UNITED AMERICAN INSURANCE COMPANY

P.O. BOX 8080, MCKINNEY, TEXAS 75070 (972) 529-5085
A Nebraska Stock Company • Administrative Offices: McKinney, Texas

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

Benefit Plans A, B, C, D, F, HDF, G, HDG, K, L, and N

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan A available. Some plans may not be available. Only applicants **first** eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

Note: A ✓means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants								Medicare First Eligible Before 2020 Only	
	A*	B*	D*	G*1*	K*	L*	M	N*	C*	F*1*
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓copays apply [3]	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2024[2]					$7,060[2]	$3,530[2]				

* Denotes plans available by United American Insurance Company

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of $2,800 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

[2] Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

[3] Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that do not result in an inpatient admission.

PREMIUM INFORMATION

We, United American Insurance Company, can only raise your premium if we raise the premium for all policies like yours in this state. Until you are age 81, your premiums will increase on each policy anniversary solely because of your age change. Your premiums may also be increased due to increasing health costs for all policies in your class.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to United American Insurance Company, P.O. Box 8080, McKinney, Texas 75070. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, DO NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all your medical costs.

Neither United American Insurance Company nor its agents are connected with Medicare.

This Outline of Coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The Company may cancel your policy and refuse to pay claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

RENEWABILITY

This policy is guaranteed renewable for life. We have the right to change the renewal premiums for this policy in accordance with our table of premium rates applicable to all policies of this form and class. This policy provides a 31-day grace period.

PLAN A

Male

Preferred Effective Date: 03/01/2020 Plan Code: 5A4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1480	740	370	124
66	1581	791	396	132
67	1671	836	418	140
68	1757	879	440	147
69	1856	928	464	155
70	1949	975	488	163
71	2033	1017	509	170
72	2082	1041	521	174
73	2122	1061	531	177
74	2156	1078	539	180
75	2187	1094	547	183
76	2211	1106	553	185
77	2211	1106	553	185
78	2211	1106	553	185
79	2211	1106	553	185
80+	2211	1106	553	185

Standard Effective Date: 03/01/2020 Plan Code: 5A6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1704	852	426	142
66	1819	910	455	152
67	1922	961	481	161
68	2021	1011	506	169
69	2135	1068	534	178
70	2242	1121	561	187
71	2340	1170	585	195
72	2396	1198	599	200
73	2442	1221	611	204
74	2481	1241	621	207
75	2517	1259	630	210
76	2544	1272	636	212
77	2544	1272	636	212
78	2544	1272	636	212
79	2544	1272	636	212
80+	2544	1272	636	212

Female

Preferred Effective Date: 03/01/2020 Plan Code: 5A5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1286	643	322	108
66	1376	688	344	115
67	1453	727	364	122
68	1528	764	382	128
69	1613	807	404	135
70	1694	847	424	142
71	1768	884	442	148
72	1809	905	453	151
73	1845	923	462	154
74	1875	938	469	157
75	1902	951	476	159
76	1923	962	481	161
77	1923	962	481	161
78	1923	962	481	161
79	1923	962	481	161
80+	1923	962	481	161

Standard Effective Date: 03/01/2020 Plan Code: 5A7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1480	740	370	124
66	1581	791	396	132
67	1671	836	418	140
68	1757	879	440	147
69	1856	928	464	155
70	1949	975	488	163
71	2033	1017	509	170
72	2082	1041	521	174
73	2122	1061	531	177
74	2156	1078	539	180
75	2187	1094	547	183
76	2211	1106	553	185
77	2211	1106	553	185
78	2211	1106	553	185
79	2211	1106	553	185
80+	2211	1106	553	185

PLAN B

Male

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2586	1293	647	216
66	2770	1385	693	231
67	2936	1468	734	245
68	3096	1548	774	258
69	3285	1643	822	274
70	3459	1730	865	289
71	3621	1811	906	302
72	3732	1866	933	311
73	3823	1912	956	319
74	3910	1955	978	326
75	3986	1993	997	333
76	4055	2028	1014	338
77	4061	2031	1016	339
78	4069	2035	1018	340
79	4074	2037	1019	340
80+	4074	2037	1019	340

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2976	1488	744	248
66	3189	1595	798	266
67	3379	1690	845	282
68	3566	1783	892	298
69	3782	1891	946	316
70	3981	1991	996	332
71	4167	2084	1042	348
72	4296	2148	1074	358
73	4397	2199	1100	367
74	4500	2250	1125	375
75	4587	2294	1147	383
76	4666	2333	1167	389
77	4673	2337	1169	390
78	4680	2340	1170	390
79	4690	2345	1173	391
80+	4690	2345	1173	391

Female

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2249	1125	563	188
66	2408	1204	602	201
67	2556	1278	639	213
68	2693	1347	674	225
69	2856	1428	714	238
70	3007	1504	752	251
71	3149	1575	788	263
72	3245	1623	812	271
73	3326	1663	832	278
74	3401	1701	851	284
75	3466	1733	867	289
76	3526	1763	882	294
77	3531	1766	883	295
78	3535	1768	884	295
79	3544	1772	886	296
80+	3544	1772	886	296

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2586	1293	647	216
66	2770	1385	693	231
67	2936	1468	734	245
68	3096	1548	774	258
69	3285	1643	822	274
70	3459	1730	865	289
71	3621	1811	906	302
72	3732	1866	933	311
73	3823	1912	956	319
74	3910	1955	978	326
75	3986	1993	997	333
76	4055	2028	1014	338
77	4061	2031	1016	339
78	4069	2035	1018	340
79	4074	2037	1019	340
80+	4074	2037	1019	340

PLAN C

Male

Preferred Effective Date: 03/15/2024 Plan Code: 5B4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3020	1510	755	252
66	3222	1611	806	269
67	3415	1708	854	285
68	3607	1804	902	301
69	3838	1919	960	320
70	4052	2026	1013	338
71	4260	2130	1065	355
72	4417	2209	1105	369
73	4552	2276	1138	380
74	4673	2337	1169	390
75	4783	2392	1196	399
76	4883	2442	1221	407
77	4960	2480	1240	414
78	5037	2519	1260	420
79	5116	2558	1279	427
80+	5217	2609	1305	435

Standard Effective Date: 03/15/2024 Plan Code: 5B6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3476	1738	869	290
66	3709	1855	928	310
67	3928	1964	982	328
68	4151	2076	1038	346
69	4415	2208	1104	368
70	4664	2332	1166	389
71	4905	2453	1227	409
72	5081	2541	1271	424
73	5241	2621	1311	437
74	5377	2689	1345	449
75	5503	2752	1376	459
76	5622	2811	1406	469
77	5709	2855	1428	476
78	5797	2899	1450	484
79	5883	2942	1471	491
80+	6004	3002	1501	501

Female

Preferred Effective Date: 03/15/2024 Plan Code: 5B5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2628	1314	657	219
66	2800	1400	700	234
67	2969	1485	743	248
68	3137	1569	785	262
69	3336	1668	834	278
70	3526	1763	882	294
71	3705	1853	927	309
72	3842	1921	961	321
73	3956	1978	989	330
74	4066	2033	1017	339
75	4160	2080	1040	347
76	4247	2124	1062	354
77	4313	2157	1079	360
78	4381	2191	1096	366
79	4449	2225	1113	371
80+	4536	2268	1134	378

Standard Effective Date: 03/15/2024 Plan Code: 5B7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3020	1510	755	252
66	3222	1611	806	269
67	3415	1708	854	285
68	3607	1804	902	301
69	3838	1919	960	320
70	4052	2026	1013	338
71	4260	2130	1065	355
72	4417	2209	1105	369
73	4552	2276	1138	380
74	4673	2337	1169	390
75	4783	2392	1196	399
76	4883	2442	1221	407
77	4960	2480	1240	414
78	5037	2519	1260	420
79	5116	2558	1279	427
80+	5217	2609	1305	435

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

PLAN D

Male

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2579	1290	645	215
66	2770	1385	693	231
67	2947	1474	737	246
68	3125	1563	782	261
69	3342	1671	836	279
70	3537	1769	885	295
71	3734	1867	934	312
72	3877	1939	970	324
73	4001	2001	1001	334
74	4117	2059	1030	344
75	4214	2107	1054	352
76	4308	2154	1077	359
77	4382	2191	1096	366
78	4450	2225	1113	371
79	4521	2261	1131	377
80+	4617	2309	1155	385

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2968	1484	742	248
66	3188	1594	797	266
67	3392	1696	848	283
68	3596	1798	899	300
69	3843	1922	961	321
70	4073	2037	1019	340
71	4296	2148	1074	358
72	4461	2231	1116	372
73	4604	2302	1151	384
74	4736	2368	1184	395
75	4849	2425	1213	405
76	4960	2480	1240	414
77	5041	2521	1261	421
78	5123	2562	1281	427
79	5205	2603	1302	434
80+	5314	2657	1329	443

Female

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2244	1122	561	187
66	2407	1204	602	201
67	2564	1282	641	214
68	2720	1360	680	227
69	2905	1453	727	243
70	3079	1540	770	257
71	3246	1623	812	271
72	3372	1686	843	281
73	3478	1739	870	290
74	3578	1789	895	299
75	3663	1832	916	306
76	3749	1875	938	313
77	3809	1905	953	318
78	3871	1936	968	323
79	3932	1966	983	328
80+	4015	2008	1004	335

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2579	1290	645	215
66	2770	1385	693	231
67	2947	1474	737	246
68	3125	1563	782	261
69	3342	1671	836	279
70	3537	1769	885	295
71	3734	1867	934	312
72	3877	1939	970	324
73	4001	2001	1001	334
74	4117	2059	1030	344
75	4214	2107	1054	352
76	4308	2154	1077	359
77	4382	2191	1096	366
78	4450	2225	1113	371
79	4521	2261	1131	377
80+	4617	2309	1155	385

PLAN F

Male

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3351	1676	838	280
66	3570	1785	893	298
67	3778	1889	945	315
68	3992	1996	998	333
69	4250	2125	1063	355
70	4487	2244	1122	374
71	4717	2359	1180	394
72	4884	2442	1221	407
73	5033	2517	1259	420
74	5171	2586	1293	431
75	5287	2644	1322	441
76	5402	2701	1351	451
77	5483	2742	1371	457
78	5570	2785	1393	465
79	5651	2826	1413	471
80+	5767	2884	1442	481

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3853	1927	964	322
66	4108	2054	1027	343
67	4353	2177	1089	363
68	4595	2298	1149	383
69	4887	2444	1222	408
70	5164	2582	1291	431
71	5427	2714	1357	453
72	5624	2812	1406	469
73	5793	2897	1449	483
74	5950	2975	1488	496
75	6086	3043	1522	508
76	6214	3107	1554	518
77	6313	3157	1579	527
78	6410	3205	1603	535
79	6505	3253	1627	543
80+	6637	3319	1660	554

Female

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2912	1456	728	243
66	3109	1555	778	260
67	3286	1643	822	274
68	3471	1736	868	290
69	3696	1848	924	308
70	3899	1950	975	325
71	4102	2051	1026	342
72	4251	2126	1063	355
73	4377	2189	1095	365
74	4496	2248	1124	375
75	4598	2299	1150	384
76	4695	2348	1174	392
77	4773	2387	1194	398
78	4843	2422	1211	404
79	4919	2460	1230	410
80+	5014	2507	1254	418

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3351	1676	838	280
66	3570	1785	893	298
67	3778	1889	945	315
68	3992	1996	998	333
69	4250	2125	1063	355
70	4487	2244	1122	374
71	4717	2359	1180	394
72	4884	2442	1221	407
73	5033	2517	1259	420
74	5171	2586	1293	431
75	5287	2644	1322	441
76	5402	2701	1351	451
77	5483	2742	1371	457
78	5570	2785	1393	465
79	5651	2826	1413	471
80+	5767	2884	1442	481

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

PLAN HDF

Male

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	607	304	152	51
66	652	326	163	55
67	693	347	174	58
68	731	366	183	61
69	779	390	195	65
70	833	417	209	70
71	878	439	220	74
72	910	455	228	76
73	938	469	235	79
74	962	481	241	81
75	1000	500	250	84
76	1022	511	256	86
77	1049	525	263	88
78	1092	546	273	91
79	1134	567	284	95
80+	1193	597	299	100

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	698	349	175	59
66	752	376	188	63
67	797	399	200	67
68	841	421	211	71
69	897	449	225	75
70	960	480	240	80
71	1008	504	252	84
72	1047	524	262	88
73	1079	540	270	90
74	1107	554	277	93
75	1151	576	288	96
76	1176	588	294	98
77	1205	603	302	101
78	1255	628	314	105
79	1307	654	327	109
80+	1373	687	344	115

Female

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	528	264	132	44
66	568	284	142	48
67	602	301	151	51
68	634	317	159	53
69	676	338	169	57
70	728	364	182	61
71	761	381	191	64
72	790	395	198	66
73	814	407	204	68
74	837	419	210	70
75	872	436	218	73
76	887	444	222	74
77	911	456	228	76
78	950	475	238	80
79	986	493	247	83
80+	1037	519	260	87

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	607	304	152	51
66	652	326	163	55
67	693	347	174	58
68	731	366	183	61
69	779	390	195	65
70	833	417	209	70
71	878	439	220	74
72	910	455	228	76
73	938	469	235	79
74	962	481	241	81
75	1000	500	250	84
76	1022	511	256	86
77	1049	525	263	88
78	1092	546	273	91
79	1134	567	284	95
80+	1193	597	299	100

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

PLAN G

Male

Preferred Effective Date: 03/15/2024 Plan Code: 5D4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2971	1486	743	248
66	3186	1593	797	266
67	3389	1695	848	283
68	3594	1797	899	300
69	3839	1920	960	320
70	4067	2034	1017	339
71	4287	2144	1072	358
72	4455	2228	1114	372
73	4593	2297	1149	383
74	4727	2364	1182	394
75	4837	2419	1210	404
76	4950	2475	1238	413
77	5028	2514	1257	419
78	5111	2556	1278	426
79	5194	2597	1299	433
80+	5303	2652	1326	442

Standard Effective Date: 03/15/2024 Plan Code: 5D6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3418	1709	855	285
66	3666	1833	917	306
67	3898	1949	975	325
68	4137	2069	1035	345
69	4418	2209	1105	369
70	4682	2341	1171	391
71	4934	2467	1234	412
72	5124	2562	1281	427
73	5288	2644	1322	441
74	5440	2720	1360	454
75	5569	2785	1393	465
76	5695	2848	1424	475
77	5786	2893	1447	483
78	5881	2941	1471	491
79	5974	2987	1494	498
80+	6099	3050	1525	509

Female

Preferred Effective Date: 03/15/2024 Plan Code: 5D5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2585	1293	647	216
66	2770	1385	693	231
67	2947	1474	737	246
68	3127	1564	782	261
69	3339	1670	835	279
70	3535	1768	884	295
71	3730	1865	933	311
72	3873	1937	969	323
73	3997	1999	1000	334
74	4109	2055	1028	343
75	4207	2104	1052	351
76	4304	2152	1076	359
77	4373	2187	1094	365
78	4443	2222	1111	371
79	4515	2258	1129	377
80+	4613	2307	1154	385

Standard Effective Date: 03/15/2024 Plan Code: 5D7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2971	1486	743	248
66	3186	1593	797	266
67	3389	1695	848	283
68	3594	1797	899	300
69	3839	1920	960	320
70	4067	2034	1017	339
71	4287	2144	1072	358
72	4455	2228	1114	372
73	4593	2297	1149	383
74	4727	2364	1182	394
75	4837	2419	1210	404
76	4950	2475	1238	413
77	5028	2514	1257	419
78	5111	2556	1278	426
79	5194	2597	1299	433
80+	5303	2652	1326	442

PLAN HDG

Male

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	607	304	152	51
66	652	326	163	55
67	693	347	174	58
68	731	366	183	61
69	779	390	195	65
70	833	417	209	70
71	878	439	220	74
72	910	455	228	76
73	938	469	235	79
74	962	481	241	81
75	1000	500	250	84
76	1022	511	256	86
77	1049	525	263	88
78	1092	546	273	91
79	1134	567	284	95
80+	1193	597	299	100

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	698	349	175	59
66	752	376	188	63
67	797	399	200	67
68	841	421	211	71
69	897	449	225	75
70	960	480	240	80
71	1008	504	252	84
72	1047	524	262	88
73	1079	540	270	90
74	1107	554	277	93
75	1151	576	288	96
76	1176	588	294	98
77	1205	603	302	101
78	1255	628	314	105
79	1307	654	327	109
80+	1373	687	344	115

Female

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	528	264	132	44
66	568	284	142	48
67	602	301	151	51
68	634	317	159	53
69	676	338	169	57
70	728	364	182	61
71	761	381	191	64
72	790	395	198	66
73	814	407	204	68
74	837	419	210	70
75	872	436	218	73
76	887	444	222	74
77	911	456	228	76
78	950	475	238	80
79	986	493	247	83
80+	1037	519	260	87

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	607	304	152	51
66	652	326	163	55
67	693	347	174	58
68	731	366	183	61
69	779	390	195	65
70	833	417	209	70
71	878	439	220	74
72	910	455	228	76
73	938	469	235	79
74	962	481	241	81
75	1000	500	250	84
76	1022	511	256	86
77	1049	525	263	88
78	1092	546	273	91
79	1134	567	284	95
80+	1193	597	299	100

PLAN K

Male

Preferred Effective Date: 03/01/2020 Plan Code: P44

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1131	566	283	95
66	1208	604	302	101
67	1286	643	322	108
68	1365	683	342	114
69	1455	728	364	122
70	1544	772	386	129
71	1625	813	407	136
72	1683	842	421	141
73	1741	871	436	146
74	1789	895	448	150
75	1841	921	461	154
76	1880	940	470	157
77	1909	955	478	160
78	1939	970	485	162
79	1968	984	492	164
80+	2012	1006	503	168

Standard Effective Date: 03/01/2020 Plan Code: P46

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1303	652	326	109
66	1391	696	348	116
67	1480	740	370	124
68	1571	786	393	131
69	1675	838	419	140
70	1778	889	445	149
71	1869	935	468	156
72	1938	969	485	162
73	2002	1001	501	167
74	2060	1030	515	172
75	2119	1060	530	177
76	2163	1082	541	181
77	2197	1099	550	184
78	2231	1116	558	186
79	2263	1132	566	189
80+	2316	1158	579	193

Female

Preferred Effective Date: 03/01/2020 Plan Code: P45

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	984	492	246	82
66	1052	526	263	88
67	1119	560	280	94
68	1187	594	297	99
69	1266	633	317	106
70	1344	672	336	112
71	1413	707	354	118
72	1464	732	366	122
73	1514	757	379	127
74	1555	778	389	130
75	1601	801	401	134
76	1636	818	409	137
77	1661	831	416	139
78	1685	843	422	141
79	1711	856	428	143
80+	1750	875	438	146

Standard Effective Date: 03/01/2020 Plan Code: P47

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1131	566	283	95
66	1208	604	302	101
67	1286	643	322	108
68	1365	683	342	114
69	1455	728	364	122
70	1544	772	386	129
71	1625	813	407	136
72	1683	842	421	141
73	1741	871	436	146
74	1789	895	448	150
75	1841	921	461	154
76	1880	940	470	157
77	1909	955	478	160
78	1939	970	485	162
79	1968	984	492	164
80+	2012	1006	503	168

PLAN L

Male

Preferred Effective Date: 01/15/2021 Plan Code: P60

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1630	815	408	136
66	1746	873	437	146
67	1858	929	465	155
68	1974	987	494	165
69	2103	1052	526	176
70	2231	1116	558	186
71	2354	1177	589	197
72	2446	1223	612	204
73	2522	1261	631	211
74	2590	1295	648	216
75	2660	1330	665	222
76	2718	1359	680	227
77	2761	1381	691	231
78	2806	1403	702	234
79	2850	1425	713	238
80+	2918	1459	730	244

Standard Effective Date: 01/15/2021 Plan Code: P62

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1877	939	470	157
66	2010	1005	503	168
67	2138	1069	535	179
68	2272	1136	568	190
69	2420	1210	605	202
70	2568	1284	642	214
71	2709	1355	678	226
72	2814	1407	704	235
73	2902	1451	726	242
74	2981	1491	746	249
75	3060	1530	765	255
76	3128	1564	782	261
77	3178	1589	795	265
78	3229	1615	808	270
79	3280	1640	820	274
80+	3357	1679	840	280

Female

Preferred Effective Date: 01/15/2021 Plan Code: P61

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1418	709	355	119
66	1518	759	380	127
67	1615	808	404	135
68	1716	858	429	143
69	1829	915	458	153
70	1941	971	486	162
71	2047	1024	512	171
72	2127	1064	532	178
73	2193	1097	549	183
74	2251	1126	563	188
75	2314	1157	579	193
76	2364	1182	591	197
77	2401	1201	601	201
78	2439	1220	610	204
79	2478	1239	620	207
80+	2537	1269	635	212

Standard Effective Date: 01/15/2021 Plan Code: P63

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1630	815	408	136
66	1746	873	437	146
67	1858	929	465	155
68	1974	987	494	165
69	2103	1052	526	176
70	2231	1116	558	186
71	2354	1177	589	197
72	2446	1223	612	204
73	2522	1261	631	211
74	2590	1295	648	216
75	2660	1330	665	222
76	2718	1359	680	227
77	2761	1381	691	231
78	2806	1403	702	234
79	2850	1425	713	238
80+	2918	1459	730	244

PLAN N

Male

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2049	1025	513	171
66	2199	1100	550	184
67	2346	1173	587	196
68	2490	1245	623	208
69	2662	1331	666	222
70	2822	1411	706	236
71	2976	1488	744	248
72	3099	1550	775	259
73	3203	1602	801	267
74	3301	1651	826	276
75	3384	1692	846	282
76	3464	1732	866	289
77	3529	1765	883	295
78	3593	1797	899	300
79	3657	1829	915	305
80+	3758	1879	940	314

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2357	1179	590	197
66	2533	1267	634	212
67	2701	1351	676	226
68	2866	1433	717	239
69	3063	1532	766	256
70	3247	1624	812	271
71	3427	1714	857	286
72	3569	1785	893	298
73	3686	1843	922	308
74	3798	1899	950	317
75	3896	1948	974	325
76	3987	1994	997	333
77	4060	2030	1015	339
78	4134	2067	1034	345
79	4210	2105	1053	351
80+	4326	2163	1082	361

Female

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1782	891	446	149
66	1912	956	478	160
67	2041	1021	511	171
68	2164	1082	541	181
69	2315	1158	579	193
70	2456	1228	614	205
71	2589	1295	648	216
72	2697	1349	675	225
73	2786	1393	697	233
74	2869	1435	718	240
75	2944	1472	736	246
76	3012	1506	753	251
77	3069	1535	768	256
78	3122	1561	781	261
79	3181	1591	796	266
80+	3268	1634	817	273

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2049	1025	513	171
66	2199	1100	550	184
67	2346	1173	587	196
68	2490	1245	623	208
69	2662	1331	666	222
70	2822	1411	706	236
71	2976	1488	744	248
72	3099	1550	775	259
73	3203	1602	801	267
74	3301	1651	826	276
75	3384	1692	846	282
76	3464	1732	866	289
77	3529	1765	883	295
78	3593	1797	899	300
79	3657	1829	915	305
80+	3758	1879	940	314

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

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

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

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

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

PARTS A & B

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 $240 of Medicare-Approved Amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

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

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

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

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

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

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

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

PARTS A & B

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 $240 of Medicare-Approved Amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

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

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

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

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

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

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

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

PARTS A & B

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 $240 of Medicare-Approved Amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

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

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

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

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

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

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

PARTS A & B

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 $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

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

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

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

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

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

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

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

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

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

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2800 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2800 DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $240 of Medicare-Approved Amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0

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

* 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.

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2800 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2800 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 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 deducitble and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

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

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

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

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

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

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

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2800 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2800 DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $240 of Medicare-Approved Amounts*	$0	$0	$240 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved Amounts	80%	20%	$0

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

* 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.

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2800 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2800 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 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 the difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

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

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

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

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

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

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

PARTS A & B

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 $240 of Medicare-Approved Amounts *****	$0	$0	$240 (Part B Deductible)♦
Remainder of Medicare-Approved Amounts	80%	10%	10%♦

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

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

PLAN L

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

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

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

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

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

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

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

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

PARTS A & B

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 $240 of Medicare-Approved Amounts *****	$0	$0	$240 (Part B Deductible)♦
Remainder of Medicare-Approved Amounts	80%	15%	5%♦

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

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

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

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

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

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

PLAN N

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

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

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

PARTS A & B

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 $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

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