

**UNITED AMERICAN INSURANCE COMPANY**  
P.O. BOX 8080, MCKINNEY, TEXAS 75070 (972) 529-5085  
A Legal Reserve 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 <sup>3</sup>	✓	✓
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 <sup>2</sup>					\$7,060 <sup>2</sup>	\$3,530 <sup>2</sup>				

\* Denotes plans available by United American Insurance Company

<sup>1</sup> 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.

<sup>2</sup> 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.

<sup>3</sup> 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. 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.

## COMMUNITY RATES FOR ALL AGES 65 AND OVER

Male/Female

Community						
Plan	A	SA	Q	M	Plan Code	Effective Date
A	2663	1332	666	222	5A8	02/15/2020
B	4142	2071	1036	346	5AQ	02/01/2023
C	5298	2649	1325	442	5B8	01/15/2024
D	5276	2638	1319	440	5BQ	01/15/2024
F	4694	2347	1174	392	5C8	01/15/2024
HDF	662	331	166	56	5CQ	01/15/2024
G	4923	2462	1231	411	5D8	01/15/2024
HDG	595	298	149	50	5HS	01/01/2020
K	1614	807	404	135	P87	01/01/2013
L	2397	1199	600	200	P90	02/15/2020
N	2481	1241	621	207	5DQ	02/15/2020

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

## UNDER AGE 65 GUARANTEED ISSUE PERIOD (G/I)

Male/Female

Community						
Plan	A	SA	Q	M	Plan Code	Effective Date
A	2663	1332	666	222	5AD	02/15/2020
B	4142	2071	1036	346	5AV	02/01/2023
C	5298	2649	1325	442	5BD	01/15/2024
D	5276	2638	1319	440	5BV	01/15/2024

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

## UNDER AGE 65 DURING OPEN ENROLLMENT (O/E)

**Male/Female**

Community						
Plan	A	SA	Q	M	Plan Code	Effective Date
A	2663	1332	666	222	5AD	02/15/2020
B	4142	2071	1036	346	5AV	02/01/2023
C	5298	2649	1325	442	5BD	01/15/2024
D	5276	2638	1319	440	5BV	01/15/2024

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

## 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
<b>HOSPITALIZATION*</b>			
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
<b>SKILLED NURSING FACILITY CARE*</b>			
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
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
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
<b>MEDICAL EXPENSES</b> – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$240 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$240 (Part B Deductible) \$0
<b>Part B Excess Charges</b> (Above Medicare-Approved Amounts)	\$0	\$0	All Costs
<b>BLOOD</b> First 3 pints Next \$240 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$240 (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES</b> – Tests for diagnostic services	100%	\$0	\$0

### PARTS A & B

<b>HOME HEALTH CARE</b> – MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies – Durable medical equipment First \$240 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	100%   \$0 80%	\$0  \$0 20%	\$0  \$240 (Part B Deductible) \$0
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## 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
<b>HOSPITALIZATION*</b>			
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
<b>SKILLED NURSING FACILITY CARE*</b>			
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
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
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
<b>MEDICAL EXPENSES</b> – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$240 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$240 (Part B Deductible) \$0
<b>Part B Excess Charges</b> (Above Medicare-Approved Amounts)	\$0	\$0	All Costs
<b>BLOOD</b> First 3 pints Next \$240 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$240 (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES</b> – Tests for diagnostic services	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE</b> – MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies – Durable medical equipment First \$240 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$240 (Part B Deductible) \$0
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## 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
<b>HOSPITALIZATION*</b>			
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
<b>SKILLED NURSING FACILITY CARE*</b>			
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
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
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
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as</b> Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$240 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$240 (Part B Deductible) Generally 20%	\$0 \$0
<b>Part B Excess Charges</b> (Above Medicare-Approved Amounts)	\$0	\$0	All Costs
<b>BLOOD</b> First 3 pints Next \$240 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All Costs \$240 (Part B Deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES</b> – Tests for diagnostic services	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE – MEDICARE-APPROVED SERVICES</b> – Medically necessary skilled care services and medical supplies – Durable medical equipment First \$240 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	100% \$0 80%	\$0 \$240 (Part B Deductible) 20%	\$0 \$0 \$0
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**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
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## 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
<b>HOSPITALIZATION*</b>			
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
<b>SKILLED NURSING FACILITY CARE*</b>			
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
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
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
<b>MEDICAL EXPENSES</b> – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$240 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$240 (Part B Deductible) \$0
<b>Part B Excess Charges</b> (Above Medicare-Approved Amounts)	\$0	\$0	All Costs
<b>BLOOD</b> First 3 pints Next \$240 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$240 (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES</b> – Tests for diagnostic services	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE</b> – MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies – Durable medical equipment First \$240 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	100%   \$0 80%	\$0   \$0 20%	\$0   \$240 (Part B Deductible) \$0
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**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>FOREIGN TRAVEL</b> – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
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**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
<b>HOSPITALIZATION*</b>			
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
<b>SKILLED NURSING FACILITY CARE*</b>			
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
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
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
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as</b> Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$240 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$240 (Part B Deductible) Generally 20%	\$0 \$0
<b>Part B Excess Charges</b> (Above Medicare-Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$240 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All Costs \$240 (Part B Deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES</b> – Tests for diagnostic services	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE – MEDICARE-APPROVED SERVICES</b> – Medically necessary skilled care services and medical supplies – Durable medical equipment First \$240 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	100%   \$0 80%	\$0  \$240 (Part B Deductible) 20%	\$0  \$0 \$0
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**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
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**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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: – While using 60 lifetime reserve days Once lifetime reserve days are used: – Additional 365 days  – Beyond the Additional 365 days	All but \$1632 All but \$408 a day  All but \$816 a day  \$0  \$0	\$1632 (Part A Deductible) \$408 a day  \$816 a day  100% of Medicare-Eligible Expenses \$0	\$0 \$0  \$0  \$0 ***  All Costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$204 a day \$0	\$0 Up to \$204 a day \$0	\$0 \$0 All Costs
<b>BLOOD</b> First 3 pints Additional Amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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
<b>MEDICAL EXPENSES</b> – 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
<b>Part B Excess Charges</b> (Above Medicare-Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$240 of Medicare-Approved Amounts*	\$0 \$0	All Costs \$0	\$0 \$240 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES</b> – Tests for diagnostic services	100%	\$0	\$0

**PARTS A & B**

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

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>FOREIGN TRAVEL</b> – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
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## 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 *
<b>HOSPITALIZATION**</b>			
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
<b>SKILLED NURSING FACILITY CARE**</b>			
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
<b>BLOOD</b>			
First 3 pints	\$0	50%	50% ♦
Additional Amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
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
<b>MEDICAL EXPENSES</b> – 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 **** Preventive Benefits for Medicare-Covered Services  Remainder of Medicare-Approved Amounts	\$0 Generally 80% or more of Medicare-approved amounts Generally 80%	\$0 Remainder of Medicare-approved amounts Generally 10%	\$240 (Part B Deductible) **** ♦ All costs above Medicare-approved amounts  Generally 10% ♦
<b>Part B Excess Charges</b> (Above Medicare-Approved Amounts)	\$0	\$0	All Costs (and they do not count toward annual out-of-pocket limit of \$7060)*
<b>BLOOD</b> First 3 pints Next \$240 of Medicare-Approved Amounts **** Remainder of Medicare-Approved Amounts	\$0 \$0 Generally 80%	50% \$0 Generally 10%	50% ♦ \$240 (Part B Deductible) **** ♦ Generally 10% ♦
<b>CLINICAL LABORATORY SERVICES</b> – Tests for diagnostic services	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE</b> – MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies – Durable medical equipment First \$240 of Medicare-Approved Amounts ***** Remainder of Medicare-Approved Amounts	100%  \$0 80%	\$0  \$0 10%	\$0  \$240 (Part B Deductible) ♦ 10% ♦
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\* 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 *
<b>HOSPITALIZATION**</b>			
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
<b>SKILLED NURSING FACILITY CARE**</b>			
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
<b>BLOOD</b>			
First 3 pints	\$0	75%	25% ♦
Additional Amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
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
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , 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 **** Preventive Benefits for Medicare-Covered Services  Remainder of Medicare-Approved Amounts	\$0 Generally 80% or more of Medicare-approved amounts Generally 80%	\$0 Remainder of Medicare-approved amounts Generally 15%	\$240 (Part B Deductible) **** ♦ All costs above Medicare-approved amounts  Generally 5% ♦
<b>Part B Excess Charges</b> (Above Medicare-Approved Amounts)	\$0	\$0	All Costs (and they do not count toward annual out-of-pocket limit of \$3530)*
<b>BLOOD</b> First 3 pints Next \$240 of Medicare-Approved Amounts **** Remainder of Medicare-Approved Amounts	\$0 \$0 Generally 80%	75% \$0 Generally 15%	25% ♦ \$240 (Part B Deductible) **** ♦ Generally 5% ♦
<b>CLINICAL LABORATORY SERVICES</b> – Tests for diagnostic services	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE – MEDICARE-APPROVED SERVICES</b> – Medically necessary skilled care services and medical supplies – Durable medical equipment First \$240 of Medicare-Approved Amounts ***** Remainder of Medicare-Approved Amounts	100%  \$0 80%	\$0  \$0 15%	\$0  \$240 (Part B Deductible) ♦ 5% ♦
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\* 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
<b>HOSPITALIZATION*</b>			
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
<b>SKILLED NURSING FACILITY CARE*</b>			
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
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
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
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as:</b> Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$240 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$0 Balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	\$240 (Part B Deductible) Up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
<b>Part B Excess Charges</b> (Above Medicare-Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b>			
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
<b>CLINICAL LABORATORY SERVICES</b>			
– Tests for diagnostic services	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE – MEDICARE-APPROVED SERVICES</b>			
– 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**

<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b>			
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