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. We will notify you by mail at your last known address on Company records, of any increase in renewal premiums at least 60 days prior to the next renewal date.

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: 02/01/2020 Plan Code: 5A4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1646	823	412	138
66	1726	863	432	144
67	1794	897	449	150
68	1850	925	463	155
69	1917	959	480	160
70	1986	993	497	166
71	2030	1015	508	170
72	2048	1024	512	171
73	2068	1034	517	173
74	2077	1039	520	174
75	2091	1046	523	175
76	2091	1046	523	175
77	2091	1046	523	175
78	2091	1046	523	175
79	2091	1046	523	175
80+	2091	1046	523	175

Standard Effective Date: 02/01/2020 Plan Code: 5A6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1894	947	474	158
66	1986	993	497	166
67	2065	1033	517	173
68	2129	1065	533	178
69	2206	1103	552	184
70	2286	1143	572	191
71	2336	1168	584	195
72	2357	1179	590	197
73	2379	1190	595	199
74	2390	1195	598	200
75	2406	1203	602	201
76	2406	1203	602	201
77	2406	1203	602	201
78	2406	1203	602	201
79	2406	1203	602	201
80+	2406	1203	602	201

Female

Preferred Effective Date: 02/01/2020 Plan Code: 5A5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1432	716	358	120
66	1501	751	376	126
67	1561	781	391	131
68	1609	805	403	135
69	1668	834	417	139
70	1728	864	432	144
71	1766	883	442	148
72	1782	891	446	149
73	1799	900	450	150
74	1807	904	452	151
75	1819	910	455	152
76	1819	910	455	152
77	1819	910	455	152
78	1819	910	455	152
79	1819	910	455	152
80+	1819	910	455	152

Standard Effective Date: 02/01/2020 Plan Code: 5A7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1646	823	412	138
66	1726	863	432	144
67	1794	897	449	150
68	1850	925	463	155
69	1917	959	480	160
70	1986	993	497	166
71	2030	1015	508	170
72	2048	1024	512	171
73	2068	1034	517	173
74	2077	1039	520	174
75	2091	1046	523	175
76	2091	1046	523	175
77	2091	1046	523	175
78	2091	1046	523	175
79	2091	1046	523	175
80+	2091	1046	523	175

PLAN B

Male

Preferred Effective Date: 02/15/2024 Plan Code: 5AM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2622	1311	656	219
66	2770	1385	693	231
67	2897	1449	725	242
68	3012	1506	753	251
69	3142	1571	786	262
70	3273	1637	819	273
71	3377	1689	845	282
72	3443	1722	861	287
73	3501	1751	876	292
74	3541	1771	886	296
75	3583	1792	896	299
76	3603	1802	901	301
77	3606	1803	902	301
78	3607	1804	902	301
79	3608	1804	902	301
80+	3608	1804	902	301

Standard Effective Date: 02/15/2024 Plan Code: 5AO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3017	1509	755	252
66	3188	1594	797	266
67	3334	1667	834	278
68	3466	1733	867	289
69	3616	1808	904	302
70	3767	1884	942	314
71	3886	1943	972	324
72	3962	1981	991	331
73	4029	2015	1008	336
74	4075	2038	1019	340
75	4123	2062	1031	344
76	4147	2074	1037	346
77	4149	2075	1038	346
78	4150	2075	1038	346
79	4152	2076	1038	346
80+	4152	2076	1038	346

Female

Preferred Effective Date: 02/15/2024 Plan Code: 5AN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2281	1141	571	191
66	2410	1205	603	201
67	2520	1260	630	210
68	2620	1310	655	219
69	2733	1367	684	228
70	2847	1424	712	238
71	2937	1469	735	245
72	2995	1498	749	250
73	3045	1523	762	254
74	3081	1541	771	257
75	3117	1559	780	260
76	3134	1567	784	262
77	3136	1568	784	262
78	3137	1569	785	262
79	3138	1569	785	262
80+	3138	1569	785	262

Standard Effective Date: 02/15/2024 Plan Code: 5AP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2622	1311	656	219
66	2770	1385	693	231
67	2897	1449	725	242
68	3012	1506	753	251
69	3142	1571	786	262
70	3273	1637	819	273
71	3377	1689	845	282
72	3443	1722	861	287
73	3501	1751	876	292
74	3541	1771	886	296
75	3583	1792	896	299
76	3603	1802	901	301
77	3606	1803	902	301
78	3607	1804	902	301
79	3608	1804	902	301
80+	3608	1804	902	301

PLAN C

Male

Preferred Effective Date: 02/15/2024 Plan Code: 5B4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3142	1571	786	262
66	3314	1657	829	277
67	3467	1734	867	289
68	3619	1810	905	302
69	3788	1894	947	316
70	3965	1983	992	331
71	4117	2059	1030	344
72	4232	2116	1058	353
73	4328	2164	1082	361
74	4410	2205	1103	368
75	4481	2241	1121	374
76	4538	2269	1135	379
77	4616	2308	1154	385
78	4691	2346	1173	391
79	4772	2386	1193	398
80+	4911	2456	1228	410

Standard Effective Date: 02/15/2024 Plan Code: 5B6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3616	1808	904	302
66	3814	1907	954	318
67	3989	1995	998	333
68	4165	2083	1042	348
69	4359	2180	1090	364
70	4563	2282	1141	381
71	4738	2369	1185	395
72	4871	2436	1218	406
73	4980	2490	1245	415
74	5075	2538	1269	423
75	5157	2579	1290	430
76	5222	2611	1306	436
77	5312	2656	1328	443
78	5398	2699	1350	450
79	5491	2746	1373	458
80+	5651	2826	1413	471

Female

Preferred Effective Date: 02/15/2024 Plan Code: 5B5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2733	1367	684	228
66	2883	1442	721	241
67	3016	1508	754	252
68	3148	1574	787	263
69	3295	1648	824	275
70	3449	1725	863	288
71	3581	1791	896	299
72	3682	1841	921	307
73	3764	1882	941	314
74	3836	1918	959	320
75	3898	1949	975	325
76	3947	1974	987	329
77	4015	2008	1004	335
78	4080	2040	1020	340
79	4151	2076	1038	346
80+	4272	2136	1068	356

Standard Effective Date: 02/15/2024 Plan Code: 5B7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3142	1571	786	262
66	3314	1657	829	277
67	3467	1734	867	289
68	3619	1810	905	302
69	3788	1894	947	316
70	3965	1983	992	331
71	4117	2059	1030	344
72	4232	2116	1058	353
73	4328	2164	1082	361
74	4410	2205	1103	368
75	4481	2241	1121	374
76	4538	2269	1135	379
77	4616	2308	1154	385
78	4691	2346	1173	391
79	4772	2386	1193	398
80+	4911	2456	1228	410

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

PLAN D

Male

Preferred Effective Date: 02/15/2024 Plan Code: 5BM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2925	1463	732	244
66	3100	1550	775	259
67	3257	1629	815	272
68	3406	1703	852	284
69	3576	1788	894	298
70	3761	1881	941	314
71	3911	1956	978	326
72	4030	2015	1008	336
73	4128	2064	1032	344
74	4209	2105	1053	351
75	4283	2142	1071	357
76	4336	2168	1084	362
77	4414	2207	1104	368
78	4495	2248	1124	375
79	4573	2287	1144	382
80+	4715	2358	1179	393

Standard Effective Date: 02/15/2024 Plan Code: 5BO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3366	1683	842	281
66	3568	1784	892	298
67	3748	1874	937	313
68	3919	1960	980	327
69	4115	2058	1029	343
70	4329	2165	1083	361
71	4501	2251	1126	376
72	4637	2319	1160	387
73	4750	2375	1188	396
74	4843	2422	1211	404
75	4928	2464	1232	411
76	4990	2495	1248	416
77	5079	2540	1270	424
78	5173	2587	1294	432
79	5263	2632	1316	439
80+	5426	2713	1357	453

Female

Preferred Effective Date: 02/15/2024 Plan Code: 5BN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2545	1273	637	213
66	2697	1349	675	225
67	2833	1417	709	237
68	2963	1482	741	247
69	3110	1555	778	260
70	3272	1636	818	273
71	3402	1701	851	284
72	3505	1753	877	293
73	3591	1796	898	300
74	3661	1831	916	306
75	3725	1863	932	311
76	3772	1886	943	315
77	3840	1920	960	320
78	3910	1955	978	326
79	3978	1989	995	332
80+	4102	2051	1026	342

Standard Effective Date: 02/15/2024 Plan Code: 5BP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2925	1463	732	244
66	3100	1550	775	259
67	3257	1629	815	272
68	3406	1703	852	284
69	3576	1788	894	298
70	3761	1881	941	314
71	3911	1956	978	326
72	4030	2015	1008	336
73	4128	2064	1032	344
74	4209	2105	1053	351
75	4283	2142	1071	357
76	4336	2168	1084	362
77	4414	2207	1104	368
78	4495	2248	1124	375
79	4573	2287	1144	382
80+	4715	2358	1179	393

PLAN F

Male

Preferred Effective Date: 02/15/2024 Plan Code: 5C4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3555	1778	889	297
66	3742	1871	936	312
67	3922	1961	981	327
68	4085	2043	1022	341
69	4279	2140	1070	357
70	4479	2240	1120	374
71	4650	2325	1163	388
72	4780	2390	1195	399
73	4885	2443	1222	408
74	4978	2489	1245	415
75	5056	2528	1264	422
76	5118	2559	1280	427
77	5207	2604	1302	434
78	5296	2648	1324	442
79	5381	2691	1346	449
80+	5541	2771	1386	462

Standard Effective Date: 02/15/2024 Plan Code: 5C6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	4091	2046	1023	341
66	4306	2153	1077	359
67	4513	2257	1129	377
68	4701	2351	1176	392
69	4925	2463	1232	411
70	5154	2577	1289	430
71	5351	2676	1338	446
72	5501	2751	1376	459
73	5621	2811	1406	469
74	5728	2864	1432	478
75	5818	2909	1455	485
76	5889	2945	1473	491
77	5991	2996	1498	500
78	6095	3048	1524	508
79	6192	3096	1548	516
80+	6376	3188	1594	532

Female

Preferred Effective Date: 02/15/2024 Plan Code: 5C5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3093	1547	774	258
66	3255	1628	814	272
67	3411	1706	853	285
68	3553	1777	889	297
69	3723	1862	931	311
70	3896	1948	974	325
71	4045	2023	1012	338
72	4158	2079	1040	347
73	4249	2125	1063	355
74	4330	2165	1083	361
75	4398	2199	1100	367
76	4452	2226	1113	371
77	4529	2265	1133	378
78	4607	2304	1152	384
79	4680	2340	1170	390
80+	4820	2410	1205	402

Standard Effective Date: 02/15/2024 Plan Code: 5C7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3555	1778	889	297
66	3742	1871	936	312
67	3922	1961	981	327
68	4085	2043	1022	341
69	4279	2140	1070	357
70	4479	2240	1120	374
71	4650	2325	1163	388
72	4780	2390	1195	399
73	4885	2443	1222	408
74	4978	2489	1245	415
75	5056	2528	1264	422
76	5118	2559	1280	427
77	5207	2604	1302	434
78	5296	2648	1324	442
79	5381	2691	1346	449
80+	5541	2771	1386	462

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

PLAN HDF

Male

Preferred — Effective Date: 02/15/2024 — Plan Code: 5CM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	457	229	115	39
66	493	247	124	42
67	531	266	133	45
68	553	277	139	47
69	578	289	145	49
70	604	302	151	51
71	629	315	158	53
72	663	332	166	56
73	694	347	174	58
74	723	362	181	61
75	752	376	188	63
76	763	382	191	64
77	776	388	194	65
78	789	395	198	66
79	802	401	201	67
80+	826	413	207	69

Standard — Effective Date: 02/15/2024 — Plan Code: 5CO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	526	263	132	44
66	568	284	142	48
67	611	306	153	51
68	637	319	160	54
69	665	333	167	56
70	696	348	174	58
71	724	362	181	61
72	763	382	191	64
73	799	400	200	67
74	832	416	208	70
75	865	433	217	73
76	878	439	220	74
77	893	447	224	75
78	908	454	227	76
79	923	462	231	77
80+	950	475	238	80

Female

Preferred — Effective Date: 02/15/2024 — Plan Code: 5CN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	398	199	100	34
66	429	215	108	36
67	462	231	116	39
68	481	241	121	41
69	503	252	126	42
70	526	263	132	44
71	547	274	137	46
72	577	289	145	49
73	604	302	151	51
74	629	315	158	53
75	654	327	164	55
76	663	332	166	56
77	675	338	169	57
78	687	344	172	58
79	698	349	175	59
80+	718	359	180	60

Standard — Effective Date: 02/15/2024 — Plan Code: 5CP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	457	229	115	39
66	493	247	124	42
67	531	266	133	45
68	553	277	139	47
69	578	289	145	49
70	604	302	151	51
71	629	315	158	53
72	663	332	166	56
73	694	347	174	58
74	723	362	181	61
75	752	376	188	63
76	763	382	191	64
77	776	388	194	65
78	789	395	198	66
79	802	401	201	67
80+	826	413	207	69

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

PLAN G

Male

Preferred Effective Date: 02/15/2024 Plan Code: 5D4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2825	1413	707	236
66	2991	1496	748	250
67	3144	1572	786	262
68	3286	1643	822	274
69	3453	1727	864	288
70	3626	1813	907	303
71	3773	1887	944	315
72	3882	1941	971	324
73	3978	1989	995	332
74	4057	2029	1015	339
75	4128	2064	1032	344
76	4182	2091	1046	349
77	4257	2129	1065	355
78	4330	2165	1083	361
79	4406	2203	1102	368
80+	4542	2271	1136	379

Standard Effective Date: 02/15/2024 Plan Code: 5D6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3251	1626	813	271
66	3442	1721	861	287
67	3618	1809	905	302
68	3782	1891	946	316
69	3973	1987	994	332
70	4172	2086	1043	348
71	4342	2171	1086	362
72	4467	2234	1117	373
73	4578	2289	1145	382
74	4669	2335	1168	390
75	4750	2375	1188	396
76	4813	2407	1204	402
77	4899	2450	1225	409
78	4982	2491	1246	416
79	5070	2535	1268	423
80+	5227	2614	1307	436

Female

Preferred Effective Date: 02/15/2024 Plan Code: 5D5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2457	1229	615	205
66	2602	1301	651	217
67	2735	1368	684	228
68	2859	1430	715	239
69	3003	1502	751	251
70	3154	1577	789	263
71	3282	1641	821	274
72	3377	1689	845	282
73	3461	1731	866	289
74	3529	1765	883	295
75	3591	1796	898	300
76	3638	1819	910	304
77	3703	1852	926	309
78	3766	1883	942	314
79	3832	1916	958	320
80+	3951	1976	988	330

Standard Effective Date: 02/15/2024 Plan Code: 5D7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2825	1413	707	236
66	2991	1496	748	250
67	3144	1572	786	262
68	3286	1643	822	274
69	3453	1727	864	288
70	3626	1813	907	303
71	3773	1887	944	315
72	3882	1941	971	324
73	3978	1989	995	332
74	4057	2029	1015	339
75	4128	2064	1032	344
76	4182	2091	1046	349
77	4257	2129	1065	355
78	4330	2165	1083	361
79	4406	2203	1102	368
80+	4542	2271	1136	379

PLAN HDG

Male

Preferred Effective Date: 02/15/2024 Plan Code: 5HO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	457	229	115	39
66	493	247	124	42
67	531	266	133	45
68	553	277	139	47
69	578	289	145	49
70	604	302	151	51
71	629	315	158	53
72	663	332	166	56
73	694	347	174	58
74	723	362	181	61
75	752	376	188	63
76	763	382	191	64
77	776	388	194	65
78	789	395	198	66
79	802	401	201	67
80+	826	413	207	69

Standard Effective Date: 02/15/2024 Plan Code: 5HQ

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	526	263	132	44
66	568	284	142	48
67	611	306	153	51
68	637	319	160	54
69	665	333	167	56
70	696	348	174	58
71	724	362	181	61
72	763	382	191	64
73	799	400	200	67
74	832	416	208	70
75	865	433	217	73
76	878	439	220	74
77	893	447	224	75
78	908	454	227	76
79	923	462	231	77
80+	950	475	238	80

Female

Preferred Effective Date: 02/15/2024 Plan Code: 5HP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	398	199	100	34
66	429	215	108	36
67	462	231	116	39
68	481	241	121	41
69	503	252	126	42
70	526	263	132	44
71	547	274	137	46
72	577	289	145	49
73	604	302	151	51
74	629	315	158	53
75	654	327	164	55
76	663	332	166	56
77	675	338	169	57
78	687	344	172	58
79	698	349	175	59
80+	718	359	180	60

Standard Effective Date: 02/15/2024 Plan Code: 5HR

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	457	229	115	39
66	493	247	124	42
67	531	266	133	45
68	553	277	139	47
69	578	289	145	49
70	604	302	151	51
71	629	315	158	53
72	663	332	166	56
73	694	347	174	58
74	723	362	181	61
75	752	376	188	63
76	763	382	191	64
77	776	388	194	65
78	789	395	198	66
79	802	401	201	67
80+	826	413	207	69

PLAN K

Male

Preferred Effective Date: 02/01/2020 Plan Code: P44

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1279	640	320	107
66	1376	688	344	115
67	1458	729	365	122
68	1532	766	383	128
69	1608	804	402	134
70	1705	853	427	143
71	1754	877	439	147
72	1787	894	447	149
73	1825	913	457	153
74	1855	928	464	155
75	1898	949	475	159
76	1926	963	482	161
77	1946	973	487	163
78	1967	984	492	164
79	1979	990	495	165
80+	2008	1004	502	168

Standard Effective Date: 02/01/2020 Plan Code: P46

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1472	736	368	123
66	1583	792	396	132
67	1678	839	420	140
68	1762	881	441	147
69	1851	926	463	155
70	1961	981	491	164
71	2018	1009	505	169
72	2056	1028	514	172
73	2100	1050	525	175
74	2135	1068	534	178
75	2184	1092	546	182
76	2216	1108	554	185
77	2239	1120	560	187
78	2264	1132	566	189
79	2277	1139	570	190
80+	2311	1156	578	193

Female

Preferred Effective Date: 02/01/2020 Plan Code: P45

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1113	557	279	93
66	1197	599	300	100
67	1268	634	317	106
68	1332	666	333	111
69	1399	700	350	117
70	1483	742	371	124
71	1525	763	382	128
72	1554	777	389	130
73	1588	794	397	133
74	1614	807	404	135
75	1651	826	413	138
76	1675	838	419	140
77	1693	847	424	142
78	1711	856	428	143
79	1721	861	431	144
80+	1747	874	437	146

Standard Effective Date: 02/01/2020 Plan Code: P47

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1279	640	320	107
66	1376	688	344	115
67	1458	729	365	122
68	1532	766	383	128
69	1608	804	402	134
70	1705	853	427	143
71	1754	877	439	147
72	1787	894	447	149
73	1825	913	457	153
74	1855	928	464	155
75	1898	949	475	159
76	1926	963	482	161
77	1946	973	487	163
78	1967	984	492	164
79	1979	990	495	165
80+	2008	1004	502	168

PLAN L

Male

Preferred Effective Date: 02/01/2020 Plan Code: P60

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1794	897	449	150
66	1931	966	483	161
67	2048	1024	512	171
68	2153	1077	539	180
69	2263	1132	566	189
70	2394	1197	599	200
71	2463	1232	616	206
72	2509	1255	628	210
73	2562	1281	641	214
74	2607	1304	652	218
75	2666	1333	667	223
76	2706	1353	677	226
77	2733	1367	684	228
78	2759	1380	690	230
79	2778	1389	695	232
80+	2820	1410	705	235

Standard Effective Date: 02/01/2020 Plan Code: P62

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2065	1033	517	173
66	2222	1111	556	186
67	2357	1179	590	197
68	2478	1239	620	207
69	2604	1302	651	217
70	2755	1378	689	230
71	2834	1417	709	237
72	2887	1444	722	241
73	2948	1474	737	246
74	3000	1500	750	250
75	3068	1534	767	256
76	3114	1557	779	260
77	3145	1573	787	263
78	3175	1588	794	265
79	3197	1599	800	267
80+	3245	1623	812	271

Female

Preferred Effective Date: 02/01/2020 Plan Code: P61

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1561	781	391	131
66	1680	840	420	140
67	1782	891	446	149
68	1873	937	469	157
69	1969	985	493	165
70	2083	1042	521	174
71	2142	1071	536	179
72	2182	1091	546	182
73	2229	1115	558	186
74	2268	1134	567	189
75	2319	1160	580	194
76	2354	1177	589	197
77	2377	1189	595	199
78	2400	1200	600	200
79	2416	1208	604	202
80+	2453	1227	614	205

Standard Effective Date: 02/01/2020 Plan Code: P63

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1794	897	449	150
66	1931	966	483	161
67	2048	1024	512	171
68	2153	1077	539	180
69	2263	1132	566	189
70	2394	1197	599	200
71	2463	1232	616	206
72	2509	1255	628	210
73	2562	1281	641	214
74	2607	1304	652	218
75	2666	1333	667	223
76	2706	1353	677	226
77	2733	1367	684	228
78	2759	1380	690	230
79	2778	1389	695	232
80+	2820	1410	705	235

PLAN N

Male

Preferred Effective Date: 02/15/2024 Plan Code: 5DM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2659	1330	665	222
66	2822	1411	706	236
67	2970	1485	743	248
68	3112	1556	778	260
69	3274	1637	819	273
70	3446	1723	862	288
71	3592	1796	898	300
72	3702	1851	926	309
73	3796	1898	949	317
74	3886	1943	972	324
75	3952	1976	988	330
76	4012	2006	1003	335
77	4096	2048	1024	342
78	4177	2089	1045	349
79	4262	2131	1066	356
80+	4415	2208	1104	368

Standard Effective Date: 02/15/2024 Plan Code: 5DO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3060	1530	765	255
66	3247	1624	812	271
67	3418	1709	855	285
68	3581	1791	896	299
69	3768	1884	942	314
70	3966	1983	992	331
71	4133	2067	1034	345
72	4260	2130	1065	355
73	4368	2184	1092	364
74	4472	2236	1118	373
75	4547	2274	1137	379
76	4617	2309	1155	385
77	4713	2357	1179	393
78	4807	2404	1202	401
79	4905	2453	1227	409
80+	5081	2541	1271	424

Female

Preferred Effective Date: 02/15/2024 Plan Code: 5DN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2313	1157	579	193
66	2454	1227	614	205
67	2584	1292	646	216
68	2707	1354	677	226
69	2848	1424	712	238
70	2998	1499	750	250
71	3124	1562	781	261
72	3220	1610	805	269
73	3302	1651	826	276
74	3381	1691	846	282
75	3437	1719	860	287
76	3490	1745	873	291
77	3563	1782	891	297
78	3633	1817	909	303
79	3708	1854	927	309
80+	3840	1920	960	320

Standard Effective Date: 02/15/2024 Plan Code: 5DP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2659	1330	665	222
66	2822	1411	706	236
67	2970	1485	743	248
68	3112	1556	778	260
69	3274	1637	819	273
70	3446	1723	862	288
71	3592	1796	898	300
72	3702	1851	926	309
73	3796	1898	949	317
74	3886	1943	972	324
75	3952	1976	988	330
76	4012	2006	1003	335
77	4096	2048	1024	342
78	4177	2089	1045	349
79	4262	2131	1066	356
80+	4415	2208	1104	368

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