

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. Until you are age 81, your premiums will increase on each policy anniversary solely because of your age change.

TOBACCO/NON-TOBACCO

Preferred rates are used during Open Enrollment and Guaranteed Issue periods. If the application is underwritten outside of Open Enrollment and Guaranteed Issue periods, preferred rates are used if you answer "NO" to the question, "Have you used tobacco in any form in the last 12 months?" If you answer "YES" to this question, standard rates are used.

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 - AREA 1 (ZIP 440-449)

Male

Preferred		Effective Date: 01/15/2020 Plan Code: 5A4		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1762	881	441	147
66	1819	910	455	152
67	1859	930	465	155
68	1888	944	472	158
69	1928	964	482	161
70	1958	979	490	164
71	1971	986	493	165
72	1971	986	493	165
73	1996	998	499	167
74	2023	1012	506	169
75	2059	1030	515	172
76	2080	1040	520	174
77	2080	1040	520	174
78	2080	1040	520	174
79	2080	1040	520	174
80+	2080	1040	520	174

Standard		Effective Date: 01/15/2020 Plan Code: 5A6		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2027	1014	507	169
66	2093	1047	524	175
67	2140	1070	535	179
68	2173	1087	544	182
69	2218	1109	555	185
70	2253	1127	564	188
71	2269	1135	568	190
72	2269	1135	568	190
73	2297	1149	575	192
74	2328	1164	582	194
75	2369	1185	593	198
76	2394	1197	599	200
77	2394	1197	599	200
78	2394	1197	599	200
79	2394	1197	599	200
80+	2394	1197	599	200

Female

Preferred		Effective Date: 01/15/2020 Plan Code: 5A5		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1532	766	383	128
66	1582	791	396	132
67	1617	809	405	135
68	1643	822	411	137
69	1677	839	420	140
70	1703	852	426	142
71	1715	858	429	143
72	1715	858	429	143
73	1736	868	434	145
74	1760	880	440	147
75	1791	896	448	150
76	1809	905	453	151
77	1809	905	453	151
78	1809	905	453	151
79	1809	905	453	151
80+	1809	905	453	151

Standard		Effective Date: 01/15/2020 Plan Code: 5A7		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1762	881	441	147
66	1819	910	455	152
67	1859	930	465	155
68	1888	944	472	158
69	1928	964	482	161
70	1958	979	490	164
71	1971	986	493	165
72	1971	986	493	165
73	1996	998	499	167
74	2023	1012	506	169
75	2059	1030	515	172
76	2080	1040	520	174
77	2080	1040	520	174
78	2080	1040	520	174
79	2080	1040	520	174
80+	2080	1040	520	174

PLAN B - AREA 1 (ZIP 440-449)

Male				
Preferred		Effective Date: 01/01/2024 Plan Code: 5AM		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3521	1761	881	294
66	3654	1827	914	305
67	3761	1881	941	314
68	3846	1923	962	321
69	3948	1974	987	329
70	4027	2014	1007	336
71	4086	2043	1022	341
72	4089	2045	1023	341
73	4197	2099	1050	350
74	4285	2143	1072	358
75	4380	2190	1095	365
76	4453	2227	1114	372
77	4472	2236	1118	373
78	4482	2241	1121	374
79	4499	2250	1125	375
80+	4499	2250	1125	375

Standard		Effective Date: 01/01/2024 Plan Code: 5AO		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	4052	2026	1013	338
66	4204	2102	1051	351
67	4328	2164	1082	361
68	4426	2213	1107	369
69	4544	2272	1136	379
70	4634	2317	1159	387
71	4702	2351	1176	392
72	4705	2353	1177	393
73	4830	2415	1208	403
74	4931	2466	1233	411
75	5040	2520	1260	420
76	5124	2562	1281	427
77	5146	2573	1287	429
78	5158	2579	1290	430
79	5177	2589	1295	432
80+	5177	2589	1295	432

Female				
Preferred		Effective Date: 01/01/2024 Plan Code: 5AN		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3063	1532	766	256
66	3178	1589	795	265
67	3272	1636	818	273
68	3346	1673	837	279
69	3435	1718	859	287
70	3503	1752	876	292
71	3555	1778	889	297
72	3556	1778	889	297
73	3651	1826	913	305
74	3727	1864	932	311
75	3810	1905	953	318
76	3874	1937	969	323
77	3890	1945	973	325
78	3899	1950	975	325
79	3914	1957	979	327
80+	3914	1957	979	327

Standard		Effective Date: 01/01/2024 Plan Code: 5AP		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3521	1761	881	294
66	3654	1827	914	305
67	3761	1881	941	314
68	3846	1923	962	321
69	3948	1974	987	329
70	4027	2014	1007	336
71	4086	2043	1022	341
72	4089	2045	1023	341
73	4197	2099	1050	350
74	4285	2143	1072	358
75	4380	2190	1095	365
76	4453	2227	1114	372
77	4472	2236	1118	373
78	4482	2241	1121	374
79	4499	2250	1125	375
80+	4499	2250	1125	375

PLAN C - AREA 1 (ZIP 440-449)

Male				
Preferred		Effective Date: 01/01/2024 Plan Code: 5B4		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3734	1867	934	312
66	3879	1940	970	324
67	3998	1999	1000	334
68	4108	2054	1027	343
69	4247	2124	1062	354
70	4371	2186	1093	365
71	4472	2236	1118	373
72	4525	2263	1132	378
73	4676	2338	1169	390
74	4800	2400	1200	400
75	4927	2464	1232	411
76	5044	2522	1261	421
77	5148	2574	1287	429
78	5249	2625	1313	438
79	5350	2675	1338	446
80+	5507	2754	1377	459

Standard		Effective Date: 01/01/2024 Plan Code: 5B6		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	4297	2149	1075	359
66	4464	2232	1116	372
67	4600	2300	1150	384
68	4727	2364	1182	394
69	4887	2444	1222	408
70	5030	2515	1258	420
71	5146	2573	1287	429
72	5207	2604	1302	434
73	5381	2691	1346	449
74	5523	2762	1381	461
75	5670	2835	1418	473
76	5804	2902	1451	484
77	5924	2962	1481	494
78	6041	3021	1511	504
79	6157	3079	1540	514
80+	6337	3169	1585	529

Female				
Preferred		Effective Date: 01/01/2024 Plan Code: 5B5		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3248	1624	812	271
66	3374	1687	844	282
67	3477	1739	870	290
68	3573	1787	894	298
69	3694	1847	924	308
70	3802	1901	951	317
71	3890	1945	973	325
72	3936	1968	984	328
73	4068	2034	1017	339
74	4175	2088	1044	348
75	4286	2143	1072	358
76	4388	2194	1097	366
77	4478	2239	1120	374
78	4566	2283	1142	381
79	4654	2327	1164	388
80+	4790	2395	1198	400

Standard		Effective Date: 01/01/2024 Plan Code: 5B7		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3734	1867	934	312
66	3879	1940	970	324
67	3998	1999	1000	334
68	4108	2054	1027	343
69	4247	2124	1062	354
70	4371	2186	1093	365
71	4472	2236	1118	373
72	4525	2263	1132	378
73	4676	2338	1169	390
74	4800	2400	1200	400
75	4927	2464	1232	411
76	5044	2522	1261	421
77	5148	2574	1287	429
78	5249	2625	1313	438
79	5350	2675	1338	446
80+	5507	2754	1377	459

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

PLAN D - AREA 1 (ZIP 440-449)

Male

Preferred		Effective Date: 01/01/2024 Plan Code: 5BM		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3514	1757	879	293
66	3659	1830	915	305
67	3788	1894	947	316
68	3895	1948	974	325
69	4036	2018	1009	337
70	4162	2081	1041	347
71	4266	2133	1067	356
72	4319	2160	1080	360
73	4472	2236	1118	373
74	4598	2299	1150	384
75	4727	2364	1182	394
76	4844	2422	1211	404
77	4948	2474	1237	413
78	5050	2525	1263	421
79	5154	2577	1289	430
80+	5314	2657	1329	443

Standard		Effective Date: 01/01/2024 Plan Code: 5BO		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	4044	2022	1011	337
66	4211	2106	1053	351
67	4359	2180	1090	364
68	4482	2241	1121	374
69	4644	2322	1161	387
70	4789	2395	1198	400
71	4909	2455	1228	410
72	4970	2485	1243	415
73	5146	2573	1287	429
74	5291	2646	1323	441
75	5439	2720	1360	454
76	5575	2788	1394	465
77	5693	2847	1424	475
78	5811	2906	1453	485
79	5931	2966	1483	495
80+	6115	3058	1529	510

Female

Preferred		Effective Date: 01/01/2024 Plan Code: 5BN		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3057	1529	765	255
66	3183	1592	796	266
67	3295	1648	824	275
68	3388	1694	847	283
69	3511	1756	878	293
70	3620	1810	905	302
71	3711	1856	928	310
72	3756	1878	939	313
73	3890	1945	973	325
74	3999	2000	1000	334
75	4112	2056	1028	343
76	4214	2107	1054	352
77	4304	2152	1076	359
78	4392	2196	1098	366
79	4483	2242	1121	374
80+	4623	2312	1156	386

Standard		Effective Date: 01/01/2024 Plan Code: 5BP		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3514	1757	879	293
66	3659	1830	915	305
67	3788	1894	947	316
68	3895	1948	974	325
69	4036	2018	1009	337
70	4162	2081	1041	347
71	4266	2133	1067	356
72	4319	2160	1080	360
73	4472	2236	1118	373
74	4598	2299	1150	384
75	4727	2364	1182	394
76	4844	2422	1211	404
77	4948	2474	1237	413
78	5050	2525	1263	421
79	5154	2577	1289	430
80+	5314	2657	1329	443

PLAN F - AREA 1 (ZIP 440-449)

Male				
Preferred		Effective Date: 01/01/2024		Plan Code: 5C4
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	4428	2214	1107	369
66	4599	2300	1150	384
67	4741	2371	1186	396
68	4872	2436	1218	406
69	5038	2519	1260	420
70	5183	2592	1296	432
71	5302	2651	1326	442
72	5364	2682	1341	447
73	5543	2772	1386	462
74	5690	2845	1423	475
75	5842	2921	1461	487
76	5975	2988	1494	498
77	6094	3047	1524	508
78	6219	3110	1555	519
79	6336	3168	1584	528
80+	6524	3262	1631	544

Standard		Effective Date: 01/01/2024		Plan Code: 5C6
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	5096	2548	1274	425
66	5292	2646	1323	441
67	5456	2728	1364	455
68	5607	2804	1402	468
69	5798	2899	1450	484
70	5964	2982	1491	497
71	6101	3051	1526	509
72	6172	3086	1543	515
73	6379	3190	1595	532
74	6548	3274	1637	546
75	6723	3362	1681	561
76	6876	3438	1719	573
77	7012	3506	1753	585
78	7157	3579	1790	597
79	7291	3646	1823	608
80+	7508	3754	1877	626

Female				
Preferred		Effective Date: 01/01/2024		Plan Code: 5C5
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3852	1926	963	321
66	4000	2000	1000	334
67	4124	2062	1031	344
68	4238	2119	1060	354
69	4383	2192	1096	366
70	4509	2255	1128	376
71	4612	2306	1153	385
72	4666	2333	1167	389
73	4822	2411	1206	402
74	4949	2475	1238	413
75	5082	2541	1271	424
76	5197	2599	1300	434
77	5301	2651	1326	442
78	5410	2705	1353	451
79	5511	2756	1378	460
80+	5675	2838	1419	473

Standard		Effective Date: 01/01/2024		Plan Code: 5C7
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	4428	2214	1107	369
66	4599	2300	1150	384
67	4741	2371	1186	396
68	4872	2436	1218	406
69	5038	2519	1260	420
70	5183	2592	1296	432
71	5302	2651	1326	442
72	5364	2682	1341	447
73	5543	2772	1386	462
74	5690	2845	1423	475
75	5842	2921	1461	487
76	5975	2988	1494	498
77	6094	3047	1524	508
78	6219	3110	1555	519
79	6336	3168	1584	528
80+	6524	3262	1631	544

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

PLAN HDF - AREA 1 (ZIP 440-449)

Male				
Preferred		Effective Date: 01/01/2024		Plan Code: 5CM
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	586	293	147	49
66	625	313	157	53
67	662	331	166	56
68	680	340	170	57
69	702	351	176	59
70	721	361	181	61
71	738	369	185	62
72	767	384	192	64
73	813	407	204	68
74	853	427	214	72
75	897	449	225	75
76	917	459	230	77
77	935	468	234	78
78	960	480	240	80
79	1008	504	252	84
80+	1088	544	272	91

Standard		Effective Date: 01/01/2024		Plan Code: 5CO
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	675	338	169	57
66	719	360	180	60
67	761	381	191	64
68	782	391	196	66
69	808	404	202	68
70	830	415	208	70
71	849	425	213	71
72	883	442	221	74
73	936	468	234	78
74	982	491	246	82
75	1032	516	258	86
76	1056	528	264	88
77	1076	538	269	90
78	1105	553	277	93
79	1160	580	290	97
80+	1252	626	313	105

Female				
Preferred		Effective Date: 01/01/2024		Plan Code: 5CN
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	510	255	128	43
66	543	272	136	46
67	576	288	144	48
68	591	296	148	50
69	611	306	153	51
70	627	314	157	53
71	642	321	161	54
72	667	334	167	56
73	707	354	177	59
74	742	371	186	62
75	780	390	195	65
76	798	399	200	67
77	814	407	204	68
78	835	418	209	70
79	877	439	220	74
80+	946	473	237	79

Standard		Effective Date: 01/01/2024		Plan Code: 5CP
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	586	293	147	49
66	625	313	157	53
67	662	331	166	56
68	680	340	170	57
69	702	351	176	59
70	721	361	181	61
71	738	369	185	62
72	767	384	192	64
73	813	407	204	68
74	853	427	214	72
75	897	449	225	75
76	917	459	230	77
77	935	468	234	78
78	960	480	240	80
79	1008	504	252	84
80+	1088	544	272	91

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

PLAN G - AREA 1 (ZIP 440-449)

Male				
Preferred		Effective Date: 01/01/2024 Plan Code: 5D4		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3057	1529	765	255
66	3183	1592	796	266
67	3295	1648	824	275
68	3390	1695	848	283
69	3510	1755	878	293
70	3617	1809	905	302
71	3706	1853	927	309
72	3752	1876	938	313
73	3886	1943	972	324
74	3994	1997	999	333
75	4108	2054	1027	343
76	4207	2104	1052	351
77	4296	2148	1074	358
78	4386	2193	1097	366
79	4474	2237	1119	373
80+	4615	2308	1154	385

Standard		Effective Date: 01/01/2024 Plan Code: 5D6		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3518	1759	880	294
66	3662	1831	916	306
67	3791	1896	948	316
68	3901	1951	976	326
69	4039	2020	1010	337
70	4162	2081	1041	347
71	4265	2133	1067	356
72	4318	2159	1080	360
73	4471	2236	1118	373
74	4597	2299	1150	384
75	4727	2364	1182	394
76	4842	2421	1211	404
77	4944	2472	1236	412
78	5047	2524	1262	421
79	5149	2575	1288	430
80+	5310	2655	1328	443

Female				
Preferred		Effective Date: 01/01/2024 Plan Code: 5D5		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2659	1330	665	222
66	2768	1384	692	231
67	2866	1433	717	239
68	2949	1475	738	246
69	3053	1527	764	255
70	3146	1573	787	263
71	3224	1612	806	269
72	3264	1632	816	272
73	3380	1690	845	282
74	3475	1738	869	290
75	3573	1787	894	298
76	3660	1830	915	305
77	3737	1869	935	312
78	3815	1908	954	318
79	3892	1946	973	325
80+	4014	2007	1004	335

Standard		Effective Date: 01/01/2024 Plan Code: 5D7		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3057	1529	765	255
66	3183	1592	796	266
67	3295	1648	824	275
68	3390	1695	848	283
69	3510	1755	878	293
70	3617	1809	905	302
71	3706	1853	927	309
72	3752	1876	938	313
73	3886	1943	972	324
74	3994	1997	999	333
75	4108	2054	1027	343
76	4207	2104	1052	351
77	4296	2148	1074	358
78	4386	2193	1097	366
79	4474	2237	1119	373
80+	4615	2308	1154	385

PLAN HDG - AREA 1 (ZIP 440-449)

Male				
Preferred		Effective Date: 01/01/2024		Plan Code: 5HO
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	586	293	147	49
66	625	313	157	53
67	662	331	166	56
68	680	340	170	57
69	702	351	176	59
70	721	361	181	61
71	738	369	185	62
72	767	384	192	64
73	813	407	204	68
74	853	427	214	72
75	897	449	225	75
76	917	459	230	77
77	935	468	234	78
78	960	480	240	80
79	1008	504	252	84
80+	1088	544	272	91

Standard		Effective Date: 01/01/2024		Plan Code: 5HQ
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	675	338	169	57
66	719	360	180	60
67	761	381	191	64
68	782	391	196	66
69	808	404	202	68
70	830	415	208	70
71	849	425	213	71
72	883	442	221	74
73	936	468	234	78
74	982	491	246	82
75	1032	516	258	86
76	1056	528	264	88
77	1076	538	269	90
78	1105	553	277	93
79	1160	580	290	97
80+	1252	626	313	105

Female				
Preferred		Effective Date: 01/01/2024		Plan Code: 5HP
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	510	255	128	43
66	543	272	136	46
67	576	288	144	48
68	591	296	148	50
69	611	306	153	51
70	627	314	157	53
71	642	321	161	54
72	667	334	167	56
73	707	354	177	59
74	742	371	186	62
75	780	390	195	65
76	798	399	200	67
77	814	407	204	68
78	835	418	209	70
79	877	439	220	74
80+	946	473	237	79

Standard		Effective Date: 01/01/2024		Plan Code: 5HR
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	586	293	147	49
66	625	313	157	53
67	662	331	166	56
68	680	340	170	57
69	702	351	176	59
70	721	361	181	61
71	738	369	185	62
72	767	384	192	64
73	813	407	204	68
74	853	427	214	72
75	897	449	225	75
76	917	459	230	77
77	935	468	234	78
78	960	480	240	80
79	1008	504	252	84
80+	1088	544	272	91

PLAN K - AREA 1 (ZIP 440-449)

Male

Preferred		Effective Date: 01/15/2020 Plan Code: P44		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1470	735	368	123
66	1583	792	396	132
67	1678	839	420	140
68	1764	882	441	147
69	1856	928	464	155
70	1965	983	492	164
71	2019	1010	505	169
72	2059	1030	515	172
73	2104	1052	526	176
74	2146	1073	537	179
75	2195	1098	549	183
76	2229	1115	558	186
77	2258	1129	565	189
78	2283	1142	571	191
79	2303	1152	576	192
80+	2354	1177	589	197

Standard		Effective Date: 01/15/2020 Plan Code: P46		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1692	846	423	141
66	1822	911	456	152
67	1931	966	483	161
68	2030	1015	508	170
69	2136	1068	534	178
70	2261	1131	566	189
71	2323	1162	581	194
72	2369	1185	593	198
73	2421	1211	606	202
74	2470	1235	618	206
75	2525	1263	632	211
76	2565	1283	642	214
77	2599	1300	650	217
78	2627	1314	657	219
79	2651	1326	663	221
80+	2709	1355	678	226

Female

Preferred		Effective Date: 01/15/2020 Plan Code: P45		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1279	640	320	107
66	1377	689	345	115
67	1459	730	365	122
68	1534	767	384	128
69	1614	807	404	135
70	1709	855	428	143
71	1756	878	439	147
72	1791	896	448	150
73	1830	915	458	153
74	1867	934	467	156
75	1909	955	478	160
76	1939	970	485	162
77	1965	983	492	164
78	1986	993	497	166
79	2004	1002	501	167
80+	2047	1024	512	171

Standard		Effective Date: 01/15/2020 Plan Code: P47		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1470	735	368	123
66	1583	792	396	132
67	1678	839	420	140
68	1764	882	441	147
69	1856	928	464	155
70	1965	983	492	164
71	2019	1010	505	169
72	2059	1030	515	172
73	2104	1052	526	176
74	2146	1073	537	179
75	2195	1098	549	183
76	2229	1115	558	186
77	2258	1129	565	189
78	2283	1142	571	191
79	2303	1152	576	192
80+	2354	1177	589	197

PLAN L - AREA 1 (ZIP 440-449)

Male

Preferred		Effective Date: 01/15/2020 Plan Code: P60		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2067	1034	517	173
66	2225	1113	557	186
67	2358	1179	590	197
68	2481	1241	621	207
69	2611	1306	653	218
70	2761	1381	691	231
71	2841	1421	711	237
72	2897	1449	725	242
73	2965	1483	742	248
74	3019	1510	755	252
75	3085	1543	772	258
76	3133	1567	784	262
77	3176	1588	794	265
78	3216	1608	804	268
79	3243	1622	811	271
80+	3310	1655	828	276

Standard		Effective Date: 01/15/2020 Plan Code: P62		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2378	1189	595	199
66	2560	1280	640	214
67	2714	1357	679	227
68	2854	1427	714	238
69	3004	1502	751	251
70	3177	1589	795	265
71	3269	1635	818	273
72	3333	1667	834	278
73	3412	1706	853	285
74	3474	1737	869	290
75	3550	1775	888	296
76	3606	1803	902	301
77	3655	1828	914	305
78	3701	1851	926	309
79	3732	1866	933	311
80+	3809	1905	953	318

Female

Preferred		Effective Date: 01/15/2020 Plan Code: P61		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1798	899	450	150
66	1935	968	484	162
67	2051	1026	513	171
68	2158	1079	540	180
69	2271	1136	568	190
70	2402	1201	601	201
71	2471	1236	618	206
72	2520	1260	630	210
73	2579	1290	645	215
74	2626	1313	657	219
75	2683	1342	671	224
76	2725	1363	682	228
77	2762	1381	691	231
78	2798	1399	700	234
79	2821	1411	706	236
80+	2880	1440	720	240

Standard		Effective Date: 01/15/2020 Plan Code: P63		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2067	1034	517	173
66	2225	1113	557	186
67	2358	1179	590	197
68	2481	1241	621	207
69	2611	1306	653	218
70	2761	1381	691	231
71	2841	1421	711	237
72	2897	1449	725	242
73	2965	1483	742	248
74	3019	1510	755	252
75	3085	1543	772	258
76	3133	1567	784	262
77	3176	1588	794	265
78	3216	1608	804	268
79	3243	1622	811	271
80+	3310	1655	828	276

PLAN N - AREA 1 (ZIP 440-449)

Male				
Preferred		Effective Date: 01/01/2024		Plan Code: 5DM
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3165	1583	792	264
66	3298	1649	825	275
67	3417	1709	855	285
68	3519	1760	880	294
69	3654	1827	914	305
70	3777	1889	945	315
71	3877	1939	970	324
72	3934	1967	984	328
73	4079	2040	1020	340
74	4201	2101	1051	351
75	4324	2162	1081	361
76	4432	2216	1108	370
77	4541	2271	1136	379
78	4648	2324	1162	388
79	4757	2379	1190	397
80+	4926	2463	1232	411

Standard		Effective Date: 01/01/2024		Plan Code: 5DO
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3642	1821	911	304
66	3795	1898	949	317
67	3932	1966	983	328
68	4049	2025	1013	338
69	4204	2102	1051	351
70	4346	2173	1087	363
71	4461	2231	1116	372
72	4527	2264	1132	378
73	4693	2347	1174	392
74	4834	2417	1209	403
75	4976	2488	1244	415
76	5100	2550	1275	425
77	5225	2613	1307	436
78	5349	2675	1338	446
79	5474	2737	1369	457
80+	5669	2835	1418	473

Female				
Preferred		Effective Date: 01/01/2024		Plan Code: 5DN
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2753	1377	689	230
66	2869	1435	718	240
67	2972	1486	743	248
68	3061	1531	766	256
69	3178	1589	795	265
70	3285	1643	822	274
71	3372	1686	843	281
72	3422	1711	856	286
73	3548	1774	887	296
74	3654	1827	914	305
75	3761	1881	941	314
76	3855	1928	964	322
77	3950	1975	988	330
78	4043	2022	1011	337
79	4138	2069	1035	345
80+	4285	2143	1072	358

Standard		Effective Date: 01/01/2024		Plan Code: 5DP
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3165	1583	792	264
66	3298	1649	825	275
67	3417	1709	855	285
68	3519	1760	880	294
69	3654	1827	914	305
70	3777	1889	945	315
71	3877	1939	970	324
72	3934	1967	984	328
73	4079	2040	1020	340
74	4201	2101	1051	351
75	4324	2162	1081	361
76	4432	2216	1108	370
77	4541	2271	1136	379
78	4648	2324	1162	388
79	4757	2379	1190	397
80+	4926	2463	1232	411

PLAN A - AREA 2 (ZIP 430-439; 450-459)

Male

Preferred		Effective Date: 01/15/2020 Plan Code: 5A4		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1594	797	399	133
66	1646	823	412	138
67	1682	841	421	141
68	1709	855	428	143
69	1744	872	436	146
70	1771	886	443	148
71	1784	892	446	149
72	1784	892	446	149
73	1806	903	452	151
74	1830	915	458	153
75	1863	932	466	156
76	1882	941	471	157
77	1882	941	471	157
78	1882	941	471	157
79	1882	941	471	157
80+	1882	941	471	157

Standard		Effective Date: 01/15/2020 Plan Code: 5A6		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1834	917	459	153
66	1894	947	474	158
67	1936	968	484	162
68	1966	983	492	164
69	2007	1004	502	168
70	2039	1020	510	170
71	2053	1027	514	172
72	2053	1027	514	172
73	2078	1039	520	174
74	2106	1053	527	176
75	2144	1072	536	179
76	2166	1083	542	181
77	2166	1083	542	181
78	2166	1083	542	181
79	2166	1083	542	181
80+	2166	1083	542	181

Female

Preferred		Effective Date: 01/15/2020 Plan Code: 5A5		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1386	693	347	116
66	1431	716	358	120
67	1463	732	366	122
68	1486	743	372	124
69	1517	759	380	127
70	1541	771	386	129
71	1552	776	388	130
72	1552	776	388	130
73	1571	786	393	131
74	1592	796	398	133
75	1620	810	405	135
76	1637	819	410	137
77	1637	819	410	137
78	1637	819	410	137
79	1637	819	410	137
80+	1637	819	410	137

Standard		Effective Date: 01/15/2020 Plan Code: 5A7		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1594	797	399	133
66	1646	823	412	138
67	1682	841	421	141
68	1709	855	428	143
69	1744	872	436	146
70	1771	886	443	148
71	1784	892	446	149
72	1784	892	446	149
73	1806	903	452	151
74	1830	915	458	153
75	1863	932	466	156
76	1882	941	471	157
77	1882	941	471	157
78	1882	941	471	157
79	1882	941	471	157
80+	1882	941	471	157

PLAN B - AREA 2 (ZIP 430-439; 450-459)

Male				
Preferred		Effective Date: 01/01/2024		Plan Code: 5AM
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3186	1593	797	266
66	3306	1653	827	276
67	3403	1702	851	284
68	3480	1740	870	290
69	3572	1786	893	298
70	3643	1822	911	304
71	3697	1849	925	309
72	3699	1850	925	309
73	3798	1899	950	317
74	3877	1939	970	324
75	3963	1982	991	331
76	4029	2015	1008	336
77	4046	2023	1012	338
78	4055	2028	1014	338
79	4071	2036	1018	340
80+	4071	2036	1018	340

Standard		Effective Date: 01/01/2024		Plan Code: 5AO
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3666	1833	917	306
66	3804	1902	951	317
67	3916	1958	979	327
68	4005	2003	1002	334
69	4111	2056	1028	343
70	4193	2097	1049	350
71	4255	2128	1064	355
72	4257	2129	1065	355
73	4370	2185	1093	365
74	4461	2231	1116	372
75	4560	2280	1140	380
76	4636	2318	1159	387
77	4656	2328	1164	388
78	4667	2334	1167	389
79	4684	2342	1171	391
80+	4684	2342	1171	391

Female				
Preferred		Effective Date: 01/01/2024		Plan Code: 5AN
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2771	1386	693	231
66	2875	1438	719	240
67	2960	1480	740	247
68	3027	1514	757	253
69	3107	1554	777	259
70	3169	1585	793	265
71	3216	1608	804	268
72	3218	1609	805	269
73	3303	1652	826	276
74	3372	1686	843	281
75	3447	1724	862	288
76	3505	1753	877	293
77	3520	1760	880	294
78	3528	1764	882	294
79	3541	1771	886	296
80+	3541	1771	886	296

Standard		Effective Date: 01/01/2024		Plan Code: 5AP
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3186	1593	797	266
66	3306	1653	827	276
67	3403	1702	851	284
68	3480	1740	870	290
69	3572	1786	893	298
70	3643	1822	911	304
71	3697	1849	925	309
72	3699	1850	925	309
73	3798	1899	950	317
74	3877	1939	970	324
75	3963	1982	991	331
76	4029	2015	1008	336
77	4046	2023	1012	338
78	4055	2028	1014	338
79	4071	2036	1018	340
80+	4071	2036	1018	340

PLAN C - AREA 2 (ZIP 430-439; 450-459)

Male

Preferred		Effective Date: 01/01/2024 Plan Code: 5B4		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3379	1690	845	282
66	3510	1755	878	293
67	3617	1809	905	302
68	3716	1858	929	310
69	3842	1921	961	321
70	3955	1978	989	330
71	4046	2023	1012	338
72	4094	2047	1024	342
73	4231	2116	1058	353
74	4342	2171	1086	362
75	4458	2229	1115	372
76	4564	2282	1141	381
77	4658	2329	1165	389
78	4749	2375	1188	396
79	4841	2421	1211	404
80+	4983	2492	1246	416

Standard		Effective Date: 01/01/2024 Plan Code: 5B6		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3888	1944	972	324
66	4039	2020	1010	337
67	4162	2081	1041	347
68	4277	2139	1070	357
69	4422	2211	1106	369
70	4551	2276	1138	380
71	4656	2328	1164	388
72	4711	2356	1178	393
73	4869	2435	1218	406
74	4997	2499	1250	417
75	5130	2565	1283	428
76	5252	2626	1313	438
77	5360	2680	1340	447
78	5465	2733	1367	456
79	5570	2785	1393	465
80+	5734	2867	1434	478

Female

Preferred		Effective Date: 01/01/2024 Plan Code: 5B5		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2939	1470	735	245
66	3053	1527	764	255
67	3146	1573	787	263
68	3233	1617	809	270
69	3342	1671	836	279
70	3440	1720	860	287
71	3520	1760	880	294
72	3561	1781	891	297
73	3680	1840	920	307
74	3777	1889	945	315
75	3878	1939	970	324
76	3970	1985	993	331
77	4052	2026	1013	338
78	4131	2066	1033	345
79	4211	2106	1053	351
80+	4334	2167	1084	362

Standard		Effective Date: 01/01/2024 Plan Code: 5B7		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3379	1690	845	282
66	3510	1755	878	293
67	3617	1809	905	302
68	3716	1858	929	310
69	3842	1921	961	321
70	3955	1978	989	330
71	4046	2023	1012	338
72	4094	2047	1024	342
73	4231	2116	1058	353
74	4342	2171	1086	362
75	4458	2229	1115	372
76	4564	2282	1141	381
77	4658	2329	1165	389
78	4749	2375	1188	396
79	4841	2421	1211	404
80+	4983	2492	1246	416

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

PLAN D - AREA 2 (ZIP 430-439; 450-459)

Male				
Preferred		Effective Date: 01/01/2024		Plan Code: 5BM
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3180	1590	795	265
66	3311	1656	828	276
67	3427	1714	857	286
68	3524	1762	881	294
69	3652	1826	913	305
70	3765	1883	942	314
71	3860	1930	965	322
72	3907	1954	977	326
73	4046	2023	1012	338
74	4160	2080	1040	347
75	4277	2139	1070	357
76	4383	2192	1096	366
77	4476	2238	1119	373
78	4569	2285	1143	381
79	4663	2332	1166	389
80+	4808	2404	1202	401

Standard		Effective Date: 01/01/2024		Plan Code: 5BO
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3659	1830	915	305
66	3810	1905	953	318
67	3944	1972	986	329
68	4055	2028	1014	338
69	4202	2101	1051	351
70	4333	2167	1084	362
71	4441	2221	1111	371
72	4496	2248	1124	375
73	4656	2328	1164	388
74	4787	2394	1197	399
75	4921	2461	1231	411
76	5044	2522	1261	421
77	5151	2576	1288	430
78	5257	2629	1315	439
79	5366	2683	1342	448
80+	5533	2767	1384	462

Female				
Preferred		Effective Date: 01/01/2024		Plan Code: 5BN
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2766	1383	692	231
66	2880	1440	720	240
67	2981	1491	746	249
68	3065	1533	767	256
69	3176	1588	794	265
70	3275	1638	819	273
71	3357	1679	840	280
72	3399	1700	850	284
73	3520	1760	880	294
74	3618	1809	905	302
75	3720	1860	930	310
76	3813	1907	954	318
77	3894	1947	974	325
78	3974	1987	994	332
79	4056	2028	1014	338
80+	4182	2091	1046	349

Standard		Effective Date: 01/01/2024		Plan Code: 5BP
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3180	1590	795	265
66	3311	1656	828	276
67	3427	1714	857	286
68	3524	1762	881	294
69	3652	1826	913	305
70	3765	1883	942	314
71	3860	1930	965	322
72	3907	1954	977	326
73	4046	2023	1012	338
74	4160	2080	1040	347
75	4277	2139	1070	357
76	4383	2192	1096	366
77	4476	2238	1119	373
78	4569	2285	1143	381
79	4663	2332	1166	389
80+	4808	2404	1202	401

PLAN F - AREA 2 (ZIP 430-439; 450-459)

Male				
Preferred		Effective Date: 01/01/2024		Plan Code: 5C4
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	4007	2004	1002	334
66	4161	2081	1041	347
67	4290	2145	1073	358
68	4408	2204	1102	368
69	4559	2280	1140	380
70	4689	2345	1173	391
71	4797	2399	1200	400
72	4853	2427	1214	405
73	5015	2508	1254	418
74	5148	2574	1287	429
75	5286	2643	1322	441
76	5406	2703	1352	451
77	5513	2757	1379	460
78	5627	2814	1407	469
79	5732	2866	1433	478
80+	5903	2952	1476	492

Standard		Effective Date: 01/01/2024		Plan Code: 5C6
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	4611	2306	1153	385
66	4788	2394	1197	399
67	4936	2468	1234	412
68	5073	2537	1269	423
69	5246	2623	1312	438
70	5396	2698	1349	450
71	5520	2760	1380	460
72	5584	2792	1396	466
73	5771	2886	1443	481
74	5924	2962	1481	494
75	6083	3042	1521	507
76	6221	3111	1556	519
77	6344	3172	1586	529
78	6475	3238	1619	540
79	6597	3299	1650	550
80+	6793	3397	1699	567

Female				
Preferred		Effective Date: 01/01/2024		Plan Code: 5C5
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3485	1743	872	291
66	3619	1810	905	302
67	3731	1866	933	311
68	3835	1918	959	320
69	3965	1983	992	331
70	4079	2040	1020	340
71	4173	2087	1044	348
72	4221	2111	1056	352
73	4362	2181	1091	364
74	4478	2239	1120	374
75	4598	2299	1150	384
76	4702	2351	1176	392
77	4796	2398	1199	400
78	4895	2448	1224	408
79	4986	2493	1247	416
80+	5135	2568	1284	428

Standard		Effective Date: 01/01/2024		Plan Code: 5C7
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	4007	2004	1002	334
66	4161	2081	1041	347
67	4290	2145	1073	358
68	4408	2204	1102	368
69	4559	2280	1140	380
70	4689	2345	1173	391
71	4797	2399	1200	400
72	4853	2427	1214	405
73	5015	2508	1254	418
74	5148	2574	1287	429
75	5286	2643	1322	441
76	5406	2703	1352	451
77	5513	2757	1379	460
78	5627	2814	1407	469
79	5732	2866	1433	478
80+	5903	2952	1476	492

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

PLAN HDF - AREA 2 (ZIP 430-439; 450-459)

Male				
Preferred		Effective Date: 01/01/2024		Plan Code: 5CM
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	531	266	133	45
66	565	283	142	48
67	599	300	150	50
68	615	308	154	52
69	635	318	159	53
70	652	326	163	55
71	668	334	167	56
72	694	347	174	58
73	736	368	184	62
74	772	386	193	65
75	812	406	203	68
76	830	415	208	70
77	846	423	212	71
78	868	434	217	73
79	912	456	228	76
80+	984	492	246	82

Standard		Effective Date: 01/01/2024		Plan Code: 5CO
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	611	306	153	51
66	650	325	163	55
67	689	345	173	58
68	708	354	177	59
69	731	366	183	61
70	751	376	188	63
71	768	384	192	64
72	799	400	200	67
73	846	423	212	71
74	889	445	223	75
75	934	467	234	78
76	955	478	239	80
77	974	487	244	82
78	999	500	250	84
79	1050	525	263	88
80+	1133	567	284	95

Female				
Preferred		Effective Date: 01/01/2024		Plan Code: 5CN
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	462	231	116	39
66	492	246	123	41
67	521	261	131	44
68	535	268	134	45
69	552	276	138	46
70	567	284	142	48
71	581	291	146	49
72	604	302	151	51
73	640	320	160	54
74	672	336	168	56
75	706	353	177	59
76	722	361	181	61
77	736	368	184	62
78	755	378	189	63
79	793	397	199	67
80+	856	428	214	72

Standard		Effective Date: 01/01/2024		Plan Code: 5CP
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	531	266	133	45
66	565	283	142	48
67	599	300	150	50
68	615	308	154	52
69	635	318	159	53
70	652	326	163	55
71	668	334	167	56
72	694	347	174	58
73	736	368	184	62
74	772	386	193	65
75	812	406	203	68
76	830	415	208	70
77	846	423	212	71
78	868	434	217	73
79	912	456	228	76
80+	984	492	246	82

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

PLAN G - AREA 2 (ZIP 430-439; 450-459)

Male

Preferred		Effective Date: 01/01/2024 Plan Code: 5D4		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2766	1383	692	231
66	2879	1440	720	240
67	2981	1491	746	249
68	3067	1534	767	256
69	3176	1588	794	265
70	3272	1636	818	273
71	3353	1677	839	280
72	3395	1698	849	283
73	3516	1758	879	293
74	3614	1807	904	302
75	3716	1858	929	310
76	3807	1904	952	318
77	3887	1944	972	324
78	3968	1984	992	331
79	4048	2024	1012	338
80+	4175	2088	1044	348

Standard		Effective Date: 01/01/2024 Plan Code: 5D6		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3183	1592	796	266
66	3314	1657	829	277
67	3430	1715	858	286
68	3530	1765	883	295
69	3654	1827	914	305
70	3765	1883	942	314
71	3859	1930	965	322
72	3907	1954	977	326
73	4046	2023	1012	338
74	4159	2080	1040	347
75	4277	2139	1070	357
76	4381	2191	1096	366
77	4473	2237	1119	373
78	4566	2283	1142	381
79	4659	2330	1165	389
80+	4804	2402	1201	401

Female

Preferred		Effective Date: 01/01/2024 Plan Code: 5D5		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2406	1203	602	201
66	2505	1253	627	209
67	2593	1297	649	217
68	2668	1334	667	223
69	2762	1381	691	231
70	2846	1423	712	238
71	2917	1459	730	244
72	2953	1477	739	247
73	3058	1529	765	255
74	3144	1572	786	262
75	3233	1617	809	270
76	3311	1656	828	276
77	3381	1691	846	282
78	3452	1726	863	288
79	3521	1761	881	294
80+	3632	1816	908	303

Standard		Effective Date: 01/01/2024 Plan Code: 5D7		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2766	1383	692	231
66	2879	1440	720	240
67	2981	1491	746	249
68	3067	1534	767	256
69	3176	1588	794	265
70	3272	1636	818	273
71	3353	1677	839	280
72	3395	1698	849	283
73	3516	1758	879	293
74	3614	1807	904	302
75	3716	1858	929	310
76	3807	1904	952	318
77	3887	1944	972	324
78	3968	1984	992	331
79	4048	2024	1012	338
80+	4175	2088	1044	348

PLAN HDG - AREA 2 (ZIP 430-439; 450-459)

Male

Preferred		Effective Date: 01/01/2024 Plan Code: 5HO		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	531	266	133	45
66	565	283	142	48
67	599	300	150	50
68	615	308	154	52
69	635	318	159	53
70	652	326	163	55
71	668	334	167	56
72	694	347	174	58
73	736	368	184	62
74	772	386	193	65
75	812	406	203	68
76	830	415	208	70
77	846	423	212	71
78	868	434	217	73
79	912	456	228	76
80+	984	492	246	82

Standard		Effective Date: 01/01/2024 Plan Code: 5HQ		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	611	306	153	51
66	650	325	163	55
67	689	345	173	58
68	708	354	177	59
69	731	366	183	61
70	751	376	188	63
71	768	384	192	64
72	799	400	200	67
73	846	423	212	71
74	889	445	223	75
75	934	467	234	78
76	955	478	239	80
77	974	487	244	82
78	999	500	250	84
79	1050	525	263	88
80+	1133	567	284	95

Female

Preferred		Effective Date: 01/01/2024 Plan Code: 5HP		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	462	231	116	39
66	492	246	123	41
67	521	261	131	44
68	535	268	134	45
69	552	276	138	46
70	567	284	142	48
71	581	291	146	49
72	604	302	151	51
73	640	320	160	54
74	672	336	168	56
75	706	353	177	59
76	722	361	181	61
77	736	368	184	62
78	755	378	189	63
79	793	397	199	67
80+	856	428	214	72

Standard		Effective Date: 01/01/2024 Plan Code: 5HR		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	531	266	133	45
66	565	283	142	48
67	599	300	150	50
68	615	308	154	52
69	635	318	159	53
70	652	326	163	55
71	668	334	167	56
72	694	347	174	58
73	736	368	184	62
74	772	386	193	65
75	812	406	203	68
76	830	415	208	70
77	846	423	212	71
78	868	434	217	73
79	912	456	228	76
80+	984	492	246	82

PLAN K - AREA 2 (ZIP 430-439; 450-459)

Male

Preferred		Effective Date: 01/15/2020 Plan Code: P44		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1330	665	333	111
66	1433	717	359	120
67	1518	759	380	127
68	1596	798	399	133
69	1679	840	420	140
70	1778	889	445	149
71	1826	913	457	153
72	1863	932	466	156
73	1903	952	476	159
74	1942	971	486	162
75	1986	993	497	166
76	2017	1009	505	169
77	2043	1022	511	171
78	2066	1033	517	173
79	2084	1042	521	174
80+	2130	1065	533	178

Standard		Effective Date: 01/15/2020 Plan Code: P46		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1531	766	383	128
66	1649	825	413	138
67	1747	874	437	146
68	1837	919	460	154
69	1932	966	483	161
70	2046	1023	512	171
71	2102	1051	526	176
72	2144	1072	536	179
73	2190	1095	548	183
74	2235	1118	559	187
75	2285	1143	572	191
76	2321	1161	581	194
77	2351	1176	588	196
78	2377	1189	595	199
79	2398	1199	600	200
80+	2451	1226	613	205

Female

Preferred		Effective Date: 01/15/2020 Plan Code: P45		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1157	579	290	97
66	1246	623	312	104
67	1320	660	330	110
68	1388	694	347	116
69	1461	731	366	122
70	1546	773	387	129
71	1589	795	398	133
72	1620	810	405	135
73	1656	828	414	138
74	1689	845	423	141
75	1727	864	432	144
76	1755	878	439	147
77	1777	889	445	149
78	1797	899	450	150
79	1813	907	454	152
80+	1852	926	463	155

Standard		Effective Date: 01/15/2020 Plan Code: P47		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1330	665	333	111
66	1433	717	359	120
67	1518	759	380	127
68	1596	798	399	133
69	1679	840	420	140
70	1778	889	445	149
71	1826	913	457	153
72	1863	932	466	156
73	1903	952	476	159
74	1942	971	486	162
75	1986	993	497	166
76	2017	1009	505	169
77	2043	1022	511	171
78	2066	1033	517	173
79	2084	1042	521	174
80+	2130	1065	533	178

PLAN L - AREA 2 (ZIP 430-439; 450-459)

Male

Preferred		Effective Date: 01/15/2020 Plan Code: P60		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1870	935	468	156
66	2013	1007	504	168
67	2134	1067	534	178
68	2244	1122	561	187
69	2362	1181	591	197
70	2498	1249	625	209
71	2570	1285	643	215
72	2621	1311	656	219
73	2683	1342	671	224
74	2731	1366	683	228
75	2791	1396	698	233
76	2835	1418	709	237
77	2873	1437	719	240
78	2910	1455	728	243
79	2934	1467	734	245
80+	2995	1498	749	250

Standard		Effective Date: 01/15/2020 Plan Code: P62		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2152	1076	538	180
66	2316	1158	579	193
67	2455	1228	614	205
68	2583	1292	646	216
69	2718	1359	680	227
70	2875	1438	719	240
71	2957	1479	740	247
72	3016	1508	754	252
73	3087	1544	772	258
74	3143	1572	786	262
75	3212	1606	803	268
76	3262	1631	816	272
77	3307	1654	827	276
78	3349	1675	838	280
79	3377	1689	845	282
80+	3447	1724	862	288

Female

Preferred		Effective Date: 01/15/2020 Plan Code: P61		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1627	814	407	136
66	1751	876	438	146
67	1856	928	464	155
68	1952	976	488	163
69	2055	1028	514	172
70	2173	1087	544	182
71	2235	1118	559	187
72	2280	1140	570	190
73	2333	1167	584	195
74	2376	1188	594	198
75	2428	1214	607	203
76	2466	1233	617	206
77	2499	1250	625	209
78	2531	1266	633	211
79	2552	1276	638	213
80+	2605	1303	652	218

Standard		Effective Date: 01/15/2020 Plan Code: P63		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1870	935	468	156
66	2013	1007	504	168
67	2134	1067	534	178
68	2244	1122	561	187
69	2362	1181	591	197
70	2498	1249	625	209
71	2570	1285	643	215
72	2621	1311	656	219
73	2683	1342	671	224
74	2731	1366	683	228
75	2791	1396	698	233
76	2835	1418	709	237
77	2873	1437	719	240
78	2910	1455	728	243
79	2934	1467	734	245
80+	2995	1498	749	250

PLAN N - AREA 2 (ZIP 430-439; 450-459)

Male

Preferred		Effective Date: 01/01/2024 Plan Code: 5DM		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2863	1432	716	239
66	2984	1492	746	249
67	3091	1546	773	258
68	3184	1592	796	266
69	3306	1653	827	276
70	3417	1709	855	285
71	3507	1754	877	293
72	3559	1780	890	297
73	3690	1845	923	308
74	3801	1901	951	317
75	3912	1956	978	326
76	4010	2005	1003	335
77	4108	2054	1027	343
78	4206	2103	1052	351
79	4304	2152	1076	359
80+	4457	2229	1115	372

Standard		Effective Date: 01/01/2024 Plan Code: 5DO		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3295	1648	824	275
66	3434	1717	859	287
67	3558	1779	890	297
68	3664	1832	916	306
69	3804	1902	951	317
70	3932	1966	983	328
71	4036	2018	1009	337
72	4096	2048	1024	342
73	4246	2123	1062	354
74	4374	2187	1094	365
75	4502	2251	1126	376
76	4614	2307	1154	385
77	4727	2364	1182	394
78	4839	2420	1210	404
79	4953	2477	1239	413
80+	5129	2565	1283	428

Female

Preferred		Effective Date: 01/01/2024 Plan Code: 5DN		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2491	1246	623	208
66	2596	1298	649	217
67	2689	1345	673	225
68	2769	1385	693	231
69	2875	1438	719	240
70	2972	1486	743	248
71	3051	1526	763	255
72	3096	1548	774	258
73	3210	1605	803	268
74	3306	1653	827	276
75	3403	1702	851	284
76	3488	1744	872	291
77	3573	1787	894	298
78	3658	1829	915	305
79	3744	1872	936	312
80+	3877	1939	970	324

Standard		Effective Date: 01/01/2024 Plan Code: 5DP		
Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2863	1432	716	239
66	2984	1492	746	249
67	3091	1546	773	258
68	3184	1592	796	266
69	3306	1653	827	276
70	3417	1709	855	285
71	3507	1754	877	293
72	3559	1780	890	297
73	3690	1845	923	308
74	3801	1901	951	317
75	3912	1956	978	326
76	4010	2005	1003	335
77	4108	2054	1027	343
78	4206	2103	1052	351
79	4304	2152	1076	359
80+	4457	2229	1115	372

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 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 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* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$240 (Part B Deductible) \$0
Part B Excess Charges (Above Medicare-Approved Amounts)	\$0	\$0	All Costs
BLOOD First 3 pints Next \$240 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$240 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES – Tests for diagnostic services	100%	\$0	\$0

PARTS A & B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$240 (Part B Deductible) \$0
Part B Excess Charges (Above Medicare-Approved Amounts)	\$0	\$0	All Costs
BLOOD First 3 pints Next \$240 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$240 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES – Tests for diagnostic services	100%	\$0	\$0

PARTS A & B

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

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

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

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* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$240 (Part B Deductible) Generally 20%	\$0 \$0
Part B Excess Charges (Above Medicare-Approved Amounts)	\$0	\$0	All Costs
BLOOD First 3 pints Next \$240 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All Costs \$240 (Part B Deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES – Tests for diagnostic services	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies – Durable medical equipment First \$240 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	100% \$0 80%	\$0 \$240 (Part B Deductible) 20%	\$0 \$0 \$0
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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 Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
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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* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$240 (Part B Deductible) \$0
Part B Excess Charges (Above Medicare-Approved Amounts)	\$0	\$0	All Costs
BLOOD First 3 pints Next \$240 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$240 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES – Tests for diagnostic services	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies – Durable medical equipment First \$240 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$240 (Part B Deductible) \$0
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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 Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
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PLAN F
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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
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* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$240 (Part B Deductible) Generally 20%	\$0 \$0
Part B Excess Charges (Above Medicare-Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$240 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All Costs \$240 (Part B Deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES – Tests for diagnostic services	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies – Durable medical equipment First \$240 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	100% \$0 80%	\$0 \$240 (Part B Deductible) 20%	\$0 \$0 \$0
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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 Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
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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 61st thru 90th day 91st day and after: – While using 60 lifetime reserve days Once lifetime reserve days are used: – Additional 365 days – Beyond the Additional 365 days	 All but \$1632 All but \$408 a day All but \$816 a day \$0 \$0	 \$1632 (Part A Deductible) \$408 a day \$816 a day 100% of Medicare-Eligible Expenses \$0	 \$0 \$0 \$0 \$0 *** All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	 All approved amounts All but \$204 a day \$0	 \$0 Up to \$204 a day \$0	 \$0 \$0 All Costs
BLOOD First 3 pints Additional Amounts	 \$0 100%	 3 pints \$0	 \$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

*** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you the balance based on any difference between its billed charges and the amount Medicare would have paid.

HIGH DEDUCTIBLE PLAN F

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

- * Once you have been billed \$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
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 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.

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 (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

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.

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 Next \$240 of Medicare-Approved Amounts*	\$0 \$0	All Costs \$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 – Durable medical equipment First \$240 of Medicare-Approved Amounts*	100% \$0	\$0 \$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 Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
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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 **** Preventive Benefits for Medicare-Covered Services Remainder of Medicare-Approved Amounts	\$0 Generally 80% or more of Medicare-approved amounts Generally 80%	\$0 Remainder of Medicare-approved amounts Generally 10%	\$240 (Part B Deductible) **** ♦ All costs above Medicare-approved amounts 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 Next \$240 of Medicare-Approved Amounts **** Remainder of Medicare-Approved Amounts	\$0 \$0 Generally 80%	50% \$0 Generally 10%	50% ♦ \$240 (Part B Deductible) **** ♦ 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 – Durable medical equipment First \$240 of Medicare-Approved Amounts ***** Remainder of Medicare-Approved Amounts	100% \$0 80%	\$0 \$0 10%	\$0 \$240 (Part B Deductible) ♦ 10% ♦
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* 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 **** Preventive Benefits for Medicare-Covered Services Remainder of Medicare-Approved Amounts	\$0 Generally 80% or more of Medicare-approved amounts Generally 80%	\$0 Remainder of Medicare-approved amounts Generally 15%	\$240 (Part B Deductible) **** ♦ All costs above Medicare-approved amounts 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 Next \$240 of Medicare-Approved Amounts **** Remainder of Medicare-Approved Amounts	\$0 \$0 Generally 80%	75% \$0 Generally 15%	25% ♦ \$240 (Part B Deductible) **** ♦ 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 – Durable medical equipment First \$240 of Medicare-Approved Amounts ***** Remainder of Medicare-Approved Amounts	100% \$0 80%	\$0 \$0 15%	\$0 \$240 (Part B Deductible) ♦ 5% ♦
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* 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* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$0 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.	\$240 (Part B Deductible) 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