241.20	\$229.14	\$252.60	\$239.97
79	\$191.14	\$181.58	\$249.57	\$237.09	\$261.35	\$248.28
80	\$197.55	\$187.67	\$257.93	\$245.03	\$270.11	\$256.60
81	\$203.95	\$193.75	\$266.29	\$252.98	\$278.86	\$264.92
82	\$210.35	\$199.83	\$274.65	\$260.92	\$287.62	\$273.24
83	\$216.59	\$205.76	\$282.80	\$268.66	\$296.15	\$281.34
84	\$222.67	\$211.54	\$290.73	\$276.19	\$304.46	\$289.24
85	\$228.58	\$217.15	\$298.45	\$283.53	\$312.54	\$296.91
86	\$234.33	\$222.61	\$305.95	\$290.65	\$320.40	\$304.38
87	\$239.26	\$227.30	\$312.39	\$296.77	\$327.14	\$310.78
88	\$244.18	\$231.97	\$318.82	\$302.88	\$333.87	\$317.18
89	\$249.11	\$236.65	\$325.25	\$308.99	\$340.61	\$323.58
90+	\$254.03	\$241.33	\$331.68	\$315.10	\$347.35	\$329.98

*Use the age 65 rate if You turned 65 this calendar year.

OHIO 2020 MONTHLY MEDICARE SUPPLEMENT RATES (Continued)

Age	MediGap Plan G without discount	MediGap Plan G with discount	MediGap Plan N without discount	MediGap Plan N with discount
65*	\$126.11	\$119.80	\$115.32	\$109.55
66	\$132.85	\$126.21	\$120.65	\$114.62
67	\$139.58	\$132.60	\$125.97	\$119.67
68	\$147.89	\$140.50	\$132.53	\$125.90
69	\$156.20	\$148.39	\$139.10	\$132.15
70	\$164.45	\$156.23	\$145.66	\$138.38
71	\$172.69	\$164.06	\$152.23	\$144.62
72	\$180.94	\$171.89	\$158.79	\$150.85
73	\$189.19	\$179.73	\$165.36	\$157.09
74	\$197.66	\$187.78	\$172.10	\$163.50
75	\$206.13	\$195.82	\$178.84	\$169.90
76	\$214.82	\$204.08	\$185.76	\$176.47
77	\$223.52	\$212.34	\$192.68	\$183.05
78	\$232.22	\$220.61	\$199.60	\$189.62
79	\$240.91	\$228.86	\$206.52	\$196.19
80	\$249.60	\$237.12	\$213.44	\$202.77
81	\$258.29	\$245.38	\$220.36	\$209.34
82	\$266.99	\$253.64	\$227.28	\$215.92
83	\$275.45	\$261.68	\$234.02	\$222.32
84	\$283.69	\$269.51	\$240.58	\$228.55
85	\$291.71	\$277.12	\$246.97	\$234.62
86	\$299.51	\$284.53	\$253.18	\$240.52
87	\$306.18	\$290.87	\$258.50	\$245.58
88	\$312.85	\$297.21	\$263.83	\$250.64
89	\$319.52	\$303.54	\$269.15	\$255.69
90+	\$326.25	\$309.94	\$274.47	\$260.75

*Use the age 65 rate if You turned 65 this calendar year.

MEDIGAP SUPPLEMENT COVERAGE BENEFIT PLANS A, C, F, G and N**PREMIUM INFORMATION**

We, Paramount Insurance Company, can only raise your premium if we raise the premium for all policies like yours in this State. Paramount determines premiums for its Medicare Supplement policies based upon attained age. This means your premium will increase automatically as you get older.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY 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 Paramount Insurance Company at our address listed above. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

- This policy may not fully cover all of your medical costs.
- Neither Paramount 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 all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

MEDIGAP 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. <ul style="list-style-type: none"> • First 60 days • Days 61–90 • Day 91 and after: <ul style="list-style-type: none"> • While using 60 lifetime reserve days • Once lifetime reserve days are used: <ul style="list-style-type: none"> • Additional 365 days • Beyond the additional 365 days 	All but \$1,408 All but \$352 a day All but \$704 a day \$0 \$0	\$0 \$352 a day \$704 a day 100% of Medicare-eligible expenses \$0	\$1,408 (Part A deductible) \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital. <ul style="list-style-type: none"> • First 20 days • Days 21–100 • Day 101 and after 	All approved amounts All but \$176 a day \$0	\$0 \$0 \$0	\$0 Up to \$176 a day All costs
BLOOD <ul style="list-style-type: none"> • First three pints • Additional amounts 	\$0 100%	3 pints \$0	\$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

** 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.

MEDIGAP PLAN A

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

*Once you have been billed \$198 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan 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, and durable medical equipment.			
• First \$198 of Medicare-approved amounts*	\$0	\$0	\$198 (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 three pints • Next \$198 of Medicare-approved amounts* • Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$198 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES • Tests for diagnostic services	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE Medicare-approved services			
• Medically necessary skilled care services and medical supplies	100%	\$0	\$0
• Durable medical equipment: First \$198 of Medicare-approved amounts*	\$0	\$0	\$198 (Part B deductible)
• Remainder of Medicare-approved amounts	80%	20%	\$0

MEDIGAP 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.

Services	Medicare Pays	Plan C Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies. <ul style="list-style-type: none"> • First 60 days • Days 61–90 • Day 91 and after: <ul style="list-style-type: none"> • While using 60 lifetime reserve days • Once lifetime reserve days are used: <ul style="list-style-type: none"> • Additional 365 days • Beyond the additional 365 days 	All but \$1,408 All but \$352 a day All but \$704 a day \$0 \$0	\$1,408 (Part A deductible) \$352 a day \$704 a day 100% of Medicare-eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital. <ul style="list-style-type: none"> • First 20 days • Days 21–100 • Day 101 and after 	All approved amounts All but \$176 a day \$0	\$0 Up to \$176 a day \$0	\$0 \$0 All costs
BLOOD <ul style="list-style-type: none"> • First three pints • Additional amounts 	\$0 100%	3 pints \$0	\$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

** 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.

MEDIGAP PLAN C

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

*Once you have been billed \$198 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan C 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, and durable medical equipment.			
• First \$198 of Medicare-approved amounts*	\$0	\$198 (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 three pints • Next \$198 of Medicare-approved amounts* • Remainder of Medicare-approved amounts	 \$0 \$0 80%	 All costs \$198 (Part B deductible) 20%	 \$0 \$0 \$0
CLINICAL LABORATORY SERVICES • Tests for diagnostic services	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE Medicare-approved services			
• Medically necessary skilled care services and medical supplies	100%	\$0	\$0
• Durable medical equipment: First \$198 of Medicare-approved amounts*	\$0	\$198 (Part B deductible)	\$0
• Remainder of Medicare-approved amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – Not covered by Medicare Medical emergency care services beginning during the first 60 days of each trip outside of 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

MEDIGAP 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. <ul style="list-style-type: none"> • First 60 days • Days 61–90 • Day 91 and after: <ul style="list-style-type: none"> • While using 60 lifetime reserve days • Once lifetime reserve days are used: <ul style="list-style-type: none"> • Additional 365 days • Beyond the additional 365 days 	All but \$1,408 All but \$352 a day All but \$704 a day \$0 \$0	\$1,408 (Part A deductible) \$352 a day \$704 a day 100% of Medicare-eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital. <ul style="list-style-type: none"> • First 20 days • Days 21–100 • Day 101 and after 	All approved amounts All but \$176 a day \$0	\$0 Up to \$176 a day \$0	\$0 \$0 All costs
BLOOD <ul style="list-style-type: none"> • First three pints • Additional amounts 	\$0 100%	3 pints \$0	\$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

** 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.

MEDIGAP PLAN F

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

*Once you have been billed \$198 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan 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, and durable medical equipment.			
• First \$198 of Medicare-approved amounts*	\$0	\$198 (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 three pints • Next \$198 of Medicare-approved amounts* • Remainder of Medicare-approved amounts	 \$0 \$0 80%	 All costs \$198 (Part B deductible) 20%	 \$0 \$0 \$0
CLINICAL LABORATORY SERVICES • Tests for diagnostic services	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE Medicare-approved services			
• Medically necessary skilled care services and medical supplies	100%	\$0	\$0
• Durable medical equipment: First \$198 of Medicare-approved amounts*	\$0	\$198 (Part B deductible)	\$0
• Remainder of Medicare-approved amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – Not covered by Medicare Medical emergency care services beginning during the first 60 days of each trip outside of 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

MEDIGAP 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 G Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies. <ul style="list-style-type: none"> • First 60 days • Days 61–90 • Day 91 and after: <ul style="list-style-type: none"> • While using 60 lifetime reserve days • Once lifetime reserve days are used: <ul style="list-style-type: none"> • Additional 365 days • Beyond the additional 365 days 	All but \$1,408 All but \$352 a day All but \$704 a day \$0 \$0	\$1,408 (Part A deductible) \$352 a day \$704 a day 100% of Medicare-eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital. <ul style="list-style-type: none"> • First 20 days • Days 21–100 • Day 101 and after 	All approved amounts All but \$176 a day \$0	\$0 Up to \$176 a day \$0	\$0 \$0 All costs
BLOOD <ul style="list-style-type: none"> • First three pints • Additional amounts 	\$0 100%	3 pints \$0	\$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

** 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.

MEDIGAP PLAN G

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

*Once you have been billed \$198 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan G 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, and durable medical equipment.			
• First \$198 of Medicare-approved amounts*	\$0	\$0	\$198 (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 three pints • Next \$198 of Medicare-approved amounts* • Remainder of Medicare-approved amounts	 \$0 \$0 80%	 All costs \$0 20%	 \$0 \$198 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES • Tests for diagnostic services	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE Medicare-approved services • Medically necessary skilled care services and medical supplies • Durable medical equipment: First \$198 of Medicare-approved amounts* • Remainder of Medicare-approved amounts	 100% \$0 80%	 \$0 \$0 20%	 \$0 \$198 (Part B deductible) \$0
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OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – Not covered by Medicare Medical emergency care services beginning during the first 60 days of each trip outside of 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
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MEDIGAP 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. <ul style="list-style-type: none"> • First 60 days • Days 61–90 • Day 91 and after: <ul style="list-style-type: none"> • While using 60 lifetime reserve days • Once lifetime reserve days are used: <ul style="list-style-type: none"> • Additional 365 days • Beyond the additional 365 days 	All but \$1,408 All but \$352 a day All but \$704 a day \$0 \$0	\$1,408 (Part A deductible) \$352 a day \$704 a day 100% of Medicare-eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital. <ul style="list-style-type: none"> • First 20 days • Days 21–100 • Day 101 and after 	All approved amounts All but \$176 a day \$0	\$0 Up to \$176 a day \$0	\$0 \$0 All costs
BLOOD <ul style="list-style-type: none"> • First three pints • Additional amounts 	\$0 100%	3 pints \$0	\$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

** 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.

MEDIGAP PLAN N

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

*Once you have been billed \$198 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan 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, and durable medical equipment.			
<ul style="list-style-type: none"> • First \$198 of Medicare-approved amounts* 	\$0	\$0	\$198 (Part B deductible)
<ul style="list-style-type: none"> • 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.
<ul style="list-style-type: none"> • Part B Excess Charges (above Medicare-approved amounts) 	\$0	\$0	All costs
BLOOD			
<ul style="list-style-type: none"> • First three pints 	\$0	All costs	\$0
<ul style="list-style-type: none"> • Next \$198 of Medicare-approved amounts* 	\$0	\$0	\$198 (Part B deductible)
<ul style="list-style-type: none"> • Remainder of Medicare-approved amounts 	80%	20%	\$0
CLINICAL LABORATORY SERVICES	100%	\$0	\$0
<ul style="list-style-type: none"> • Tests for diagnostic services 			

PARTS A & B

HOME HEALTH CARE Medicare-approved services			
<ul style="list-style-type: none"> • Medically necessary skilled care services and medical supplies 	100%	\$0	\$0
<ul style="list-style-type: none"> • Durable medical equipment: First \$198 of Medicare-approved amounts* 	\$0	\$0	\$198 (Part B deductible)
<ul style="list-style-type: none"> • Remainder of Medicare-approved amounts 	80%	20%	\$0

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OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – Not covered by Medicare			
Medical emergency care services beginning during the first 60 days of each trip outside of the USA.	\$0	\$0	\$250
<ul style="list-style-type: none"> • First \$250 each calendar year • Remainder of charges 	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

