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. Your premiums may also be increased due to increasing health costs for all policies in your class.

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.

PLAN A

Male

Preferred Effective Date: 06/01/2020 Plan Code: 5A4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1957	979	490	164
66	2049	1025	513	171
67	2132	1066	533	178
68	2197	1099	550	184
69	2278	1139	570	190
70	2353	1177	589	197
71	2414	1207	604	202
72	2437	1219	610	204
73	2468	1234	617	206
74	2483	1242	621	207
75	2508	1254	627	209
76	2511	1256	628	210
77	2511	1256	628	210
78	2511	1256	628	210
79	2511	1256	628	210
80+	2511	1256	628	210

Standard Effective Date: 06/01/2020 Plan Code: 5A6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2252	1126	563	188
66	2358	1179	590	197
67	2453	1227	614	205
68	2528	1264	632	211
69	2621	1311	656	219
70	2707	1354	677	226
71	2778	1389	695	232
72	2805	1403	702	234
73	2840	1420	710	237
74	2857	1429	715	239
75	2886	1443	722	241
76	2889	1445	723	241
77	2889	1445	723	241
78	2889	1445	723	241
79	2889	1445	723	241
80+	2889	1445	723	241

Female

Preferred Effective Date: 06/01/2020 Plan Code: 5A5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1702	851	426	142
66	1783	892	446	149
67	1854	927	464	155
68	1911	956	478	160
69	1982	991	496	166
70	2047	1024	512	171
71	2100	1050	525	175
72	2120	1060	530	177
73	2147	1074	537	179
74	2160	1080	540	180
75	2181	1091	546	182
76	2184	1092	546	182
77	2184	1092	546	182
78	2184	1092	546	182
79	2184	1092	546	182
80+	2184	1092	546	182

Standard Effective Date: 06/01/2020 Plan Code: 5A7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1957	979	490	164
66	2049	1025	513	171
67	2132	1066	533	178
68	2197	1099	550	184
69	2278	1139	570	190
70	2353	1177	589	197
71	2414	1207	604	202
72	2437	1219	610	204
73	2468	1234	617	206
74	2483	1242	621	207
75	2508	1254	627	209
76	2511	1256	628	210
77	2511	1256	628	210
78	2511	1256	628	210
79	2511	1256	628	210
80+	2511	1256	628	210

PLAN B

Male

Preferred Effective Date: 06/01/2023 Plan Code: 5AM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3181	1591	796	266
66	3348	1674	837	279
67	3496	1748	874	292
68	3621	1811	906	302
69	3776	1888	944	315
70	3914	1957	979	327
71	4030	2015	1008	336
72	4103	2052	1026	342
73	4177	2089	1045	349
74	4232	2116	1058	353
75	4300	2150	1075	359
76	4338	2169	1085	362
77	4345	2173	1087	363
78	4354	2177	1089	363
79	4366	2183	1092	364
80+	4366	2183	1092	364

Standard Effective Date: 06/01/2023 Plan Code: 5AO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3660	1830	915	305
66	3853	1927	964	322
67	4023	2012	1006	336
68	4166	2083	1042	348
69	4346	2173	1087	363
70	4504	2252	1126	376
71	4637	2319	1160	387
72	4722	2361	1181	394
73	4807	2404	1202	401
74	4871	2436	1218	406
75	4948	2474	1237	413
76	4992	2496	1248	416
77	5000	2500	1250	417
78	5011	2506	1253	418
79	5024	2512	1256	419
80+	5024	2512	1256	419

Female

Preferred Effective Date: 06/01/2023 Plan Code: 5AN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2767	1384	692	231
66	2912	1456	728	243
67	3041	1521	761	254
68	3149	1575	788	263
69	3285	1643	822	274
70	3405	1703	852	284
71	3505	1753	877	293
72	3569	1785	893	298
73	3633	1817	909	303
74	3682	1841	921	307
75	3740	1870	935	312
76	3774	1887	944	315
77	3779	1890	945	315
78	3788	1894	947	316
79	3798	1899	950	317
80+	3798	1899	950	317

Standard Effective Date: 06/01/2023 Plan Code: 5AP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3181	1591	796	266
66	3348	1674	837	279
67	3496	1748	874	292
68	3621	1811	906	302
69	3776	1888	944	315
70	3914	1957	979	327
71	4030	2015	1008	336
72	4103	2052	1026	342
73	4177	2089	1045	349
74	4232	2116	1058	353
75	4300	2150	1075	359
76	4338	2169	1085	362
77	4345	2173	1087	363
78	4354	2177	1089	363
79	4366	2183	1092	364
80+	4366	2183	1092	364

PLAN C

Male

Preferred Effective Date: 06/01/2023 Plan Code: 5B4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3340	1670	835	279
66	3516	1758	879	293
67	3672	1836	918	306
68	3816	1908	954	318
69	3993	1997	999	333
70	4160	2080	1040	347
71	4307	2154	1077	359
72	4414	2207	1104	368
73	4524	2262	1131	377
74	4612	2306	1153	385
75	4699	2350	1175	392
76	4772	2386	1193	398
77	4851	2426	1213	405
78	4927	2464	1232	411
79	5007	2504	1252	418
80+	5129	2565	1283	428

Standard Effective Date: 06/01/2023 Plan Code: 5B6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3843	1922	961	321
66	4046	2023	1012	338
67	4225	2113	1057	353
68	4391	2196	1098	366
69	4595	2298	1149	383
70	4787	2394	1197	399
71	4957	2479	1240	414
72	5079	2540	1270	424
73	5206	2603	1302	434
74	5307	2654	1327	443
75	5408	2704	1352	451
76	5491	2746	1373	458
77	5582	2791	1396	466
78	5669	2835	1418	473
79	5762	2881	1441	481
80+	5902	2951	1476	492

Female

Preferred Effective Date: 06/01/2023 Plan Code: 5B5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2905	1453	727	243
66	3058	1529	765	255
67	3194	1597	799	267
68	3319	1660	830	277
69	3474	1737	869	290
70	3618	1809	905	302
71	3747	1874	937	313
72	3840	1920	960	320
73	3935	1968	984	328
74	4011	2006	1003	335
75	4088	2044	1022	341
76	4151	2076	1038	346
77	4220	2110	1055	352
78	4285	2143	1072	358
79	4355	2178	1089	363
80+	4461	2231	1116	372

Standard Effective Date: 06/01/2023 Plan Code: 5B7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3340	1670	835	279
66	3516	1758	879	293
67	3672	1836	918	306
68	3816	1908	954	318
69	3993	1997	999	333
70	4160	2080	1040	347
71	4307	2154	1077	359
72	4414	2207	1104	368
73	4524	2262	1131	377
74	4612	2306	1153	385
75	4699	2350	1175	392
76	4772	2386	1193	398
77	4851	2426	1213	405
78	4927	2464	1232	411
79	5007	2504	1252	418
80+	5129	2565	1283	428

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

PLAN D

Male

Preferred Effective Date: 06/01/2023 Plan Code: 5BM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3148	1574	787	263
66	3324	1662	831	277
67	3483	1742	871	291
68	3628	1814	907	303
69	3807	1904	952	318
70	3977	1989	995	332
71	4126	2063	1032	344
72	4234	2117	1059	353
73	4342	2171	1086	362
74	4431	2216	1108	370
75	4525	2263	1132	378
76	4593	2297	1149	383
77	4676	2338	1169	390
78	4754	2377	1189	397
79	4833	2417	1209	403
80+	4959	2480	1240	414

Standard Effective Date: 06/01/2023 Plan Code: 5BO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3623	1812	906	302
66	3825	1913	957	319
67	4008	2004	1002	334
68	4175	2088	1044	348
69	4381	2191	1096	366
70	4577	2289	1145	382
71	4748	2374	1187	396
72	4872	2436	1218	406
73	4997	2499	1250	417
74	5099	2550	1275	425
75	5207	2604	1302	434
76	5286	2643	1322	441
77	5381	2691	1346	449
78	5470	2735	1368	456
79	5561	2781	1391	464
80+	5706	2853	1427	476

Female

Preferred Effective Date: 06/01/2023 Plan Code: 5BN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2739	1370	685	229
66	2891	1446	723	241
67	3029	1515	758	253
68	3156	1578	789	263
69	3312	1656	828	276
70	3460	1730	865	289
71	3589	1795	898	300
72	3683	1842	921	307
73	3777	1889	945	315
74	3854	1927	964	322
75	3936	1968	984	328
76	3996	1998	999	333
77	4067	2034	1017	339
78	4135	2068	1034	345
79	4204	2102	1051	351
80+	4313	2157	1079	360

Standard Effective Date: 06/01/2023 Plan Code: 5BP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3148	1574	787	263
66	3324	1662	831	277
67	3483	1742	871	291
68	3628	1814	907	303
69	3807	1904	952	318
70	3977	1989	995	332
71	4126	2063	1032	344
72	4234	2117	1059	353
73	4342	2171	1086	362
74	4431	2216	1108	370
75	4525	2263	1132	378
76	4593	2297	1149	383
77	4676	2338	1169	390
78	4754	2377	1189	397
79	4833	2417	1209	403
80+	4959	2480	1240	414

PLAN F

Male

Preferred Effective Date: 06/01/2023 Plan Code: 5C4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3553	1777	889	297
66	3734	1867	934	312
67	3895	1948	974	325
68	4051	2026	1013	338
69	4239	2120	1060	354
70	4416	2208	1104	368
71	4569	2285	1143	381
72	4681	2341	1171	391
73	4797	2399	1200	400
74	4891	2446	1223	408
75	4986	2493	1247	416
76	5059	2530	1265	422
77	5145	2573	1287	429
78	5227	2614	1307	436
79	5308	2654	1327	443
80+	5436	2718	1359	453

Standard Effective Date: 06/01/2023 Plan Code: 5C6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	4089	2045	1023	341
66	4297	2149	1075	359
67	4482	2241	1121	374
68	4662	2331	1166	389
69	4878	2439	1220	407
70	5082	2541	1271	424
71	5258	2629	1315	439
72	5387	2694	1347	449
73	5521	2761	1381	461
74	5629	2815	1408	470
75	5738	2869	1435	479
76	5822	2911	1456	486
77	5920	2960	1480	494
78	6015	3008	1504	502
79	6108	3054	1527	509
80+	6256	3128	1564	522

Female

Preferred Effective Date: 06/01/2023 Plan Code: 5C5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3091	1546	773	258
66	3248	1624	812	271
67	3388	1694	847	283
68	3524	1762	881	294
69	3687	1844	922	308
70	3841	1921	961	321
71	3974	1987	994	332
72	4072	2036	1018	340
73	4173	2087	1044	348
74	4255	2128	1064	355
75	4338	2169	1085	362
76	4401	2201	1101	367
77	4475	2238	1119	373
78	4547	2274	1137	379
79	4617	2309	1155	385
80+	4729	2365	1183	395

Standard Effective Date: 06/01/2023 Plan Code: 5C7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3553	1777	889	297
66	3734	1867	934	312
67	3895	1948	974	325
68	4051	2026	1013	338
69	4239	2120	1060	354
70	4416	2208	1104	368
71	4569	2285	1143	381
72	4681	2341	1171	391
73	4797	2399	1200	400
74	4891	2446	1223	408
75	4986	2493	1247	416
76	5059	2530	1265	422
77	5145	2573	1287	429
78	5227	2614	1307	436
79	5308	2654	1327	443
80+	5436	2718	1359	453

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

PLAN HDF

Male

Preferred Effective Date: 06/01/2023 Plan Code: 5CM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	394	197	99	33
66	424	212	106	36
67	454	227	114	38
68	473	237	119	40
69	494	247	124	42
70	514	257	129	43
71	532	266	133	45
72	560	280	140	47
73	587	294	147	49
74	613	307	154	52
75	641	321	161	54
76	666	333	167	56
77	695	348	174	58
78	723	362	181	61
79	753	377	189	63
80+	799	400	200	67

Standard Effective Date: 06/01/2023 Plan Code: 5CO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	454	227	114	38
66	488	244	122	41
67	522	261	131	44
68	544	272	136	46
69	569	285	143	48
70	591	296	148	50
71	612	306	153	51
72	644	322	161	54
73	676	338	169	57
74	705	353	177	59
75	737	369	185	62
76	767	384	192	64
77	800	400	200	67
78	832	416	208	70
79	866	433	217	73
80+	919	460	230	77

Female

Preferred Effective Date: 06/01/2023 Plan Code: 5CN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	343	172	86	29
66	369	185	93	31
67	395	198	99	33
68	412	206	103	35
69	430	215	108	36
70	447	224	112	38
71	463	232	116	39
72	487	244	122	41
73	511	256	128	43
74	533	267	134	45
75	557	279	140	47
76	580	290	145	49
77	605	303	152	51
78	629	315	158	53
79	655	328	164	55
80+	695	348	174	58

Standard Effective Date: 06/01/2023 Plan Code: 5CP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	394	197	99	33
66	424	212	106	36
67	454	227	114	38
68	473	237	119	40
69	494	247	124	42
70	514	257	129	43
71	532	266	133	45
72	560	280	140	47
73	587	294	147	49
74	613	307	154	52
75	641	321	161	54
76	666	333	167	56
77	695	348	174	58
78	723	362	181	61
79	753	377	189	63
80+	799	400	200	67

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

PLAN G

Male

Preferred Effective Date: 06/01/2023 Plan Code: 5D4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3011	1506	753	251
66	3182	1591	796	266
67	3331	1666	833	278
68	3472	1736	868	290
69	3640	1820	910	304
70	3802	1901	951	317
71	3943	1972	986	329
72	4047	2024	1012	338
73	4150	2075	1038	346
74	4237	2119	1060	354
75	4324	2162	1081	361
76	4393	2197	1099	367
77	4467	2234	1117	373
78	4543	2272	1136	379
79	4616	2308	1154	385
80+	4736	2368	1184	395

Standard Effective Date: 06/01/2023 Plan Code: 5D6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3465	1733	867	289
66	3661	1831	916	306
67	3833	1917	959	320
68	3995	1998	999	333
69	4188	2094	1047	349
70	4375	2188	1094	365
71	4537	2269	1135	379
72	4657	2329	1165	389
73	4776	2388	1194	398
74	4875	2438	1219	407
75	4976	2488	1244	415
76	5055	2528	1264	422
77	5141	2571	1286	429
78	5228	2614	1307	436
79	5312	2656	1328	443
80+	5449	2725	1363	455

Female

Preferred Effective Date: 06/01/2023 Plan Code: 5D5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2619	1310	655	219
66	2767	1384	692	231
67	2898	1449	725	242
68	3020	1510	755	252
69	3166	1583	792	264
70	3307	1654	827	276
71	3430	1715	858	286
72	3520	1760	880	294
73	3610	1805	903	301
74	3685	1843	922	308
75	3762	1881	941	314
76	3821	1911	956	319
77	3886	1943	972	324
78	3952	1976	988	330
79	4015	2008	1004	335
80+	4119	2060	1030	344

Standard Effective Date: 06/01/2023 Plan Code: 5D7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3011	1506	753	251
66	3182	1591	796	266
67	3331	1666	833	278
68	3472	1736	868	290
69	3640	1820	910	304
70	3802	1901	951	317
71	3943	1972	986	329
72	4047	2024	1012	338
73	4150	2075	1038	346
74	4237	2119	1060	354
75	4324	2162	1081	361
76	4393	2197	1099	367
77	4467	2234	1117	373
78	4543	2272	1136	379
79	4616	2308	1154	385
80+	4736	2368	1184	395

PLAN HDG

Male

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	375	188	94	32
66	404	202	101	34
67	433	217	109	37
68	451	226	113	38
69	471	236	118	40
70	489	245	123	41
71	506	253	127	43
72	533	267	134	45
73	560	280	140	47
74	584	292	146	49
75	610	305	153	51
76	634	317	159	53
77	662	331	166	56
78	689	345	173	58
79	717	359	180	60
80+	760	380	190	64

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	431	216	108	36
66	465	233	117	39
67	498	249	125	42
68	519	260	130	44
69	542	271	136	46
70	563	282	141	47
71	583	292	146	49
72	613	307	154	52
73	644	322	161	54
74	672	336	168	56
75	702	351	176	59
76	730	365	183	61
77	762	381	191	64
78	793	397	199	67
79	825	413	207	69
80+	875	438	219	73

Female

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	326	163	82	28
66	351	176	88	30
67	376	188	94	32
68	392	196	98	33
69	410	205	103	35
70	425	213	107	36
71	440	220	110	37
72	464	232	116	39
73	487	244	122	41
74	508	254	127	43
75	530	265	133	45
76	552	276	138	46
77	576	288	144	48
78	599	300	150	50
79	623	312	156	52
80+	661	331	166	56

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	375	188	94	32
66	404	202	101	34
67	433	217	109	37
68	451	226	113	38
69	471	236	118	40
70	489	245	123	41
71	506	253	127	43
72	533	267	134	45
73	560	280	140	47
74	584	292	146	49
75	610	305	153	51
76	634	317	159	53
77	662	331	166	56
78	689	345	173	58
79	717	359	180	60
80+	760	380	190	64

PLAN K

Male

Preferred Effective Date: 01/01/2014 Plan Code: P44

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1255	628	314	105
66	1351	676	338	113
67	1433	717	359	120
68	1506	753	377	126
69	1585	793	397	133
70	1674	837	419	140
71	1721	861	431	144
72	1757	879	440	147
73	1791	896	448	150
74	1823	912	456	152
75	1865	933	467	156
76	1890	945	473	158
77	1910	955	478	160
78	1923	962	481	161
79	1937	969	485	162
80+	1963	982	491	164

Standard Effective Date: 01/01/2014 Plan Code: P46

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1444	722	361	121
66	1555	778	389	130
67	1649	825	413	138
68	1733	867	434	145
69	1824	912	456	152
70	1926	963	482	161
71	1980	990	495	165
72	2022	1011	506	169
73	2061	1031	516	172
74	2098	1049	525	175
75	2146	1073	537	179
76	2175	1088	544	182
77	2197	1099	550	184
78	2213	1107	554	185
79	2229	1115	558	186
80+	2259	1130	565	189

Female

Preferred Effective Date: 01/01/2014 Plan Code: P45

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1092	546	273	91
66	1175	588	294	98
67	1247	624	312	104
68	1310	655	328	110
69	1379	690	345	115
70	1456	728	364	122
71	1497	749	375	125
72	1528	764	382	128
73	1558	779	390	130
74	1586	793	397	133
75	1622	811	406	136
76	1644	822	411	137
77	1661	831	416	139
78	1673	837	419	140
79	1685	843	422	141
80+	1708	854	427	143

Standard Effective Date: 01/01/2014 Plan Code: P47

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1255	628	314	105
66	1351	676	338	113
67	1433	717	359	120
68	1506	753	377	126
69	1585	793	397	133
70	1674	837	419	140
71	1721	861	431	144
72	1757	879	440	147
73	1791	896	448	150
74	1823	912	456	152
75	1865	933	467	156
76	1890	945	473	158
77	1910	955	478	160
78	1923	962	481	161
79	1937	969	485	162
80+	1963	982	491	164

PLAN L

Male

Preferred Effective Date: 06/01/2020 Plan Code: P60

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1871	936	468	156
66	2017	1009	505	169
67	2138	1069	535	179
68	2248	1124	562	188
69	2367	1184	592	198
70	2496	1248	624	208
71	2570	1285	643	215
72	2620	1310	655	219
73	2676	1338	669	223
74	2723	1362	681	227
75	2778	1389	695	232
76	2820	1410	705	235
77	2848	1424	712	238
78	2873	1437	719	240
79	2892	1446	723	241
80+	2927	1464	732	244

Standard Effective Date: 06/01/2020 Plan Code: P62

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2153	1077	539	180
66	2322	1161	581	194
67	2460	1230	615	205
68	2587	1294	647	216
69	2723	1362	681	227
70	2872	1436	718	240
71	2957	1479	740	247
72	3015	1508	754	252
73	3080	1540	770	257
74	3134	1567	784	262
75	3197	1599	800	267
76	3245	1623	812	271
77	3278	1639	820	274
78	3306	1653	827	276
79	3328	1664	832	278
80+	3369	1685	843	281

Female

Preferred Effective Date: 06/01/2020 Plan Code: P61

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1628	814	407	136
66	1755	878	439	147
67	1860	930	465	155
68	1956	978	489	163
69	2059	1030	515	172
70	2171	1086	543	181
71	2235	1118	559	187
72	2279	1140	570	190
73	2328	1164	582	194
74	2369	1185	593	198
75	2416	1208	604	202
76	2453	1227	614	205
77	2478	1239	620	207
78	2499	1250	625	209
79	2516	1258	629	210
80+	2546	1273	637	213

Standard Effective Date: 06/01/2020 Plan Code: P63

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1871	936	468	156
66	2017	1009	505	169
67	2138	1069	535	179
68	2248	1124	562	188
69	2367	1184	592	198
70	2496	1248	624	208
71	2570	1285	643	215
72	2620	1310	655	219
73	2676	1338	669	223
74	2723	1362	681	227
75	2778	1389	695	232
76	2820	1410	705	235
77	2848	1424	712	238
78	2873	1437	719	240
79	2892	1446	723	241
80+	2927	1464	732	244

PLAN N

Male

Preferred Effective Date: 06/01/2022 Plan Code: 5DM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2431	1216	608	203
66	2565	1283	642	214
67	2689	1345	673	225
68	2810	1405	703	235
69	2951	1476	738	246
70	3085	1543	772	258
71	3205	1603	802	268
72	3296	1648	824	275
73	3389	1695	848	283
74	3460	1730	865	289
75	3536	1768	884	295
76	3599	1800	900	300
77	3669	1835	918	306
78	3741	1871	936	312
79	3810	1905	953	318
80+	3925	1963	982	328

Standard Effective Date: 06/01/2022 Plan Code: 5DO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2797	1399	700	234
66	2952	1476	738	246
67	3095	1548	774	258
68	3233	1617	809	270
69	3396	1698	849	283
70	3551	1776	888	296
71	3688	1844	922	308
72	3793	1897	949	317
73	3900	1950	975	325
74	3982	1991	996	332
75	4069	2035	1018	340
76	4142	2071	1036	346
77	4222	2111	1056	352
78	4305	2153	1077	359
79	4384	2192	1096	366
80+	4517	2259	1130	377

Female

Preferred Effective Date: 06/01/2022 Plan Code: 5DN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2114	1057	529	177
66	2231	1116	558	186
67	2339	1170	585	195
68	2444	1222	611	204
69	2567	1284	642	214
70	2684	1342	671	224
71	2788	1394	697	233
72	2867	1434	717	239
73	2948	1474	737	246
74	3010	1505	753	251
75	3076	1538	769	257
76	3131	1566	783	261
77	3191	1596	798	266
78	3254	1627	814	272
79	3314	1657	829	277
80+	3414	1707	854	285

Standard Effective Date: 06/01/2022 Plan Code: 5DP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2431	1216	608	203
66	2565	1283	642	214
67	2689	1345	673	225
68	2810	1405	703	235
69	2951	1476	738	246
70	3085	1543	772	258
71	3205	1603	802	268
72	3296	1648	824	275
73	3389	1695	848	283
74	3460	1730	865	289
75	3536	1768	884	295
76	3599	1800	900	300
77	3669	1835	918	306
78	3741	1871	936	312
79	3810	1905	953	318
80+	3925	1963	982	328

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

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

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

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

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

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

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

PARTS A & B

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

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

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

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

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

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

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

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

PARTS A & B

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

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

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

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

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

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

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

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

PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

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

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

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

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

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

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

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

PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

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

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

** This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2800 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2800. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

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

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

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

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

** This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2800 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2800. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

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

PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

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

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

** This high deductible plan pays the same benefits as Plan G after one has paid a calendar year $2800 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

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

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

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

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

** This high deductible plan pays the same benefits as Plan G after one has paid a calendar year $2800 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

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

PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN K

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

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

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

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

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved Amounts ****	$0	$0	$240 (Part B Deductible) **** ♦
Preventive Benefits for Medicare-Covered Services	Generally 80% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All Costs (and they do not count toward annual out-of-pocket limit of $7060)*
BLOOD			
First 3 pints	$0	50%	50% ♦
Next $240 of Medicare-Approved Amounts ****	$0	$0	$240 (Part B Deductible) **** ♦
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
CLINICAL LABORATORY SERVICES			
– Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $240 of Medicare-Approved Amounts *****	$0	$0	$240 (Part B Deductible) ♦
Remainder of Medicare-Approved Amounts	80%	10%	10% ♦

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

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

PLAN L

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

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

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

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

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved Amounts ****	$0	$0	$240 (Part B Deductible) ****♦
Preventive Benefits for Medicare-Covered Services	Generally 80% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 15%	Generally 5%♦
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All Costs (and they do not count toward annual out-of-pocket limit of $3530)*
BLOOD			
First 3 pints	$0	75%	25%♦
Next $240 of Medicare-Approved Amounts ****	$0	$0	$240 (Part B Deductible) ****♦
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 15%	Generally 5%♦
CLINICAL LABORATORY SERVICES			
– Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $240 of Medicare-Approved Amounts *****	$0	$0	$240 (Part B Deductible)♦
Remainder of Medicare-Approved Amounts	80%	15%	5%♦

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

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

PLAN N
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

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

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

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

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

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

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

PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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