

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, 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	1967	984	492	164	5A9	08/01/2021
B	3772	1886	943	315	5AR	09/01/2023
C	4850	2425	1213	405	5B9	09/01/2023
D	4262	2131	1066	356	5BR	09/01/2023
F	4441	2221	1111	371	5C9	09/01/2023
HDF	671	336	168	56	5CR	09/01/2023
G	3875	1938	969	323	5D9	09/01/2023
HDG	614	307	154	52	5HT	09/01/2023

Standard						
Plan	A	SA	Q	M	Plan Code	Effective Date
A	2264	1132	566	189	5AB	08/01/2021
B	4341	2171	1086	362	5AT	09/01/2023
C	5581	2791	1396	466	5BB	09/01/2023
D	4905	2453	1227	409	5BT	09/01/2023
F	5110	2555	1278	426	5CB	09/01/2023
HDF	772	386	193	65	5CT	09/01/2023
G	4459	2230	1115	372	5DB	09/01/2023
HDG	707	354	177	59	5HV	09/01/2023

Female

Preferred						
Plan	A	SA	Q	M	Plan Code	Effective Date
A	1711	856	428	143	5AA	08/01/2021
B	3281	1641	821	274	5AS	09/01/2023
C	4219	2110	1055	352	5BA	09/01/2023
D	3708	1854	927	309	5BS	09/01/2023
F	3863	1932	966	322	5CA	09/01/2023
HDF	583	292	146	49	5CS	09/01/2023
G	3370	1685	843	281	5DA	09/01/2023
HDG	534	267	134	45	5HU	09/01/2023

Standard						
Plan	A	SA	Q	M	Plan Code	Effective Date
A	1967	984	492	164	5AC	08/01/2021
B	3772	1886	943	315	5AU	09/01/2023
C	4850	2425	1213	405	5BC	09/01/2023
D	4262	2131	1066	356	5BU	09/01/2023
F	4441	2221	1111	371	5CC	09/01/2023
HDF	671	336	168	56	5CU	09/01/2023
G	3875	1938	969	323	5DC	09/01/2023
HDG	614	307	154	52	5HW	09/01/2023

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	1967	984	492	164	5A9	08/01/2021
B	3772	1886	943	315	5AR	09/01/2023
C	4850	2425	1213	405	5B9	09/01/2023
D	4262	2131	1066	356	5BR	09/01/2023
F	4441	2221	1111	371	5C9	09/01/2023
HDF	671	336	168	56	5CR	09/01/2023
G	3875	1938	969	323	5D9	09/01/2023
HDG	614	307	154	52	5HT	09/01/2023
N	2813	1407	704	235	5DR	09/01/2023

Standard						
Plan	A	SA	Q	M	Plan Code	Effective Date
A	2264	1132	566	189	5AB	08/01/2021
B	4341	2171	1086	362	5AT	09/01/2023
C	5581	2791	1396	466	5BB	09/01/2023
D	4905	2453	1227	409	5BT	09/01/2023
F	5110	2555	1278	426	5CB	09/01/2023
HDF	772	386	193	65	5CT	09/01/2023
G	4459	2230	1115	372	5DB	09/01/2023
HDG	707	354	177	59	5HV	09/01/2023
N	3237	1619	810	270	5DT	09/01/2023

Female

Preferred						
Plan	A	SA	Q	M	Plan Code	Effective Date
A	1711	856	428	143	5AA	08/01/2021
B	3281	1641	821	274	5AS	09/01/2023
C	4219	2110	1055	352	5BA	09/01/2023
D	3708	1854	927	309	5BS	09/01/2023
F	3863	1932	966	322	5CA	09/01/2023
HDF	583	292	146	49	5CS	09/01/2023
G	3370	1685	843	281	5DA	09/01/2023
HDG	534	267	134	45	5HU	09/01/2023
N	2447	1224	612	204	5DS	09/01/2023

Standard						
Plan	A	SA	Q	M	Plan Code	Effective Date
A	1967	984	492	164	5AC	08/01/2021
B	3772	1886	943	315	5AU	09/01/2023
C	4850	2425	1213	405	5BC	09/01/2023
D	4262	2131	1066	356	5BU	09/01/2023
F	4441	2221	1111	371	5CC	09/01/2023
HDF	671	336	168	56	5CU	09/01/2023
G	3875	1938	969	323	5DC	09/01/2023
HDG	614	307	154	52	5HW	09/01/2023
N	2813	1407	704	235	5DU	09/01/2023

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: 06/15/2019		Plan Code: 5A0
Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	1837	919	460	154
66	1904	952	476	159
67	1904	952	476	159
68	1904	952	476	159
69	1904	952	476	159
70	1967	984	492	164
71	1967	984	492	164
72	1967	984	492	164
73	1967	984	492	164
74	1967	984	492	164
75	1967	984	492	164
76	1967	984	492	164
77	1967	984	492	164
78	1967	984	492	164
79	1967	984	492	164
80+	1967	984	492	164

Standard		Effective Date: 06/15/2019		Plan Code: 5A2
Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	2114	1057	529	177
66	2191	1096	548	183
67	2191	1096	548	183
68	2191	1096	548	183
69	2191	1096	548	183
70	2264	1132	566	189
71	2264	1132	566	189
72	2264	1132	566	189
73	2264	1132	566	189
74	2264	1132	566	189
75	2264	1132	566	189
76	2264	1132	566	189
77	2264	1132	566	189
78	2264	1132	566	189
79	2264	1132	566	189
80+	2264	1132	566	189

Female				
Preferred		Effective Date: 06/15/2019		Plan Code: 5A1
Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	1598	799	400	134
66	1656	828	414	138
67	1656	828	414	138
68	1656	828	414	138
69	1656	828	414	138
70	1711	856	428	143
71	1711	856	428	143
72	1711	856	428	143
73	1711	856	428	143
74	1711	856	428	143
75	1711	856	428	143
76	1711	856	428	143
77	1711	856	428	143
78	1711	856	428	143
79	1711	856	428	143
80+	1711	856	428	143

Standard		Effective Date: 06/15/2019		Plan Code: 5A3
Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	1837	919	460	154
66	1904	952	476	159
67	1904	952	476	159
68	1904	952	476	159
69	1904	952	476	159
70	1967	984	492	164
71	1967	984	492	164
72	1967	984	492	164
73	1967	984	492	164
74	1967	984	492	164
75	1967	984	492	164
76	1967	984	492	164
77	1967	984	492	164
78	1967	984	492	164
79	1967	984	492	164
80+	1967	984	492	164

PLAN B

Male				
Preferred		Effective Date: 09/01/2023		Plan Code: 5AI
Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3460	1730	865	289
66	3621	1811	906	302
67	3621	1811	906	302
68	3621	1811	906	302
69	3621	1811	906	302
70	3812	1906	953	318
71	3812	1906	953	318
72	3812	1906	953	318
73	3812	1906	953	318
74	3812	1906	953	318
75	3812	1906	953	318
76	3812	1906	953	318
77	3812	1906	953	318
78	3812	1906	953	318
79	3812	1906	953	318
80+	3812	1906	953	318

Standard		Effective Date: 09/01/2023		Plan Code: 5AK
Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3982	1991	996	332
66	4166	2083	1042	348
67	4166	2083	1042	348
68	4166	2083	1042	348
69	4166	2083	1042	348
70	4386	2193	1097	366
71	4386	2193	1097	366
72	4386	2193	1097	366
73	4386	2193	1097	366
74	4386	2193	1097	366
75	4386	2193	1097	366
76	4386	2193	1097	366
77	4386	2193	1097	366
78	4386	2193	1097	366
79	4386	2193	1097	366
80+	4386	2193	1097	366

Female				
Preferred		Effective Date: 09/01/2023		Plan Code: 5AJ
Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3010	1505	753	251
66	3149	1575	788	263
67	3149	1575	788	263
68	3149	1575	788	263
69	3149	1575	788	263
70	3316	1658	829	277
71	3316	1658	829	277
72	3316	1658	829	277
73	3316	1658	829	277
74	3316	1658	829	277
75	3316	1658	829	277
76	3316	1658	829	277
77	3316	1658	829	277
78	3316	1658	829	277
79	3316	1658	829	277
80+	3316	1658	829	277

Standard		Effective Date: 09/01/2023		Plan Code: 5AL
Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3460	1730	865	289
66	3621	1811	906	302
67	3621	1811	906	302
68	3621	1811	906	302
69	3621	1811	906	302
70	3812	1906	953	318
71	3812	1906	953	318
72	3812	1906	953	318
73	3812	1906	953	318
74	3812	1906	953	318
75	3812	1906	953	318
76	3812	1906	953	318
77	3812	1906	953	318
78	3812	1906	953	318
79	3812	1906	953	318
80+	3812	1906	953	318

PLAN C

Male				
Preferred		Effective Date: 09/01/2023		Plan Code: 5B0
Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3897	1949	975	325
66	4112	2056	1028	343
67	4112	2056	1028	343
68	4112	2056	1028	343
69	4112	2056	1028	343
70	4431	2216	1108	370
71	4431	2216	1108	370
72	4431	2216	1108	370
73	4431	2216	1108	370
74	4431	2216	1108	370
75	4668	2334	1167	389
76	4668	2334	1167	389
77	4668	2334	1167	389
78	4668	2334	1167	389
79	4668	2334	1167	389
80+	4850	2425	1213	405

Standard		Effective Date: 09/01/2023		Plan Code: 5B2
Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	4485	2243	1122	374
66	4732	2366	1183	395
67	4732	2366	1183	395
68	4732	2366	1183	395
69	4732	2366	1183	395
70	5099	2550	1275	425
71	5099	2550	1275	425
72	5099	2550	1275	425
73	5099	2550	1275	425
74	5099	2550	1275	425
75	5372	2686	1343	448
76	5372	2686	1343	448
77	5372	2686	1343	448
78	5372	2686	1343	448
79	5372	2686	1343	448
80+	5581	2791	1396	466

Female				
Preferred		Effective Date: 09/01/2023		Plan Code: 5B1
Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3390	1695	848	283
66	3577	1789	895	299
67	3577	1789	895	299
68	3577	1789	895	299
69	3577	1789	895	299
70	3854	1927	964	322
71	3854	1927	964	322
72	3854	1927	964	322
73	3854	1927	964	322
74	3854	1927	964	322
75	4061	2031	1016	339
76	4061	2031	1016	339
77	4061	2031	1016	339
78	4061	2031	1016	339
79	4061	2031	1016	339
80+	4219	2110	1055	352

Standard		Effective Date: 09/01/2023		Plan Code: 5B3
Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3897	1949	975	325
66	4112	2056	1028	343
67	4112	2056	1028	343
68	4112	2056	1028	343
69	4112	2056	1028	343
70	4431	2216	1108	370
71	4431	2216	1108	370
72	4431	2216	1108	370
73	4431	2216	1108	370
74	4431	2216	1108	370
75	4668	2334	1167	389
76	4668	2334	1167	389
77	4668	2334	1167	389
78	4668	2334	1167	389
79	4668	2334	1167	389
80+	4850	2425	1213	405

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

PLAN D

Male				
Preferred		Effective Date: 09/01/2023		Plan Code: 5BI
Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3610	1805	903	301
66	3820	1910	955	319
67	3820	1910	955	319
68	3820	1910	955	319
69	3820	1910	955	319
70	4135	2068	1034	345
71	4135	2068	1034	345
72	4135	2068	1034	345
73	4135	2068	1034	345
74	4135	2068	1034	345
75	4371	2186	1093	365
76	4371	2186	1093	365
77	4371	2186	1093	365
78	4371	2186	1093	365
79	4371	2186	1093	365
80+	4548	2274	1137	379

Standard		Effective Date: 09/01/2023		Plan Code: 5BK
Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	4154	2077	1039	347
66	4396	2198	1099	367
67	4396	2198	1099	367
68	4396	2198	1099	367
69	4396	2198	1099	367
70	4759	2380	1190	397
71	4759	2380	1190	397
72	4759	2380	1190	397
73	4759	2380	1190	397
74	4759	2380	1190	397
75	5030	2515	1258	420
76	5030	2515	1258	420
77	5030	2515	1258	420
78	5030	2515	1258	420
79	5030	2515	1258	420
80+	5233	2617	1309	437

Female				
Preferred		Effective Date: 09/01/2023		Plan Code: 5BJ
Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3140	1570	785	262
66	3323	1662	831	277
67	3323	1662	831	277
68	3323	1662	831	277
69	3323	1662	831	277
70	3597	1799	900	300
71	3597	1799	900	300
72	3597	1799	900	300
73	3597	1799	900	300
74	3597	1799	900	300
75	3802	1901	951	317
76	3802	1901	951	317
77	3802	1901	951	317
78	3802	1901	951	317
79	3802	1901	951	317
80+	3956	1978	989	330

Standard		Effective Date: 09/01/2023		Plan Code: 5BL
Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3610	1805	903	301
66	3820	1910	955	319
67	3820	1910	955	319
68	3820	1910	955	319
69	3820	1910	955	319
70	4135	2068	1034	345
71	4135	2068	1034	345
72	4135	2068	1034	345
73	4135	2068	1034	345
74	4135	2068	1034	345
75	4371	2186	1093	365
76	4371	2186	1093	365
77	4371	2186	1093	365
78	4371	2186	1093	365
79	4371	2186	1093	365
80+	4548	2274	1137	379

PLAN F

Male				
Preferred		Effective Date: 09/01/2023		Plan Code: 5C0
Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3911	1956	978	326
66	4127	2064	1032	344
67	4127	2064	1032	344
68	4127	2064	1032	344
69	4127	2064	1032	344
70	4443	2222	1111	371
71	4443	2222	1111	371
72	4443	2222	1111	371
73	4443	2222	1111	371
74	4443	2222	1111	371
75	4684	2342	1171	391
76	4684	2342	1171	391
77	4684	2342	1171	391
78	4684	2342	1171	391
79	4684	2342	1171	391
80+	4865	2433	1217	406

Standard		Effective Date: 09/01/2023		Plan Code: 5C2
Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	4501	2251	1126	376
66	4749	2375	1188	396
67	4749	2375	1188	396
68	4749	2375	1188	396
69	4749	2375	1188	396
70	5113	2557	1279	427
71	5113	2557	1279	427
72	5113	2557	1279	427
73	5113	2557	1279	427
74	5113	2557	1279	427
75	5390	2695	1348	450
76	5390	2695	1348	450
77	5390	2695	1348	450
78	5390	2695	1348	450
79	5390	2695	1348	450
80+	5598	2799	1400	467

Female				
Preferred		Effective Date: 09/01/2023		Plan Code: 5C1
Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3402	1701	851	284
66	3590	1795	898	300
67	3590	1795	898	300
68	3590	1795	898	300
69	3590	1795	898	300
70	3865	1933	967	323
71	3865	1933	967	323
72	3865	1933	967	323
73	3865	1933	967	323
74	3865	1933	967	323
75	4075	2038	1019	340
76	4075	2038	1019	340
77	4075	2038	1019	340
78	4075	2038	1019	340
79	4075	2038	1019	340
80+	4232	2116	1058	353

Standard		Effective Date: 09/01/2023		Plan Code: 5C3
Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3911	1956	978	326
66	4127	2064	1032	344
67	4127	2064	1032	344
68	4127	2064	1032	344
69	4127	2064	1032	344
70	4443	2222	1111	371
71	4443	2222	1111	371
72	4443	2222	1111	371
73	4443	2222	1111	371
74	4443	2222	1111	371
75	4684	2342	1171	391
76	4684	2342	1171	391
77	4684	2342	1171	391
78	4684	2342	1171	391
79	4684	2342	1171	391
80+	4865	2433	1217	406

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

PLAN HDF

Male				
Preferred		Effective Date: 09/01/2023		Plan Code: 5CI
Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	615	308	154	52
66	656	328	164	55
67	656	328	164	55
68	656	328	164	55
69	656	328	164	55
70	719	360	180	60
71	719	360	180	60
72	719	360	180	60
73	719	360	180	60
74	719	360	180	60
75	806	403	202	68
76	806	403	202	68
77	806	403	202	68
78	806	403	202	68
79	806	403	202	68
80+	886	443	222	74

Standard		Effective Date: 09/01/2023		Plan Code: 5CK
Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	708	354	177	59
66	755	378	189	63
67	755	378	189	63
68	755	378	189	63
69	755	378	189	63
70	827	414	207	69
71	827	414	207	69
72	827	414	207	69
73	827	414	207	69
74	827	414	207	69
75	928	464	232	78
76	928	464	232	78
77	928	464	232	78
78	928	464	232	78
79	928	464	232	78
80+	1020	510	255	85

Female				
Preferred		Effective Date: 09/01/2023		Plan Code: 5CJ
Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	535	268	134	45
66	570	285	143	48
67	570	285	143	48
68	570	285	143	48
69	570	285	143	48
70	625	313	157	53
71	625	313	157	53
72	625	313	157	53
73	625	313	157	53
74	625	313	157	53
75	701	351	176	59
76	701	351	176	59
77	701	351	176	59
78	701	351	176	59
79	701	351	176	59
80+	771	386	193	65

Standard		Effective Date: 09/01/2023		Plan Code: 5CL
Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	615	308	154	52
66	656	328	164	55
67	656	328	164	55
68	656	328	164	55
69	656	328	164	55
70	719	360	180	60
71	719	360	180	60
72	719	360	180	60
73	719	360	180	60
74	719	360	180	60
75	806	403	202	68
76	806	403	202	68
77	806	403	202	68
78	806	403	202	68
79	806	403	202	68
80+	886	443	222	74

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

PLAN G

Male				
Preferred		Effective Date: 09/01/2023		Plan Code: 5D0
Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3468	1734	867	289
66	3670	1835	918	306
67	3670	1835	918	306
68	3670	1835	918	306
69	3670	1835	918	306
70	3971	1986	993	331
71	3971	1986	993	331
72	3971	1986	993	331
73	3971	1986	993	331
74	3971	1986	993	331
75	4197	2099	1050	350
76	4197	2099	1050	350
77	4197	2099	1050	350
78	4197	2099	1050	350
79	4197	2099	1050	350
80+	4368	2184	1092	364

Standard		Effective Date: 09/01/2023		Plan Code: 5D2
Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3991	1996	998	333
66	4223	2112	1056	352
67	4223	2112	1056	352
68	4223	2112	1056	352
69	4223	2112	1056	352
70	4569	2285	1143	381
71	4569	2285	1143	381
72	4569	2285	1143	381
73	4569	2285	1143	381
74	4569	2285	1143	381
75	4830	2415	1208	403
76	4830	2415	1208	403
77	4830	2415	1208	403
78	4830	2415	1208	403
79	4830	2415	1208	403
80+	5027	2514	1257	419

Female				
Preferred		Effective Date: 09/01/2023		Plan Code: 5D1
Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3016	1508	754	252
66	3192	1596	798	266
67	3192	1596	798	266
68	3192	1596	798	266
69	3192	1596	798	266
70	3454	1727	864	288
71	3454	1727	864	288
72	3454	1727	864	288
73	3454	1727	864	288
74	3454	1727	864	288
75	3651	1826	913	305
76	3651	1826	913	305
77	3651	1826	913	305
78	3651	1826	913	305
79	3651	1826	913	305
80+	3800	1900	950	317

Standard		Effective Date: 09/01/2023		Plan Code: 5D3
Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3468	1734	867	289
66	3670	1835	918	306
67	3670	1835	918	306
68	3670	1835	918	306
69	3670	1835	918	306
70	3971	1986	993	331
71	3971	1986	993	331
72	3971	1986	993	331
73	3971	1986	993	331
74	3971	1986	993	331
75	4197	2099	1050	350
76	4197	2099	1050	350
77	4197	2099	1050	350
78	4197	2099	1050	350
79	4197	2099	1050	350
80+	4368	2184	1092	364

PLAN HDG

Male				
Preferred		Effective Date: 09/01/2020		Plan Code: 5HK
Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	575	288	144	48
66	613	307	154	52
67	613	307	154	52
68	613	307	154	52
69	613	307	154	52
70	672	336	168	56
71	672	336	168	56
72	672	336	168	56
73	672	336	168	56
74	672	336	168	56
75	754	377	189	63
76	754	377	189	63
77	754	377	189	63
78	754	377	189	63
79	754	377	189	63
80+	829	415	208	70

Standard		Effective Date: 09/01/2020		Plan Code: 5HM
Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	661	331	166	56
66	705	353	177	59
67	705	353	177	59
68	705	353	177	59
69	705	353	177	59
70	773	387	194	65
71	773	387	194	65
72	773	387	194	65
73	773	387	194	65
74	773	387	194	65
75	868	434	217	73
76	868	434	217	73
77	868	434	217	73
78	868	434	217	73
79	868	434	217	73
80+	954	477	239	80

Female				
Preferred		Effective Date: 09/01/2020		Plan Code: 5HL
Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	500	250	125	42
66	533	267	134	45
67	533	267	134	45
68	533	267	134	45
69	533	267	134	45
70	584	292	146	49
71	584	292	146	49
72	584	292	146	49
73	584	292	146	49
74	584	292	146	49
75	656	328	164	55
76	656	328	164	55
77	656	328	164	55
78	656	328	164	55
79	656	328	164	55
80+	721	361	181	61

Standard		Effective Date: 09/01/2020		Plan Code: 5HN
Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	575	288	144	48
66	613	307	154	52
67	613	307	154	52
68	613	307	154	52
69	613	307	154	52
70	672	336	168	56
71	672	336	168	56
72	672	336	168	56
73	672	336	168	56
74	672	336	168	56
75	754	377	189	63
76	754	377	189	63
77	754	377	189	63
78	754	377	189	63
79	754	377	189	63
80+	829	415	208	70

PLAN N

Male				
Preferred		Effective Date: 09/01/2023		Plan Code: 5DI
Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	2813	1407	704	235
66	2984	1492	746	249
67	2984	1492	746	249
68	2984	1492	746	249
69	2984	1492	746	249
70	3244	1622	811	271
71	3244	1622	811	271
72	3244	1622	811	271
73	3244	1622	811	271
74	3244	1622	811	271
75	3460	1730	865	289
76	3460	1730	865	289
77	3460	1730	865	289
78	3460	1730	865	289
79	3460	1730	865	289
80+	3635	1818	909	303

Standard		Effective Date: 09/01/2023		Plan Code: 5DK
Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3237	1619	810	270
66	3434	1717	859	287
67	3434	1717	859	287
68	3434	1717	859	287
69	3434	1717	859	287
70	3732	1866	933	311
71	3732	1866	933	311
72	3732	1866	933	311
73	3732	1866	933	311
74	3732	1866	933	311
75	3982	1991	996	332
76	3982	1991	996	332
77	3982	1991	996	332
78	3982	1991	996	332
79	3982	1991	996	332
80+	4184	2092	1046	349

Female				
Preferred		Effective Date: 09/01/2023		Plan Code: 5DJ
Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	2447	1224	612	204
66	2596	1298	649	217
67	2596	1298	649	217
68	2596	1298	649	217
69	2596	1298	649	217
70	2821	1411	706	236
71	2821	1411	706	236
72	2821	1411	706	236
73	2821	1411	706	236
74	2821	1411	706	236
75	3010	1505	753	251
76	3010	1505	753	251
77	3010	1505	753	251
78	3010	1505	753	251
79	3010	1505	753	251
80+	3162	1581	791	264

Standard		Effective Date: 09/01/2023		Plan Code: 5DL
Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	2813	1407	704	235
66	2984	1492	746	249
67	2984	1492	746	249
68	2984	1492	746	249
69	2984	1492	746	249
70	3244	1622	811	271
71	3244	1622	811	271
72	3244	1622	811	271
73	3244	1622	811	271
74	3244	1622	811	271
75	3460	1730	865	289
76	3460	1730	865	289
77	3460	1730	865	289
78	3460	1730	865	289
79	3460	1730	865	289
80+	3635	1818	909	303

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* 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
--	--------------------	-------------------	---

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
--	--------------------	-------------------	---

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
--	----------------------------	---	-----------------------

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
--	------------	--	---

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
--	----------------------------	---------------------------	---

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
--	------------	--	---

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 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.

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* 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
--	----------------------------	---	-----------------------

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
--	------------	--	---

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 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.

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 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
--	------------	--	---

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 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
--	--------------------	-------------------	---

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
--	------------	--	---