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 [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.

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.

UNDER AGE 65 GUARANTEED ISSUE PERIOD (G/I)

Male

Preferred

Plan	A	SA	Q	M	Plan Code	Effective Date
A	1964	982	491	164	5EW	08/01/2021
B	3937	1969	985	329	5F0	01/01/2024
C	4822	2411	1206	402	5F4	01/01/2024
D	4649	2325	1163	388	5F8	01/01/2024
F	4069	2035	1018	340	5FC	01/01/2024
HDF	758	379	190	64	5FG	01/01/2024
G	4443	2222	1111	371	5FK	01/01/2024
HDG	758	379	190	64	5I6	01/01/2024
K	1727	864	432	144	5FO	08/01/2021
L	2430	1215	608	203	5FS	08/01/2021

Female

Preferred

Plan	A	SA	Q	M	Plan Code	Effective Date
A	1708	854	427	143	5EX	08/01/2021
B	3424	1712	856	286	5F1	01/01/2024
C	4194	2097	1049	350	5F5	01/01/2024
D	4043	2022	1011	337	5F9	01/01/2024
F	3539	1770	885	295	5FD	01/01/2024
HDF	659	330	165	55	5FH	01/01/2024
G	3864	1932	966	322	5FL	01/01/2024
HDG	659	330	165	55	5I7	01/01/2024
K	1502	751	376	126	5FP	08/01/2021
L	2114	1057	529	177	5FT	08/01/2021

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

Preferred

Plan	A	SA	Q	M	Plan Code	Effective Date
A	1964	982	491	164	5EW	08/01/2021
B	3937	1969	985	329	5F0	01/01/2024
C	4822	2411	1206	402	5F4	01/01/2024
D	4649	2325	1163	388	5F8	01/01/2024
F	4069	2035	1018	340	5FC	01/01/2024
HDF	758	379	190	64	5FG	01/01/2024
G	4443	2222	1111	371	5FK	01/01/2024
HDG	758	379	190	64	5I6	01/01/2024
K	1727	864	432	144	5FO	08/01/2021
L	2430	1215	608	203	5FS	08/01/2021
N	3820	1910	955	319	5FW	01/01/2023

Female

Preferred

Plan	A	SA	Q	M	Plan Code	Effective Date
A	1708	854	427	143	5EX	08/01/2021
B	3424	1712	856	286	5F1	01/01/2024
C	4194	2097	1049	350	5F5	01/01/2024
D	4043	2022	1011	337	5F9	01/01/2024
F	3539	1770	885	295	5FD	01/01/2024
HDF	659	330	165	55	5FH	01/01/2024
G	3864	1932	966	322	5FL	01/01/2024
HDG	659	330	165	55	5I7	01/01/2024
K	1502	751	376	126	5FP	08/01/2021
L	2114	1057	529	177	5FT	08/01/2021
N	3322	1661	831	277	5FX	01/01/2023

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

PLAN A

Male

Preferred Effective Date: 01/01/2021 Plan Code: 5A0

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	1846	923	462	154
66	1907	954	477	159
67	1907	954	477	159
68	1907	954	477	159
69	1907	954	477	159
70	1964	982	491	164
71	1964	982	491	164
72	1964	982	491	164
73	1964	982	491	164
74	1964	982	491	164
75	1964	982	491	164
76	1964	982	491	164
77	1964	982	491	164
78	1964	982	491	164
79	1964	982	491	164
80+	1964	982	491	164

Standard Effective Date: 01/01/2021 Plan Code: 5A2

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	2125	1063	532	178
66	2195	1098	549	183
67	2195	1098	549	183
68	2195	1098	549	183
69	2195	1098	549	183
70	2261	1131	566	189
71	2261	1131	566	189
72	2261	1131	566	189
73	2261	1131	566	189
74	2261	1131	566	189
75	2261	1131	566	189
76	2261	1131	566	189
77	2261	1131	566	189
78	2261	1131	566	189
79	2261	1131	566	189
80+	2261	1131	566	189

Female

Preferred Effective Date: 01/01/2021 Plan Code: 5A1

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	1606	803	402	134
66	1659	830	415	139
67	1659	830	415	139
68	1659	830	415	139
69	1659	830	415	139
70	1708	854	427	143
71	1708	854	427	143
72	1708	854	427	143
73	1708	854	427	143
74	1708	854	427	143
75	1708	854	427	143
76	1708	854	427	143
77	1708	854	427	143
78	1708	854	427	143
79	1708	854	427	143
80+	1708	854	427	143

Standard Effective Date: 01/01/2021 Plan Code: 5A3

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	1846	923	462	154
66	1907	954	477	159
67	1907	954	477	159
68	1907	954	477	159
69	1907	954	477	159
70	1964	982	491	164
71	1964	982	491	164
72	1964	982	491	164
73	1964	982	491	164
74	1964	982	491	164
75	1964	982	491	164
76	1964	982	491	164
77	1964	982	491	164
78	1964	982	491	164
79	1964	982	491	164
80+	1964	982	491	164

PLAN B

Male

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3547	1774	887	296
66	3695	1848	924	308
67	3695	1848	924	308
68	3695	1848	924	308
69	3695	1848	924	308
70	3878	1939	970	324
71	3878	1939	970	324
72	3878	1939	970	324
73	3878	1939	970	324
74	3878	1939	970	324
75	3937	1969	985	329
76	3937	1969	985	329
77	3937	1969	985	329
78	3937	1969	985	329
79	3937	1969	985	329
80+	3937	1969	985	329

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	4083	2042	1021	341
66	4252	2126	1063	355
67	4252	2126	1063	355
68	4252	2126	1063	355
69	4252	2126	1063	355
70	4463	2232	1116	372
71	4463	2232	1116	372
72	4463	2232	1116	372
73	4463	2232	1116	372
74	4463	2232	1116	372
75	4531	2266	1133	378
76	4531	2266	1133	378
77	4531	2266	1133	378
78	4531	2266	1133	378
79	4531	2266	1133	378
80+	4531	2266	1133	378

Female

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3085	1543	772	258
66	3213	1607	804	268
67	3213	1607	804	268
68	3213	1607	804	268
69	3213	1607	804	268
70	3373	1687	844	282
71	3373	1687	844	282
72	3373	1687	844	282
73	3373	1687	844	282
74	3373	1687	844	282
75	3424	1712	856	286
76	3424	1712	856	286
77	3424	1712	856	286
78	3424	1712	856	286
79	3424	1712	856	286
80+	3424	1712	856	286

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3547	1774	887	296
66	3695	1848	924	308
67	3695	1848	924	308
68	3695	1848	924	308
69	3695	1848	924	308
70	3878	1939	970	324
71	3878	1939	970	324
72	3878	1939	970	324
73	3878	1939	970	324
74	3878	1939	970	324
75	3937	1969	985	329
76	3937	1969	985	329
77	3937	1969	985	329
78	3937	1969	985	329
79	3937	1969	985	329
80+	3937	1969	985	329

PLAN C

Male

Preferred Effective Date: 01/01/2024 Plan Code: 5B0

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3860	1930	965	322
66	4050	2025	1013	338
67	4050	2025	1013	338
68	4050	2025	1013	338
69	4050	2025	1013	338
70	4335	2168	1084	362
71	4335	2168	1084	362
72	4335	2168	1084	362
73	4335	2168	1084	362
74	4335	2168	1084	362
75	4617	2309	1155	385
76	4617	2309	1155	385
77	4617	2309	1155	385
78	4617	2309	1155	385
79	4617	2309	1155	385
80+	4822	2411	1206	402

Standard Effective Date: 01/01/2024 Plan Code: 5B2

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	4442	2221	1111	371
66	4661	2331	1166	389
67	4661	2331	1166	389
68	4661	2331	1166	389
69	4661	2331	1166	389
70	4988	2494	1247	416
71	4988	2494	1247	416
72	4988	2494	1247	416
73	4988	2494	1247	416
74	4988	2494	1247	416
75	5314	2657	1329	443
76	5314	2657	1329	443
77	5314	2657	1329	443
78	5314	2657	1329	443
79	5314	2657	1329	443
80+	5550	2775	1388	463

Female

Preferred Effective Date: 01/01/2024 Plan Code: 5B1

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3357	1679	840	280
66	3522	1761	881	294
67	3522	1761	881	294
68	3522	1761	881	294
69	3522	1761	881	294
70	3770	1885	943	315
71	3770	1885	943	315
72	3770	1885	943	315
73	3770	1885	943	315
74	3770	1885	943	315
75	4015	2008	1004	335
76	4015	2008	1004	335
77	4015	2008	1004	335
78	4015	2008	1004	335
79	4015	2008	1004	335
80+	4194	2097	1049	350

Standard Effective Date: 01/01/2024 Plan Code: 5B3

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3860	1930	965	322
66	4050	2025	1013	338
67	4050	2025	1013	338
68	4050	2025	1013	338
69	4050	2025	1013	338
70	4335	2168	1084	362
71	4335	2168	1084	362
72	4335	2168	1084	362
73	4335	2168	1084	362
74	4335	2168	1084	362
75	4617	2309	1155	385
76	4617	2309	1155	385
77	4617	2309	1155	385
78	4617	2309	1155	385
79	4617	2309	1155	385
80+	4822	2411	1206	402

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

PLAN D

Male

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3669	1835	918	306
66	3865	1933	967	323
67	3865	1933	967	323
68	3865	1933	967	323
69	3865	1933	967	323
70	4155	2078	1039	347
71	4155	2078	1039	347
72	4155	2078	1039	347
73	4155	2078	1039	347
74	4155	2078	1039	347
75	4440	2220	1110	370
76	4440	2220	1110	370
77	4440	2220	1110	370
78	4440	2220	1110	370
79	4440	2220	1110	370
80+	4649	2325	1163	388

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	4222	2111	1056	352
66	4448	2224	1112	371
67	4448	2224	1112	371
68	4448	2224	1112	371
69	4448	2224	1112	371
70	4782	2391	1196	399
71	4782	2391	1196	399
72	4782	2391	1196	399
73	4782	2391	1196	399
74	4782	2391	1196	399
75	5110	2555	1278	426
76	5110	2555	1278	426
77	5110	2555	1278	426
78	5110	2555	1278	426
79	5110	2555	1278	426
80+	5351	2676	1338	446

Female

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3191	1596	798	266
66	3361	1681	841	281
67	3361	1681	841	281
68	3361	1681	841	281
69	3361	1681	841	281
70	3614	1807	904	302
71	3614	1807	904	302
72	3614	1807	904	302
73	3614	1807	904	302
74	3614	1807	904	302
75	3861	1931	966	322
76	3861	1931	966	322
77	3861	1931	966	322
78	3861	1931	966	322
79	3861	1931	966	322
80+	4043	2022	1011	337

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3669	1835	918	306
66	3865	1933	967	323
67	3865	1933	967	323
68	3865	1933	967	323
69	3865	1933	967	323
70	4155	2078	1039	347
71	4155	2078	1039	347
72	4155	2078	1039	347
73	4155	2078	1039	347
74	4155	2078	1039	347
75	4440	2220	1110	370
76	4440	2220	1110	370
77	4440	2220	1110	370
78	4440	2220	1110	370
79	4440	2220	1110	370
80+	4649	2325	1163	388

PLAN F

Male

Preferred Effective Date: 01/01/2024 Plan Code: 5C0

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3257	1629	815	272
66	3422	1711	856	286
67	3422	1711	856	286
68	3422	1711	856	286
69	3422	1711	856	286
70	3658	1829	915	305
71	3658	1829	915	305
72	3658	1829	915	305
73	3658	1829	915	305
74	3658	1829	915	305
75	3898	1949	975	325
76	3898	1949	975	325
77	3898	1949	975	325
78	3898	1949	975	325
79	3898	1949	975	325
80+	4069	2035	1018	340

Standard Effective Date: 01/01/2024 Plan Code: 5C2

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3749	1875	938	313
66	3938	1969	985	329
67	3938	1969	985	329
68	3938	1969	985	329
69	3938	1969	985	329
70	4210	2105	1053	351
71	4210	2105	1053	351
72	4210	2105	1053	351
73	4210	2105	1053	351
74	4210	2105	1053	351
75	4485	2243	1122	374
76	4485	2243	1122	374
77	4485	2243	1122	374
78	4485	2243	1122	374
79	4485	2243	1122	374
80+	4683	2342	1171	391

Female

Preferred Effective Date: 01/01/2024 Plan Code: 5C1

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	2833	1417	709	237
66	2976	1488	744	248
67	2976	1488	744	248
68	2976	1488	744	248
69	2976	1488	744	248
70	3181	1591	796	266
71	3181	1591	796	266
72	3181	1591	796	266
73	3181	1591	796	266
74	3181	1591	796	266
75	3389	1695	848	283
76	3389	1695	848	283
77	3389	1695	848	283
78	3389	1695	848	283
79	3389	1695	848	283
80+	3539	1770	885	295

Standard Effective Date: 01/01/2024 Plan Code: 5C3

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3257	1629	815	272
66	3422	1711	856	286
67	3422	1711	856	286
68	3422	1711	856	286
69	3422	1711	856	286
70	3658	1829	915	305
71	3658	1829	915	305
72	3658	1829	915	305
73	3658	1829	915	305
74	3658	1829	915	305
75	3898	1949	975	325
76	3898	1949	975	325
77	3898	1949	975	325
78	3898	1949	975	325
79	3898	1949	975	325
80+	4069	2035	1018	340

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

PLAN HDF

Male

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	564	282	141	47
66	599	300	150	50
67	599	300	150	50
68	599	300	150	50
69	599	300	150	50
70	653	327	164	55
71	653	327	164	55
72	653	327	164	55
73	653	327	164	55
74	653	327	164	55
75	707	354	177	59
76	707	354	177	59
77	707	354	177	59
78	707	354	177	59
79	707	354	177	59
80+	758	379	190	64

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	649	325	163	55
66	690	345	173	58
67	690	345	173	58
68	690	345	173	58
69	690	345	173	58
70	751	376	188	63
71	751	376	188	63
72	751	376	188	63
73	751	376	188	63
74	751	376	188	63
75	813	407	204	68
76	813	407	204	68
77	813	407	204	68
78	813	407	204	68
79	813	407	204	68
80+	873	437	219	73

Female

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	490	245	123	41
66	521	261	131	44
67	521	261	131	44
68	521	261	131	44
69	521	261	131	44
70	568	284	142	48
71	568	284	142	48
72	568	284	142	48
73	568	284	142	48
74	568	284	142	48
75	615	308	154	52
76	615	308	154	52
77	615	308	154	52
78	615	308	154	52
79	615	308	154	52
80+	659	330	165	55

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	564	282	141	47
66	599	300	150	50
67	599	300	150	50
68	599	300	150	50
69	599	300	150	50
70	653	327	164	55
71	653	327	164	55
72	653	327	164	55
73	653	327	164	55
74	653	327	164	55
75	707	354	177	59
76	707	354	177	59
77	707	354	177	59
78	707	354	177	59
79	707	354	177	59
80+	758	379	190	64

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

PLAN G

Male

Preferred Effective Date: 01/01/2024 Plan Code: 5D0

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3509	1755	878	293
66	3696	1848	924	308
67	3696	1848	924	308
68	3696	1848	924	308
69	3696	1848	924	308
70	3972	1986	993	331
71	3972	1986	993	331
72	3972	1986	993	331
73	3972	1986	993	331
74	3972	1986	993	331
75	4244	2122	1061	354
76	4244	2122	1061	354
77	4244	2122	1061	354
78	4244	2122	1061	354
79	4244	2122	1061	354
80+	4443	2222	1111	371

Standard Effective Date: 01/01/2024 Plan Code: 5D2

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	4038	2019	1010	337
66	4253	2127	1064	355
67	4253	2127	1064	355
68	4253	2127	1064	355
69	4253	2127	1064	355
70	4571	2286	1143	381
71	4571	2286	1143	381
72	4571	2286	1143	381
73	4571	2286	1143	381
74	4571	2286	1143	381
75	4885	2443	1222	408
76	4885	2443	1222	408
77	4885	2443	1222	408
78	4885	2443	1222	408
79	4885	2443	1222	408
80+	5113	2557	1279	427

Female

Preferred Effective Date: 01/01/2024 Plan Code: 5D1

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3051	1526	763	255
66	3214	1607	804	268
67	3214	1607	804	268
68	3214	1607	804	268
69	3214	1607	804	268
70	3454	1727	864	288
71	3454	1727	864	288
72	3454	1727	864	288
73	3454	1727	864	288
74	3454	1727	864	288
75	3691	1846	923	308
76	3691	1846	923	308
77	3691	1846	923	308
78	3691	1846	923	308
79	3691	1846	923	308
80+	3864	1932	966	322

Standard Effective Date: 01/01/2024 Plan Code: 5D3

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3509	1755	878	293
66	3696	1848	924	308
67	3696	1848	924	308
68	3696	1848	924	308
69	3696	1848	924	308
70	3972	1986	993	331
71	3972	1986	993	331
72	3972	1986	993	331
73	3972	1986	993	331
74	3972	1986	993	331
75	4244	2122	1061	354
76	4244	2122	1061	354
77	4244	2122	1061	354
78	4244	2122	1061	354
79	4244	2122	1061	354
80+	4443	2222	1111	371

PLAN HDG

Male

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	564	282	141	47
66	599	300	150	50
67	599	300	150	50
68	599	300	150	50
69	599	300	150	50
70	653	327	164	55
71	653	327	164	55
72	653	327	164	55
73	653	327	164	55
74	653	327	164	55
75	707	354	177	59
76	707	354	177	59
77	707	354	177	59
78	707	354	177	59
79	707	354	177	59
80+	758	379	190	64

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	649	325	163	55
66	690	345	173	58
67	690	345	173	58
68	690	345	173	58
69	690	345	173	58
70	751	376	188	63
71	751	376	188	63
72	751	376	188	63
73	751	376	188	63
74	751	376	188	63
75	813	407	204	68
76	813	407	204	68
77	813	407	204	68
78	813	407	204	68
79	813	407	204	68
80+	873	437	219	73

Female

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	490	245	123	41
66	521	261	131	44
67	521	261	131	44
68	521	261	131	44
69	521	261	131	44
70	568	284	142	48
71	568	284	142	48
72	568	284	142	48
73	568	284	142	48
74	568	284	142	48
75	615	308	154	52
76	615	308	154	52
77	615	308	154	52
78	615	308	154	52
79	615	308	154	52
80+	659	330	165	55

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

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	564	282	141	47
66	599	300	150	50
67	599	300	150	50
68	599	300	150	50
69	599	300	150	50
70	653	327	164	55
71	653	327	164	55
72	653	327	164	55
73	653	327	164	55
74	653	327	164	55
75	707	354	177	59
76	707	354	177	59
77	707	354	177	59
78	707	354	177	59
79	707	354	177	59
80+	758	379	190	64

PLAN K

Male

Preferred Effective Date: 01/01/2021 Plan Code: P40

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	1454	727	364	122
66	1512	756	378	126
67	1512	756	378	126
68	1512	756	378	126
69	1512	756	378	126
70	1613	807	404	135
71	1613	807	404	135
72	1613	807	404	135
73	1613	807	404	135
74	1613	807	404	135
75	1693	847	424	142
76	1693	847	424	142
77	1693	847	424	142
78	1693	847	424	142
79	1693	847	424	142
80+	1727	864	432	144

Standard Effective Date: 01/01/2021 Plan Code: P42

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	1674	837	419	140
66	1740	870	435	145
67	1740	870	435	145
68	1740	870	435	145
69	1740	870	435	145
70	1856	928	464	155
71	1856	928	464	155
72	1856	928	464	155
73	1856	928	464	155
74	1856	928	464	155
75	1948	974	487	163
76	1948	974	487	163
77	1948	974	487	163
78	1948	974	487	163
79	1948	974	487	163
80+	1987	994	497	166

Female

Preferred Effective Date: 01/01/2021 Plan Code: P41

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	1265	633	317	106
66	1315	658	329	110
67	1315	658	329	110
68	1315	658	329	110
69	1315	658	329	110
70	1403	702	351	117
71	1403	702	351	117
72	1403	702	351	117
73	1403	702	351	117
74	1403	702	351	117
75	1472	736	368	123
76	1472	736	368	123
77	1472	736	368	123
78	1472	736	368	123
79	1472	736	368	123
80+	1502	751	376	126

Standard Effective Date: 01/01/2021 Plan Code: P43

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	1454	727	364	122
66	1512	756	378	126
67	1512	756	378	126
68	1512	756	378	126
69	1512	756	378	126
70	1613	807	404	135
71	1613	807	404	135
72	1613	807	404	135
73	1613	807	404	135
74	1613	807	404	135
75	1693	847	424	142
76	1693	847	424	142
77	1693	847	424	142
78	1693	847	424	142
79	1693	847	424	142
80+	1727	864	432	144

PLAN L

Male

Preferred Effective Date: 01/01/2021 Plan Code: P56

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	2046	1023	512	171
66	2127	1064	532	178
67	2127	1064	532	178
68	2127	1064	532	178
69	2127	1064	532	178
70	2270	1135	568	190
71	2270	1135	568	190
72	2270	1135	568	190
73	2270	1135	568	190
74	2270	1135	568	190
75	2383	1192	596	199
76	2383	1192	596	199
77	2383	1192	596	199
78	2383	1192	596	199
79	2383	1192	596	199
80+	2430	1215	608	203

Standard Effective Date: 01/01/2021 Plan Code: P58

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	2355	1178	589	197
66	2447	1224	612	204
67	2447	1224	612	204
68	2447	1224	612	204
69	2447	1224	612	204
70	2613	1307	654	218
71	2613	1307	654	218
72	2613	1307	654	218
73	2613	1307	654	218
74	2613	1307	654	218
75	2743	1372	686	229
76	2743	1372	686	229
77	2743	1372	686	229
78	2743	1372	686	229
79	2743	1372	686	229
80+	2797	1399	700	234

Female

Preferred Effective Date: 01/01/2021 Plan Code: P57

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	1779	890	445	149
66	1849	925	463	155
67	1849	925	463	155
68	1849	925	463	155
69	1849	925	463	155
70	1974	987	494	165
71	1974	987	494	165
72	1974	987	494	165
73	1974	987	494	165
74	1974	987	494	165
75	2073	1037	519	173
76	2073	1037	519	173
77	2073	1037	519	173
78	2073	1037	519	173
79	2073	1037	519	173
80+	2114	1057	529	177

Standard Effective Date: 01/01/2021 Plan Code: P59

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	2046	1023	512	171
66	2127	1064	532	178
67	2127	1064	532	178
68	2127	1064	532	178
69	2127	1064	532	178
70	2270	1135	568	190
71	2270	1135	568	190
72	2270	1135	568	190
73	2270	1135	568	190
74	2270	1135	568	190
75	2383	1192	596	199
76	2383	1192	596	199
77	2383	1192	596	199
78	2383	1192	596	199
79	2383	1192	596	199
80+	2430	1215	608	203

PLAN N

Male

Preferred Effective Date: 01/01/2023 Plan Code: 5DI

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	2943	1472	736	246
66	3108	1554	777	259
67	3108	1554	777	259
68	3108	1554	777	259
69	3108	1554	777	259
70	3354	1677	839	280
71	3354	1677	839	280
72	3354	1677	839	280
73	3354	1677	839	280
74	3354	1677	839	280
75	3613	1807	904	302
76	3613	1807	904	302
77	3613	1807	904	302
78	3613	1807	904	302
79	3613	1807	904	302
80+	3820	1910	955	319

Standard Effective Date: 01/01/2023 Plan Code: 5DK

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	3387	1694	847	283
66	3577	1789	895	299
67	3577	1789	895	299
68	3577	1789	895	299
69	3577	1789	895	299
70	3860	1930	965	322
71	3860	1930	965	322
72	3860	1930	965	322
73	3860	1930	965	322
74	3860	1930	965	322
75	4158	2079	1040	347
76	4158	2079	1040	347
77	4158	2079	1040	347
78	4158	2079	1040	347
79	4158	2079	1040	347
80+	4396	2198	1099	367

Female

Preferred Effective Date: 01/01/2023 Plan Code: 5DJ

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	2559	1280	640	214
66	2703	1352	676	226
67	2703	1352	676	226
68	2703	1352	676	226
69	2703	1352	676	226
70	2917	1459	730	244
71	2917	1459	730	244
72	2917	1459	730	244
73	2917	1459	730	244
74	2917	1459	730	244
75	3142	1571	786	262
76	3142	1571	786	262
77	3142	1571	786	262
78	3142	1571	786	262
79	3142	1571	786	262
80+	3322	1661	831	277

Standard Effective Date: 01/01/2023 Plan Code: 5DL

Issue Age	Annual	Semi Annual	Quarterly	Monthly
65	2943	1472	736	246
66	3108	1554	777	259
67	3108	1554	777	259
68	3108	1554	777	259
69	3108	1554	777	259
70	3354	1677	839	280
71	3354	1677	839	280
72	3354	1677	839	280
73	3354	1677	839	280
74	3354	1677	839	280
75	3613	1807	904	302
76	3613	1807	904	302
77	3613	1807	904	302
78	3613	1807	904	302
79	3613	1807	904	302
80+	3820	1910	955	319

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

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

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

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

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

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

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

PARTS A & B

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

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

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

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

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

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

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

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

PARTS A & B

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

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

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

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

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

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

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

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

PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

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

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

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

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

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

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

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

PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

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

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

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

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

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

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

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

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

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

PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

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

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

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

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

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

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

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

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

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

PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN K

* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $7060 each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit DOES NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

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

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

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

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

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

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

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $240 of Medicare-Approved Amounts *****	$0	$0	$240 (Part B Deductible) ♦
Remainder of Medicare-Approved Amounts	80%	10%	10% ♦

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

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

PLAN L

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

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

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

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

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

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

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

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

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $240 of Medicare-Approved Amounts *****	$0	$0	$240 (Part B Deductible)♦
Remainder of Medicare-Approved Amounts	80%	15%	5%♦

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

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

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

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

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

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

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

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

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

PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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