

**INSURANCE COMPANY OF NORTH AMERICA**  
**Outline of Medicare Supplement Coverage**  
**Benefit Plans A, F, G, N and High Deductible Plan G**

**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 in your state. Only applicants' **first** eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

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

Benefits	Plans Available to All Applicants									Medicare first eligible before 2020 only		
	A	B	D	G	G <sup>1</sup>	K	L	M	N	C	F	F <sup>1</sup>
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%	✓	✓	✓	✓	✓
Blood (first three pints)	✓	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	✓	50%	75%	✓	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	✓	50%	75%	50%	✓	✓	✓	✓
Medicare Part B deductible										✓	✓	✓
Medicare Part B excess charges				✓	✓						✓	✓
Foreign travel emergency (up to plan limits)			✓	✓	✓			✓	✓	✓	✓	✓
Out-of-pocket limit in 2026 <sup>2</sup>						\$8000 <sup>2</sup>	\$4000 <sup>2</sup>					

<sup>1</sup>Plans F and G also have a high deductible option which requires first paying a plan deductible of \$2950 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

<sup>2</sup>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.

<sup>3</sup>Plan N pays 100% of the Part B coinsurance, except for a copayment of up to \$20 for some office visits and up to a \$50 copayment for emergency room visits that do not result in an inpatient admission.

**INSURANCE COMPANY OF NORTH AMERICA**  
**MICHIGAN Standard Plans MALE Rates - ANNUAL**  
 FOR USE IN ZIP CODES: 480, 482, 483, 485

Attained Age	Preferred					Attained Age	Standard				
	Plan A	Plan F	Plan G	HD Plan G	Plan N		Plan A	Plan F	Plan G	HD Plan G	Plan N
65	2,192	3,161	2,435	820	1,729	65	2,520	3,633	2,799	943	1,989
66	2,192	3,161	2,435	820	1,729	66	2,520	3,633	2,799	943	1,989
67	2,192	3,161	2,435	820	1,729	67	2,520	3,633	2,799	943	1,989
68	2,192	3,161	2,435	820	1,729	68	2,520	3,633	2,799	943	1,989
69	2,192	3,161	2,435	820	1,729	69	2,520	3,633	2,799	943	1,989
70	2,212	3,255	2,459	826	1,765	70	2,545	3,744	2,827	951	2,030
71	2,278	3,352	2,531	853	1,818	71	2,619	3,855	2,910	981	2,090
72	2,360	3,467	2,621	882	1,882	72	2,713	3,988	3,014	1,015	2,166
73	2,442	3,591	2,713	912	1,948	73	2,808	4,129	3,120	1,050	2,240
74	2,527	3,715	2,808	945	2,018	74	2,905	4,272	3,228	1,087	2,320
75	2,627	3,864	2,918	982	2,096	75	3,021	4,443	3,357	1,130	2,411
76	2,734	4,019	3,038	1,022	2,179	76	3,146	4,621	3,495	1,175	2,506
77	2,842	4,177	3,158	1,063	2,268	77	3,269	4,803	3,632	1,222	2,608
78	2,957	4,345	3,285	1,106	2,357	78	3,402	4,996	3,780	1,271	2,712
79	3,075	4,520	3,417	1,150	2,452	79	3,536	5,198	3,929	1,322	2,820
80	3,196	4,701	3,551	1,197	2,550	80	3,675	5,406	4,083	1,376	2,932
81	3,343	4,912	3,714	1,250	2,664	81	3,844	5,648	4,271	1,437	3,062
82	3,493	5,129	3,881	1,307	2,784	82	4,016	5,899	4,463	1,502	3,202
83	3,649	5,362	4,055	1,365	2,910	83	4,196	6,166	4,662	1,569	3,346
84	3,814	5,606	4,237	1,427	3,042	84	4,386	6,448	4,873	1,640	3,498
85	3,985	5,856	4,427	1,490	3,179	85	4,582	6,735	5,091	1,712	3,655
86	4,164	6,119	4,627	1,557	3,321	86	4,788	7,036	5,321	1,791	3,819
87	4,350	6,393	4,834	1,628	3,472	87	5,003	7,352	5,559	1,871	3,993
88	4,545	6,683	5,050	1,700	3,626	88	5,228	7,685	5,808	1,955	4,170
89	4,753	6,983	5,281	1,777	3,790	89	5,465	8,030	6,072	2,043	4,359
90	4,965	7,295	5,517	1,856	3,959	90	5,710	8,389	6,343	2,134	4,553
91	5,187	7,623	5,763	1,941	4,138	91	5,966	8,766	6,628	2,232	4,758
92	5,419	7,967	6,022	2,026	4,322	92	6,233	9,162	6,925	2,330	4,970
93	5,666	8,327	6,296	2,119	4,517	93	6,517	9,575	7,241	2,437	5,195
94	5,920	8,701	6,578	2,214	4,721	94	6,808	10,007	7,565	2,546	5,429
95	6,186	9,092	6,873	2,311	4,934	95	7,113	10,457	7,903	2,659	5,673
96	6,464	9,503	7,183	2,417	5,154	96	7,433	10,927	8,259	2,780	5,927
97	6,756	9,929	7,506	2,526	5,387	97	7,769	11,419	8,631	2,904	6,194
98	7,059	10,378	7,844	2,638	5,629	98	8,119	11,934	9,021	3,034	6,474
99	7,377	10,843	8,197	2,757	5,881	99	8,483	12,471	9,426	3,172	6,762

Modal Factors:      Semi Annual: 0.5000    Quarterly: 0.25000    Monthly: Divide by 12

**INSURANCE COMPANY OF NORTH AMERICA**  
**MICHIGAN Standard Plans MALE Rates - ANNUAL**  
 FOR USE IN ZIP CODES: 481, 484, 486-489

Attained Age	Preferred					Attained Age	Standard				
	Plan A	Plan F	Plan G	HD Plan G	Plan N		Plan A	Plan F	Plan G	HD Plan G	Plan N
65	2,060	2,972	2,290	771	1,625	65	2,369	3,416	2,632	886	1,870
66	2,060	2,972	2,290	771	1,625	66	2,369	3,416	2,632	886	1,870
67	2,060	2,972	2,290	771	1,625	67	2,369	3,416	2,632	886	1,870
68	2,060	2,972	2,290	771	1,625	68	2,369	3,416	2,632	886	1,870
69	2,060	2,972	2,290	771	1,625	69	2,369	3,416	2,632	886	1,870
70	2,080	3,060	2,311	777	1,659	70	2,393	3,520	2,658	895	1,909
71	2,142	3,152	2,380	802	1,709	71	2,462	3,624	2,736	922	1,965
72	2,219	3,260	2,465	829	1,770	72	2,551	3,749	2,834	954	2,036
73	2,296	3,376	2,551	858	1,831	73	2,640	3,882	2,933	987	2,106
74	2,376	3,493	2,640	889	1,897	74	2,731	4,017	3,035	1,022	2,181
75	2,470	3,633	2,744	923	1,970	75	2,840	4,178	3,156	1,062	2,266
76	2,570	3,779	2,856	961	2,049	76	2,958	4,345	3,286	1,105	2,356
77	2,672	3,927	2,969	999	2,133	77	3,073	4,516	3,414	1,149	2,452
78	2,780	4,085	3,089	1,040	2,216	78	3,198	4,698	3,553	1,195	2,550
79	2,891	4,250	3,212	1,081	2,305	79	3,324	4,887	3,694	1,243	2,651
80	3,005	4,420	3,338	1,125	2,398	80	3,456	5,082	3,839	1,294	2,757
81	3,143	4,618	3,492	1,175	2,505	81	3,614	5,310	4,015	1,351	2,879
82	3,284	4,822	3,649	1,228	2,618	82	3,776	5,546	4,196	1,413	3,010
83	3,431	5,041	3,812	1,283	2,736	83	3,945	5,797	4,384	1,475	3,145
84	3,586	5,270	3,983	1,341	2,860	84	4,124	6,062	4,582	1,542	3,288
85	3,746	5,506	4,162	1,401	2,988	85	4,308	6,332	4,786	1,610	3,436
86	3,915	5,753	4,350	1,464	3,122	86	4,502	6,615	5,003	1,683	3,591
87	4,090	6,010	4,544	1,530	3,264	87	4,704	6,912	5,227	1,759	3,754
88	4,273	6,283	4,748	1,598	3,409	88	4,915	7,225	5,461	1,838	3,920
89	4,468	6,565	4,965	1,670	3,564	89	5,138	7,550	5,709	1,921	4,098
90	4,668	6,858	5,187	1,745	3,722	90	5,368	7,887	5,964	2,007	4,281
91	4,876	7,167	5,418	1,825	3,891	91	5,609	8,242	6,232	2,098	4,474
92	5,095	7,490	5,662	1,904	4,063	92	5,860	8,614	6,511	2,191	4,673
93	5,327	7,829	5,919	1,992	4,247	93	6,127	9,003	6,808	2,292	4,884
94	5,566	8,180	6,184	2,081	4,439	94	6,400	9,408	7,112	2,394	5,104
95	5,816	8,548	6,462	2,173	4,638	95	6,687	9,831	7,430	2,500	5,333
96	6,077	8,934	6,753	2,273	4,846	96	6,988	10,273	7,764	2,614	5,573
97	6,351	9,335	7,057	2,375	5,064	97	7,304	10,736	8,115	2,730	5,824
98	6,637	9,757	7,375	2,481	5,292	98	7,633	11,220	8,481	2,852	6,086
99	6,936	10,194	7,707	2,592	5,529	99	7,976	11,725	8,862	2,982	6,358

Modal Factors:      Semi Annual: 0.5000    Quarterly: 0.25000    Monthly: Divide by 12

**INSURANCE COMPANY OF NORTH AMERICA**  
**MICHIGAN Standard Plans MALE Rates - ANNUAL**  
 FOR USE IN ZIP CODES: ALL EXCEPT 480-489

Attained Age	Preferred					Attained Age	Standard				
	Plan A	Plan F	Plan G	HD Plan G	Plan N		Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,854	2,675	2,061	694	1,463	65	2,132	3,074	2,369	798	1,683
66	1,854	2,675	2,061	694	1,463	66	2,132	3,074	2,369	798	1,683
67	1,854	2,675	2,061	694	1,463	67	2,132	3,074	2,369	798	1,683
68	1,854	2,675	2,061	694	1,463	68	2,132	3,074	2,369	798	1,683
69	1,854	2,675	2,061	694	1,463	69	2,132	3,074	2,369	798	1,683
70	1,872	2,754	2,080	699	1,493	70	2,153	3,168	2,392	805	1,718
71	1,927	2,837	2,142	722	1,538	71	2,216	3,262	2,463	830	1,769
72	1,997	2,934	2,218	746	1,593	72	2,296	3,374	2,551	859	1,832
73	2,066	3,038	2,296	772	1,648	73	2,376	3,493	2,640	889	1,895
74	2,138	3,144	2,376	800	1,707	74	2,458	3,615	2,731	920	1,963
75	2,223	3,270	2,469	831	1,773	75	2,556	3,760	2,840	956	2,040
76	2,313	3,401	2,570	865	1,844	76	2,662	3,910	2,957	994	2,121
77	2,405	3,534	2,672	899	1,919	77	2,766	4,064	3,073	1,034	2,207
78	2,502	3,676	2,780	936	1,995	78	2,878	4,228	3,198	1,076	2,295
79	2,602	3,825	2,891	973	2,075	79	2,992	4,398	3,324	1,118	2,386
80	2,705	3,978	3,005	1,013	2,158	80	3,110	4,574	3,455	1,164	2,481
81	2,829	4,156	3,142	1,057	2,254	81	3,253	4,779	3,614	1,216	2,591
82	2,956	4,340	3,284	1,106	2,356	82	3,398	4,991	3,776	1,271	2,709
83	3,088	4,537	3,431	1,155	2,463	83	3,550	5,217	3,945	1,328	2,831
84	3,227	4,743	3,585	1,207	2,574	84	3,711	5,456	4,124	1,388	2,959
85	3,372	4,955	3,746	1,261	2,690	85	3,877	5,699	4,308	1,449	3,093
86	3,524	5,178	3,915	1,317	2,810	86	4,052	5,954	4,502	1,515	3,232
87	3,681	5,409	4,090	1,377	2,937	87	4,234	6,221	4,704	1,583	3,379
88	3,846	5,655	4,273	1,438	3,068	88	4,424	6,503	4,915	1,654	3,528
89	4,022	5,908	4,469	1,503	3,207	89	4,624	6,795	5,138	1,729	3,688
90	4,201	6,173	4,668	1,571	3,350	90	4,831	7,098	5,368	1,806	3,853
91	4,389	6,451	4,876	1,642	3,502	91	5,048	7,418	5,608	1,888	4,026
92	4,586	6,741	5,095	1,714	3,657	92	5,274	7,753	5,860	1,972	4,206
93	4,794	7,046	5,327	1,793	3,822	93	5,515	8,102	6,127	2,062	4,396
94	5,010	7,362	5,566	1,873	3,995	94	5,760	8,467	6,401	2,154	4,594
95	5,234	7,693	5,816	1,956	4,175	95	6,019	8,848	6,687	2,250	4,800
96	5,469	8,041	6,078	2,045	4,361	96	6,290	9,246	6,988	2,352	5,015
97	5,716	8,401	6,351	2,137	4,558	97	6,573	9,663	7,303	2,457	5,241
98	5,973	8,781	6,637	2,232	4,763	98	6,870	10,098	7,633	2,567	5,478
99	6,242	9,175	6,936	2,333	4,976	99	7,178	10,552	7,976	2,684	5,722

Modal Factors:      Semi Annual: 0.5000    Quarterly: 0.25000    Monthly: Divide by 12

**INSURANCE COMPANY OF NORTH AMERICA**  
**MICHIGAN Standard Plans FEMALE Rates - ANNUAL**  
 FOR USE IN ZIP CODES: 480, 482, 483, 485

Attained Age	Preferred					Attained Age	Standard				
	Plan A	Plan F	Plan G	HD Plan G	Plan N		Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,940	2,797	2,155	725	1,530	65	2,230	3,216	2,478	834	1,760
66	1,940	2,797	2,155	725	1,530	66	2,230	3,216	2,478	834	1,760
67	1,940	2,797	2,155	725	1,530	67	2,230	3,216	2,478	834	1,760
68	1,940	2,797	2,155	725	1,530	68	2,230	3,216	2,478	834	1,760
69	1,940	2,797	2,155	725	1,530	69	2,230	3,216	2,478	834	1,760
70	1,958	2,880	2,175	732	1,562	70	2,250	3,313	2,501	842	1,796
71	2,015	2,966	2,240	754	1,608	71	2,318	3,411	2,575	868	1,849
72	2,089	3,069	2,320	781	1,666	72	2,401	3,529	2,668	898	1,916
73	2,161	3,177	2,401	807	1,723	73	2,485	3,654	2,761	929	1,982
74	2,237	3,288	2,485	837	1,785	74	2,571	3,781	2,857	962	2,053
75	2,324	3,420	2,583	869	1,855	75	2,673	3,933	2,971	1,000	2,133
76	2,420	3,556	2,689	905	1,929	76	2,783	4,090	3,092	1,040	2,218
77	2,516	3,696	2,795	940	2,007	77	2,892	4,250	3,214	1,082	2,308
78	2,617	3,845	2,908	978	2,086	78	3,010	4,422	3,344	1,125	2,400
79	2,721	4,000	3,024	1,017	2,170	79	3,129	4,600	3,477	1,170	2,496
80	2,828	4,160	3,143	1,059	2,257	80	3,253	4,784	3,614	1,218	2,595
81	2,958	4,346	3,287	1,106	2,357	81	3,402	4,998	3,780	1,271	2,710
82	3,091	4,539	3,435	1,156	2,464	82	3,555	5,220	3,949	1,329	2,834
83	3,229	4,745	3,588	1,208	2,575	83	3,714	5,456	4,126	1,389	2,961
84	3,374	4,961	3,749	1,262	2,691	84	3,881	5,706	4,312	1,452	3,095
85	3,526	5,183	3,918	1,318	2,813	85	4,055	5,960	4,505	1,515	3,235
86	3,685	5,415	4,094	1,377	2,939	86	4,238	6,227	4,709	1,585	3,380
87	3,851	5,658	4,278	1,441	3,072	87	4,428	6,506	4,920	1,657	3,533
88	4,023	5,914	4,469	1,504	3,209	88	4,627	6,801	5,140	1,730	3,691
89	4,207	6,179	4,673	1,572	3,354	89	4,836	7,106	5,374	1,808	3,858
90	4,393	6,456	4,881	1,643	3,503	90	5,053	7,424	5,614	1,889	4,029
91	4,590	6,746	5,101	1,717	3,662	91	5,280	7,758	5,866	1,975	4,211
92	4,797	7,050	5,329	1,793	3,825	92	5,515	8,108	6,129	2,062	4,398
93	5,014	7,369	5,571	1,875	3,997	93	5,767	8,473	6,408	2,157	4,597
94	5,239	7,700	5,821	1,959	4,178	94	6,025	8,855	6,694	2,253	4,805
95	5,474	8,046	6,082	2,046	4,365	95	6,294	9,254	6,994	2,353	5,020
96	5,721	8,409	6,356	2,139	4,561	96	6,578	9,670	7,309	2,460	5,246
97	5,978	8,787	6,642	2,235	4,767	97	6,875	10,105	7,638	2,570	5,481
98	6,248	9,184	6,942	2,335	4,981	98	7,185	10,561	7,983	2,685	5,729
99	6,528	9,596	7,254	2,440	5,205	99	7,508	11,036	8,342	2,806	5,985

Modal Factors:      Semi Annual: 0.5000    Quarterly: 0.25000    Monthly: Divide by 12

**INSURANCE COMPANY OF NORTH AMERICA**  
**MICHIGAN Standard Plans FEMALE Rates - ANNUAL**  
 FOR USE IN ZIP CODES: 481, 484, 486-489

Attained Age	Preferred					Attained Age	Standard				
	Plan A	Plan F	Plan G	HD Plan G	Plan N		Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,824	2,629	2,026	682	1,439	65	2,097	3,023	2,329	784	1,655
66	1,824	2,629	2,026	682	1,439	66	2,097	3,023	2,329	784	1,655
67	1,824	2,629	2,026	682	1,439	67	2,097	3,023	2,329	784	1,655
68	1,824	2,629	2,026	682	1,439	68	2,097	3,023	2,329	784	1,655
69	1,824	2,629	2,026	682	1,439	69	2,097	3,023	2,329	784	1,655
70	1,840	2,708	2,045	688	1,468	70	2,116	3,115	2,351	791	1,689
71	1,894	2,789	2,106	709	1,512	71	2,179	3,207	2,421	816	1,739
72	1,964	2,885	2,181	734	1,566	72	2,257	3,318	2,508	845	1,802
73	2,032	2,987	2,257	759	1,620	73	2,336	3,435	2,596	873	1,864
74	2,103	3,091	2,336	786	1,678	74	2,417	3,555	2,686	904	1,931
75	2,185	3,215	2,429	817	1,744	75	2,514	3,698	2,793	940	2,005
76	2,275	3,344	2,528	851	1,813	76	2,616	3,846	2,907	978	2,085
77	2,366	3,475	2,628	884	1,887	77	2,719	3,996	3,022	1,017	2,170
78	2,461	3,615	2,734	920	1,961	78	2,830	4,157	3,144	1,057	2,256
79	2,559	3,761	2,843	956	2,040	79	2,942	4,324	3,269	1,100	2,346
80	2,659	3,911	2,955	996	2,122	80	3,058	4,498	3,398	1,145	2,440
81	2,781	4,086	3,090	1,040	2,216	81	3,198	4,699	3,553	1,195	2,548
82	2,906	4,268	3,229	1,087	2,317	82	3,342	4,907	3,713	1,250	2,664
83	3,036	4,461	3,373	1,136	2,421	83	3,492	5,130	3,879	1,306	2,784
84	3,172	4,664	3,525	1,187	2,530	84	3,649	5,364	4,054	1,365	2,910
85	3,315	4,873	3,683	1,239	2,645	85	3,812	5,604	4,236	1,424	3,041
86	3,465	5,091	3,849	1,295	2,763	86	3,985	5,855	4,427	1,490	3,178
87	3,620	5,319	4,022	1,354	2,888	87	4,163	6,117	4,625	1,557	3,322
88	3,782	5,560	4,202	1,414	3,017	88	4,350	6,394	4,833	1,626	3,470
89	3,955	5,810	4,394	1,478	3,153	89	4,547	6,681	5,053	1,700	3,627
90	4,130	6,069	4,589	1,544	3,293	90	4,750	6,979	5,278	1,776	3,788
91	4,315	6,342	4,795	1,614	3,443	91	4,964	7,293	5,515	1,857	3,959
92	4,510	6,628	5,010	1,686	3,596	92	5,185	7,623	5,762	1,939	4,135
93	4,714	6,928	5,238	1,763	3,758	93	5,422	7,967	6,024	2,028	4,322
94	4,925	7,239	5,472	1,841	3,928	94	5,664	8,326	6,293	2,118	4,517
95	5,147	7,565	5,718	1,923	4,104	95	5,918	8,700	6,575	2,212	4,719
96	5,378	7,906	5,976	2,011	4,288	96	6,184	9,091	6,871	2,313	4,932
97	5,620	8,261	6,245	2,102	4,481	97	6,463	9,501	7,181	2,416	5,153
98	5,874	8,634	6,526	2,195	4,683	98	6,755	9,929	7,506	2,525	5,386
99	6,138	9,022	6,820	2,294	4,893	99	7,059	10,376	7,843	2,639	5,627

Modal Factors:      Semi Annual: 0.5000    Quarterly: 0.25000    Monthly: Divide by 12

**INSURANCE COMPANY OF NORTH AMERICA**  
**MICHIGAN Standard Plans FEMALE Rates - ANNUAL**  
 FOR USE IN ZIP CODES: ALL EXCEPT 480-489

Attained Age	Preferred					Attained Age	Standard				
	Plan A	Plan F	Plan G	HD Plan G	Plan N		Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,641	2,366	1,823	614	1,295	65	1,887	2,721	2,097	706	1,490
66	1,641	2,366	1,823	614	1,295	66	1,887	2,721	2,097	706	1,490
67	1,641	2,366	1,823	614	1,295	67	1,887	2,721	2,097	706	1,490
68	1,641	2,366	1,823	614	1,295	68	1,887	2,721	2,097	706	1,490
69	1,641	2,366	1,823	614	1,295	69	1,887	2,721	2,097	706	1,490
70	1,656	2,437	1,841	619	1,322	70	1,904	2,803	2,116	712	1,520
71	1,705	2,510	1,895	638	1,361	71	1,961	2,886	2,179	735	1,565
72	1,768	2,597	1,963	661	1,410	72	2,032	2,986	2,258	760	1,622
73	1,829	2,688	2,032	683	1,458	73	2,102	3,092	2,336	786	1,677
74	1,893	2,782	2,102	708	1,510	74	2,175	3,199	2,417	814	1,737
75	1,967	2,893	2,186	736	1,569	75	2,262	3,328	2,514	846	1,805
76	2,048	3,009	2,275	766	1,632	76	2,355	3,461	2,617	880	1,876
77	2,129	3,127	2,365	795	1,698	77	2,447	3,597	2,720	915	1,953
78	2,215	3,254	2,460	828	1,765	78	2,547	3,741	2,830	952	2,030
79	2,303	3,385	2,559	861	1,836	79	2,648	3,892	2,942	990	2,112
80	2,393	3,520	2,659	896	1,910	80	2,752	4,048	3,058	1,031	2,196
81	2,503	3,678	2,781	936	1,995	81	2,878	4,229	3,198	1,076	2,293
82	2,615	3,841	2,906	978	2,085	82	3,008	4,417	3,342	1,125	2,398
83	2,732	4,015	3,036	1,022	2,179	83	3,142	4,617	3,491	1,175	2,505
84	2,855	4,198	3,173	1,068	2,277	84	3,284	4,828	3,649	1,229	2,619
85	2,984	4,385	3,315	1,115	2,380	85	3,431	5,043	3,812	1,282	2,737
86	3,118	4,582	3,464	1,165	2,487	86	3,586	5,269	3,985	1,341	2,860
87	3,258	4,787	3,620	1,219	2,599	87	3,747	5,505	4,163	1,402	2,990
88	3,404	5,004	3,782	1,272	2,715	88	3,915	5,754	4,349	1,464	3,123
89	3,559	5,229	3,954	1,330	2,838	89	4,092	6,013	4,547	1,530	3,264
90	3,717	5,463	4,130	1,390	2,964	90	4,275	6,281	4,750	1,598	3,409
91	3,884	5,708	4,316	1,453	3,098	91	4,468	6,564	4,963	1,671	3,563
92	4,059	5,965	4,509	1,517	3,236	92	4,667	6,861	5,186	1,745	3,722
93	4,243	6,235	4,714	1,587	3,382	93	4,880	7,170	5,422	1,825	3,890
94	4,433	6,515	4,925	1,657	3,535	94	5,098	7,493	5,664	1,906	4,066
95	4,632	6,808	5,146	1,731	3,694	95	5,326	7,830	5,918	1,991	4,247
96	4,841	7,115	5,378	1,810	3,859	96	5,566	8,182	6,184	2,082	4,439
97	5,058	7,435	5,620	1,891	4,033	97	5,817	8,551	6,463	2,175	4,638
98	5,286	7,771	5,874	1,976	4,215	98	6,080	8,936	6,755	2,272	4,847
99	5,524	8,120	6,138	2,065	4,404	99	6,353	9,338	7,059	2,375	5,064

Modal Factors:      Semi Annual: 0.5000    Quarterly: 0.25000    Monthly: Divide by 12

## **PREMIUM INFORMATION**

Insurance Company of North America may change your premium on any premium due date if a new table of rates is applicable to the policy. The change in the table of rates will apply to all covered persons in the same class. Class is defined as attained age, gender, underwriting class, state of issue, and your most recent zip code of residence in the state of issue. Premiums are based on your attained age and will change on your policy anniversary date.

## **DISCLOSURES**

Use this outline to compare benefits and premiums among policies.

## **READ YOUR POLICY VERY CAREFULLY**

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and Insurance Company of North America.

## **RIGHT TO RETURN POLICY**

If you find that you are not satisfied with your policy, you may return it to: Insurance Company of North America, Medicare Supplement Administration, P.O. Box 10858, Clearwater, Florida 33757-8858. 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, less any claims paid.

## **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 Insurance Company of North America 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 and 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. Insurance Company of North America 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.**

**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 PAYS	YOU PAY
<p><b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61<sup>st</sup> thru 90<sup>th</sup> day 91<sup>st</sup> day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days</p>	<p>All but \$1736 All but \$434 a day  All but \$868 a day  \$0 \$0</p>	<p>\$0 \$434 a day  \$868 a day  100% of Medicare eligible expenses \$0</p>	<p>\$1736 (Part A deductible) \$0  \$0  \$0** 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 First 20 days 21<sup>st</sup> thru 100<sup>th</sup> day 101<sup>st</sup> day and after</p>	<p>All approved amounts All but \$217 a day \$0</p>	<p>\$0 \$0 \$0</p>	<p>\$0 Up to \$217 a day 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> You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.</p>	<p>All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care</p>	<p>Medicare copayment/coinsurance</p>	<p>\$0</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 \$283 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<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 tests, durable medical equipment, First \$283 of Medicare Approved Amounts*	\$0	\$0	\$283 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
<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 \$283 of Medicare Approved Amounts*	\$0	\$0	\$283 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment First \$283 of Medicare Approved Amounts*	\$0	\$0	\$283 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

**PLAN 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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> 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 \$1736 All but \$434 a day  All but \$868 a day  \$0 \$0	\$1736 (Part A deductible) \$434 a day  \$868 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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$217 a day \$0	\$0 Up to \$217 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> 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.

**PLAN F**

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

\*Once you have been billed \$283 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 tests, durable medical equipment, First \$283 of Medicare Approved Amounts*	\$0	\$283 (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints	\$0	All costs	\$0
Next \$283 of Medicare Approved amounts*	\$0	\$283 (Part B deductible)	\$0
Remainder of Medicare Approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

**PLAN F  
PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
- First \$283 of Medicare Approved Amounts*	\$0	\$283 (Part B deductible)	\$0
- Remainder of Medicare Approved Amounts	80%	20%	\$0

**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	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

## PLAN G

### MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> 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 \$1736 All but \$434 a day All but \$868 a day \$0 \$0	\$1736 (Part A deductible) \$434 a day \$868 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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$217 a day \$0	\$0 Up to \$217 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> 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.

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

\*Once you have been billed \$283 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<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 tests, durable medical equipment, First \$283 of Medicare Approved Amounts*	\$0	\$0	\$283 (Unless Part B deductible has been met)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints	\$0	All costs	\$0
Next \$283 of Medicare Approved Amounts*	\$0	\$0	\$283 (Unless Part B deductible has been met)
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

**PLAN G  
PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b>			
<b>MEDICARE APPROVED SERVICES</b>			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
- First \$283 of Medicare Approved Amounts*	\$0	\$0	\$283 (Unless Part B deductible has been met)
- Remainder of Medicare Approved Amounts	80%	20%	\$0

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<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	\$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

**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 \$2950 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are \$2950. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2950 DEDUCTIBLE ** PLAN PAYS	IN ADDITION TO \$2950 DEDUCTIBLE ** YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> 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 \$1736 All but \$434 a day  All but \$868 a day  \$0 \$0	\$1736 (Part A deductible) \$434 a day  \$868 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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$217 a day \$0	\$0 Up to \$217 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> 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.

## HIGH DEDUCTIBLE PLAN G

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

\*Once you have been billed \$283 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.

\*\*This high deductible plan pays the same benefits as Plan G after you have paid a calendar year \$2950 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are \$2950. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2950 DEDUCTIBLE ** PLAN PAYS	IN ADDITION TO \$2950 DEDUCTIBLE ** YOU PAY
<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 tests, durable medical equipment, First \$283 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0  Generally 80%	\$0  Generally 20%	\$283 (Unless Part B deductible has been met)  \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints  Next \$283 of Medicare Approved amounts*  Remainder of Medicare Approved amounts	\$0  \$0  80%	All costs  \$0  20%	\$0  \$283 (Unless Part B deductible has been met)  \$0
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

**HIGH DEDUCTIBLE PLAN G**

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>AFTER YOU PAY \$2950 DEDUCTIBLE ** PLAN PAYS</b>	<b>IN ADDITION TO \$2950 DEDUCTIBLE ** YOU PAY</b>
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
- First \$283 of Medicare Approved Amounts*	\$0	\$0	\$283 (Unless Part B deductible has been met)
- Remainder of Medicare Approved Amounts	80%	20%	\$0

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>AFTER YOU PAY \$2950 DEDUCTIBLE ** PLAN PAYS</b>	<b>IN ADDITION TO \$2950 DEDUCTIBLE ** 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	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

**PLAN N**

**MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

\*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 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 First 60 days 61<sup>st</sup> thru 90<sup>th</sup> day 91<sup>st</sup> day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days</p>	<p>All but \$1736 All but \$434 a day  All but \$868 a day  \$0 \$0</p>	<p>\$1736 (Part A deductible) \$434 a day  \$868 a day  100% of Medicare eligible expenses \$0</p>	<p>\$0 \$0  \$0  \$0** 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 First 20 days 21<sup>st</sup> thru 100<sup>th</sup> day 101<sup>st</sup> day and after</p>	<p>All approved amounts All but \$217 a day \$0</p>	<p>\$0 Up to \$217 a day \$0</p>	<p>\$0 \$0 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> You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.</p>	<p>All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care</p>	<p>Medicare copayment/coinsurance</p>	<p>\$0</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 N**

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

\*Once you have been billed \$283 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p><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 tests, durable medical equipment,</p> <p>First \$283 of Medicare                      Approved Amounts*</p> <p>Remainder of Medicare                      Approved Amounts</p>	<p>\$0</p> <p>Generally 80%</p>	<p>\$0</p> <p>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.</p>	<p>\$283 (Part B deductible)</p> <p>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.</p>
<p><b>PART B EXCESS CHARGES</b>                      (Above Medicare Approved Amounts)</p>	<p>\$0</p>	<p>\$0</p>	<p>All costs</p>
<p><b>BLOOD</b>                      First 3 pints                      Next \$283 of Medicare Approved Amounts*                      Remainder of Medicare Approved Amounts</p>	<p>\$0                      \$0                      80%</p>	<p>All costs                      \$0                      20%</p>	<p>\$0                      \$283 (Part B deductible)                      \$0</p>
<p><b>CLINICAL LABORATORY SERVICES –</b>                      TESTS FOR DIAGNOSTIC SERVICES</p>	<p>100%</p>	<p>\$0</p>	<p>\$0</p>

(continued)

**PLAN N  
PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTH CARE</b>			
MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
- First \$283 of Medicare Approved Amounts*	\$0	\$0	\$283 (Part B deductible)
- Remainder of Medicare Approved Amounts	80%	20%	\$0

**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	\$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.