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: 01/01/2021 Plan Code: 5A4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1314	657	329	110
66	1377	689	345	115
67	1430	715	358	120
68	1478	739	370	124
69	1533	767	384	128
70	1585	793	397	133
71	1623	812	406	136
72	1638	819	410	137
73	1659	830	415	139
74	1669	835	418	140
75	1684	842	421	141
76	1686	843	422	141
77	1686	843	422	141
78	1686	843	422	141
79	1686	843	422	141
80+	1686	843	422	141

Standard Effective Date: 01/01/2021 Plan Code: 5A6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1512	756	378	126
66	1584	792	396	132
67	1646	823	412	138
68	1701	851	426	142
69	1764	882	441	147
70	1824	912	456	152
71	1868	934	467	156
72	1885	943	472	158
73	1909	955	478	160
74	1921	961	481	161
75	1938	969	485	162
76	1941	971	486	162
77	1941	971	486	162
78	1941	971	486	162
79	1941	971	486	162
80+	1941	971	486	162

Female

Preferred Effective Date: 01/01/2021 Plan Code: 5A5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1143	572	286	96
66	1197	599	300	100
67	1244	622	311	104
68	1286	643	322	108
69	1333	667	334	112
70	1379	690	345	115
71	1412	706	353	118
72	1425	713	357	119
73	1443	722	361	121
74	1452	726	363	121
75	1465	733	367	123
76	1467	734	367	123
77	1467	734	367	123
78	1467	734	367	123
79	1467	734	367	123
80+	1467	734	367	123

Standard Effective Date: 01/01/2021 Plan Code: 5A7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1314	657	329	110
66	1377	689	345	115
67	1430	715	358	120
68	1478	739	370	124
69	1533	767	384	128
70	1585	793	397	133
71	1623	812	406	136
72	1638	819	410	137
73	1659	830	415	139
74	1669	835	418	140
75	1684	842	421	141
76	1686	843	422	141
77	1686	843	422	141
78	1686	843	422	141
79	1686	843	422	141
80+	1686	843	422	141

PLAN B

Male

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2341	1171	586	196
66	2466	1233	617	206
67	2576	1288	644	215
68	2679	1340	670	224
69	2795	1398	699	233
70	2897	1449	725	242
71	2985	1493	747	249
72	3041	1521	761	254
73	3097	1549	775	259
74	3147	1574	787	263
75	3199	1600	800	267
76	3227	1614	807	269
77	3236	1618	809	270
78	3248	1624	812	271
79	3257	1629	815	272
80+	3257	1629	815	272

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2694	1347	674	225
66	2838	1419	710	237
67	2964	1482	741	247
68	3082	1541	771	257
69	3216	1608	804	268
70	3334	1667	834	278
71	3435	1718	859	287
72	3499	1750	875	292
73	3564	1782	891	297
74	3622	1811	906	302
75	3681	1841	921	307
76	3714	1857	929	310
77	3724	1862	931	311
78	3737	1869	935	312
79	3748	1874	937	313
80+	3748	1874	937	313

Female

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2036	1018	509	170
66	2145	1073	537	179
67	2241	1121	561	187
68	2330	1165	583	195
69	2431	1216	608	203
70	2520	1260	630	210
71	2597	1299	650	217
72	2645	1323	662	221
73	2694	1347	674	225
74	2738	1369	685	229
75	2782	1391	696	232
76	2807	1404	702	234
77	2815	1408	704	235
78	2825	1413	707	236
79	2833	1417	709	237
80+	2833	1417	709	237

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2341	1171	586	196
66	2466	1233	617	206
67	2576	1288	644	215
68	2679	1340	670	224
69	2795	1398	699	233
70	2897	1449	725	242
71	2985	1493	747	249
72	3041	1521	761	254
73	3097	1549	775	259
74	3147	1574	787	263
75	3199	1600	800	267
76	3227	1614	807	269
77	3236	1618	809	270
78	3248	1624	812	271
79	3257	1629	815	272
80+	3257	1629	815	272

PLAN C

Male

Preferred Effective Date: 01/01/2024 Plan Code: 5B4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2845	1423	712	238
66	2989	1495	748	250
67	3120	1560	780	260
68	3255	1628	814	272
69	3413	1707	854	285
70	3560	1780	890	297
71	3690	1845	923	308
72	3783	1892	946	316
73	3878	1939	970	324
74	3963	1982	991	331
75	4047	2024	1012	338
76	4111	2056	1028	343
77	4188	2094	1047	349
78	4263	2132	1066	356
79	4342	2171	1086	362
80+	4466	2233	1117	373

Standard Effective Date: 01/01/2024 Plan Code: 5B6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3274	1637	819	273
66	3440	1720	860	287
67	3590	1795	898	300
68	3746	1873	937	313
69	3928	1964	982	328
70	4096	2048	1024	342
71	4246	2123	1062	354
72	4353	2177	1089	363
73	4463	2232	1116	372
74	4561	2281	1141	381
75	4657	2329	1165	389
76	4730	2365	1183	395
77	4819	2410	1205	402
78	4906	2453	1227	409
79	4997	2499	1250	417
80+	5140	2570	1285	429

Female

Preferred Effective Date: 01/01/2024 Plan Code: 5B5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2475	1238	619	207
66	2600	1300	650	217
67	2714	1357	679	227
68	2832	1416	708	236
69	2969	1485	743	248
70	3096	1548	774	258
71	3210	1605	803	268
72	3291	1646	823	275
73	3373	1687	844	282
74	3448	1724	862	288
75	3520	1760	880	294
76	3576	1788	894	298
77	3643	1822	911	304
78	3709	1855	928	310
79	3777	1889	945	315
80+	3885	1943	972	324

Standard Effective Date: 01/01/2024 Plan Code: 5B7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2845	1423	712	238
66	2989	1495	748	250
67	3120	1560	780	260
68	3255	1628	814	272
69	3413	1707	854	285
70	3560	1780	890	297
71	3690	1845	923	308
72	3783	1892	946	316
73	3878	1939	970	324
74	3963	1982	991	331
75	4047	2024	1012	338
76	4111	2056	1028	343
77	4188	2094	1047	349
78	4263	2132	1066	356
79	4342	2171	1086	362
80+	4466	2233	1117	373

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

PLAN D

Male

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2776	1388	694	232
66	2933	1467	734	245
67	3074	1537	769	257
68	3216	1608	804	268
69	3381	1691	846	282
70	3535	1768	884	295
71	3672	1836	918	306
72	3773	1887	944	315
73	3878	1939	970	324
74	3968	1984	992	331
75	4057	2029	1015	339
76	4122	2061	1031	344
77	4203	2102	1051	351
78	4287	2144	1072	358
79	4368	2184	1092	364
80+	4506	2253	1127	376

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3194	1597	799	267
66	3375	1688	844	282
67	3537	1769	885	295
68	3701	1851	926	309
69	3891	1946	973	325
70	4068	2034	1017	339
71	4225	2113	1057	353
72	4342	2171	1086	362
73	4463	2232	1116	372
74	4566	2283	1142	381
75	4669	2335	1168	390
76	4744	2372	1186	396
77	4836	2418	1209	403
78	4933	2467	1234	412
79	5027	2514	1257	419
80+	5185	2593	1297	433

Female

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2414	1207	604	202
66	2551	1276	638	213
67	2674	1337	669	223
68	2797	1399	700	234
69	2941	1471	736	246
70	3075	1538	769	257
71	3194	1597	799	267
72	3282	1641	821	274
73	3373	1687	844	282
74	3451	1726	863	288
75	3529	1765	883	295
76	3586	1793	897	299
77	3656	1828	914	305
78	3729	1865	933	311
79	3800	1900	950	317
80+	3919	1960	980	327

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2776	1388	694	232
66	2933	1467	734	245
67	3074	1537	769	257
68	3216	1608	804	268
69	3381	1691	846	282
70	3535	1768	884	295
71	3672	1836	918	306
72	3773	1887	944	315
73	3878	1939	970	324
74	3968	1984	992	331
75	4057	2029	1015	339
76	4122	2061	1031	344
77	4203	2102	1051	351
78	4287	2144	1072	358
79	4368	2184	1092	364
80+	4506	2253	1127	376

PLAN F

Male

Preferred Effective Date: 01/01/2024 Plan Code: 5C4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2795	1398	699	233
66	2937	1469	735	245
67	3063	1532	766	256
68	3193	1597	799	267
69	3346	1673	837	279
70	3489	1745	873	291
71	3614	1807	904	302
72	3705	1853	927	309
73	3799	1900	950	317
74	3885	1943	972	324
75	3965	1983	992	331
76	4027	2014	1007	336
77	4103	2052	1026	342
78	4175	2088	1044	348
79	4253	2127	1064	355
80+	4376	2188	1094	365

Standard Effective Date: 01/01/2024 Plan Code: 5C6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3216	1608	804	268
66	3380	1690	845	282
67	3525	1763	882	294
68	3675	1838	919	307
69	3850	1925	963	321
70	4015	2008	1004	335
71	4159	2080	1040	347
72	4263	2132	1066	356
73	4372	2186	1093	365
74	4471	2236	1118	373
75	4563	2282	1141	381
76	4635	2318	1159	387
77	4722	2361	1181	394
78	4804	2402	1201	401
79	4894	2447	1224	408
80+	5035	2518	1259	420

Female

Preferred Effective Date: 01/01/2024 Plan Code: 5C5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2431	1216	608	203
66	2555	1278	639	213
67	2664	1332	666	222
68	2778	1389	695	232
69	2911	1456	728	243
70	3035	1518	759	253
71	3144	1572	786	262
72	3223	1612	806	269
73	3304	1652	826	276
74	3380	1690	845	282
75	3449	1725	863	288
76	3503	1752	876	292
77	3569	1785	893	298
78	3631	1816	908	303
79	3699	1850	925	309
80+	3806	1903	952	318

Standard Effective Date: 01/01/2024 Plan Code: 5C7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2795	1398	699	233
66	2937	1469	735	245
67	3063	1532	766	256
68	3193	1597	799	267
69	3346	1673	837	279
70	3489	1745	873	291
71	3614	1807	904	302
72	3705	1853	927	309
73	3799	1900	950	317
74	3885	1943	972	324
75	3965	1983	992	331
76	4027	2014	1007	336
77	4103	2052	1026	342
78	4175	2088	1044	348
79	4253	2127	1064	355
80+	4376	2188	1094	365

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

PLAN HDF

Male

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	403	202	101	34
66	435	218	109	37
67	466	233	117	39
68	484	242	121	41
69	508	254	127	43
70	531	266	133	45
71	549	275	138	46
72	577	289	145	49
73	607	304	152	51
74	635	318	159	53
75	663	332	166	56
76	675	338	169	57
77	687	344	172	58
78	700	350	175	59
79	712	356	178	60
80+	734	367	184	62

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	463	232	116	39
66	500	250	125	42
67	536	268	134	45
68	557	279	140	47
69	585	293	147	49
70	611	306	153	51
71	632	316	158	53
72	664	332	166	56
73	698	349	175	59
74	731	366	183	61
75	763	382	191	64
76	777	389	195	65
77	790	395	198	66
78	805	403	202	68
79	820	410	205	69
80+	844	422	211	71

Female

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	350	175	88	30
66	378	189	95	32
67	405	203	102	34
68	421	211	106	36
69	442	221	111	37
70	462	231	116	39
71	478	239	120	40
72	502	251	126	42
73	528	264	132	44
74	553	277	139	47
75	577	289	145	49
76	587	294	147	49
77	597	299	150	50
78	608	304	152	51
79	620	310	155	52
80+	638	319	160	54

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	403	202	101	34
66	435	218	109	37
67	466	233	117	39
68	484	242	121	41
69	508	254	127	43
70	531	266	133	45
71	549	275	138	46
72	577	289	145	49
73	607	304	152	51
74	635	318	159	53
75	663	332	166	56
76	675	338	169	57
77	687	344	172	58
78	700	350	175	59
79	712	356	178	60
80+	734	367	184	62

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

PLAN G

Male

Preferred Effective Date: 01/01/2024 Plan Code: 5D4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2120	1060	530	177
66	2239	1120	560	187
67	2344	1172	586	196
68	2452	1226	613	205
69	2578	1289	645	215
70	2696	1348	674	225
71	2800	1400	700	234
72	2876	1438	719	240
73	2954	1477	739	247
74	3022	1511	756	252
75	3091	1546	773	258
76	3141	1571	786	262
77	3204	1602	801	267
78	3266	1633	817	273
79	3327	1664	832	278
80+	3431	1716	858	286

Standard Effective Date: 01/01/2024 Plan Code: 5D6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2440	1220	610	204
66	2576	1288	644	215
67	2698	1349	675	225
68	2822	1411	706	236
69	2967	1484	742	248
70	3102	1551	776	259
71	3222	1611	806	269
72	3310	1655	828	276
73	3399	1700	850	284
74	3478	1739	870	290
75	3557	1779	890	297
76	3614	1807	904	302
77	3687	1844	922	308
78	3758	1879	940	314
79	3828	1914	957	319
80+	3949	1975	988	330

Female

Preferred Effective Date: 01/01/2024 Plan Code: 5D5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1844	922	461	154
66	1947	974	487	163
67	2039	1020	510	170
68	2133	1067	534	178
69	2243	1122	561	187
70	2345	1173	587	196
71	2436	1218	609	203
72	2502	1251	626	209
73	2570	1285	643	215
74	2629	1315	658	220
75	2689	1345	673	225
76	2732	1366	683	228
77	2787	1394	697	233
78	2841	1421	711	237
79	2894	1447	724	242
80+	2985	1493	747	249

Standard Effective Date: 01/01/2024 Plan Code: 5D7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2120	1060	530	177
66	2239	1120	560	187
67	2344	1172	586	196
68	2452	1226	613	205
69	2578	1289	645	215
70	2696	1348	674	225
71	2800	1400	700	234
72	2876	1438	719	240
73	2954	1477	739	247
74	3022	1511	756	252
75	3091	1546	773	258
76	3141	1571	786	262
77	3204	1602	801	267
78	3266	1633	817	273
79	3327	1664	832	278
80+	3431	1716	858	286

PLAN HDG

Male

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	403	202	101	34
66	435	218	109	37
67	466	233	117	39
68	484	242	121	41
69	508	254	127	43
70	531	266	133	45
71	549	275	138	46
72	577	289	145	49
73	607	304	152	51
74	635	318	159	53
75	663	332	166	56
76	675	338	169	57
77	687	344	172	58
78	700	350	175	59
79	712	356	178	60
80+	734	367	184	62

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	463	232	116	39
66	500	250	125	42
67	536	268	134	45
68	557	279	140	47
69	585	293	147	49
70	611	306	153	51
71	632	316	158	53
72	664	332	166	56
73	698	349	175	59
74	731	366	183	61
75	763	382	191	64
76	777	389	195	65
77	790	395	198	66
78	805	403	202	68
79	820	410	205	69
80+	844	422	211	71

Female

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	350	175	88	30
66	378	189	95	32
67	405	203	102	34
68	421	211	106	36
69	442	221	111	37
70	462	231	116	39
71	478	239	120	40
72	502	251	126	42
73	528	264	132	44
74	553	277	139	47
75	577	289	145	49
76	587	294	147	49
77	597	299	150	50
78	608	304	152	51
79	620	310	155	52
80+	638	319	160	54

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	403	202	101	34
66	435	218	109	37
67	466	233	117	39
68	484	242	121	41
69	508	254	127	43
70	531	266	133	45
71	549	275	138	46
72	577	289	145	49
73	607	304	152	51
74	635	318	159	53
75	663	332	166	56
76	675	338	169	57
77	687	344	172	58
78	700	350	175	59
79	712	356	178	60
80+	734	367	184	62

PLAN K

Male

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1184	592	296	99
66	1276	638	319	107
67	1350	675	338	113
68	1419	710	355	119
69	1488	744	372	124
70	1576	788	394	132
71	1618	809	405	135
72	1650	825	413	138
73	1684	842	421	141
74	1715	858	429	143
75	1752	876	438	146
76	1779	890	445	149
77	1797	899	450	150
78	1816	908	454	152
79	1828	914	457	153
80+	1857	929	465	155

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1363	682	341	114
66	1469	735	368	123
67	1553	777	389	130
68	1633	817	409	137
69	1712	856	428	143
70	1814	907	454	152
71	1862	931	466	156
72	1899	950	475	159
73	1938	969	485	162
74	1974	987	494	165
75	2016	1008	504	168
76	2048	1024	512	171
77	2068	1034	517	173
78	2089	1045	523	175
79	2104	1052	526	176
80+	2137	1069	535	179

Female

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1030	515	258	86
66	1110	555	278	93
67	1174	587	294	98
68	1235	618	309	103
69	1294	647	324	108
70	1371	686	343	115
71	1407	704	352	118
72	1435	718	359	120
73	1465	733	367	123
74	1492	746	373	125
75	1524	762	381	127
76	1548	774	387	129
77	1564	782	391	131
78	1579	790	395	132
79	1590	795	398	133
80+	1616	808	404	135

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1184	592	296	99
66	1276	638	319	107
67	1350	675	338	113
68	1419	710	355	119
69	1488	744	372	124
70	1576	788	394	132
71	1618	809	405	135
72	1650	825	413	138
73	1684	842	421	141
74	1715	858	429	143
75	1752	876	438	146
76	1779	890	445	149
77	1797	899	450	150
78	1816	908	454	152
79	1828	914	457	153
80+	1857	929	465	155

PLAN L

Male

Preferred Effective Date: 01/01/2014 Plan Code: P60

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1662	831	416	139
66	1787	894	447	149
67	1895	948	474	158
68	1991	996	498	166
69	2091	1046	523	175
70	2211	1106	553	185
71	2272	1136	568	190
72	2318	1159	580	194
73	2366	1183	592	198
74	2408	1204	602	201
75	2461	1231	616	206
76	2497	1249	625	209
77	2526	1263	632	211
78	2551	1276	638	213
79	2567	1284	642	214
80+	2606	1303	652	218

Standard Effective Date: 01/01/2014 Plan Code: P62

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1912	956	478	160
66	2056	1028	514	172
67	2180	1090	545	182
68	2291	1146	573	191
69	2406	1203	602	201
70	2544	1272	636	212
71	2614	1307	654	218
72	2667	1334	667	223
73	2722	1361	681	227
74	2771	1386	693	231
75	2832	1416	708	236
76	2873	1437	719	240
77	2907	1454	727	243
78	2936	1468	734	245
79	2955	1478	739	247
80+	2999	1500	750	250

Female

Preferred Effective Date: 01/01/2014 Plan Code: P61

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1446	723	362	121
66	1554	777	389	130
67	1648	824	412	138
68	1732	866	433	145
69	1819	910	455	152
70	1923	962	481	161
71	1976	988	494	165
72	2016	1008	504	168
73	2058	1029	515	172
74	2095	1048	524	175
75	2140	1070	535	179
76	2172	1086	543	181
77	2197	1099	550	184
78	2219	1110	555	185
79	2233	1117	559	187
80+	2267	1134	567	189

Standard Effective Date: 01/01/2014 Plan Code: P63

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1662	831	416	139
66	1787	894	447	149
67	1895	948	474	158
68	1991	996	498	166
69	2091	1046	523	175
70	2211	1106	553	185
71	2272	1136	568	190
72	2318	1159	580	194
73	2366	1183	592	198
74	2408	1204	602	201
75	2461	1231	616	206
76	2497	1249	625	209
77	2526	1263	632	211
78	2551	1276	638	213
79	2567	1284	642	214
80+	2606	1303	652	218

PLAN N

Male

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2028	1014	507	169
66	2143	1072	536	179
67	2250	1125	563	188
68	2355	1178	589	197
69	2483	1242	621	207
70	2597	1299	650	217
71	2705	1353	677	226
72	2782	1391	696	232
73	2864	1432	716	239
74	2936	1468	734	245
75	3004	1502	751	251
76	3062	1531	766	256
77	3129	1565	783	261
78	3197	1599	800	267
79	3264	1632	816	272
80+	3380	1690	845	282

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2334	1167	584	195
66	2467	1234	617	206
67	2590	1295	648	216
68	2710	1355	678	226
69	2857	1429	715	239
70	2989	1495	748	250
71	3113	1557	779	260
72	3202	1601	801	267
73	3296	1648	824	275
74	3379	1690	845	282
75	3457	1729	865	289
76	3524	1762	881	294
77	3601	1801	901	301
78	3678	1839	920	307
79	3756	1878	939	313
80+	3890	1945	973	325

Female

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1764	882	441	147
66	1865	933	467	156
67	1957	979	490	164
68	2048	1024	512	171
69	2160	1080	540	180
70	2259	1130	565	189
71	2353	1177	589	197
72	2420	1210	605	202
73	2492	1246	623	208
74	2554	1277	639	213
75	2613	1307	654	218
76	2663	1332	666	222
77	2722	1361	681	227
78	2780	1390	695	232
79	2839	1420	710	237
80+	2940	1470	735	245

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2028	1014	507	169
66	2143	1072	536	179
67	2250	1125	563	188
68	2355	1178	589	197
69	2483	1242	621	207
70	2597	1299	650	217
71	2705	1353	677	226
72	2782	1391	696	232
73	2864	1432	716	239
74	2936	1468	734	245
75	3004	1502	751	251
76	3062	1531	766	256
77	3129	1565	783	261
78	3197	1599	800	267
79	3264	1632	816	272
80+	3380	1690	845	282

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