UNITED AMERICAN INSURANCE COMPANY

P.O. BOX 8080, MCKINNEY, TEXAS 75070 (972) 529-5085
A Nebraska Stock Company • Administrative Offices: McKinney, Texas

Benefit Chart of Medicare Supplement Plans Sold on or After January 1, 2020

Benefit Plans A, B, C, D, F, HDF, G, HDG, K, L, and N

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan A available. Some plans may not be available. Only applicants **first** eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

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

Benefits	Plans Available to All Applicants								Medicare First Eligible Before 2020 Only	
	A*	B*	D*	G*1*	K*	L*	M	N*	C*	F*1*
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓copays apply [3]	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2024[2]					$7,060[2]	$3,530[2]				

* Denotes plans available by United American Insurance Company

[1] Plans F and G also have a high deductible option which requires first paying a plan deductible of $2,800 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

[2] Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

[3] Plan N pays 100% of the Part B coinsurance, except for a 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.

PREMIUM INFORMATION

We, United American Insurance Company, can only raise your premium if we raise the premium for all policies like yours in this state.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to United American Insurance Company, P.O. Box 8080, McKinney, Texas 75070. 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 your medical costs.

Neither United American 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 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. The Company may cancel your policy and refuse to pay claims if you leave out or falsify important medical information.

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

PLAN A

Male

Preferred Effective Date: 01/01/2020 Plan Code: 5A0

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	2109	1055	528	176
66	2129	1065	533	178
67	2129	1065	533	178
68	2129	1065	533	178
69	2129	1065	533	178
70	2129	1065	533	178
71	2129	1065	533	178
72	2129	1065	533	178
73	2129	1065	533	178
74	2129	1065	533	178
75	2129	1065	533	178
76	2129	1065	533	178
77	2129	1065	533	178
78	2129	1065	533	178
79	2129	1065	533	178
80+	2129	1065	533	178

Standard Effective Date: 01/01/2020 Plan Code: 5A2

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	2427	1214	607	203
66	2449	1225	613	205
67	2449	1225	613	205
68	2449	1225	613	205
69	2449	1225	613	205
70	2449	1225	613	205
71	2449	1225	613	205
72	2449	1225	613	205
73	2449	1225	613	205
74	2449	1225	613	205
75	2449	1225	613	205
76	2449	1225	613	205
77	2449	1225	613	205
78	2449	1225	613	205
79	2449	1225	613	205
80+	2449	1225	613	205

Female

Preferred Effective Date: 01/01/2020 Plan Code: 5A1

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	1835	918	459	153
66	1851	926	463	155
67	1851	926	463	155
68	1851	926	463	155
69	1851	926	463	155
70	1851	926	463	155
71	1851	926	463	155
72	1851	926	463	155
73	1851	926	463	155
74	1851	926	463	155
75	1851	926	463	155
76	1851	926	463	155
77	1851	926	463	155
78	1851	926	463	155
79	1851	926	463	155
80+	1851	926	463	155

Standard Effective Date: 01/01/2020 Plan Code: 5A3

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	2109	1055	528	176
66	2129	1065	533	178
67	2129	1065	533	178
68	2129	1065	533	178
69	2129	1065	533	178
70	2129	1065	533	178
71	2129	1065	533	178
72	2129	1065	533	178
73	2129	1065	533	178
74	2129	1065	533	178
75	2129	1065	533	178
76	2129	1065	533	178
77	2129	1065	533	178
78	2129	1065	533	178
79	2129	1065	533	178
80+	2129	1065	533	178

PLAN B

Male

Preferred

Effective Date: 01/01/2020 Plan Code: 5AI

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	2985	1493	747	249
66	3035	1518	759	253
67	3035	1518	759	253
68	3035	1518	759	253
69	3035	1518	759	253
70	3074	1537	769	257
71	3074	1537	769	257
72	3074	1537	769	257
73	3074	1537	769	257
74	3074	1537	769	257
75	3074	1537	769	257
76	3074	1537	769	257
77	3074	1537	769	257
78	3074	1537	769	257
79	3074	1537	769	257
80+	3074	1537	769	257

Standard

Effective Date: 01/01/2020 Plan Code: 5AK

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3435	1718	859	287
66	3493	1747	874	292
67	3493	1747	874	292
68	3493	1747	874	292
69	3493	1747	874	292
70	3537	1769	885	295
71	3537	1769	885	295
72	3537	1769	885	295
73	3537	1769	885	295
74	3537	1769	885	295
75	3537	1769	885	295
76	3537	1769	885	295
77	3537	1769	885	295
78	3537	1769	885	295
79	3537	1769	885	295
80+	3537	1769	885	295

Female

Preferred

Effective Date: 01/01/2020 Plan Code: 5AJ

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	2597	1299	650	217
66	2640	1320	660	220
67	2640	1320	660	220
68	2640	1320	660	220
69	2640	1320	660	220
70	2674	1337	669	223
71	2674	1337	669	223
72	2674	1337	669	223
73	2674	1337	669	223
74	2674	1337	669	223
75	2674	1337	669	223
76	2674	1337	669	223
77	2674	1337	669	223
78	2674	1337	669	223
79	2674	1337	669	223
80+	2674	1337	669	223

Standard

Effective Date: 01/01/2020 Plan Code: 5AL

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	2985	1493	747	249
66	3035	1518	759	253
67	3035	1518	759	253
68	3035	1518	759	253
69	3035	1518	759	253
70	3074	1537	769	257
71	3074	1537	769	257
72	3074	1537	769	257
73	3074	1537	769	257
74	3074	1537	769	257
75	3074	1537	769	257
76	3074	1537	769	257
77	3074	1537	769	257
78	3074	1537	769	257
79	3074	1537	769	257
80+	3074	1537	769	257

PLAN C

Male

Preferred Effective Date: 01/01/2024 Plan Code: 5B0

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	4591	2296	1148	383
66	4709	2355	1178	393
67	4709	2355	1178	393
68	4709	2355	1178	393
69	4709	2355	1178	393
70	4849	2425	1213	405
71	4849	2425	1213	405
72	4849	2425	1213	405
73	4849	2425	1213	405
74	4849	2425	1213	405
75	5042	2521	1261	421
76	5042	2521	1261	421
77	5042	2521	1261	421
78	5042	2521	1261	421
79	5042	2521	1261	421
80+	5157	2579	1290	430

Standard Effective Date: 01/01/2024 Plan Code: 5B2

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	5283	2642	1321	441
66	5419	2710	1355	452
67	5419	2710	1355	452
68	5419	2710	1355	452
69	5419	2710	1355	452
70	5580	2790	1395	465
71	5580	2790	1395	465
72	5580	2790	1395	465
73	5580	2790	1395	465
74	5580	2790	1395	465
75	5802	2901	1451	484
76	5802	2901	1451	484
77	5802	2901	1451	484
78	5802	2901	1451	484
79	5802	2901	1451	484
80+	5935	2968	1484	495

Female

Preferred Effective Date: 01/01/2024 Plan Code: 5B1

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3994	1997	999	333
66	4096	2048	1024	342
67	4096	2048	1024	342
68	4096	2048	1024	342
69	4096	2048	1024	342
70	4218	2109	1055	352
71	4218	2109	1055	352
72	4218	2109	1055	352
73	4218	2109	1055	352
74	4218	2109	1055	352
75	4386	2193	1097	366
76	4386	2193	1097	366
77	4386	2193	1097	366
78	4386	2193	1097	366
79	4386	2193	1097	366
80+	4486	2243	1122	374

Standard Effective Date: 01/01/2024 Plan Code: 5B3

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	4591	2296	1148	383
66	4709	2355	1178	393
67	4709	2355	1178	393
68	4709	2355	1178	393
69	4709	2355	1178	393
70	4849	2425	1213	405
71	4849	2425	1213	405
72	4849	2425	1213	405
73	4849	2425	1213	405
74	4849	2425	1213	405
75	5042	2521	1261	421
76	5042	2521	1261	421
77	5042	2521	1261	421
78	5042	2521	1261	421
79	5042	2521	1261	421
80+	5157	2579	1290	430

Only applicants first eligible for Medicare before 2020 may purchase Plans C, F, and High Deducible F.

PLAN D

Male

Preferred Effective Date: 01/01/2024 Plan Code: 5BI

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	4527	2264	1132	378
66	4649	2325	1163	388
67	4649	2325	1163	388
68	4649	2325	1163	388
69	4649	2325	1163	388
70	4799	2400	1200	400
71	4799	2400	1200	400
72	4799	2400	1200	400
73	4799	2400	1200	400
74	4799	2400	1200	400
75	4997	2499	1250	417
76	4997	2499	1250	417
77	4997	2499	1250	417
78	4997	2499	1250	417
79	4997	2499	1250	417
80+	5119	2560	1280	427

Standard Effective Date: 01/01/2024 Plan Code: 5BK

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	5210	2605	1303	435
66	5350	2675	1338	446
67	5350	2675	1338	446
68	5350	2675	1338	446
69	5350	2675	1338	446
70	5522	2761	1381	461
71	5522	2761	1381	461
72	5522	2761	1381	461
73	5522	2761	1381	461
74	5522	2761	1381	461
75	5750	2875	1438	480
76	5750	2875	1438	480
77	5750	2875	1438	480
78	5750	2875	1438	480
79	5750	2875	1438	480
80+	5891	2946	1473	491

Female

Preferred Effective Date: 01/01/2024 Plan Code: 5BJ

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3938	1969	985	329
66	4044	2022	1011	337
67	4044	2022	1011	337
68	4044	2022	1011	337
69	4044	2022	1011	337
70	4174	2087	1044	348
71	4174	2087	1044	348
72	4174	2087	1044	348
73	4174	2087	1044	348
74	4174	2087	1044	348
75	4347	2174	1087	363
76	4347	2174	1087	363
77	4347	2174	1087	363
78	4347	2174	1087	363
79	4347	2174	1087	363
80+	4453	2227	1114	372

Standard Effective Date: 01/01/2024 Plan Code: 5BL

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	4527	2264	1132	378
66	4649	2325	1163	388
67	4649	2325	1163	388
68	4649	2325	1163	388
69	4649	2325	1163	388
70	4799	2400	1200	400
71	4799	2400	1200	400
72	4799	2400	1200	400
73	4799	2400	1200	400
74	4799	2400	1200	400
75	4997	2499	1250	417
76	4997	2499	1250	417
77	4997	2499	1250	417
78	4997	2499	1250	417
79	4997	2499	1250	417
80+	5119	2560	1280	427

PLAN F

Male

Preferred — Effective Date: 01/01/2024 — Plan Code: 5C0

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	4034	2017	1009	337
66	4135	2068	1034	345
67	4135	2068	1034	345
68	4135	2068	1034	345
69	4135	2068	1034	345
70	4258	2129	1065	355
71	4258	2129	1065	355
72	4258	2129	1065	355
73	4258	2129	1065	355
74	4258	2129	1065	355
75	4428	2214	1107	369
76	4428	2214	1107	369
77	4428	2214	1107	369
78	4428	2214	1107	369
79	4428	2214	1107	369
80+	4527	2264	1132	378

Standard — Effective Date: 01/01/2024 — Plan Code: 5C2

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	4642	2321	1161	387
66	4759	2380	1190	397
67	4759	2380	1190	397
68	4759	2380	1190	397
69	4759	2380	1190	397
70	4900	2450	1225	409
71	4900	2450	1225	409
72	4900	2450	1225	409
73	4900	2450	1225	409
74	4900	2450	1225	409
75	5095	2548	1274	425
76	5095	2548	1274	425
77	5095	2548	1274	425
78	5095	2548	1274	425
79	5095	2548	1274	425
80+	5210	2605	1303	435

Female

Preferred — Effective Date: 01/01/2024 — Plan Code: 5C1

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3509	1755	878	293
66	3597	1799	900	300
67	3597	1799	900	300
68	3597	1799	900	300
69	3597	1799	900	300
70	3704	1852	926	309
71	3704	1852	926	309
72	3704	1852	926	309
73	3704	1852	926	309
74	3704	1852	926	309
75	3852	1926	963	321
76	3852	1926	963	321
77	3852	1926	963	321
78	3852	1926	963	321
79	3852	1926	963	321
80+	3938	1969	985	329

Standard — Effective Date: 01/01/2024 — Plan Code: 5C3

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	4034	2017	1009	337
66	4135	2068	1034	345
67	4135	2068	1034	345
68	4135	2068	1034	345
69	4135	2068	1034	345
70	4258	2129	1065	355
71	4258	2129	1065	355
72	4258	2129	1065	355
73	4258	2129	1065	355
74	4258	2129	1065	355
75	4428	2214	1107	369
76	4428	2214	1107	369
77	4428	2214	1107	369
78	4428	2214	1107	369
79	4428	2214	1107	369
80+	4527	2264	1132	378

Only applicants first eligible for Medicare before 2020 may purchase Plans C, F, and High Deducible F.

PLAN HDF

Male

Preferred — Effective Date: 01/01/2024 — Plan Code: 5CI

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	771	386	193	65
66	801	401	201	67
67	801	401	201	67
68	801	401	201	67
69	801	401	201	67
70	836	418	209	70
71	836	418	209	70
72	836	418	209	70
73	836	418	209	70
74	836	418	209	70
75	897	449	225	75
76	897	449	225	75
77	897	449	225	75
78	897	449	225	75
79	897	449	225	75
80+	953	477	239	80

Standard — Effective Date: 01/01/2024 — Plan Code: 5CK

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	887	444	222	74
66	922	461	231	77
67	922	461	231	77
68	922	461	231	77
69	922	461	231	77
70	962	481	241	81
71	962	481	241	81
72	962	481	241	81
73	962	481	241	81
74	962	481	241	81
75	1032	516	258	86
76	1032	516	258	86
77	1032	516	258	86
78	1032	516	258	86
79	1032	516	258	86
80+	1096	548	274	92

Female

Preferred — Effective Date: 01/01/2024 — Plan Code: 5CJ

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	671	336	168	56
66	697	349	175	59
67	697	349	175	59
68	697	349	175	59
69	697	349	175	59
70	727	364	182	61
71	727	364	182	61
72	727	364	182	61
73	727	364	182	61
74	727	364	182	61
75	780	390	195	65
76	780	390	195	65
77	780	390	195	65
78	780	390	195	65
79	780	390	195	65
80+	829	415	208	70

Standard — Effective Date: 01/01/2024 — Plan Code: 5CL

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	771	386	193	65
66	801	401	201	67
67	801	401	201	67
68	801	401	201	67
69	801	401	201	67
70	836	418	209	70
71	836	418	209	70
72	836	418	209	70
73	836	418	209	70
74	836	418	209	70
75	897	449	225	75
76	897	449	225	75
77	897	449	225	75
78	897	449	225	75
79	897	449	225	75
80+	953	477	239	80

Only applicants first eligible for Medicare before 2020 may purchase Plans C, F, and High Deducible F.

PLAN G

Male

Preferred Effective Date: 01/01/2024 Plan Code: 5D0

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	2235	1118	559	187
66	2295	1148	574	192
67	2295	1148	574	192
68	2295	1148	574	192
69	2295	1148	574	192
70	2370	1185	593	198
71	2370	1185	593	198
72	2370	1185	593	198
73	2370	1185	593	198
74	2370	1185	593	198
75	2466	1233	617	206
76	2466	1233	617	206
77	2466	1233	617	206
78	2466	1233	617	206
79	2466	1233	617	206
80+	2527	1264	632	211

Standard Effective Date: 01/01/2024 Plan Code: 5D2

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	2572	1286	643	215
66	2641	1321	661	221
67	2641	1321	661	221
68	2641	1321	661	221
69	2641	1321	661	221
70	2727	1364	682	228
71	2727	1364	682	228
72	2727	1364	682	228
73	2727	1364	682	228
74	2727	1364	682	228
75	2838	1419	710	237
76	2838	1419	710	237
77	2838	1419	710	237
78	2838	1419	710	237
79	2838	1419	710	237
80+	2908	1454	727	243

Female

Preferred Effective Date: 01/01/2024 Plan Code: 5D1

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	1944	972	486	162
66	1996	998	499	167
67	1996	998	499	167
68	1996	998	499	167
69	1996	998	499	167
70	2061	1031	516	172
71	2061	1031	516	172
72	2061	1031	516	172
73	2061	1031	516	172
74	2061	1031	516	172
75	2145	1073	537	179
76	2145	1073	537	179
77	2145	1073	537	179
78	2145	1073	537	179
79	2145	1073	537	179
80+	2198	1099	550	184

Standard Effective Date: 01/01/2024 Plan Code: 5D3

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	2235	1118	559	187
66	2295	1148	574	192
67	2295	1148	574	192
68	2295	1148	574	192
69	2295	1148	574	192
70	2370	1185	593	198
71	2370	1185	593	198
72	2370	1185	593	198
73	2370	1185	593	198
74	2370	1185	593	198
75	2466	1233	617	206
76	2466	1233	617	206
77	2466	1233	617	206
78	2466	1233	617	206
79	2466	1233	617	206
80+	2527	1264	632	211

PLAN HDG

Male

Preferred Effective Date: 01/01/2024 Plan Code: 5HK

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	771	386	193	65
66	801	401	201	67
67	801	401	201	67
68	801	401	201	67
69	801	401	201	67
70	836	418	209	70
71	836	418	209	70
72	836	418	209	70
73	836	418	209	70
74	836	418	209	70
75	897	449	225	75
76	897	449	225	75
77	897	449	225	75
78	897	449	225	75
79	897	449	225	75
80+	953	477	239	80

Standard Effective Date: 01/01/2024 Plan Code: 5HM

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	887	444	222	74
66	922	461	231	77
67	922	461	231	77
68	922	461	231	77
69	922	461	231	77
70	962	481	241	81
71	962	481	241	81
72	962	481	241	81
73	962	481	241	81
74	962	481	241	81
75	1032	516	258	86
76	1032	516	258	86
77	1032	516	258	86
78	1032	516	258	86
79	1032	516	258	86
80+	1096	548	274	92

Female

Preferred Effective Date: 01/01/2024 Plan Code: 5HL

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	671	336	168	56
66	697	349	175	59
67	697	349	175	59
68	697	349	175	59
69	697	349	175	59
70	727	364	182	61
71	727	364	182	61
72	727	364	182	61
73	727	364	182	61
74	727	364	182	61
75	780	390	195	65
76	780	390	195	65
77	780	390	195	65
78	780	390	195	65
79	780	390	195	65
80+	829	415	208	70

Standard Effective Date: 01/01/2024 Plan Code: 5HN

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	771	386	193	65
66	801	401	201	67
67	801	401	201	67
68	801	401	201	67
69	801	401	201	67
70	836	418	209	70
71	836	418	209	70
72	836	418	209	70
73	836	418	209	70
74	836	418	209	70
75	897	449	225	75
76	897	449	225	75
77	897	449	225	75
78	897	449	225	75
79	897	449	225	75
80+	953	477	239	80

PLAN K

Male

Preferred Effective Date: 01/01/2020 Plan Code: P40

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	1748	874	437	146
66	1837	919	460	154
67	1837	919	460	154
68	1837	919	460	154
69	1837	919	460	154
70	1921	961	481	161
71	1921	961	481	161
72	1921	961	481	161
73	1921	961	481	161
74	1921	961	481	161
75	1982	991	496	166
76	1982	991	496	166
77	1982	991	496	166
78	1982	991	496	166
79	1982	991	496	166
80+	2025	1013	507	169

Standard Effective Date: 01/01/2020 Plan Code: P42

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	2012	1006	503	168
66	2114	1057	529	177
67	2114	1057	529	177
68	2114	1057	529	177
69	2114	1057	529	177
70	2211	1106	553	185
71	2211	1106	553	185
72	2211	1106	553	185
73	2211	1106	553	185
74	2211	1106	553	185
75	2281	1141	571	191
76	2281	1141	571	191
77	2281	1141	571	191
78	2281	1141	571	191
79	2281	1141	571	191
80+	2330	1165	583	195

Female

Preferred Effective Date: 01/01/2020 Plan Code: P41

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	1521	761	381	127
66	1598	799	400	134
67	1598	799	400	134
68	1598	799	400	134
69	1598	799	400	134
70	1671	836	418	140
71	1671	836	418	140
72	1671	836	418	140
73	1671	836	418	140
74	1671	836	418	140
75	1724	862	431	144
76	1724	862	431	144
77	1724	862	431	144
78	1724	862	431	144
79	1724	862	431	144
80+	1761	881	441	147

Standard Effective Date: 01/01/2020 Plan Code: P43

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	1748	874	437	146
66	1837	919	460	154
67	1837	919	460	154
68	1837	919	460	154
69	1837	919	460	154
70	1921	961	481	161
71	1921	961	481	161
72	1921	961	481	161
73	1921	961	481	161
74	1921	961	481	161
75	1982	991	496	166
76	1982	991	496	166
77	1982	991	496	166
78	1982	991	496	166
79	1982	991	496	166
80+	2025	1013	507	169

PLAN L

Male

Preferred Effective Date: 01/01/2024 Plan Code: P56

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	2579	1290	645	215
66	2715	1358	679	227
67	2715	1358	679	227
68	2715	1358	679	227
69	2715	1358	679	227
70	2840	1420	710	237
71	2840	1420	710	237
72	2840	1420	710	237
73	2840	1420	710	237
74	2840	1420	710	237
75	2930	1465	733	245
76	2930	1465	733	245
77	2930	1465	733	245
78	2930	1465	733	245
79	2930	1465	733	245
80+	2996	1498	749	250

Standard Effective Date: 01/01/2024 Plan Code: P58

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	2968	1484	742	248
66	3124	1562	781	261
67	3124	1562	781	261
68	3124	1562	781	261
69	3124	1562	781	261
70	3268	1634	817	273
71	3268	1634	817	273
72	3268	1634	817	273
73	3268	1634	817	273
74	3268	1634	817	273
75	3371	1686	843	281
76	3371	1686	843	281
77	3371	1686	843	281
78	3371	1686	843	281
79	3371	1686	843	281
80+	3447	1724	862	288

Female

Preferred Effective Date: 01/01/2024 Plan Code: P57

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	2244	1122	561	187
66	2362	1181	591	197
67	2362	1181	591	197
68	2362	1181	591	197
69	2362	1181	591	197
70	2470	1235	618	206
71	2470	1235	618	206
72	2470	1235	618	206
73	2470	1235	618	206
74	2470	1235	618	206
75	2548	1274	637	213
76	2548	1274	637	213
77	2548	1274	637	213
78	2548	1274	637	213
79	2548	1274	637	213
80+	2606	1303	652	218

Standard Effective Date: 01/01/2024 Plan Code: P59

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	2579	1290	645	215
66	2715	1358	679	227
67	2715	1358	679	227
68	2715	1358	679	227
69	2715	1358	679	227
70	2840	1420	710	237
71	2840	1420	710	237
72	2840	1420	710	237
73	2840	1420	710	237
74	2840	1420	710	237
75	2930	1465	733	245
76	2930	1465	733	245
77	2930	1465	733	245
78	2930	1465	733	245
79	2930	1465	733	245
80+	2996	1498	749	250

PLAN N

Male

Preferred Effective Date: 01/01/2024 Plan Code: 5DI

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	2978	1489	745	249
66	3063	1532	766	256
67	3063	1532	766	256
68	3063	1532	766	256
69	3063	1532	766	256
70	3174	1587	794	265
71	3174	1587	794	265
72	3174	1587	794	265
73	3174	1587	794	265
74	3174	1587	794	265
75	3327	1664	832	278
76	3327	1664	832	278
77	3327	1664	832	278
78	3327	1664	832	278
79	3327	1664	832	278
80+	3436	1718	859	287

Standard Effective Date: 01/01/2024 Plan Code: 5DK

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3426	1713	857	286
66	3525	1763	882	294
67	3525	1763	882	294
68	3525	1763	882	294
69	3525	1763	882	294
70	3653	1827	914	305
71	3653	1827	914	305
72	3653	1827	914	305
73	3653	1827	914	305
74	3653	1827	914	305
75	3828	1914	957	319
76	3828	1914	957	319
77	3828	1914	957	319
78	3828	1914	957	319
79	3828	1914	957	319
80+	3954	1977	989	330

Female

Preferred Effective Date: 01/01/2024 Plan Code: 5DJ

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	2590	1295	648	216
66	2664	1332	666	222
67	2664	1332	666	222
68	2664	1332	666	222
69	2664	1332	666	222
70	2761	1381	691	231
71	2761	1381	691	231
72	2761	1381	691	231
73	2761	1381	691	231
74	2761	1381	691	231
75	2894	1447	724	242
76	2894	1447	724	242
77	2894	1447	724	242
78	2894	1447	724	242
79	2894	1447	724	242
80+	2989	1495	748	250

Standard Effective Date: 01/01/2024 Plan Code: 5DL

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	2978	1489	745	249
66	3063	1532	766	256
67	3063	1532	766	256
68	3063	1532	766	256
69	3063	1532	766	256
70	3174	1587	794	265
71	3174	1587	794	265
72	3174	1587	794	265
73	3174	1587	794	265
74	3174	1587	794	265
75	3327	1664	832	278
76	3327	1664	832	278
77	3327	1664	832	278
78	3327	1664	832	278
79	3327	1664	832	278
80+	3436	1718	859	287

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
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1632	$0	$1632 (Part A Deductible)
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0 **
– Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	$0	Up to $204 a day
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and	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 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 $240 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
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved Amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $240 of Medicare-Approved Amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
– Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $240 of Medicare-Approved Amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

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
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1632	$1632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0 **
– Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	$0	Up to $204 a day
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

** **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 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 $240 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
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved Amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $240 of Medicare-Approved Amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
– Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $240 of Medicare-Approved Amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

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 PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1632	$1632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0 **
– Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment, coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

** **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 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 $240 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
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved Amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $240 of Medicare-Approved Amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$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 $240 of Medicare-Approved Amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN 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
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1632	$1632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0 **
– Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited coinsurance, 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 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 $240 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
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved Amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges(Above Medicare-Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $240 of Medicare-Approved Amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
– Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $240 of Medicare-Approved Amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN F or 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 benefits as Plan F after one has paid a calendar year $2800 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2800. 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 separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2800 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2800 DEDUCTIBLE,** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1632	$1632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0 ***
– Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

*** **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 the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F or HIGH DEDUCTIBLE PLAN F
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

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

** This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2800 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2800. 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 separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2800 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2800 DEDUCTIBLE,** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved Amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $240 of Medicare-Approved Amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$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 $240 of Medicare-Approved Amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G or HIGH DEDUCTIBLE PLAN G
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

** This high deductible plan pays the same benefits as Plan G after one has paid a calendar year $2800 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2800. 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 $2800 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2800 DEDUCTIBLE,** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1632	$1632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0 ***
– Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

*** **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 the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G or HIGH DEDUCTIBLE PLAN G
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

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

** This high deductible plan pays the same benefits as Plan G after one has paid a calendar year $2800 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2800. 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 $2800 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2800 DEDUCTIBLE,** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved Amounts*	$0	$0	$240 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $240 of Medicare-Approved Amounts*	$0	$0	$240 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
– Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $240 of Medicare-Approved Amounts*	$0	$0	$240 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN K

* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $7060 each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit DOES NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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 *
HOSPITALIZATION**			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1632	$816 (50% of Part A Deductible)	$816 (50% of Part A Deductible) ♦
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0 ***
– Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE**			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $102 a day (50% of Part A Coinsurance)	Up to $102 a day (50% of Part A Coinsurance) ♦
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	50%	50% ♦
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	50% of copayment/ coinsurance	50% of copayment/ coinsurance ♦

*** **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 the balance based on any difference between its billed charges and the amount Medicare would have paid.

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved Amounts ****	$0	$0	$240 (Part B Deductible) **** ♦
Preventive Benefits for Medicare-Covered Services	Generally 80% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All Costs (and they do not count toward annual out-of-pocket limit of $7060)*
BLOOD			
First 3 pints	$0	50%	50% ♦
Next $240 of Medicare-Approved Amounts ****	$0	$0	$240 (Part B Deductible) **** ♦
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
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 $240 of Medicare-Approved Amounts *****	$0	$0	$240 (Part B Deductible) ♦
Remainder of Medicare-Approved Amounts	80%	10%	10% ♦

* This plan limits your annual out-of-pocket payment for Medicare-approved amounts $7060 per year. **However, this limit DOES NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

***** Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN L

* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $3530 each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit DOES NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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 *
HOSPITALIZATION**			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1632	$1224 (75% of Part A Deductible)	$408 (25% of Part A Deductible) ♦
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0 ***
– Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE**			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $153 a day (75% of Part A Coinsurance)	Up to $51 a day (25% of Part A Coinsurance) ♦
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	75%	25% ♦
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	75% of copayment/ coinsurance	25% of copayment/ coinsurance ♦

*** **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 the balance based on any difference between its billed charges and the amount Medicare would have paid.

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved Amounts ****	$0	$0	$240 (Part B Deductible) ****♦
Preventive Benefits for Medicare-Covered Services	Generally 80% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 15%	Generally 5%♦
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All Costs (and they do not count toward annual out-of-pocket limit of $3530)*
BLOOD			
First 3 pints	$0	75%	25%♦
Next $240 of Medicare-Approved Amounts ****	$0	$0	$240 (Part B Deductible) ****♦
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 15%	Generally 5%♦
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 $240 of Medicare-Approved Amounts *****	$0	$0	$240 (Part B Deductible)♦
Remainder of Medicare-Approved Amounts	80%	15%	5%♦

* This plan limits your annual out-of-pocket payment for Medicare-approved amounts $3530 per year. **However, this limit DOES NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

***** Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

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
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1632	$1632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0 **
– Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

** **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 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 $240 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
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as:			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved Amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges(Above Medicare-Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $240 of Medicare-Approved Amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
– Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $240 of Medicare-Approved Amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum