UNITED AMERICAN INSURANCE COMPANY

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

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

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

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

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

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

* Denotes plans available by United American Insurance Company

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

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

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

PREMIUM INFORMATION

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

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN POLICY

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

POLICY REPLACEMENT

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

NOTICE

This policy may not fully cover all your medical costs.

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

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

COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

RENEWABILITY

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

PLAN A

Male

Preferred Effective Date: 06/15/2020 Plan Code: 5A4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1517	759	380	127
66	1593	797	399	133
67	1660	830	415	139
68	1724	862	431	144
69	1793	897	449	150
70	1862	931	466	156
71	1906	953	477	159
72	1922	961	481	161
73	1937	969	485	162
74	1941	971	486	162
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+	1948	974	487	163

Standard Effective Date: 06/15/2020 Plan Code: 5A6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1745	873	437	146
66	1834	917	459	153
67	1910	955	478	160
68	1984	992	496	166
69	2063	1032	516	172
70	2142	1071	536	179
71	2194	1097	549	183
72	2212	1106	553	185
73	2229	1115	558	186
74	2233	1117	559	187
75	2242	1121	561	187
76	2242	1121	561	187
77	2242	1121	561	187
78	2242	1121	561	187
79	2242	1121	561	187
80+	2242	1121	561	187

Female

Preferred Effective Date: 06/15/2020 Plan Code: 5A5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1319	660	330	110
66	1386	693	347	116
67	1444	722	361	121
68	1499	750	375	125
69	1560	780	390	130
70	1619	810	405	135
71	1658	829	415	139
72	1672	836	418	140
73	1685	843	422	141
74	1688	844	422	141
75	1694	847	424	142
76	1694	847	424	142
77	1694	847	424	142
78	1694	847	424	142
79	1694	847	424	142
80+	1694	847	424	142

Standard Effective Date: 06/15/2020 Plan Code: 5A7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1517	759	380	127
66	1593	797	399	133
67	1660	830	415	139
68	1724	862	431	144
69	1793	897	449	150
70	1862	931	466	156
71	1906	953	477	159
72	1922	961	481	161
73	1937	969	485	162
74	1941	971	486	162
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+	1948	974	487	163

PLAN B

Male

Preferred Effective Date: 06/15/2023 Plan Code: 5AM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2776	1388	694	232
66	2932	1466	733	245
67	3066	1533	767	256
68	3201	1601	801	267
69	3344	1672	836	279
70	3489	1745	873	291
71	3586	1793	897	299
72	3649	1825	913	305
73	3708	1854	927	309
74	3740	1870	935	312
75	3783	1892	946	316
76	3799	1900	950	317
77	3799	1900	950	317
78	3799	1900	950	317
79	3799	1900	950	317
80+	3799	1900	950	317

Standard Effective Date: 06/15/2023 Plan Code: 5AO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3194	1597	799	267
66	3374	1687	844	282
67	3528	1764	882	294
68	3683	1842	921	307
69	3848	1924	962	321
70	4015	2008	1004	335
71	4127	2064	1032	344
72	4199	2100	1050	350
73	4267	2134	1067	356
74	4304	2152	1076	359
75	4353	2177	1089	363
76	4372	2186	1093	365
77	4372	2186	1093	365
78	4372	2186	1093	365
79	4372	2186	1093	365
80+	4372	2186	1093	365

Female

Preferred Effective Date: 06/15/2023 Plan Code: 5AN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2414	1207	604	202
66	2550	1275	638	213
67	2667	1334	667	223
68	2784	1392	696	232
69	2909	1455	728	243
70	3035	1518	759	253
71	3120	1560	780	260
72	3174	1587	794	265
73	3225	1613	807	269
74	3253	1627	814	272
75	3291	1646	823	275
76	3304	1652	826	276
77	3304	1652	826	276
78	3304	1652	826	276
79	3304	1652	826	276
80+	3304	1652	826	276

Standard Effective Date: 06/15/2023 Plan Code: 5AP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2776	1388	694	232
66	2932	1466	733	245
67	3066	1533	767	256
68	3201	1601	801	267
69	3344	1672	836	279
70	3489	1745	873	291
71	3586	1793	897	299
72	3649	1825	913	305
73	3708	1854	927	309
74	3740	1870	935	312
75	3783	1892	946	316
76	3799	1900	950	317
77	3799	1900	950	317
78	3799	1900	950	317
79	3799	1900	950	317
80+	3799	1900	950	317

PLAN C

Male

Preferred Effective Date: 06/15/2023 Plan Code: 5B4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2946	1473	737	246
66	3107	1554	777	259
67	3252	1626	813	271
68	3401	1701	851	284
69	3563	1782	891	297
70	3729	1865	933	311
71	3855	1928	964	322
72	3949	1975	988	330
73	4040	2020	1010	337
74	4104	2052	1026	342
75	4174	2087	1044	348
76	4225	2113	1057	353
77	4266	2133	1067	356
78	4305	2153	1077	359
79	4345	2173	1087	363
80+	4392	2196	1098	366

Standard Effective Date: 06/15/2023 Plan Code: 5B6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3390	1695	848	283
66	3575	1788	894	298
67	3742	1871	936	312
68	3913	1957	979	327
69	4100	2050	1025	342
70	4292	2146	1073	358
71	4437	2219	1110	370
72	4545	2273	1137	379
73	4649	2325	1163	388
74	4723	2362	1181	394
75	4803	2402	1201	401
76	4862	2431	1216	406
77	4909	2455	1228	410
78	4954	2477	1239	413
79	5000	2500	1250	417
80+	5054	2527	1264	422

Female

Preferred Effective Date: 06/15/2023 Plan Code: 5B5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2562	1281	641	214
66	2702	1351	676	226
67	2829	1415	708	236
68	2958	1479	740	247
69	3099	1550	775	259
70	3244	1622	811	271
71	3354	1677	839	280
72	3435	1718	859	287
73	3514	1757	879	293
74	3570	1785	893	298
75	3631	1816	908	303
76	3675	1838	919	307
77	3710	1855	928	310
78	3745	1873	937	313
79	3779	1890	945	315
80+	3820	1910	955	319

Standard Effective Date: 06/15/2023 Plan Code: 5B7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2946	1473	737	246
66	3107	1554	777	259
67	3252	1626	813	271
68	3401	1701	851	284
69	3563	1782	891	297
70	3729	1865	933	311
71	3855	1928	964	322
72	3949	1975	988	330
73	4040	2020	1010	337
74	4104	2052	1026	342
75	4174	2087	1044	348
76	4225	2113	1057	353
77	4266	2133	1067	356
78	4305	2153	1077	359
79	4345	2173	1087	363
80+	4392	2196	1098	366

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

PLAN D

Male

Preferred Effective Date: 06/15/2023 Plan Code: 5BM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2758	1379	690	230
66	2920	1460	730	244
67	3064	1532	766	256
68	3217	1609	805	269
69	3383	1692	846	282
70	3555	1778	889	297
71	3680	1840	920	307
72	3774	1887	944	315
73	3866	1933	967	323
74	3932	1966	983	328
75	4000	2000	1000	334
76	4053	2027	1014	338
77	4095	2048	1024	342
78	4134	2067	1034	345
79	4173	2087	1044	348
80+	4220	2110	1055	352

Standard Effective Date: 06/15/2023 Plan Code: 5BO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3173	1587	794	265
66	3360	1680	840	280
67	3526	1763	882	294
68	3702	1851	926	309
69	3893	1947	974	325
70	4091	2046	1023	341
71	4235	2118	1059	353
72	4343	2172	1086	362
73	4449	2225	1113	371
74	4525	2263	1132	378
75	4603	2302	1151	384
76	4664	2332	1166	389
77	4712	2356	1178	393
78	4757	2379	1190	397
79	4802	2401	1201	401
80+	4856	2428	1214	405

Female

Preferred Effective Date: 06/15/2023 Plan Code: 5BN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2399	1200	600	200
66	2540	1270	635	212
67	2665	1333	667	223
68	2798	1399	700	234
69	2943	1472	736	246
70	3093	1547	774	258
71	3201	1601	801	267
72	3283	1642	821	274
73	3363	1682	841	281
74	3421	1711	856	286
75	3479	1740	870	290
76	3526	1763	882	294
77	3562	1781	891	297
78	3596	1798	899	300
79	3630	1815	908	303
80+	3670	1835	918	306

Standard Effective Date: 06/15/2023 Plan Code: 5BP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2758	1379	690	230
66	2920	1460	730	244
67	3064	1532	766	256
68	3217	1609	805	269
69	3383	1692	846	282
70	3555	1778	889	297
71	3680	1840	920	307
72	3774	1887	944	315
73	3866	1933	967	323
74	3932	1966	983	328
75	4000	2000	1000	334
76	4053	2027	1014	338
77	4095	2048	1024	342
78	4134	2067	1034	345
79	4173	2087	1044	348
80+	4220	2110	1055	352

PLAN F

Male

Preferred Effective Date: 06/15/2023 Plan Code: 5C4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3247	1624	812	271
66	3419	1710	855	285
67	3576	1788	894	298
68	3738	1869	935	312
69	3918	1959	980	327
70	4102	2051	1026	342
71	4240	2120	1060	354
72	4346	2173	1087	363
73	4442	2221	1111	371
74	4511	2256	1128	376
75	4591	2296	1148	383
76	4643	2322	1161	387
77	4689	2345	1173	391
78	4732	2366	1183	395
79	4775	2388	1194	398
80+	4824	2412	1206	402

Standard Effective Date: 06/15/2023 Plan Code: 5C6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3736	1868	934	312
66	3934	1967	984	328
67	4115	2058	1029	343
68	4302	2151	1076	359
69	4509	2255	1128	376
70	4721	2361	1181	394
71	4879	2440	1220	407
72	5001	2501	1251	417
73	5111	2556	1278	426
74	5191	2596	1298	433
75	5283	2642	1321	441
76	5342	2671	1336	446
77	5395	2698	1349	450
78	5446	2723	1362	454
79	5495	2748	1374	458
80+	5551	2776	1388	463

Female

Preferred Effective Date: 06/15/2023 Plan Code: 5C5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2824	1412	706	236
66	2974	1487	744	248
67	3110	1555	778	260
68	3252	1626	813	271
69	3409	1705	853	285
70	3568	1784	892	298
71	3688	1844	922	308
72	3780	1890	945	315
73	3864	1932	966	322
74	3924	1962	981	327
75	3994	1997	999	333
76	4038	2019	1010	337
77	4078	2039	1020	340
78	4116	2058	1029	343
79	4154	2077	1039	347
80+	4196	2098	1049	350

Standard Effective Date: 06/15/2023 Plan Code: 5C7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3247	1624	812	271
66	3419	1710	855	285
67	3576	1788	894	298
68	3738	1869	935	312
69	3918	1959	980	327
70	4102	2051	1026	342
71	4240	2120	1060	354
72	4346	2173	1087	363
73	4442	2221	1111	371
74	4511	2256	1128	376
75	4591	2296	1148	383
76	4643	2322	1161	387
77	4689	2345	1173	391
78	4732	2366	1183	395
79	4775	2388	1194	398
80+	4824	2412	1206	402

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

PLAN HDF

Male

Preferred — Effective Date: 06/15/2023 — Plan Code: 5CM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	417	209	105	35
66	451	226	113	38
67	484	242	121	41
68	506	253	127	43
69	531	266	133	45
70	555	278	139	47
71	575	288	144	48
72	604	302	151	51
73	632	316	158	53
74	658	329	165	55
75	686	343	172	58
76	693	347	174	58
77	700	350	175	59
78	706	353	177	59
79	712	356	178	60
80+	721	361	181	61

Standard — Effective Date: 06/15/2023 — Plan Code: 5CO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	479	240	120	40
66	519	260	130	44
67	557	279	140	47
68	583	292	146	49
69	611	306	153	51
70	639	320	160	54
71	661	331	166	56
72	696	348	174	58
73	728	364	182	61
74	757	379	190	64
75	789	395	198	66
76	798	399	200	67
77	805	403	202	68
78	812	406	203	68
79	820	410	205	69
80+	830	415	208	70

Female

Preferred — Effective Date: 06/15/2023 — Plan Code: 5CN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	362	181	91	31
66	392	196	98	33
67	421	211	106	36
68	440	220	110	37
69	462	231	116	39
70	483	242	121	41
71	500	250	125	42
72	526	263	132	44
73	550	275	138	46
74	572	286	143	48
75	596	298	149	50
76	603	302	151	51
77	608	304	152	51
78	614	307	154	52
79	620	310	155	52
80+	627	314	157	53

Standard — Effective Date: 06/15/2023 — Plan Code: 5CP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	417	209	105	35
66	451	226	113	38
67	484	242	121	41
68	506	253	127	43
69	531	266	133	45
70	555	278	139	47
71	575	288	144	48
72	604	302	151	51
73	632	316	158	53
74	658	329	165	55
75	686	343	172	58
76	693	347	174	58
77	700	350	175	59
78	706	353	177	59
79	712	356	178	60
80+	721	361	181	61

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

PLAN G

Male

Preferred Effective Date: 06/15/2023 Plan Code: 5D4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2641	1321	661	221
66	2794	1397	699	233
67	2935	1468	734	245
68	3080	1540	770	257
69	3235	1618	809	270
70	3399	1700	850	284
71	3520	1760	880	294
72	3610	1805	903	301
73	3698	1849	925	309
74	3760	1880	940	314
75	3827	1914	957	319
76	3876	1938	969	323
77	3914	1957	979	327
78	3952	1976	988	330
79	3991	1996	998	333
80+	4034	2017	1009	337

Standard Effective Date: 06/15/2023 Plan Code: 5D6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3039	1520	760	254
66	3215	1608	804	268
67	3377	1689	845	282
68	3544	1772	886	296
69	3723	1862	931	311
70	3912	1956	978	326
71	4051	2026	1013	338
72	4154	2077	1039	347
73	4256	2128	1064	355
74	4327	2164	1082	361
75	4404	2202	1101	367
76	4460	2230	1115	372
77	4504	2252	1126	376
78	4547	2274	1137	379
79	4593	2297	1149	383
80+	4642	2321	1161	387

Female

Preferred Effective Date: 06/15/2023 Plan Code: 5D5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2297	1149	575	192
66	2430	1215	608	203
67	2553	1277	639	213
68	2679	1340	670	224
69	2814	1407	704	235
70	2957	1479	740	247
71	3062	1531	766	256
72	3140	1570	785	262
73	3217	1609	805	269
74	3271	1636	818	273
75	3329	1665	833	278
76	3371	1686	843	281
77	3405	1703	852	284
78	3437	1719	860	287
79	3472	1736	868	290
80+	3509	1755	878	293

Standard Effective Date: 06/15/2023 Plan Code: 5D7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2641	1321	661	221
66	2794	1397	699	233
67	2935	1468	734	245
68	3080	1540	770	257
69	3235	1618	809	270
70	3399	1700	850	284
71	3520	1760	880	294
72	3610	1805	903	301
73	3698	1849	925	309
74	3760	1880	940	314
75	3827	1914	957	319
76	3876	1938	969	323
77	3914	1957	979	327
78	3952	1976	988	330
79	3991	1996	998	333
80+	4034	2017	1009	337

PLAN HDG

Male

Preferred Effective Date: 06/15/2023 Plan Code: 5HO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	417	209	105	35
66	451	226	113	38
67	484	242	121	41
68	506	253	127	43
69	531	266	133	45
70	555	278	139	47
71	575	288	144	48
72	604	302	151	51
73	632	316	158	53
74	658	329	165	55
75	686	343	172	58
76	693	347	174	58
77	700	350	175	59
78	706	353	177	59
79	712	356	178	60
80+	721	361	181	61

Standard Effective Date: 06/15/2023 Plan Code: 5HQ

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	479	240	120	40
66	519	260	130	44
67	557	279	140	47
68	583	292	146	49
69	611	306	153	51
70	639	320	160	54
71	661	331	166	56
72	696	348	174	58
73	728	364	182	61
74	757	379	190	64
75	789	395	198	66
76	798	399	200	67
77	805	403	202	68
78	812	406	203	68
79	820	410	205	69
80+	830	415	208	70

Female

Preferred Effective Date: 06/15/2023 Plan Code: 5HP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	362	181	91	31
66	392	196	98	33
67	421	211	106	36
68	440	220	110	37
69	462	231	116	39
70	483	242	121	41
71	500	250	125	42
72	526	263	132	44
73	550	275	138	46
74	572	286	143	48
75	596	298	149	50
76	603	302	151	51
77	608	304	152	51
78	614	307	154	52
79	620	310	155	52
80+	627	314	157	53

Standard Effective Date: 06/15/2023 Plan Code: 5HR

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	417	209	105	35
66	451	226	113	38
67	484	242	121	41
68	506	253	127	43
69	531	266	133	45
70	555	278	139	47
71	575	288	144	48
72	604	302	151	51
73	632	316	158	53
74	658	329	165	55
75	686	343	172	58
76	693	347	174	58
77	700	350	175	59
78	706	353	177	59
79	712	356	178	60
80+	721	361	181	61

PLAN K

Male

Preferred Effective Date: 06/15/2020 Plan Code: P44

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1164	582	291	97
66	1253	627	314	105
67	1328	664	332	111
68	1397	699	350	117
69	1469	735	368	123
70	1551	776	388	130
71	1596	798	399	133
72	1625	813	407	136
73	1661	831	416	139
74	1690	845	423	141
75	1727	864	432	144
76	1756	878	439	147
77	1776	888	444	148
78	1792	896	448	150
79	1806	903	452	151
80+	1835	918	459	153

Standard Effective Date: 06/15/2020 Plan Code: P46

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1340	670	335	112
66	1442	721	361	121
67	1528	764	382	128
68	1608	804	402	134
69	1690	845	423	141
70	1785	893	447	149
71	1836	918	459	153
72	1871	936	468	156
73	1911	956	478	160
74	1944	972	486	162
75	1987	994	497	166
76	2020	1010	505	169
77	2044	1022	511	171
78	2062	1031	516	172
79	2078	1039	520	174
80+	2111	1056	528	176

Female

Preferred Effective Date: 06/15/2020 Plan Code: P45

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1013	507	254	85
66	1090	545	273	91
67	1155	578	289	97
68	1215	608	304	102
69	1277	639	320	107
70	1349	675	338	113
71	1388	694	347	116
72	1414	707	354	118
73	1445	723	362	121
74	1470	735	368	123
75	1502	751	376	126
76	1527	764	382	128
77	1545	773	387	129
78	1559	780	390	130
79	1571	786	393	131
80+	1596	798	399	133

Standard Effective Date: 06/15/2020 Plan Code: P47

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1164	582	291	97
66	1253	627	314	105
67	1328	664	332	111
68	1397	699	350	117
69	1469	735	368	123
70	1551	776	388	130
71	1596	798	399	133
72	1625	813	407	136
73	1661	831	416	139
74	1690	845	423	141
75	1727	864	432	144
76	1756	878	439	147
77	1776	888	444	148
78	1792	896	448	150
79	1806	903	452	151
80+	1835	918	459	153

PLAN L

Male

Preferred Effective Date: 06/15/2020 Plan Code: P60

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1636	818	409	137
66	1762	881	441	147
67	1867	934	467	156
68	1964	982	491	164
69	2063	1032	516	172
70	2180	1090	545	182
71	2245	1123	562	188
72	2288	1144	572	191
73	2336	1168	584	195
74	2378	1189	595	199
75	2429	1215	608	203
76	2469	1235	618	206
77	2495	1248	624	208
78	2522	1261	631	211
79	2543	1272	636	212
80+	2579	1290	645	215

Standard Effective Date: 06/15/2020 Plan Code: P62

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1883	942	471	157
66	2028	1014	507	169
67	2148	1074	537	179
68	2260	1130	565	189
69	2374	1187	594	198
70	2508	1254	627	209
71	2583	1292	646	216
72	2633	1317	659	220
73	2688	1344	672	224
74	2737	1369	685	229
75	2795	1398	699	233
76	2841	1421	711	237
77	2871	1436	718	240
78	2902	1451	726	242
79	2926	1463	732	244
80+	2968	1484	742	248

Female

Preferred Effective Date: 06/15/2020 Plan Code: P61

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1423	712	356	119
66	1533	767	384	128
67	1624	812	406	136
68	1708	854	427	143
69	1795	898	449	150
70	1896	948	474	158
71	1953	977	489	163
72	1990	995	498	166
73	2032	1016	508	170
74	2069	1035	518	173
75	2113	1057	529	177
76	2148	1074	537	179
77	2170	1085	543	181
78	2193	1097	549	183
79	2212	1106	553	185
80+	2244	1122	561	187

Standard Effective Date: 06/15/2020 Plan Code: P63

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1636	818	409	137
66	1762	881	441	147
67	1867	934	467	156
68	1964	982	491	164
69	2063	1032	516	172
70	2180	1090	545	182
71	2245	1123	562	188
72	2288	1144	572	191
73	2336	1168	584	195
74	2378	1189	595	199
75	2429	1215	608	203
76	2469	1235	618	206
77	2495	1248	624	208
78	2522	1261	631	211
79	2543	1272	636	212
80+	2579	1290	645	215

PLAN N

Male

Preferred Effective Date: 06/15/2023 Plan Code: 5DM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2278	1139	570	190
66	2413	1207	604	202
67	2539	1270	635	212
68	2663	1332	666	222
69	2805	1403	702	234
70	2950	1475	738	246
71	3058	1529	765	255
72	3144	1572	786	262
73	3227	1614	807	269
74	3284	1642	821	274
75	3346	1673	837	279
76	3401	1701	851	284
77	3440	1720	860	287
78	3481	1741	871	291
79	3524	1762	881	294
80+	3584	1792	896	299

Standard Effective Date: 06/15/2023 Plan Code: 5DO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2621	1311	656	219
66	2776	1388	694	232
67	2921	1461	731	244
68	3064	1532	766	256
69	3227	1614	807	269
70	3394	1697	849	283
71	3519	1760	880	294
72	3618	1809	905	302
73	3714	1857	929	310
74	3779	1890	945	315
75	3850	1925	963	321
76	3913	1957	979	327
77	3959	1980	990	330
78	4005	2003	1002	334
79	4056	2028	1014	338
80+	4125	2063	1032	344

Female

Preferred Effective Date: 06/15/2023 Plan Code: 5DN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1982	991	496	166
66	2099	1050	525	175
67	2208	1104	552	184
68	2316	1158	579	193
69	2440	1220	610	204
70	2566	1283	642	214
71	2660	1330	665	222
72	2735	1368	684	228
73	2807	1404	702	234
74	2857	1429	715	239
75	2911	1456	728	243
76	2958	1479	740	247
77	2992	1496	748	250
78	3028	1514	757	253
79	3066	1533	767	256
80+	3118	1559	780	260

Standard Effective Date: 06/15/2023 Plan Code: 5DP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2278	1139	570	190
66	2413	1207	604	202
67	2539	1270	635	212
68	2663	1332	666	222
69	2805	1403	702	234
70	2950	1475	738	246
71	3058	1529	765	255
72	3144	1572	786	262
73	3227	1614	807	269
74	3284	1642	821	274
75	3346	1673	837	279
76	3401	1701	851	284
77	3440	1720	860	287
78	3481	1741	871	291
79	3524	1762	881	294
80+	3584	1792	896	299

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