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.

RENEWABILITY

This policy is guaranteed renewable for life. We have the right to change the renewal premiums for this policy in accordance with our table of premium rates applicable to all policies of this form and class. This policy provides a 31-day grace period.

UNDER AGE 65 GUARANTEED ISSUE PERIOD (G/I)

Male

Preferred

Plan	A	SA	Q	M	Plan Code	Effective Date
A	10905	5453	2727	909	5A9	01/01/2023
B	12352	6176	3088	1030	5AR	01/01/2023
C	13321	6661	3331	1111	5B9	01/01/2024
D	12742	6371	3186	1062	5BR	01/01/2024
F	15487	7744	3872	1291	5C9	01/01/2024
HDF	6182	3091	1546	516	5CR	01/01/2024
G	13537	6769	3385	1129	5D9	01/01/2024
HDG	6238	3119	1560	520	5HT	01/01/2024
K	5373	2687	1344	448	P48	01/01/2023
L	7817	3909	1955	652	P64	01/01/2024

Standard

Plan	A	SA	Q	M	Plan Code	Effective Date
A	12549	6275	3138	1046	5AB	01/01/2023
B	14215	7108	3554	1185	5AT	01/01/2023
C	15329	7665	3833	1278	5BB	01/01/2024
D	14663	7332	3666	1222	5BT	01/01/2024
F	17822	8911	4456	1486	5CB	01/01/2024
HDF	7113	3557	1779	593	5CT	01/01/2024
G	15578	7789	3895	1299	5DB	01/01/2024
HDG	7179	3590	1795	599	5HV	01/01/2024
K	6183	3092	1546	516	P50	01/01/2023
L	8995	4498	2249	750	P66	01/01/2024

Female

Preferred

Plan	A	SA	Q	M	Plan Code	Effective Date
A	9486	4743	2372	791	5AA	01/01/2023
B	10745	5373	2687	896	5AS	01/01/2023
C	11587	5794	2897	966	5BA	01/01/2024
D	11084	5542	2771	924	5BS	01/01/2024
F	13471	6736	3368	1123	5CA	01/01/2024
HDF	5377	2689	1345	449	5CS	01/01/2024
G	11775	5888	2944	982	5DA	01/01/2024
HDG	5426	2713	1357	453	5HU	01/01/2024
K	4674	2337	1169	390	P49	01/01/2023
L	6799	3400	1700	567	P65	01/01/2024

Standard

Plan	A	SA	Q	M	Plan Code	Effective Date
A	10905	5453	2727	909	5AC	01/01/2023
B	12352	6176	3088	1030	5AU	01/01/2023
C	13321	6661	3331	1111	5BC	01/01/2024
D	12742	6371	3186	1062	5BU	01/01/2024
F	15487	7744	3872	1291	5CC	01/01/2024
HDF	6182	3091	1546	516	5CU	01/01/2024
G	13537	6769	3385	1129	5DC	01/01/2024
HDG	6238	3119	1560	520	5HW	01/01/2024
K	5373	2687	1344	448	P51	01/01/2023
L	7817	3909	1955	652	P67	01/01/2024

Only applicants first eligible for Medicare Part A before 2020 may purchase Plans C, F, and High Deductible Plan F.

UNDER AGE 65 DURING OPEN ENROLLMENT (O/E)

Male

Preferred

Plan	A	SA	Q	M	Plan Code	Effective Date
A	10905	5453	2727	909	5A9	01/01/2023
B	12352	6176	3088	1030	5AR	01/01/2023
C	13321	6661	3331	1111	5B9	01/01/2024
D	12742	6371	3186	1062	5BR	01/01/2024
F	15487	7744	3872	1291	5C9	01/01/2024
HDF	6182	3091	1546	516	5CR	01/01/2024
G	13537	6769	3385	1129	5D9	01/01/2024
HDG	6238	3119	1560	520	5HT	01/01/2024
K	5373	2687	1344	448	P48	01/01/2023
L	7817	3909	1955	652	P64	01/01/2024
N	9221	4611	2306	769	5DR	01/01/2024

Standard

Plan	A	SA	Q	M	Plan Code	Effective Date
A	12549	6275	3138	1046	5AB	01/01/2023
B	14215	7108	3554	1185	5AT	01/01/2023
C	15329	7665	3833	1278	5BB	01/01/2024
D	14663	7332	3666	1222	5BT	01/01/2024
F	17822	8911	4456	1486	5CB	01/01/2024
HDF	7113	3557	1779	593	5CT	01/01/2024
G	15578	7789	3895	1299	5DB	01/01/2024
HDG	7179	3590	1795	599	5HV	01/01/2024
K	6183	3092	1546	516	P50	01/01/2023
L	8995	4498	2249	750	P66	01/01/2024
N	10611	5306	2653	885	5DT	01/01/2024

Female

Preferred

Plan	A	SA	Q	M	Plan Code	Effective Date
A	9486	4743	2372	791	5AA	01/01/2023
B	10745	5373	2687	896	5AS	01/01/2023
C	11587	5794	2897	966	5BA	01/01/2024
D	11084	5542	2771	924	5BS	01/01/2024
F	13471	6736	3368	1123	5CA	01/01/2024
HDF	5377	2689	1345	449	5CS	01/01/2024
G	11775	5888	2944	982	5DA	01/01/2024
HDG	5426	2713	1357	453	5HU	01/01/2024
K	4674	2337	1169	390	P49	01/01/2023
L	6799	3400	1700	567	P65	01/01/2024
N	8021	4011	2006	669	5DS	01/01/2024

Standard

Plan	A	SA	Q	M	Plan Code	Effective Date
A	10905	5453	2727	909	5AC	01/01/2023
B	12352	6176	3088	1030	5AU	01/01/2023
C	13321	6661	3331	1111	5BC	01/01/2024
D	12742	6371	3186	1062	5BU	01/01/2024
F	15487	7744	3872	1291	5CC	01/01/2024
HDF	6182	3091	1546	516	5CU	01/01/2024
G	13537	6769	3385	1129	5DC	01/01/2024
HDG	6238	3119	1560	520	5HW	01/01/2024
K	5373	2687	1344	448	P51	01/01/2023
L	7817	3909	1955	652	P67	01/01/2024
N	9221	4611	2306	769	5DU	01/01/2024

Only applicants first eligible for Medicare Part A before 2020 may purchase Plans C, F, and High Deductible Plan F.

UNDER AGE 65 UNDERWRITTEN (U/W)

Male

Preferred

Plan	A	SA	Q	M	Plan Code	Effective Date
B	12352	6176	3088	1030	5GW	01/01/2023
HDF	6182	3091	1546	516	5H0	01/01/2024

Standard

Plan	A	SA	Q	M	Plan Code	Effective Date
B	14215	7108	3554	1185	5GY	01/01/2023
HDF	7113	3557	1779	593	5H2	01/01/2024

Female

Preferred

Plan	A	SA	Q	M	Plan Code	Effective Date
B	10745	5373	2687	896	5GX	01/01/2023
HDF	5377	2689	1345	449	5H1	01/01/2024

Standard

Plan	A	SA	Q	M	Plan Code	Effective Date
B	12352	6176	3088	1030	5GZ	01/01/2023
HDF	6182	3091	1546	516	5H3	01/01/2024

Only applicants first eligible for Medicare Part A before 2020 may purchase Plans C, F, and High Deductible Plan F.

PLAN A

Male

Preferred Effective Date: 03/01/2020 Plan Code: 5A0

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	1988	994	497	166
66	2021	1011	506	169
67	2021	1011	506	169
68	2021	1011	506	169
69	2021	1011	506	169
70	2025	1013	507	169
71	2025	1013	507	169
72	2025	1013	507	169
73	2025	1013	507	169
74	2025	1013	507	169
75	2025	1013	507	169
76	2025	1013	507	169
77	2025	1013	507	169
78	2025	1013	507	169
79	2025	1013	507	169
80+	2025	1013	507	169

Standard Effective Date: 03/01/2020 Plan Code: 5A2

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	2287	1144	572	191
66	2325	1163	582	194
67	2325	1163	582	194
68	2325	1163	582	194
69	2325	1163	582	194
70	2330	1165	583	195
71	2330	1165	583	195
72	2330	1165	583	195
73	2330	1165	583	195
74	2330	1165	583	195
75	2330	1165	583	195
76	2330	1165	583	195
77	2330	1165	583	195
78	2330	1165	583	195
79	2330	1165	583	195
80+	2330	1165	583	195

Female

Preferred Effective Date: 03/01/2020 Plan Code: 5A1

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	1729	865	433	145
66	1758	879	440	147
67	1758	879	440	147
68	1758	879	440	147
69	1758	879	440	147
70	1761	881	441	147
71	1761	881	441	147
72	1761	881	441	147
73	1761	881	441	147
74	1761	881	441	147
75	1761	881	441	147
76	1761	881	441	147
77	1761	881	441	147
78	1761	881	441	147
79	1761	881	441	147
80+	1761	881	441	147

Standard Effective Date: 03/01/2020 Plan Code: 5A3

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	1988	994	497	166
66	2021	1011	506	169
67	2021	1011	506	169
68	2021	1011	506	169
69	2021	1011	506	169
70	2025	1013	507	169
71	2025	1013	507	169
72	2025	1013	507	169
73	2025	1013	507	169
74	2025	1013	507	169
75	2025	1013	507	169
76	2025	1013	507	169
77	2025	1013	507	169
78	2025	1013	507	169
79	2025	1013	507	169
80+	2025	1013	507	169

PLAN B

Male

Preferred Effective Date: 01/01/2023 Plan Code: 5AI

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3785	1893	947	316
66	3890	1945	973	325
67	3890	1945	973	325
68	3890	1945	973	325
69	3890	1945	973	325
70	3990	1995	998	333
71	3990	1995	998	333
72	3990	1995	998	333
73	3990	1995	998	333
74	3990	1995	998	333
75	4002	2001	1001	334
76	4002	2001	1001	334
77	4002	2001	1001	334
78	4002	2001	1001	334
79	4002	2001	1001	334
80+	4002	2001	1001	334

Standard Effective Date: 01/01/2023 Plan Code: 5AK

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	4356	2178	1089	363
66	4476	2238	1119	373
67	4476	2238	1119	373
68	4476	2238	1119	373
69	4476	2238	1119	373
70	4592	2296	1148	383
71	4592	2296	1148	383
72	4592	2296	1148	383
73	4592	2296	1148	383
74	4592	2296	1148	383
75	4605	2303	1152	384
76	4605	2303	1152	384
77	4605	2303	1152	384
78	4605	2303	1152	384
79	4605	2303	1152	384
80+	4605	2303	1152	384

Female

Preferred Effective Date: 01/01/2023 Plan Code: 5AJ

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3292	1646	823	275
66	3383	1692	846	282
67	3383	1692	846	282
68	3383	1692	846	282
69	3383	1692	846	282
70	3471	1736	868	290
71	3471	1736	868	290
72	3471	1736	868	290
73	3471	1736	868	290
74	3471	1736	868	290
75	3481	1741	871	291
76	3481	1741	871	291
77	3481	1741	871	291
78	3481	1741	871	291
79	3481	1741	871	291
80+	3481	1741	871	291

Standard Effective Date: 01/01/2023 Plan Code: 5AL

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3785	1893	947	316
66	3890	1945	973	325
67	3890	1945	973	325
68	3890	1945	973	325
69	3890	1945	973	325
70	3990	1995	998	333
71	3990	1995	998	333
72	3990	1995	998	333
73	3990	1995	998	333
74	3990	1995	998	333
75	4002	2001	1001	334
76	4002	2001	1001	334
77	4002	2001	1001	334
78	4002	2001	1001	334
79	4002	2001	1001	334
80+	4002	2001	1001	334

PLAN C

Male

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	4272	2136	1068	356
66	4431	2216	1108	370
67	4431	2216	1108	370
68	4431	2216	1108	370
69	4431	2216	1108	370
70	4632	2316	1158	386
71	4632	2316	1158	386
72	4632	2316	1158	386
73	4632	2316	1158	386
74	4632	2316	1158	386
75	4871	2436	1218	406
76	4871	2436	1218	406
77	4871	2436	1218	406
78	4871	2436	1218	406
79	4871	2436	1218	406
80+	5072	2536	1268	423

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	4916	2458	1229	410
66	5099	2550	1275	425
67	5099	2550	1275	425
68	5099	2550	1275	425
69	5099	2550	1275	425
70	5330	2665	1333	445
71	5330	2665	1333	445
72	5330	2665	1333	445
73	5330	2665	1333	445
74	5330	2665	1333	445
75	5605	2803	1402	468
76	5605	2803	1402	468
77	5605	2803	1402	468
78	5605	2803	1402	468
79	5605	2803	1402	468
80+	5837	2919	1460	487

Female

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3716	1858	929	310
66	3854	1927	964	322
67	3854	1927	964	322
68	3854	1927	964	322
69	3854	1927	964	322
70	4029	2015	1008	336
71	4029	2015	1008	336
72	4029	2015	1008	336
73	4029	2015	1008	336
74	4029	2015	1008	336
75	4237	2119	1060	354
76	4237	2119	1060	354
77	4237	2119	1060	354
78	4237	2119	1060	354
79	4237	2119	1060	354
80+	4412	2206	1103	368

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	4272	2136	1068	356
66	4431	2216	1108	370
67	4431	2216	1108	370
68	4431	2216	1108	370
69	4431	2216	1108	370
70	4632	2316	1158	386
71	4632	2316	1158	386
72	4632	2316	1158	386
73	4632	2316	1158	386
74	4632	2316	1158	386
75	4871	2436	1218	406
76	4871	2436	1218	406
77	4871	2436	1218	406
78	4871	2436	1218	406
79	4871	2436	1218	406
80+	5072	2536	1268	423

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	4193	2097	1049	350
66	4355	2178	1089	363
67	4355	2178	1089	363
68	4355	2178	1089	363
69	4355	2178	1089	363
70	4571	2286	1143	381
71	4571	2286	1143	381
72	4571	2286	1143	381
73	4571	2286	1143	381
74	4571	2286	1143	381
75	4818	2409	1205	402
76	4818	2409	1205	402
77	4818	2409	1205	402
78	4818	2409	1205	402
79	4818	2409	1205	402
80+	5029	2515	1258	420

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	4825	2413	1207	403
66	5012	2506	1253	418
67	5012	2506	1253	418
68	5012	2506	1253	418
69	5012	2506	1253	418
70	5260	2630	1315	439
71	5260	2630	1315	439
72	5260	2630	1315	439
73	5260	2630	1315	439
74	5260	2630	1315	439
75	5544	2772	1386	462
76	5544	2772	1386	462
77	5544	2772	1386	462
78	5544	2772	1386	462
79	5544	2772	1386	462
80+	5787	2894	1447	483

Female

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3647	1824	912	304
66	3788	1894	947	316
67	3788	1894	947	316
68	3788	1894	947	316
69	3788	1894	947	316
70	3976	1988	994	332
71	3976	1988	994	332
72	3976	1988	994	332
73	3976	1988	994	332
74	3976	1988	994	332
75	4191	2096	1048	350
76	4191	2096	1048	350
77	4191	2096	1048	350
78	4191	2096	1048	350
79	4191	2096	1048	350
80+	4375	2188	1094	365

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	4193	2097	1049	350
66	4355	2178	1089	363
67	4355	2178	1089	363
68	4355	2178	1089	363
69	4355	2178	1089	363
70	4571	2286	1143	381
71	4571	2286	1143	381
72	4571	2286	1143	381
73	4571	2286	1143	381
74	4571	2286	1143	381
75	4818	2409	1205	402
76	4818	2409	1205	402
77	4818	2409	1205	402
78	4818	2409	1205	402
79	4818	2409	1205	402
80+	5029	2515	1258	420

PLAN F

Male

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	4926	2463	1232	411
66	5108	2554	1277	426
67	5108	2554	1277	426
68	5108	2554	1277	426
69	5108	2554	1277	426
70	5342	2671	1336	446
71	5342	2671	1336	446
72	5342	2671	1336	446
73	5342	2671	1336	446
74	5342	2671	1336	446
75	5610	2805	1403	468
76	5610	2805	1403	468
77	5610	2805	1403	468
78	5610	2805	1403	468
79	5610	2805	1403	468
80+	5842	2921	1461	487

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	5668	2834	1417	473
66	5878	2939	1470	490
67	5878	2939	1470	490
68	5878	2939	1470	490
69	5878	2939	1470	490
70	6147	3074	1537	513
71	6147	3074	1537	513
72	6147	3074	1537	513
73	6147	3074	1537	513
74	6147	3074	1537	513
75	6456	3228	1614	538
76	6456	3228	1614	538
77	6456	3228	1614	538
78	6456	3228	1614	538
79	6456	3228	1614	538
80+	6723	3362	1681	561

Female

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	4285	2143	1072	358
66	4443	2222	1111	371
67	4443	2222	1111	371
68	4443	2222	1111	371
69	4443	2222	1111	371
70	4647	2324	1162	388
71	4647	2324	1162	388
72	4647	2324	1162	388
73	4647	2324	1162	388
74	4647	2324	1162	388
75	4880	2440	1220	407
76	4880	2440	1220	407
77	4880	2440	1220	407
78	4880	2440	1220	407
79	4880	2440	1220	407
80+	5082	2541	1271	424

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	4926	2463	1232	411
66	5108	2554	1277	426
67	5108	2554	1277	426
68	5108	2554	1277	426
69	5108	2554	1277	426
70	5342	2671	1336	446
71	5342	2671	1336	446
72	5342	2671	1336	446
73	5342	2671	1336	446
74	5342	2671	1336	446
75	5610	2805	1403	468
76	5610	2805	1403	468
77	5610	2805	1403	468
78	5610	2805	1403	468
79	5610	2805	1403	468
80+	5842	2921	1461	487

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	711	356	178	60
66	744	372	186	62
67	744	372	186	62
68	744	372	186	62
69	744	372	186	62
70	791	396	198	66
71	791	396	198	66
72	791	396	198	66
73	791	396	198	66
74	791	396	198	66
75	845	423	212	71
76	845	423	212	71
77	845	423	212	71
78	845	423	212	71
79	845	423	212	71
80+	888	444	222	74

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	819	410	205	69
66	857	429	215	72
67	857	429	215	72
68	857	429	215	72
69	857	429	215	72
70	911	456	228	76
71	911	456	228	76
72	911	456	228	76
73	911	456	228	76
74	911	456	228	76
75	972	486	243	81
76	972	486	243	81
77	972	486	243	81
78	972	486	243	81
79	972	486	243	81
80+	1021	511	256	86

Female

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	619	310	155	52
66	648	324	162	54
67	648	324	162	54
68	648	324	162	54
69	648	324	162	54
70	688	344	172	58
71	688	344	172	58
72	688	344	172	58
73	688	344	172	58
74	688	344	172	58
75	735	368	184	62
76	735	368	184	62
77	735	368	184	62
78	735	368	184	62
79	735	368	184	62
80+	772	386	193	65

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	711	356	178	60
66	744	372	186	62
67	744	372	186	62
68	744	372	186	62
69	744	372	186	62
70	791	396	198	66
71	791	396	198	66
72	791	396	198	66
73	791	396	198	66
74	791	396	198	66
75	845	423	212	71
76	845	423	212	71
77	845	423	212	71
78	845	423	212	71
79	845	423	212	71
80+	888	444	222	74

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	4043	2022	1011	337
66	4204	2102	1051	351
67	4204	2102	1051	351
68	4204	2102	1051	351
69	4204	2102	1051	351
70	4412	2206	1103	368
71	4412	2206	1103	368
72	4412	2206	1103	368
73	4412	2206	1103	368
74	4412	2206	1103	368
75	4648	2324	1162	388
76	4648	2324	1162	388
77	4648	2324	1162	388
78	4648	2324	1162	388
79	4648	2324	1162	388
80+	4847	2424	1212	404

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	4653	2327	1164	388
66	4837	2419	1210	404
67	4837	2419	1210	404
68	4837	2419	1210	404
69	4837	2419	1210	404
70	5077	2539	1270	424
71	5077	2539	1270	424
72	5077	2539	1270	424
73	5077	2539	1270	424
74	5077	2539	1270	424
75	5349	2675	1338	446
76	5349	2675	1338	446
77	5349	2675	1338	446
78	5349	2675	1338	446
79	5349	2675	1338	446
80+	5577	2789	1395	465

Female

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3517	1759	880	294
66	3657	1829	915	305
67	3657	1829	915	305
68	3657	1829	915	305
69	3657	1829	915	305
70	3838	1919	960	320
71	3838	1919	960	320
72	3838	1919	960	320
73	3838	1919	960	320
74	3838	1919	960	320
75	4043	2022	1011	337
76	4043	2022	1011	337
77	4043	2022	1011	337
78	4043	2022	1011	337
79	4043	2022	1011	337
80+	4216	2108	1054	352

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	4043	2022	1011	337
66	4204	2102	1051	351
67	4204	2102	1051	351
68	4204	2102	1051	351
69	4204	2102	1051	351
70	4412	2206	1103	368
71	4412	2206	1103	368
72	4412	2206	1103	368
73	4412	2206	1103	368
74	4412	2206	1103	368
75	4648	2324	1162	388
76	4648	2324	1162	388
77	4648	2324	1162	388
78	4648	2324	1162	388
79	4648	2324	1162	388
80+	4847	2424	1212	404

PLAN HDG

Male

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	711	356	178	60
66	744	372	186	62
67	744	372	186	62
68	744	372	186	62
69	744	372	186	62
70	791	396	198	66
71	791	396	198	66
72	791	396	198	66
73	791	396	198	66
74	791	396	198	66
75	845	423	212	71
76	845	423	212	71
77	845	423	212	71
78	845	423	212	71
79	845	423	212	71
80+	888	444	222	74

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	819	410	205	69
66	857	429	215	72
67	857	429	215	72
68	857	429	215	72
69	857	429	215	72
70	911	456	228	76
71	911	456	228	76
72	911	456	228	76
73	911	456	228	76
74	911	456	228	76
75	972	486	243	81
76	972	486	243	81
77	972	486	243	81
78	972	486	243	81
79	972	486	243	81
80+	1021	511	256	86

Female

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	619	310	155	52
66	648	324	162	54
67	648	324	162	54
68	648	324	162	54
69	648	324	162	54
70	688	344	172	58
71	688	344	172	58
72	688	344	172	58
73	688	344	172	58
74	688	344	172	58
75	735	368	184	62
76	735	368	184	62
77	735	368	184	62
78	735	368	184	62
79	735	368	184	62
80+	772	386	193	65

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	711	356	178	60
66	744	372	186	62
67	744	372	186	62
68	744	372	186	62
69	744	372	186	62
70	791	396	198	66
71	791	396	198	66
72	791	396	198	66
73	791	396	198	66
74	791	396	198	66
75	845	423	212	71
76	845	423	212	71
77	845	423	212	71
78	845	423	212	71
79	845	423	212	71
80+	888	444	222	74

PLAN K

Male

Preferred Effective Date: 03/01/2020 Plan Code: P40

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	1539	770	385	129
66	1601	801	401	134
67	1601	801	401	134
68	1601	801	401	134
69	1601	801	401	134
70	1709	855	428	143
71	1709	855	428	143
72	1709	855	428	143
73	1709	855	428	143
74	1709	855	428	143
75	1777	889	445	149
76	1777	889	445	149
77	1777	889	445	149
78	1777	889	445	149
79	1777	889	445	149
80+	1801	901	451	151

Standard Effective Date: 03/01/2020 Plan Code: P42

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	1771	886	443	148
66	1842	921	461	154
67	1842	921	461	154
68	1842	921	461	154
69	1842	921	461	154
70	1966	983	492	164
71	1966	983	492	164
72	1966	983	492	164
73	1966	983	492	164
74	1966	983	492	164
75	2045	1023	512	171
76	2045	1023	512	171
77	2045	1023	512	171
78	2045	1023	512	171
79	2045	1023	512	171
80+	2072	1036	518	173

Female

Preferred Effective Date: 03/01/2020 Plan Code: P41

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	1339	670	335	112
66	1393	697	349	117
67	1393	697	349	117
68	1393	697	349	117
69	1393	697	349	117
70	1486	743	372	124
71	1486	743	372	124
72	1486	743	372	124
73	1486	743	372	124
74	1486	743	372	124
75	1546	773	387	129
76	1546	773	387	129
77	1546	773	387	129
78	1546	773	387	129
79	1546	773	387	129
80+	1566	783	392	131

Standard Effective Date: 03/01/2020 Plan Code: P43

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	1539	770	385	129
66	1601	801	401	134
67	1601	801	401	134
68	1601	801	401	134
69	1601	801	401	134
70	1709	855	428	143
71	1709	855	428	143
72	1709	855	428	143
73	1709	855	428	143
74	1709	855	428	143
75	1777	889	445	149
76	1777	889	445	149
77	1777	889	445	149
78	1777	889	445	149
79	1777	889	445	149
80+	1801	901	451	151

PLAN L

Male

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	2272	1136	568	190
66	2361	1181	591	197
67	2361	1181	591	197
68	2361	1181	591	197
69	2361	1181	591	197
70	2519	1260	630	210
71	2519	1260	630	210
72	2519	1260	630	210
73	2519	1260	630	210
74	2519	1260	630	210
75	2623	1312	656	219
76	2623	1312	656	219
77	2623	1312	656	219
78	2623	1312	656	219
79	2623	1312	656	219
80+	2659	1330	665	222

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	2614	1307	654	218
66	2717	1359	680	227
67	2717	1359	680	227
68	2717	1359	680	227
69	2717	1359	680	227
70	2899	1450	725	242
71	2899	1450	725	242
72	2899	1450	725	242
73	2899	1450	725	242
74	2899	1450	725	242
75	3018	1509	755	252
76	3018	1509	755	252
77	3018	1509	755	252
78	3018	1509	755	252
79	3018	1509	755	252
80+	3060	1530	765	255

Female

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	1976	988	494	165
66	2054	1027	514	172
67	2054	1027	514	172
68	2054	1027	514	172
69	2054	1027	514	172
70	2192	1096	548	183
71	2192	1096	548	183
72	2192	1096	548	183
73	2192	1096	548	183
74	2192	1096	548	183
75	2282	1141	571	191
76	2282	1141	571	191
77	2282	1141	571	191
78	2282	1141	571	191
79	2282	1141	571	191
80+	2313	1157	579	193

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	2272	1136	568	190
66	2361	1181	591	197
67	2361	1181	591	197
68	2361	1181	591	197
69	2361	1181	591	197
70	2519	1260	630	210
71	2519	1260	630	210
72	2519	1260	630	210
73	2519	1260	630	210
74	2519	1260	630	210
75	2623	1312	656	219
76	2623	1312	656	219
77	2623	1312	656	219
78	2623	1312	656	219
79	2623	1312	656	219
80+	2659	1330	665	222

PLAN N

Male

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	2830	1415	708	236
66	2947	1474	737	246
67	2947	1474	737	246
68	2947	1474	737	246
69	2947	1474	737	246
70	3107	1554	777	259
71	3107	1554	777	259
72	3107	1554	777	259
73	3107	1554	777	259
74	3107	1554	777	259
75	3302	1651	826	276
76	3302	1651	826	276
77	3302	1651	826	276
78	3302	1651	826	276
79	3302	1651	826	276
80+	3477	1739	870	290

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3257	1629	815	272
66	3391	1696	848	283
67	3391	1696	848	283
68	3391	1696	848	283
69	3391	1696	848	283
70	3575	1788	894	298
71	3575	1788	894	298
72	3575	1788	894	298
73	3575	1788	894	298
74	3575	1788	894	298
75	3800	1900	950	317
76	3800	1900	950	317
77	3800	1900	950	317
78	3800	1900	950	317
79	3800	1900	950	317
80+	4002	2001	1001	334

Female

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	2462	1231	616	206
66	2563	1282	641	214
67	2563	1282	641	214
68	2563	1282	641	214
69	2563	1282	641	214
70	2702	1351	676	226
71	2702	1351	676	226
72	2702	1351	676	226
73	2702	1351	676	226
74	2702	1351	676	226
75	2872	1436	718	240
76	2872	1436	718	240
77	2872	1436	718	240
78	2872	1436	718	240
79	2872	1436	718	240
80+	3025	1513	757	253

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	2830	1415	708	236
66	2947	1474	737	246
67	2947	1474	737	246
68	2947	1474	737	246
69	2947	1474	737	246
70	3107	1554	777	259
71	3107	1554	777	259
72	3107	1554	777	259
73	3107	1554	777	259
74	3107	1554	777	259
75	3302	1651	826	276
76	3302	1651	826	276
77	3302	1651	826	276
78	3302	1651	826	276
79	3302	1651	826	276
80+	3477	1739	870	290

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