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: 02/15/2019 Plan Code: 5A4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1450	725	363	121
66	1532	766	383	128
67	1602	801	401	134
68	1663	832	416	139
69	1734	867	434	145
70	1803	902	451	151
71	1858	929	465	155
72	1881	941	471	157
73	1903	952	476	159
74	1915	958	479	160
75	1929	965	483	161
76	1930	965	483	161
77	1930	965	483	161
78	1930	965	483	161
79	1930	965	483	161
80+	1930	965	483	161

Standard Effective Date: 02/15/2019 Plan Code: 5A6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1669	835	418	140
66	1762	881	441	147
67	1844	922	461	154
68	1914	957	479	160
69	1996	998	499	167
70	2075	1038	519	173
71	2138	1069	535	179
72	2164	1082	541	181
73	2190	1095	548	183
74	2204	1102	551	184
75	2220	1110	555	185
76	2221	1111	556	186
77	2221	1111	556	186
78	2221	1111	556	186
79	2221	1111	556	186
80+	2221	1111	556	186

Female

Preferred Effective Date: 02/15/2019 Plan Code: 5A5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1262	631	316	106
66	1332	666	333	111
67	1394	697	349	117
68	1446	723	362	121
69	1509	755	378	126
70	1568	784	392	131
71	1616	808	404	135
72	1636	818	409	137
73	1655	828	414	138
74	1666	833	417	139
75	1678	839	420	140
76	1679	840	420	140
77	1679	840	420	140
78	1679	840	420	140
79	1679	840	420	140
80+	1679	840	420	140

Standard Effective Date: 02/15/2019 Plan Code: 5A7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1450	725	363	121
66	1532	766	383	128
67	1602	801	401	134
68	1663	832	416	139
69	1734	867	434	145
70	1803	902	451	151
71	1858	929	465	155
72	1881	941	471	157
73	1903	952	476	159
74	1915	958	479	160
75	1929	965	483	161
76	1930	965	483	161
77	1930	965	483	161
78	1930	965	483	161
79	1930	965	483	161
80+	1930	965	483	161

PLAN B

Male

Preferred Effective Date: 09/15/2023 Plan Code: 5AM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2597	1299	650	217
66	2753	1377	689	230
67	2889	1445	723	241
68	3013	1507	754	252
69	3158	1579	790	264
70	3293	1647	824	275
71	3404	1702	851	284
72	3468	1734	867	289
73	3533	1767	884	295
74	3579	1790	895	299
75	3624	1812	906	302
76	3651	1826	913	305
77	3660	1830	915	305
78	3665	1833	917	306
79	3672	1836	918	306
80+	3672	1836	918	306

Standard Effective Date: 09/15/2023 Plan Code: 5AO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2989	1495	748	250
66	3168	1584	792	264
67	3324	1662	831	277
68	3467	1734	867	289
69	3634	1817	909	303
70	3789	1895	948	316
71	3917	1959	980	327
72	3991	1996	998	333
73	4066	2033	1017	339
74	4118	2059	1030	344
75	4170	2085	1043	348
76	4202	2101	1051	351
77	4212	2106	1053	351
78	4218	2109	1055	352
79	4225	2113	1057	353
80+	4225	2113	1057	353

Female

Preferred Effective Date: 09/15/2023 Plan Code: 5AN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2259	1130	565	189
66	2395	1198	599	200
67	2513	1257	629	210
68	2621	1311	656	219
69	2747	1374	687	229
70	2864	1432	716	239
71	2961	1481	741	247
72	3016	1508	754	252
73	3073	1537	769	257
74	3113	1557	779	260
75	3152	1576	788	263
76	3176	1588	794	265
77	3184	1592	796	266
78	3188	1594	797	266
79	3194	1597	799	267
80+	3194	1597	799	267

Standard Effective Date: 09/15/2023 Plan Code: 5AP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2597	1299	650	217
66	2753	1377	689	230
67	2889	1445	723	241
68	3013	1507	754	252
69	3158	1579	790	264
70	3293	1647	824	275
71	3404	1702	851	284
72	3468	1734	867	289
73	3533	1767	884	295
74	3579	1790	895	299
75	3624	1812	906	302
76	3651	1826	913	305
77	3660	1830	915	305
78	3665	1833	917	306
79	3672	1836	918	306
80+	3672	1836	918	306

PLAN C

Male

Preferred Effective Date: 09/15/2023 Plan Code: 5B4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3072	1536	768	256
66	3254	1627	814	272
67	3411	1706	853	285
68	3570	1785	893	298
69	3765	1883	942	314
70	3946	1973	987	329
71	4104	2052	1026	342
72	4218	2109	1055	352
73	4326	2163	1082	361
74	4414	2207	1104	368
75	4504	2252	1126	376
76	4575	2288	1144	382
77	4655	2328	1164	388
78	4739	2370	1185	395
79	4823	2412	1206	402
80+	4964	2482	1241	414

Standard Effective Date: 09/15/2023 Plan Code: 5B6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3535	1768	884	295
66	3745	1873	937	313
67	3925	1963	982	328
68	4109	2055	1028	343
69	4332	2166	1083	361
70	4541	2271	1136	379
71	4723	2362	1181	394
72	4853	2427	1214	405
73	4979	2490	1245	415
74	5079	2540	1270	424
75	5183	2592	1296	432
76	5265	2633	1317	439
77	5357	2679	1340	447
78	5453	2727	1364	455
79	5550	2775	1388	463
80+	5712	2856	1428	476

Female

Preferred Effective Date: 09/15/2023 Plan Code: 5B5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2672	1336	668	223
66	2831	1416	708	236
67	2967	1484	742	248
68	3106	1553	777	259
69	3275	1638	819	273
70	3433	1717	859	287
71	3570	1785	893	298
72	3669	1835	918	306
73	3763	1882	941	314
74	3840	1920	960	320
75	3918	1959	980	327
76	3980	1990	995	332
77	4050	2025	1013	338
78	4122	2061	1031	344
79	4195	2098	1049	350
80+	4318	2159	1080	360

Standard Effective Date: 09/15/2023 Plan Code: 5B7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3072	1536	768	256
66	3254	1627	814	272
67	3411	1706	853	285
68	3570	1785	893	298
69	3765	1883	942	314
70	3946	1973	987	329
71	4104	2052	1026	342
72	4218	2109	1055	352
73	4326	2163	1082	361
74	4414	2207	1104	368
75	4504	2252	1126	376
76	4575	2288	1144	382
77	4655	2328	1164	388
78	4739	2370	1185	395
79	4823	2412	1206	402
80+	4964	2482	1241	414

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

PLAN D

Male

Preferred Effective Date: 09/15/2023 Plan Code: 5BM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2722	1361	681	227
66	2896	1448	724	242
67	3049	1525	763	255
68	3202	1601	801	267
69	3386	1693	847	283
70	3560	1780	890	297
71	3713	1857	929	310
72	3819	1910	955	319
73	3925	1963	982	328
74	4008	2004	1002	334
75	4095	2048	1024	342
76	4162	2081	1041	347
77	4240	2120	1060	354
78	4321	2161	1081	361
79	4400	2200	1100	367
80+	4537	2269	1135	379

Standard Effective Date: 09/15/2023 Plan Code: 5BO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3133	1567	784	262
66	3333	1667	834	278
67	3509	1755	878	293
68	3685	1843	922	308
69	3896	1948	974	325
70	4096	2048	1024	342
71	4273	2137	1069	357
72	4395	2198	1099	367
73	4517	2259	1130	377
74	4612	2306	1153	385
75	4712	2356	1178	393
76	4789	2395	1198	400
77	4879	2440	1220	407
78	4973	2487	1244	415
79	5063	2532	1266	422
80+	5221	2611	1306	436

Female

Preferred Effective Date: 09/15/2023 Plan Code: 5BN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2368	1184	592	198
66	2519	1260	630	210
67	2652	1326	663	221
68	2785	1393	697	233
69	2945	1473	737	246
70	3096	1548	774	258
71	3230	1615	808	270
72	3322	1661	831	277
73	3414	1707	854	285
74	3487	1744	872	291
75	3562	1781	891	297
76	3620	1810	905	302
77	3688	1844	922	308
78	3759	1880	940	314
79	3827	1914	957	319
80+	3946	1973	987	329

Standard Effective Date: 09/15/2023 Plan Code: 5BP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2722	1361	681	227
66	2896	1448	724	242
67	3049	1525	763	255
68	3202	1601	801	267
69	3386	1693	847	283
70	3560	1780	890	297
71	3713	1857	929	310
72	3819	1910	955	319
73	3925	1963	982	328
74	4008	2004	1002	334
75	4095	2048	1024	342
76	4162	2081	1041	347
77	4240	2120	1060	354
78	4321	2161	1081	361
79	4400	2200	1100	367
80+	4537	2269	1135	379

PLAN F

Male

Preferred Effective Date: 03/15/2024 Plan Code: 5C4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3282	1641	821	274
66	3471	1736	868	290
67	3638	1819	910	304
68	3808	1904	952	318
69	4007	2004	1002	334
70	4206	2103	1052	351
71	4373	2187	1094	365
72	4493	2247	1124	375
73	4608	2304	1152	384
74	4703	2352	1176	392
75	4797	2399	1200	400
76	4870	2435	1218	406
77	4961	2481	1241	414
78	5046	2523	1262	421
79	5137	2569	1285	429
80+	5287	2644	1322	441

Standard Effective Date: 03/15/2024 Plan Code: 5C6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3777	1889	945	315
66	3994	1997	999	333
67	4186	2093	1047	349
68	4383	2192	1096	366
69	4611	2306	1153	385
70	4840	2420	1210	404
71	5033	2517	1259	420
72	5170	2585	1293	431
73	5303	2652	1326	442
74	5413	2707	1354	452
75	5521	2761	1381	461
76	5604	2802	1401	467
77	5709	2855	1428	476
78	5807	2904	1452	484
79	5911	2956	1478	493
80+	6084	3042	1521	507

Female

Preferred Effective Date: 03/15/2024 Plan Code: 5C5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2855	1428	714	238
66	3019	1510	755	252
67	3164	1582	791	264
68	3313	1657	829	277
69	3486	1743	872	291
70	3658	1829	915	305
71	3804	1902	951	317
72	3908	1954	977	326
73	4009	2005	1003	335
74	4091	2046	1023	341
75	4173	2087	1044	348
76	4236	2118	1059	353
77	4315	2158	1079	360
78	4390	2195	1098	366
79	4468	2234	1117	373
80+	4599	2300	1150	384

Standard Effective Date: 03/15/2024 Plan Code: 5C7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3282	1641	821	274
66	3471	1736	868	290
67	3638	1819	910	304
68	3808	1904	952	318
69	4007	2004	1002	334
70	4206	2103	1052	351
71	4373	2187	1094	365
72	4493	2247	1124	375
73	4608	2304	1152	384
74	4703	2352	1176	392
75	4797	2399	1200	400
76	4870	2435	1218	406
77	4961	2481	1241	414
78	5046	2523	1262	421
79	5137	2569	1285	429
80+	5287	2644	1322	441

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

PLAN HDF

Male

Preferred — Effective Date: 03/15/2024 — Plan Code: 5CM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	494	247	124	42
66	538	269	135	45
67	579	290	145	49
68	607	304	152	51
69	640	320	160	54
70	671	336	168	56
71	696	348	174	58
72	735	368	184	62
73	772	386	193	65
74	807	404	202	68
75	844	422	211	71
76	858	429	215	72
77	874	437	219	73
78	916	458	229	77
79	957	479	240	80
80+	1030	515	258	86

Standard — Effective Date: 03/15/2024 — Plan Code: 5CO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	569	285	143	48
66	619	310	155	52
67	666	333	167	56
68	698	349	175	59
69	736	368	184	62
70	772	386	193	65
71	801	401	201	67
72	846	423	212	71
73	889	445	223	75
74	929	465	233	78
75	971	486	243	81
76	987	494	247	83
77	1005	503	252	84
78	1054	527	264	88
79	1101	551	276	92
80+	1185	593	297	99

Female

Preferred — Effective Date: 03/15/2024 — Plan Code: 5CN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	430	215	108	36
66	468	234	117	39
67	504	252	126	42
68	528	264	132	44
69	556	278	139	47
70	583	292	146	49
71	606	303	152	51
72	639	320	160	54
73	672	336	168	56
74	702	351	176	59
75	734	367	184	62
76	746	373	187	63
77	760	380	190	64
78	797	399	200	67
79	832	416	208	70
80+	896	448	224	75

Standard — Effective Date: 03/15/2024 — Plan Code: 5CP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	494	247	124	42
66	538	269	135	45
67	579	290	145	49
68	607	304	152	51
69	640	320	160	54
70	671	336	168	56
71	696	348	174	58
72	735	368	184	62
73	772	386	193	65
74	807	404	202	68
75	844	422	211	71
76	858	429	215	72
77	874	437	219	73
78	916	458	229	77
79	957	479	240	80
80+	1030	515	258	86

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

PLAN G

Male

Preferred Effective Date: 09/15/2023 Plan Code: 5D4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2679	1340	670	224
66	2848	1424	712	238
67	2996	1498	749	250
68	3147	1574	787	263
69	3325	1663	832	278
70	3497	1749	875	292
71	3643	1822	911	304
72	3751	1876	938	313
73	3853	1927	964	322
74	3938	1969	985	329
75	4019	2010	1005	335
76	4083	2042	1021	341
77	4162	2081	1041	347
78	4238	2119	1060	354
79	4318	2159	1080	360
80+	4450	2225	1113	371

Standard Effective Date: 09/15/2023 Plan Code: 5D6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3082	1541	771	257
66	3278	1639	820	274
67	3447	1724	862	288
68	3622	1811	906	302
69	3826	1913	957	319
70	4024	2012	1006	336
71	4192	2096	1048	350
72	4316	2158	1079	360
73	4434	2217	1109	370
74	4531	2266	1133	378
75	4625	2313	1157	386
76	4698	2349	1175	392
77	4789	2395	1198	400
78	4877	2439	1220	407
79	4969	2485	1243	415
80+	5121	2561	1281	427

Female

Preferred Effective Date: 09/15/2023 Plan Code: 5D5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2330	1165	583	195
66	2478	1239	620	207
67	2606	1303	652	218
68	2738	1369	685	229
69	2892	1446	723	241
70	3042	1521	761	254
71	3169	1585	793	265
72	3263	1632	816	272
73	3352	1676	838	280
74	3425	1713	857	286
75	3496	1748	874	292
76	3552	1776	888	296
77	3620	1810	905	302
78	3686	1843	922	308
79	3756	1878	939	313
80+	3871	1936	968	323

Standard Effective Date: 09/15/2023 Plan Code: 5D7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2679	1340	670	224
66	2848	1424	712	238
67	2996	1498	749	250
68	3147	1574	787	263
69	3325	1663	832	278
70	3497	1749	875	292
71	3643	1822	911	304
72	3751	1876	938	313
73	3853	1927	964	322
74	3938	1969	985	329
75	4019	2010	1005	335
76	4083	2042	1021	341
77	4162	2081	1041	347
78	4238	2119	1060	354
79	4318	2159	1080	360
80+	4450	2225	1113	371

PLAN HDG

Male

Preferred Effective Date: 03/15/2024 Plan Code: 5HO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	455	228	114	38
66	493	247	124	42
67	530	265	133	45
68	555	278	139	47
69	587	294	147	49
70	615	308	154	52
71	638	319	160	54
72	674	337	169	57
73	708	354	177	59
74	740	370	185	62
75	773	387	194	65
76	786	393	197	66
77	800	400	200	67
78	841	421	211	71
79	878	439	220	74
80+	944	472	236	79

Standard Effective Date: 03/15/2024 Plan Code: 5HQ

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	524	262	131	44
66	568	284	142	48
67	610	305	153	51
68	639	320	160	54
69	676	338	169	57
70	708	354	177	59
71	734	367	184	62
72	776	388	194	65
73	815	408	204	68
74	852	426	213	71
75	890	445	223	75
76	905	453	227	76
77	921	461	231	77
78	967	484	242	81
79	1010	505	253	85
80+	1086	543	272	91

Female

Preferred Effective Date: 03/15/2024 Plan Code: 5HP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	396	198	99	33
66	429	215	108	36
67	461	231	116	39
68	483	242	121	41
69	511	256	128	43
70	535	268	134	45
71	555	278	139	47
72	586	293	147	49
73	616	308	154	52
74	644	322	161	54
75	673	337	169	57
76	684	342	171	57
77	696	348	174	58
78	731	366	183	61
79	764	382	191	64
80+	821	411	206	69

Standard Effective Date: 03/15/2024 Plan Code: 5HR

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	455	228	114	38
66	493	247	124	42
67	530	265	133	45
68	555	278	139	47
69	587	294	147	49
70	615	308	154	52
71	638	319	160	54
72	674	337	169	57
73	708	354	177	59
74	740	370	185	62
75	773	387	194	65
76	786	393	197	66
77	800	400	200	67
78	841	421	211	71
79	878	439	220	74
80+	944	472	236	79

PLAN K

Male

Preferred Effective Date: 04/01/2020 Plan Code: P44

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1323	662	331	111
66	1428	714	357	119
67	1512	756	378	126
68	1592	796	398	133
69	1674	837	419	140
70	1774	887	444	148
71	1823	912	456	152
72	1863	932	466	156
73	1903	952	476	159
74	1943	972	486	162
75	1985	993	497	166
76	2023	1012	506	169
77	2054	1027	514	172
78	2077	1039	520	174
79	2105	1053	527	176
80+	2157	1079	540	180

Standard Effective Date: 04/01/2020 Plan Code: P46

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1523	762	381	127
66	1643	822	411	137
67	1740	870	435	145
68	1832	916	458	153
69	1926	963	482	161
70	2041	1021	511	171
71	2098	1049	525	175
72	2143	1072	536	179
73	2190	1095	548	183
74	2236	1118	559	187
75	2285	1143	572	191
76	2328	1164	582	194
77	2363	1182	591	197
78	2390	1195	598	200
79	2422	1211	606	202
80+	2483	1242	621	207

Female

Preferred Effective Date: 04/01/2020 Plan Code: P45

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1151	576	288	96
66	1242	621	311	104
67	1315	658	329	110
68	1385	693	347	116
69	1456	728	364	122
70	1543	772	386	129
71	1586	793	397	133
72	1620	810	405	135
73	1655	828	414	138
74	1690	845	423	141
75	1727	864	432	144
76	1760	880	440	147
77	1786	893	447	149
78	1807	904	452	151
79	1831	916	458	153
80+	1877	939	470	157

Standard Effective Date: 04/01/2020 Plan Code: P47

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1323	662	331	111
66	1428	714	357	119
67	1512	756	378	126
68	1592	796	398	133
69	1674	837	419	140
70	1774	887	444	148
71	1823	912	456	152
72	1863	932	466	156
73	1903	952	476	159
74	1943	972	486	162
75	1985	993	497	166
76	2023	1012	506	169
77	2054	1027	514	172
78	2077	1039	520	174
79	2105	1053	527	176
80+	2157	1079	540	180

PLAN L

Male

Preferred Effective Date: 04/01/2020 Plan Code: P60

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1864	932	466	156
66	2007	1004	502	168
67	2130	1065	533	178
68	2240	1120	560	187
69	2357	1179	590	197
70	2493	1247	624	208
71	2566	1283	642	214
72	2624	1312	656	219
73	2682	1341	671	224
74	2732	1366	683	228
75	2798	1399	700	234
76	2843	1422	711	237
77	2890	1445	723	241
78	2928	1464	732	244
79	2962	1481	741	247
80+	3035	1518	759	253

Standard Effective Date: 04/01/2020 Plan Code: P62

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2145	1073	537	179
66	2309	1155	578	193
67	2451	1226	613	205
68	2577	1289	645	215
69	2712	1356	678	226
70	2868	1434	717	239
71	2953	1477	739	247
72	3020	1510	755	252
73	3086	1543	772	258
74	3144	1572	786	262
75	3220	1610	805	269
76	3272	1636	818	273
77	3326	1663	832	278
78	3370	1685	843	281
79	3408	1704	852	284
80+	3493	1747	874	292

Female

Preferred Effective Date: 04/01/2020 Plan Code: P61

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1621	811	406	136
66	1746	873	437	146
67	1852	926	463	155
68	1948	974	487	163
69	2050	1025	513	171
70	2168	1084	542	181
71	2232	1116	558	186
72	2283	1142	571	191
73	2333	1167	584	195
74	2376	1188	594	198
75	2434	1217	609	203
76	2473	1237	619	207
77	2514	1257	629	210
78	2547	1274	637	213
79	2576	1288	644	215
80+	2640	1320	660	220

Standard Effective Date: 04/01/2020 Plan Code: P63

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1864	932	466	156
66	2007	1004	502	168
67	2130	1065	533	178
68	2240	1120	560	187
69	2357	1179	590	197
70	2493	1247	624	208
71	2566	1283	642	214
72	2624	1312	656	219
73	2682	1341	671	224
74	2732	1366	683	228
75	2798	1399	700	234
76	2843	1422	711	237
77	2890	1445	723	241
78	2928	1464	732	244
79	2962	1481	741	247
80+	3035	1518	759	253

PLAN N

Male

Preferred Effective Date: 09/15/2023 Plan Code: 5DM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2139	1070	535	179
66	2272	1136	568	190
67	2397	1199	600	200
68	2524	1262	631	211
69	2668	1334	667	223
70	2805	1403	702	234
71	2931	1466	733	245
72	3022	1511	756	252
73	3113	1557	779	260
74	3186	1593	797	266
75	3258	1629	815	272
76	3314	1657	829	277
77	3383	1692	846	282
78	3455	1728	864	288
79	3527	1764	882	294
80+	3657	1829	915	305

Standard Effective Date: 09/15/2023 Plan Code: 5DO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2462	1231	616	206
66	2614	1307	654	218
67	2758	1379	690	230
68	2904	1452	726	242
69	3070	1535	768	256
70	3227	1614	807	269
71	3372	1686	843	281
72	3478	1739	870	290
73	3583	1792	896	299
74	3666	1833	917	306
75	3750	1875	938	313
76	3814	1907	954	318
77	3893	1947	974	325
78	3976	1988	994	332
79	4058	2029	1015	339
80+	4208	2104	1052	351

Female

Preferred Effective Date: 09/15/2023 Plan Code: 5DN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1861	931	466	156
66	1976	988	494	165
67	2085	1043	522	174
68	2195	1098	549	183
69	2321	1161	581	194
70	2440	1220	610	204
71	2549	1275	638	213
72	2629	1315	658	220
73	2708	1354	677	226
74	2771	1386	693	231
75	2834	1417	709	237
76	2883	1442	721	241
77	2943	1472	736	246
78	3005	1503	752	251
79	3068	1534	767	256
80+	3181	1591	796	266

Standard Effective Date: 09/15/2023 Plan Code: 5DP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2139	1070	535	179
66	2272	1136	568	190
67	2397	1199	600	200
68	2524	1262	631	211
69	2668	1334	667	223
70	2805	1403	702	234
71	2931	1466	733	245
72	3022	1511	756	252
73	3113	1557	779	260
74	3186	1593	797	266
75	3258	1629	815	272
76	3314	1657	829	277
77	3383	1692	846	282
78	3455	1728	864	288
79	3527	1764	882	294
80+	3657	1829	915	305

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