UNITED INSURANCE COMPANY OF AMERICA

Outline of Medicare Supplement Coverage
Benefit Plans A, D, F, G, High Deductible G, and N

Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020

NOTICE TO BUYER: This policy may not cover all of the costs associated with medical care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.

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 copay	✔	✔	✔	✔	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]					**$7,220[2]**	**$3,610[2]**				

Note: A ✓ means 100% of the benefit is paid. **+Only applicants first eligible for Medicare before January 1, 2020 may purchase Plans C, F, and high deductible F.** This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available. Every company must make Plan A available.

[1] Plans F and G also have a high deductible option which require first paying a plan deductible of $2870 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 co-payment of up to $20 for some office visits and up to a $50 co-payment for emergency room visits that do not result in an inpatient admission.

United Insurance Company of America

Monthly Premiums
For Use in Zip Codes: 330-334
Female Rates

Issue Age	Preferred					
	Plan A	Plan D	Plan F	Plan G	Plan N	Plan HG
Under 65	978.08	1,084.42	1,205.25	1,095.17	841.75	460.83
65	305.67	338.92	376.58	342.33	263.08	144.00
66	305.67	338.92	376.58	342.33	263.08	144.00
67	305.67	338.92	376.58	342.33	263.08	144.00
68	311.08	344.83	383.25	348.25	267.75	146.58
69	316.83	351.08	390.25	354.67	272.67	149.25
70	322.17	357.25	396.92	360.83	277.33	151.75
71	328.50	364.00	404.67	367.83	282.67	154.83
72	334.25	370.33	411.67	374.08	287.50	157.33
73	343.17	380.42	422.75	384.17	295.25	161.67
74	352.75	391.00	434.42	394.92	303.50	166.17
75	361.92	401.00	445.75	405.17	311.42	170.42
76	370.50	410.92	456.50	414.83	319.00	174.58
77	379.17	420.25	467.17	424.58	326.33	178.67
78	386.33	428.00	475.75	432.25	332.42	181.92
79	393.33	435.92	484.33	440.17	338.33	185.17
80	400.50	444.00	493.33	448.42	344.67	188.58
81	407.67	451.83	502.33	456.50	350.92	192.00
82	415.25	460.33	511.50	464.75	357.25	195.58
83	424.17	470.17	522.58	475.00	365.08	199.92
84	433.75	480.75	534.33	485.67	373.42	204.42
85	443.25	491.33	546.17	496.25	381.50	208.83
86	453.08	502.17	558.17	507.17	389.92	213.33
87	463.17	513.50	570.58	518.67	398.50	218.17
88	473.42	524.58	583.17	530.00	407.33	222.92
89	483.83	536.42	596.08	541.83	416.50	227.92
90	494.42	548.08	609.17	553.67	425.50	232.92
91	505.42	560.17	622.67	565.92	435.00	238.17
92	516.50	572.75	636.33	578.50	444.67	243.33
93	528.17	585.33	650.50	591.25	454.42	248.75
94	539.67	598.08	664.83	604.17	464.42	254.17
95	551.50	611.33	679.42	617.42	474.67	259.83
96	563.92	624.83	694.50	631.08	485.08	265.42
97	576.00	638.67	709.58	645.08	495.83	271.33
98	588.75	652.50	725.17	659.08	506.67	277.33
99+	601.67	666.83	741.17	673.50	517.75	283.42

Issue Age	Standard					
	Plan A	Plan D	Plan F	Plan G	Plan N	Plan HG
Under 65	1,095.00	1,214.08	1,349.33	1,226.42	942.83	516.17
65	342.33	379.50	421.67	383.25	294.75	161.25
66	342.33	379.50	421.67	383.25	294.75	161.25
67	342.33	379.50	421.67	383.25	294.75	161.25
68	348.42	386.33	429.25	390.08	299.75	164.17
69	354.67	393.33	436.92	397.08	305.33	167.00
70	361.00	400.17	444.83	404.25	310.67	170.08
71	367.83	407.83	453.08	412.00	316.67	173.33
72	374.25	414.67	461.00	419.00	322.17	176.33
73	384.33	426.17	473.58	430.50	330.83	181.00
74	394.92	437.67	486.33	442.17	339.58	185.92
75	405.17	449.17	499.25	453.83	348.75	190.92
76	415.25	460.08	511.33	464.58	357.00	195.42
77	424.58	470.50	523.17	475.42	365.50	200.08
78	432.50	479.33	532.67	484.17	372.08	203.67
79	440.58	488.17	542.58	493.17	379.17	207.42
80	448.67	497.08	552.42	502.00	385.92	211.17
81	456.75	506.08	562.50	511.33	392.92	215.17
82	465.00	515.42	572.92	520.50	400.17	219.08
83	475.42	526.75	585.67	532.17	409.08	223.92
84	485.83	538.42	598.42	543.83	418.08	228.83
85	496.75	550.42	611.92	556.00	427.42	234.00
86	507.50	562.50	625.17	568.25	436.75	239.00
87	518.67	574.92	639.00	580.67	446.33	244.25
88	530.17	587.67	653.00	593.58	456.17	249.67
89	542.00	600.58	667.58	606.67	466.25	255.17
90	553.83	614.00	682.50	620.33	476.67	260.92
91	566.08	627.50	697.33	633.75	487.08	266.67
92	578.67	641.33	712.83	647.83	497.83	272.42
93	591.25	655.33	728.58	662.00	509.00	278.58
94	604.50	670.08	744.58	676.92	520.25	284.67
95	617.83	684.83	760.92	691.58	531.58	290.92
96	631.08	699.67	777.67	706.92	543.25	297.42
97	644.92	715.00	794.67	722.17	555.17	303.83
98	659.33	730.92	812.33	738.33	567.50	310.50
99+	673.83	746.92	830.25	754.50	579.92	317.33

Modal Factors: Annual = Monthly X 12 Semi-Annual = Monthly X 6 Quarterly = Monthly X 3

The above rates do not include the $15 one-time policy fee.

To calculate the Household discount of 3%:

Monthly premium X modal factor = modal premium (round to the nearest whole cent
Modal premium X .97 = discounted premium

United Insurance Company of America

Monthly Premiums
For Use in Zip Codes: 330-334
Male Rates

Issue Age	Preferred					
	Plan A	Plan D	Plan F	Plan G	Plan N	Plan HG
Under 65	1,076.67	1,193.42	1,325.92	1,205.08	926.50	506.83
65	336.42	372.83	414.33	376.58	289.50	158.42
66	336.42	372.83	414.33	376.58	289.50	158.42
67	336.42	372.83	414.33	376.58	289.50	158.42
68	342.33	379.33	421.50	383.08	294.50	161.08
69	348.25	386.17	429.08	389.92	299.75	164.00
70	354.33	393.17	436.75	396.92	305.17	167.00
71	361.50	400.50	445.25	404.67	311.08	170.25
72	367.67	407.50	452.75	411.67	316.25	173.17
73	377.50	418.42	465.17	422.75	324.92	177.83
74	387.92	429.92	477.75	434.08	333.67	182.67
75	398.00	441.08	490.33	445.42	342.50	187.50
76	407.67	451.67	502.17	456.33	350.75	192.00
77	417.00	462.25	513.67	466.92	358.83	196.50
78	424.92	470.75	523.33	475.58	365.67	200.08
79	432.67	479.67	533.00	484.58	372.50	203.83
80	440.58	488.17	542.58	493.17	379.17	207.42
81	448.67	497.08	552.42	502.00	385.92	211.17
82	456.75	506.08	562.50	511.33	392.92	215.17
83	466.75	517.42	575.08	522.58	401.58	219.83
84	477.17	528.92	587.83	534.33	410.75	224.83
85	487.58	540.42	600.75	546.00	419.50	229.67
86	498.42	552.58	614.00	558.17	428.83	234.75
87	509.50	564.83	627.83	570.58	438.58	240.08
88	520.67	577.25	641.50	583.17	448.25	245.33
89	532.33	590.00	655.67	595.92	458.00	250.75
90	544.00	603.08	670.25	609.17	468.17	256.25
91	556.00	616.17	685.00	622.50	478.42	261.83
92	568.25	629.83	699.92	636.17	489.00	267.58
93	580.83	643.67	715.50	650.17	500.00	273.50
94	593.58	658.00	731.33	664.67	510.75	279.67
95	606.83	672.42	747.50	679.25	522.08	285.75
96	620.00	686.92	763.67	694.17	533.58	292.00
97	633.58	702.42	780.50	709.42	545.25	298.50
98	647.58	717.83	797.75	725.17	557.25	304.92
99+	662.00	733.67	815.33	741.00	569.50	311.75

Issue Age	Standard					
	Plan A	Plan D	Plan F	Plan G	Plan N	Plan HG
Under 65	1,204.92	1,335.50	1,484.17	1,349.08	1,036.83	567.17
65	376.42	417.42	463.92	421.50	324.00	177.25
66	376.42	417.42	463.92	421.50	324.00	177.25
67	376.42	417.42	463.92	421.50	324.00	177.25
68	383.08	424.75	472.17	429.08	329.75	180.50
69	390.08	432.50	480.58	436.92	335.83	183.75
70	396.92	440.00	489.00	444.50	341.75	186.92
71	404.67	448.67	498.42	452.92	348.25	190.58
72	411.83	456.33	507.17	461.00	354.33	194.00
73	422.92	468.75	521.00	473.58	363.83	199.17
74	434.58	481.67	535.17	486.50	373.92	204.75
75	445.92	494.08	549.17	499.08	383.83	209.92
76	456.50	505.92	562.33	511.17	392.92	215.00
77	467.17	517.75	575.42	523.00	401.92	220.00
78	475.92	527.50	586.17	532.67	409.50	224.17
79	484.58	537.00	596.83	542.42	417.00	228.25
80	493.33	546.83	607.75	552.42	424.75	232.42
81	502.33	556.75	618.92	562.33	432.25	236.50
82	511.67	567.00	630.17	572.75	440.17	241.00
83	523.00	579.33	644.00	585.33	449.92	246.25
84	534.50	592.50	658.42	598.42	459.92	251.83
85	546.33	605.42	672.75	611.50	470.00	257.17
86	558.17	618.67	687.67	625.00	480.42	262.92
87	570.58	632.33	702.92	638.83	491.00	268.67
88	583.50	646.75	718.58	653.17	502.00	274.75
89	596.08	660.58	734.17	667.17	512.92	280.67
90	609.58	675.42	750.67	682.25	524.42	287.00
91	622.67	690.17	767.25	697.17	535.92	293.25
92	636.50	705.25	784.08	712.67	547.75	299.75
93	650.67	721.25	801.50	728.42	559.83	306.42
94	664.67	736.67	818.75	744.25	572.00	313.00
95	679.58	753.00	836.92	760.58	584.75	320.00
96	694.33	769.75	855.42	777.50	597.67	327.08
97	709.92	786.83	874.25	794.67	610.83	334.25
98	725.17	803.67	893.50	811.92	624.08	341.58
99+	741.17	821.67	913.25	830.08	637.92	349.17

Modal Factors: Annual = Monthly X 12 Semi-Annual = Monthly X 6 Quarterly = Monthly X 3

The above rates do not include the $15 one-time policy fee.

To calculate the Household discount of 3%:

Monthly premium X modal factor = modal premium (round to the nearest whole cent)
Modal premium X .97 = discounted premium

United Insurance Company of America

Monthly Premiums
For Use in Zip Codes: 322, 335-337, 346, 349
Female Rates

Issue Age	Preferred					
	Plan A	Plan D	Plan F	Plan G	Plan N	Plan HG
Under 65	687.33	762.00	846.92	769.58	591.50	323.83
65	214.83	238.17	264.67	240.50	184.92	101.25
66	214.83	238.17	264.67	240.50	184.92	101.25
67	214.83	238.17	264.67	240.50	184.92	101.25
68	218.58	242.33	269.33	244.67	188.17	103.00
69	222.58	246.75	274.25	249.25	191.58	104.83
70	226.42	251.00	278.92	253.50	194.83	106.67
71	230.83	255.83	284.33	258.50	198.67	108.75
72	234.83	260.25	289.25	262.92	202.08	110.58
73	241.17	267.33	297.08	269.92	207.50	113.58
74	247.83	274.75	305.25	277.50	213.25	116.75
75	254.33	281.83	313.25	284.75	218.83	119.75
76	260.33	288.75	320.83	291.50	224.17	122.67
77	266.42	295.33	328.25	298.33	229.33	125.58
78	271.50	300.75	334.33	303.75	233.58	127.83
79	276.42	306.33	340.33	309.33	237.75	130.08
80	281.42	312.00	346.67	315.17	242.17	132.50
81	286.50	317.50	353.00	320.83	246.58	134.92
82	291.75	323.42	359.42	326.58	251.00	137.42
83	298.08	330.42	367.25	333.83	256.58	140.50
84	304.75	337.83	375.42	341.25	262.33	143.58
85	311.50	345.25	383.75	348.67	268.08	146.75
86	318.42	352.83	392.25	356.42	274.00	149.92
87	325.50	360.83	400.92	364.50	280.08	153.33
88	332.67	368.67	409.75	372.42	286.25	156.58
89	340.00	377.00	418.83	380.75	292.67	160.17
90	347.42	385.17	428.08	389.08	299.00	163.67
91	355.17	393.58	437.58	397.67	305.67	167.33
92	362.92	402.42	447.17	406.50	312.50	171.00
93	371.17	411.33	457.08	415.42	319.25	174.75
94	379.25	420.25	467.17	424.58	326.33	178.58
95	387.58	429.58	477.42	433.92	333.58	182.58
96	396.25	439.08	488.00	443.50	340.83	186.50
97	404.75	448.75	498.58	453.33	348.42	190.67
98	413.67	458.50	509.58	463.17	356.00	194.83
99+	422.75	468.58	520.83	473.25	363.83	199.17

Issue Age	Standard					
	Plan A	Plan D	Plan F	Plan G	Plan N	Plan HG
Under 65	769.42	853.08	948.17	861.83	662.58	362.67
65	240.50	266.67	296.33	269.33	207.08	113.33
66	240.50	266.67	296.33	269.33	207.08	113.33
67	240.50	266.67	296.33	269.33	207.08	113.33
68	244.83	271.50	301.58	274.08	210.67	115.33
69	249.25	276.42	307.08	279.00	214.58	117.33
70	253.67	281.17	312.58	284.08	218.33	119.50
71	258.50	286.58	318.42	289.50	222.50	121.75
72	263.00	291.42	324.00	294.42	226.42	123.92
73	270.08	299.50	332.83	302.50	232.50	127.25
74	277.50	307.58	341.75	310.75	238.67	130.58
75	284.75	315.67	350.83	318.92	245.08	134.17
76	291.75	323.33	359.33	326.50	250.92	137.33
77	298.33	330.67	367.67	334.08	256.83	140.58
78	303.92	336.83	374.33	340.25	261.50	143.08
79	309.58	343.00	381.25	346.58	266.42	145.75
80	315.25	349.33	388.17	352.75	271.17	148.42
81	320.92	355.67	395.25	359.33	276.17	151.17
82	326.75	362.17	402.58	365.75	281.17	154.00
83	334.08	370.17	411.58	373.92	287.50	157.33
84	341.42	378.33	420.50	382.17	293.83	160.75
85	349.08	386.83	430.00	390.75	300.33	164.42
86	356.67	395.25	439.33	399.33	306.92	168.00
87	364.50	404.00	449.00	408.00	313.58	171.67
88	372.58	412.92	458.83	417.08	320.58	175.42
89	380.92	422.00	469.08	426.33	327.58	179.33
90	389.17	431.50	479.58	435.92	334.92	183.33
91	397.75	440.92	490.00	445.33	342.25	187.42
92	406.58	450.67	500.92	455.25	349.83	191.42
93	415.42	460.50	512.00	465.17	357.67	195.75
94	424.83	470.83	523.25	475.67	365.58	200.00
95	434.17	481.17	534.75	486.00	373.58	204.42
96	443.50	491.67	546.42	496.75	381.75	209.00
97	453.17	502.42	558.42	507.42	390.08	213.50
98	463.25	513.67	570.83	518.83	398.83	218.17
99+	473.50	524.83	583.42	530.17	407.50	223.00

Modal Factors: Annual = Monthly X 12 Semi-Annual = Monthly X 6 Quarterly = Monthly X 3

The above rates do not include the $15 one-time policy fee.

To calculate the Household discount of 3%:

Monthly premium X modal factor = modal premium (round to the nearest whole cent
Modal premium X .97 = discounted premium

United Insurance Company of America

Monthly Premiums
For Use in Zip Codes: 322, 335-337, 346, 349
Male Rates

Issue Age	Preferred					
	Plan A	Plan D	Plan F	Plan G	Plan N	Plan HG
Under 65	756.58	838.58	931.75	846.83	651.08	356.17
65	236.42	262.00	291.17	264.67	203.42	111.33
66	236.42	262.00	291.17	264.67	203.42	111.33
67	236.42	262.00	291.17	264.67	203.42	111.33
68	240.50	266.50	296.17	269.17	207.00	113.17
69	244.67	271.33	301.50	274.00	210.67	115.25
70	249.00	276.25	306.92	278.92	214.42	117.33
71	254.08	281.42	312.83	284.33	218.58	119.67
72	258.33	286.33	318.17	289.25	222.25	121.67
73	265.25	294.08	326.83	297.08	228.33	124.92
74	272.58	302.17	335.67	305.00	234.50	128.33
75	279.67	309.92	344.50	313.00	240.67	131.75
76	286.50	317.42	352.83	320.67	246.50	134.92
77	293.00	324.83	360.92	328.08	252.17	138.08
78	298.58	330.75	367.75	334.17	256.92	140.58
79	304.00	337.08	374.58	340.50	261.75	143.25
80	309.58	343.00	381.25	346.58	266.42	145.75
81	315.25	349.33	388.17	352.75	271.17	148.42
82	320.92	355.67	395.25	359.33	276.17	151.17
83	328.00	363.58	404.08	367.25	282.17	154.50
84	335.33	371.67	413.08	375.42	288.58	158.00
85	342.67	379.75	422.17	383.67	294.83	161.42
86	350.25	388.33	431.50	392.25	301.33	164.92
87	358.00	396.92	441.17	400.92	308.17	168.75
88	365.83	405.58	450.83	409.75	315.00	172.42
89	374.08	414.58	460.75	418.75	321.83	176.17
90	382.25	423.75	471.00	428.08	329.00	180.08
91	390.75	433.00	481.33	437.42	336.17	184.00
92	399.33	442.58	491.83	447.00	343.67	188.00
93	408.17	452.33	502.75	456.83	351.33	192.17
94	417.08	462.42	513.92	467.08	358.92	196.50
95	426.42	472.50	525.25	477.33	366.83	200.75
96	435.67	482.75	536.58	487.75	374.92	205.17
97	445.25	493.58	548.50	498.50	383.17	209.75
98	455.08	504.42	560.58	509.58	391.58	214.25
99+	465.17	515.50	572.92	520.75	400.17	219.08

Issue Age	Standard					
	Plan A	Plan D	Plan F	Plan G	Plan N	Plan HG
Under 65	846.67	938.42	1,042.92	948.00	728.58	398.58
65	264.50	293.33	326.00	296.17	227.67	124.58
66	264.50	293.33	326.00	296.17	227.67	124.58
67	264.50	293.33	326.00	296.17	227.67	124.58
68	269.17	298.50	331.75	301.50	231.67	126.83
69	274.08	303.92	337.75	307.08	236.00	129.08
70	278.92	309.17	343.67	312.33	240.17	131.42
71	284.33	315.25	350.25	318.25	244.67	133.92
72	289.42	320.67	356.42	324.00	249.00	136.33
73	297.17	329.42	366.08	332.83	255.67	139.92
74	305.42	338.50	376.08	341.92	262.75	143.83
75	313.33	347.17	385.92	350.75	269.67	147.50
76	320.83	355.50	395.17	359.17	276.17	151.08
77	328.25	363.83	404.33	367.50	282.42	154.58
78	334.42	370.67	411.92	374.33	287.75	157.50
79	340.50	377.33	419.33	381.17	293.00	160.42
80	346.67	384.25	427.08	388.17	298.50	163.33
81	353.00	391.25	434.92	395.17	303.75	166.17
82	359.58	398.42	442.83	402.42	309.33	169.33
83	367.50	407.17	452.58	411.33	316.17	173.00
84	375.58	416.33	462.67	420.50	323.17	176.92
85	383.92	425.42	472.75	429.75	330.25	180.75
86	392.25	434.75	483.25	439.17	337.58	184.75
87	400.92	444.33	493.92	448.92	345.00	188.83
88	410.00	454.42	504.92	459.00	352.75	193.08
89	418.83	464.17	515.92	468.83	360.42	197.25
90	428.33	474.67	527.50	479.42	368.50	201.67
91	437.58	485.00	539.17	489.92	376.58	206.08
92	447.25	495.58	551.00	500.75	384.92	210.67
93	457.25	506.83	563.25	511.92	393.33	215.33
94	467.08	517.67	575.33	523.00	401.92	220.00
95	477.58	529.17	588.08	534.50	410.92	224.92
96	487.92	540.92	601.08	546.33	420.00	229.83
97	498.92	552.92	614.33	558.42	429.25	234.83
98	509.58	564.75	627.83	570.58	438.58	240.00
99+	520.83	577.33	641.75	583.33	448.25	245.33

Modal Factors: Annual = Monthly X 12 Semi-Annual = Monthly X 6 Quarterly = Monthly X 3

The above rates do not include the $15 one-time policy fee.

To calculate the Household discount of 3%:

Monthly premium X modal factor = modal premium (round to the nearest whole cent)
Modal premium X .97 = discounted premium

United Insurance Company of America

Monthly Premiums

For Use in Zip Codes: ALL EXCEPT 322, 330-337, 346, 349

Female Rates

Issue Age	Preferred					
	Plan A	Plan D	Plan F	Plan G	Plan N	Plan HG
Under 65	645.00	715.08	794.83	722.25	555.08	303.92
65	201.58	223.50	248.33	225.75	173.50	95.00
66	201.58	223.50	248.33	225.75	173.50	95.00
67	201.58	223.50	248.33	225.75	173.50	95.00
68	205.17	227.42	252.75	229.67	176.58	96.67
69	208.92	231.58	257.33	233.92	179.75	98.42
70	212.50	235.58	261.75	237.92	182.83	100.08
71	216.58	240.08	266.83	242.58	186.42	102.08
72	220.42	244.25	271.42	246.67	189.58	103.75
73	226.33	250.83	278.83	253.33	194.67	106.58
74	232.58	257.83	286.50	260.42	200.17	109.58
75	238.67	264.50	293.92	267.17	205.33	112.42
76	244.33	271.00	301.08	273.58	210.33	115.08
77	250.00	277.17	308.08	280.00	215.17	117.83
78	254.75	282.25	313.75	285.08	219.25	120.00
79	259.33	287.42	319.42	290.25	223.17	122.08
80	264.08	292.75	325.33	295.75	227.25	124.33
81	268.83	298.00	331.25	301.08	231.42	126.58
82	273.83	303.58	337.33	306.50	235.58	129.00
83	279.75	310.08	344.67	313.25	240.75	131.83
84	286.00	317.08	352.33	320.25	246.25	134.75
85	292.33	324.00	360.17	327.25	251.58	137.75
86	298.83	331.17	368.08	334.50	257.08	140.67
87	305.42	338.58	376.25	342.08	262.83	143.92
88	312.17	345.92	384.58	349.50	268.58	147.00
89	319.08	353.75	393.08	357.33	274.67	150.33
90	326.08	361.50	401.75	365.17	280.58	153.58
91	333.25	369.42	410.58	373.17	286.83	157.08
92	340.58	377.67	419.58	381.50	293.25	160.50
93	348.33	386.00	429.00	389.92	299.67	164.00
94	355.92	394.42	438.42	398.42	306.25	167.58
95	363.75	403.17	448.08	407.17	313.00	171.42
96	371.92	412.00	458.00	416.17	319.92	175.08
97	379.83	421.17	467.92	425.42	327.00	178.92
98	388.25	430.25	478.25	434.67	334.08	182.83
99+	396.75	439.75	488.75	444.17	341.42	186.92

Issue Age	Standard					
	Plan A	Plan D	Plan F	Plan G	Plan N	Plan HG
Under 65	722.08	800.58	889.83	808.83	621.75	340.42
65	225.75	250.25	278.08	252.75	194.33	106.33
66	225.75	250.25	278.08	252.75	194.33	106.33
67	225.75	250.25	278.08	252.75	194.33	106.33
68	229.75	254.75	283.08	257.25	197.67	108.25
69	233.92	259.33	288.17	261.83	201.33	110.17
70	238.08	263.83	293.33	266.58	204.92	112.17
71	242.58	269.00	298.83	271.67	208.83	114.25
72	246.83	273.50	304.00	276.33	212.50	116.33
73	253.42	281.08	312.33	283.92	218.17	119.42
74	260.42	288.67	320.75	291.58	224.00	122.58
75	267.17	296.17	329.25	299.25	230.00	125.92
76	273.83	303.42	337.17	306.42	235.42	128.83
77	280.00	310.33	345.00	313.50	241.00	131.92
78	285.17	316.08	351.25	319.33	245.42	134.33
79	290.50	321.92	357.83	325.25	250.00	136.83
80	295.83	327.83	364.33	331.00	254.50	139.25
81	301.17	333.75	370.92	337.17	259.17	141.92
82	306.67	339.92	377.83	343.25	263.83	144.50
83	313.50	347.33	386.25	350.92	269.83	147.67
84	320.33	355.08	394.67	358.58	275.75	150.92
85	327.58	363.00	403.50	366.67	281.92	154.33
86	334.67	370.92	412.25	374.75	288.00	157.67
87	342.08	379.08	421.42	382.92	294.33	161.08
88	349.58	387.50	430.67	391.42	300.83	164.67
89	357.42	396.08	440.25	400.08	307.42	168.33
90	365.25	404.92	450.08	409.08	314.33	172.08
91	373.33	413.83	459.92	418.00	321.17	175.92
92	381.58	422.92	470.08	427.17	328.33	179.67
93	389.92	432.17	480.50	436.58	335.67	183.67
94	398.67	441.92	491.00	446.42	343.08	187.75
95	407.42	451.58	501.83	456.08	350.58	191.83
96	416.17	461.42	512.83	466.17	358.25	196.17
97	425.33	471.50	524.08	476.25	366.08	200.42
98	434.75	482.00	535.67	486.92	374.25	204.75
99+	444.33	492.58	547.5	497.58	382.42	209.25

Modal Factors: Annual = Monthly X 12 Semi-Annual = Monthly X 6 Quarterly = Monthly X 3

The above rates do not include the $15 one-time policy fee.

To calculate the Household discount of 3%:

Monthly premium X modal factor = modal premium (round to the nearest whole cent
Modal premium X .97 = discounted premium

United Insurance Company of America

Monthly Premiums
For Use in Zip Codes: ALL EXCEPT 322, 330-337, 346, 349
Male Rates

Issue Age	Preferred					
	Plan A	Plan D	Plan F	Plan G	Plan N	Plan HG
Under 65	710.00	787.00	874.42	794.67	611.00	334.25
65	221.83	245.83	273.25	248.33	190.92	104.50
66	221.83	245.83	273.25	248.33	190.92	104.50
67	221.83	245.83	273.25	248.33	190.92	104.50
68	225.75	250.17	278.00	252.58	194.25	106.25
69	229.67	254.67	282.92	257.08	197.67	108.17
70	233.67	259.25	288.00	261.75	201.25	110.17
71	238.42	264.08	293.58	266.83	205.17	112.25
72	242.42	268.75	298.58	271.42	208.58	114.17
73	248.92	275.92	306.75	278.83	214.25	117.25
74	255.83	283.50	315.00	286.25	220.08	120.42
75	262.42	290.92	323.33	293.75	225.83	123.67
76	268.83	297.83	331.17	300.92	231.33	126.58
77	275.00	304.83	338.75	307.92	236.67	129.58
78	280.25	310.42	345.08	313.58	241.17	131.92
79	285.33	316.33	351.50	319.50	245.67	134.42
80	290.50	321.92	357.83	325.25	250.00	136.83
81	295.83	327.83	364.33	331.00	254.50	139.25
82	301.17	333.75	370.92	337.17	259.17	141.92
83	307.83	341.25	379.25	344.67	264.83	145.00
84	314.67	348.83	387.67	352.33	270.83	148.25
85	321.58	356.33	396.17	360.08	276.67	151.50
86	328.67	364.42	404.92	368.08	282.83	154.83
87	336.00	372.50	414.08	376.25	289.25	158.33
88	343.33	380.67	423.08	384.58	295.58	161.75
89	351.08	389.08	432.42	393.00	302.00	165.33
90	358.75	397.67	442.00	401.75	308.75	169.00
91	366.67	406.33	451.75	410.50	315.50	172.67
92	374.75	415.33	461.58	419.50	322.50	176.50
93	383.00	424.50	471.83	428.75	329.75	180.42
94	391.42	433.92	482.25	438.33	336.83	184.42
95	400.17	443.42	492.92	447.92	344.33	188.42
96	408.83	453.00	503.58	457.75	351.83	192.58
97	417.83	463.17	514.75	467.83	359.58	196.83
98	427.08	473.42	526.08	478.25	367.50	201.08
99+	436.58	483.83	537.67	488.67	375.58	205.58

Issue Age	Standard					
	Plan A	Plan D	Plan F	Plan G	Plan N	Plan HG
Under 65	794.58	880.67	978.75	889.67	683.75	374.00
65	248.25	275.25	305.92	278.00	213.67	116.92
66	248.25	275.25	305.92	278.00	213.67	116.92
67	248.25	275.25	305.92	278.00	213.67	116.92
68	252.58	280.08	311.33	282.92	217.42	119.00
69	257.25	285.17	316.92	288.17	221.50	121.17
70	261.75	290.17	322.50	293.17	225.42	123.25
71	266.83	295.83	328.67	298.67	229.67	125.67
72	271.58	300.92	334.50	304.00	233.67	127.92
73	278.92	309.08	343.58	312.33	239.92	131.33
74	286.58	317.67	352.92	320.83	246.58	135.00
75	294.08	325.83	362.17	329.17	253.08	138.42
76	301.08	333.67	370.83	337.08	259.17	141.75
77	308.08	341.42	379.50	344.92	265.08	145.08
78	313.83	347.83	386.58	351.25	270.00	147.83
79	319.50	354.08	393.58	357.67	275.00	150.50
80	325.33	360.67	400.75	364.33	280.08	153.25
81	331.25	367.17	408.17	370.83	285.08	156.00
82	337.42	373.92	415.58	377.67	290.25	158.92
83	344.92	382.08	424.75	386.00	296.67	162.33
84	352.50	390.75	434.17	394.67	303.33	166.08
85	360.25	399.25	443.67	403.25	309.92	169.58
86	368.08	408.00	453.50	412.17	316.83	173.42
87	376.25	417.00	463.58	421.25	323.83	177.17
88	384.83	426.50	473.83	430.75	331.00	181.17
89	393.08	435.58	484.17	440.00	338.25	185.08
90	402.00	445.42	495.08	449.92	345.83	189.25
91	410.58	455.17	505.92	459.75	353.42	193.42
92	419.75	465.08	517.08	469.92	361.25	197.67
93	429.08	475.67	528.58	480.42	369.17	202.08
94	438.33	485.83	539.92	490.83	377.25	206.42
95	448.17	496.58	551.92	501.58	385.67	211.08
96	457.83	507.58	564.08	512.67	394.17	215.67
97	468.17	518.83	576.58	524.08	402.83	220.42
98	478.25	530.00	589.25	535.42	411.58	225.25
99+	488.75	541.83	602.25	547.42	420.67	230.25

Modal Factors: Annual = Monthly X 12 Semi-Annual = Monthly X 6 Quarterly = Monthly X 3

The above rates do not include the $15 one-time policy fee.

To calculate the Household discount of 3%:

Monthly premium X modal factor = modal premium (round to the nearest whole cent)
Modal premium X .97 = discounted premium

BASIC BENEFITS

Hospitalization – Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses – Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or co-payments.
Blood – First three pints of blood each year.
Hospice — Part A coinsurance.

PREMIUM INFORMATION

We, United Insurance Company of America, can only raise your premium for all policies like yours in the state of Florida.

Household Discount: In order to be eligible for the household discount under a United Insurance Company of America Medicare supplement policy, you must apply for a Medicare supplement policy at the same time as another Medicare-eligible adult or the other Medicare- eligible adult must currently be covered by a Medicare supplement policy issued by United Insurance Company of America. The Medicare-eligible adult must be either (a) a member of your household with whom you are currently residing and have continuously resided for the last 12 months (limited to three Medicare-eligible adults), or (b) someone with whom you are currently residing and who is your spouse or with whom you are in a civil union partnership. The household discount will only be applicable if a policy for each applicant is issued. The discounted rates will be 3 percent lower than the individual rates and will apply as long as the policies remain in force.

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 United Insurance Company of America.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to: United Insurance Company of America, Medicare Supplement Administration, P.O. Box 10864, Clearwater, Florida 33757-8864. 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.

NOTICE

Neither United Insurance Company of America 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.

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. Use this outline to compare benefits and premiums among policies.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, and it is **NOT** an "Open Enrollment or Guaranteed Issue status application," be sure to answer truthfully and completely all questions about your medical and health history. The policy is issued on the basis that the answers to all questions and all information shown in the application are correct and complete. The company may cancel your policy and refuse to pay any claims if you make misstatements, leave out or falsify important information. Review the application carefully before you sign it. Be certain that all information has been properly recorded. To review "Open Enrollment" timeframes please go to the following link on the Medicare.gov website:
https://www.medicare.gov/supplement-other-insurance/when-can-i-buy-medigap/when-can-i-buy-medigap.html

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 $1676	$0	$1676 (Part A deductible)
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	$0	Up to $209.50 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 co-payment/ 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 for 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 $257 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 $257 of Medicare Approved Amounts*	$0	$0	$257 (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 $257 of Medicare Approved Amounts*	$0	$0	$257 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First $257 of Medicare Approved Amounts*	$0	$0	$257 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

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 $1676	$1676 (Part A deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	Up to $209.50 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 co-payment/ 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 for 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 $257 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 $257 of Medicare Approved Amounts*	$0	$0	$257 (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 $257 of Medicare Approved Amounts*	$0	$0	$257(Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN D

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment First $257 of Medicare Approved Amounts*	$0	$0	$257 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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+

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 $1676	$1676 (Part A deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	Up to $209.50 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 co-payment/ 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 for the balance based on any difference between its billed charges and the amount Medicare would have paid.

+Only applicants first eligible for Medicare before January 1, 2020 may purchase Plans C, F, and high deductible F.

PLAN F+

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

*Once you have been billed $257 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 $257 of Medicare Approved Amounts*	$0	$257 (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 $257 of Medicare Approved Amounts*	$0	$257 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

+Only applicants first eligible for Medicare before January 1, 2020 may purchase Plans C, F, and high deductible F.

PLAN F+

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment First $257 of Medicare Approved Amounts*	$0	$257 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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

+Only applicants first eligible for Medicare before January 1, 2020 may purchase Plans C, F, and high deductible F.

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1676	$1676 (Part A deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	Up to $209.50 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 co-payment/ 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 for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G

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

*Once you have been billed $257 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 $257 of Medicare Approved Amounts*	$0	$0	$257 (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 $257 of Medicare Approved Amounts*	$0	$0	$257 (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

PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First $257 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% $0 80%	$0 $0 20%	$0 $257 (Unless Part B deductible has been met) $0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

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

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

**This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $2870 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses exceed $2870. 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 $2870 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2870 DEDUCTIBLE** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1676	$1676 (Part A	$0
61st thru 90th day	All but $419 a day	deductible) $419 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	Up to $209.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

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

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2870 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2870 DEDUCTIBLE** YOU PAY
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ 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 for the balance based on any difference between its billed charges and the amount Medicare would have paid.

HIGH DEDUCTIBLE PLAN G

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

*Once you have been billed $257 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 you have paid a calendar year $2870 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses exceed $2870. 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 $2870 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2870 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 $257 of Medicare Approved Amounts*	$0	$0	$257 (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 $257 of Medicare Approved Amounts*	$0	$0	$257 (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

HIGH DEDUCTIBLE PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2870 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2870 DEDUCTIBLE** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First $257 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% $0 80%	$0 $0 20%	$0 $257 (Unless Part B deductible has been met) $0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2870 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2870 DEDUCTIBLE** YOU PAY
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 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 $1676	$1676 (Part A deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	Up to $209.50 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 co-payment/ 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 for 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 $257 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 $257 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	$0 Generally 80%	$0 Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	$257 (Part B deductible) Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD First 3 pints Next $257 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	$0 $0 80%	All costs $0 20%	$0 $257 (Part B deductible) $0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment First $257 of Medicare Approved Amounts*	$0	$0	$257 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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