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 and either Plan C or F available for those eligible for Medicare prior to January 1, 2020, and either Plan D or Plan G available for those eligible for Medicare on or after January 1, 2020. 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: 01/01/2013 Plan Code: 5A4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1535	768	384	128
66	1597	799	400	134
67	1650	825	413	138
68	1689	845	423	141
69	1742	871	436	146
70	1787	894	447	149
71	1818	909	455	152
72	1818	909	455	152
73	1845	923	462	154
74	1863	932	466	156
75	1881	941	471	157
76	1888	944	472	158
77	1888	944	472	158
78	1888	944	472	158
79	1888	944	472	158
80+	1888	944	472	158

Standard Effective Date: 01/01/2013 Plan Code: 5A6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1766	883	442	148
66	1838	919	460	154
67	1898	949	475	159
68	1944	972	486	162
69	2005	1003	502	168
70	2057	1029	515	172
71	2093	1047	524	175
72	2093	1047	524	175
73	2123	1062	531	177
74	2144	1072	536	179
75	2164	1082	541	181
76	2173	1087	544	182
77	2173	1087	544	182
78	2173	1087	544	182
79	2173	1087	544	182
80+	2173	1087	544	182

Female

Preferred Effective Date: 01/01/2013 Plan Code: 5A5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1335	668	334	112
66	1389	695	348	116
67	1435	718	359	120
68	1469	735	368	123
69	1515	758	379	127
70	1554	777	389	130
71	1581	791	396	132
72	1581	791	396	132
73	1605	803	402	134
74	1620	810	405	135
75	1635	818	409	137
76	1642	821	411	137
77	1642	821	411	137
78	1642	821	411	137
79	1642	821	411	137
80+	1642	821	411	137

Standard Effective Date: 01/01/2013 Plan Code: 5A7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1535	768	384	128
66	1597	799	400	134
67	1650	825	413	138
68	1689	845	423	141
69	1742	871	436	146
70	1787	894	447	149
71	1818	909	455	152
72	1818	909	455	152
73	1845	923	462	154
74	1863	932	466	156
75	1881	941	471	157
76	1888	944	472	158
77	1888	944	472	158
78	1888	944	472	158
79	1888	944	472	158
80+	1888	944	472	158

PLAN B

Male

Preferred Effective Date: 03/01/2023 Plan Code: 5AM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3044	1522	761	254
66	3188	1594	797	266
67	3314	1657	829	277
68	3421	1711	856	286
69	3543	1772	886	296
70	3658	1829	915	305
71	3750	1875	938	313
72	3790	1895	948	316
73	3866	1933	967	323
74	3929	1965	983	328
75	3983	1992	996	332
76	4020	2010	1005	335
77	4020	2010	1005	335
78	4020	2010	1005	335
79	4020	2010	1005	335
80+	4020	2010	1005	335

Standard Effective Date: 03/01/2023 Plan Code: 5AO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3503	1752	876	292
66	3668	1834	917	306
67	3814	1907	954	318
68	3937	1969	985	329
69	4078	2039	1020	340
70	4210	2105	1053	351
71	4316	2158	1079	360
72	4362	2181	1091	364
73	4450	2225	1113	371
74	4521	2261	1131	377
75	4584	2292	1146	382
76	4626	2313	1157	386
77	4626	2313	1157	386
78	4626	2313	1157	386
79	4626	2313	1157	386
80+	4626	2313	1157	386

Female

Preferred Effective Date: 03/01/2023 Plan Code: 5AN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2647	1324	662	221
66	2772	1386	693	231
67	2882	1441	721	241
68	2975	1488	744	248
69	3081	1541	771	257
70	3181	1591	796	266
71	3262	1631	816	272
72	3296	1648	824	275
73	3362	1681	841	281
74	3417	1709	855	285
75	3464	1732	866	289
76	3496	1748	874	292
77	3496	1748	874	292
78	3496	1748	874	292
79	3496	1748	874	292
80+	3496	1748	874	292

Standard Effective Date: 03/01/2023 Plan Code: 5AP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3044	1522	761	254
66	3188	1594	797	266
67	3314	1657	829	277
68	3421	1711	856	286
69	3543	1772	886	296
70	3658	1829	915	305
71	3750	1875	938	313
72	3790	1895	948	316
73	3866	1933	967	323
74	3929	1965	983	328
75	3983	1992	996	332
76	4020	2010	1005	335
77	4020	2010	1005	335
78	4020	2010	1005	335
79	4020	2010	1005	335
80+	4020	2010	1005	335

PLAN C

Male

Preferred Effective Date: 03/01/2023 Plan Code: 5B4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3377	1689	845	282
66	3538	1769	885	295
67	3674	1837	919	307
68	3807	1904	952	318
69	3963	1982	991	331
70	4111	2056	1028	343
71	4243	2122	1061	354
72	4315	2158	1079	360
73	4435	2218	1109	370
74	4531	2266	1133	378
75	4622	2311	1156	386
76	4701	2351	1176	392
77	4766	2383	1192	398
78	4833	2417	1209	403
79	4897	2449	1225	409
80+	4997	2499	1250	417

Standard Effective Date: 03/01/2023 Plan Code: 5B6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3886	1943	972	324
66	4071	2036	1018	340
67	4228	2114	1057	353
68	4382	2191	1096	366
69	4561	2281	1141	381
70	4731	2366	1183	395
71	4883	2442	1221	407
72	4966	2483	1242	414
73	5103	2552	1276	426
74	5215	2608	1304	435
75	5320	2660	1330	444
76	5410	2705	1353	451
77	5485	2743	1372	458
78	5562	2781	1391	464
79	5636	2818	1409	470
80+	5751	2876	1438	480

Female

Preferred Effective Date: 03/01/2023 Plan Code: 5B5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2936	1468	734	245
66	3077	1539	770	257
67	3195	1598	799	267
68	3311	1656	828	276
69	3446	1723	862	288
70	3575	1788	894	298
71	3690	1845	923	308
72	3753	1877	939	313
73	3856	1928	964	322
74	3941	1971	986	329
75	4020	2010	1005	335
76	4088	2044	1022	341
77	4145	2073	1037	346
78	4203	2102	1051	351
79	4259	2130	1065	355
80+	4346	2173	1087	363

Standard Effective Date: 03/01/2023 Plan Code: 5B7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3377	1689	845	282
66	3538	1769	885	295
67	3674	1837	919	307
68	3807	1904	952	318
69	3963	1982	991	331
70	4111	2056	1028	343
71	4243	2122	1061	354
72	4315	2158	1079	360
73	4435	2218	1109	370
74	4531	2266	1133	378
75	4622	2311	1156	386
76	4701	2351	1176	392
77	4766	2383	1192	398
78	4833	2417	1209	403
79	4897	2449	1225	409
80+	4997	2499	1250	417

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

PLAN D

Male

Preferred Effective Date: 03/01/2023 Plan Code: 5BM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3185	1593	797	266
66	3344	1672	836	279
67	3486	1743	872	291
68	3618	1809	905	302
69	3783	1892	946	316
70	3931	1966	983	328
71	4063	2032	1016	339
72	4139	2070	1035	345
73	4259	2130	1065	355
74	4356	2178	1089	363
75	4447	2224	1112	371
76	4525	2263	1132	378
77	4596	2298	1149	383
78	4660	2330	1165	389
79	4726	2363	1182	394
80+	4827	2414	1207	403

Standard Effective Date: 03/01/2023 Plan Code: 5BO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3666	1833	917	306
66	3849	1925	963	321
67	4012	2006	1003	335
68	4164	2082	1041	347
69	4353	2177	1089	363
70	4524	2262	1131	377
71	4676	2338	1169	390
72	4764	2382	1191	397
73	4902	2451	1226	409
74	5013	2507	1254	418
75	5118	2559	1280	427
76	5207	2604	1302	434
77	5289	2645	1323	441
78	5363	2682	1341	447
79	5438	2719	1360	454
80+	5555	2778	1389	463

Female

Preferred Effective Date: 03/01/2023 Plan Code: 5BN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2770	1385	693	231
66	2908	1454	727	243
67	3032	1516	758	253
68	3147	1574	787	263
69	3290	1645	823	275
70	3418	1709	855	285
71	3533	1767	884	295
72	3600	1800	900	300
73	3704	1852	926	309
74	3788	1894	947	316
75	3868	1934	967	323
76	3935	1968	984	328
77	3997	1999	1000	334
78	4053	2027	1014	338
79	4110	2055	1028	343
80+	4197	2099	1050	350

Standard Effective Date: 03/01/2023 Plan Code: 5BP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3185	1593	797	266
66	3344	1672	836	279
67	3486	1743	872	291
68	3618	1809	905	302
69	3783	1892	946	316
70	3931	1966	983	328
71	4063	2032	1016	339
72	4139	2070	1035	345
73	4259	2130	1065	355
74	4356	2178	1089	363
75	4447	2224	1112	371
76	4525	2263	1132	378
77	4596	2298	1149	383
78	4660	2330	1165	389
79	4726	2363	1182	394
80+	4827	2414	1207	403

PLAN F

Male

Preferred Effective Date: 03/01/2023 Plan Code: 5C4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3657	1829	915	305
66	3828	1914	957	319
67	3976	1988	994	332
68	4117	2059	1030	344
69	4287	2144	1072	358
70	4446	2223	1112	371
71	4586	2293	1147	383
72	4672	2336	1168	390
73	4793	2397	1199	400
74	4901	2451	1226	409
75	4998	2499	1250	417
76	5081	2541	1271	424
77	5156	2578	1289	430
78	5225	2613	1307	436
79	5295	2648	1324	442
80+	5400	2700	1350	450

Standard Effective Date: 03/01/2023 Plan Code: 5C6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	4209	2105	1053	351
66	4405	2203	1102	368
67	4576	2288	1144	382
68	4738	2369	1185	395
69	4934	2467	1234	412
70	5117	2559	1280	427
71	5278	2639	1320	440
72	5377	2689	1345	449
73	5516	2758	1379	460
74	5640	2820	1410	470
75	5752	2876	1438	480
76	5848	2924	1462	488
77	5934	2967	1484	495
78	6013	3007	1504	502
79	6093	3047	1524	508
80+	6215	3108	1554	518

Female

Preferred Effective Date: 03/01/2023 Plan Code: 5C5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3180	1590	795	265
66	3329	1665	833	278
67	3458	1729	865	289
68	3580	1790	895	299
69	3729	1865	933	311
70	3867	1934	967	323
71	3988	1994	997	333
72	4063	2032	1016	339
73	4168	2084	1042	348
74	4262	2131	1066	356
75	4347	2174	1087	363
76	4419	2210	1105	369
77	4484	2242	1121	374
78	4544	2272	1136	379
79	4605	2303	1152	384
80+	4696	2348	1174	392

Standard Effective Date: 03/01/2023 Plan Code: 5C7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3657	1829	915	305
66	3828	1914	957	319
67	3976	1988	994	332
68	4117	2059	1030	344
69	4287	2144	1072	358
70	4446	2223	1112	371
71	4586	2293	1147	383
72	4672	2336	1168	390
73	4793	2397	1199	400
74	4901	2451	1226	409
75	4998	2499	1250	417
76	5081	2541	1271	424
77	5156	2578	1289	430
78	5225	2613	1307	436
79	5295	2648	1324	442
80+	5400	2700	1350	450

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

PLAN HDF

Male

Preferred Effective Date: 03/01/2023 Plan Code: 5CM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	465	233	117	39
66	498	249	125	42
67	532	266	133	45
68	551	276	138	46
69	572	286	143	48
70	595	298	149	50
71	613	307	154	52
72	640	320	160	54
73	674	337	169	57
74	705	353	177	59
75	737	369	185	62
76	750	375	188	63
77	759	380	190	64
78	784	392	196	66
79	812	406	203	68
80+	855	428	214	72

Standard Effective Date: 03/01/2023 Plan Code: 5CO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	535	268	134	45
66	574	287	144	48
67	612	306	153	51
68	634	317	159	53
69	659	330	165	55
70	685	343	172	58
71	706	353	177	59
72	737	369	185	62
73	776	388	194	65
74	811	406	203	68
75	848	424	212	71
76	863	432	216	72
77	874	437	219	73
78	902	451	226	76
79	934	467	234	78
80+	984	492	246	82

Female

Preferred Effective Date: 03/01/2023 Plan Code: 5CN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	404	202	101	34
66	433	217	109	37
67	462	231	116	39
68	479	240	120	40
69	498	249	125	42
70	517	259	130	44
71	533	267	134	45
72	557	279	140	47
73	587	294	147	49
74	613	307	154	52
75	641	321	161	54
76	652	326	163	55
77	660	330	165	55
78	682	341	171	57
79	706	353	177	59
80+	743	372	186	62

Standard Effective Date: 03/01/2023 Plan Code: 5CP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	465	233	117	39
66	498	249	125	42
67	532	266	133	45
68	551	276	138	46
69	572	286	143	48
70	595	298	149	50
71	613	307	154	52
72	640	320	160	54
73	674	337	169	57
74	705	353	177	59
75	737	369	185	62
76	750	375	188	63
77	759	380	190	64
78	784	392	196	66
79	812	406	203	68
80+	855	428	214	72

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

PLAN G

Male

Preferred Effective Date: 03/01/2023 Plan Code: 5D4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3108	1554	777	259
66	3263	1632	816	272
67	3405	1703	852	284
68	3531	1766	883	295
69	3686	1843	922	308
70	3833	1917	959	320
71	3959	1980	990	330
72	4035	2018	1009	337
73	4150	2075	1038	346
74	4247	2124	1062	354
75	4335	2168	1084	362
76	4408	2204	1102	368
77	4478	2239	1120	374
78	4539	2270	1135	379
79	4605	2303	1152	384
80+	4703	2352	1176	392

Standard Effective Date: 03/01/2023 Plan Code: 5D6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3577	1789	895	299
66	3755	1878	939	313
67	3918	1959	980	327
68	4064	2032	1016	339
69	4242	2121	1061	354
70	4411	2206	1103	368
71	4556	2278	1139	380
72	4644	2322	1161	387
73	4776	2388	1194	398
74	4887	2444	1222	408
75	4988	2494	1247	416
76	5073	2537	1269	423
77	5153	2577	1289	430
78	5223	2612	1306	436
79	5300	2650	1325	442
80+	5412	2706	1353	451

Female

Preferred Effective Date: 03/01/2023 Plan Code: 5D5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2703	1352	676	226
66	2837	1419	710	237
67	2961	1481	741	247
68	3071	1536	768	256
69	3205	1603	802	268
70	3333	1667	834	278
71	3443	1722	861	287
72	3509	1755	878	293
73	3609	1805	903	301
74	3693	1847	924	308
75	3770	1885	943	315
76	3833	1917	959	320
77	3894	1947	974	325
78	3947	1974	987	329
79	4005	2003	1002	334
80+	4090	2045	1023	341

Standard Effective Date: 03/01/2023 Plan Code: 5D7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3108	1554	777	259
66	3263	1632	816	272
67	3405	1703	852	284
68	3531	1766	883	295
69	3686	1843	922	308
70	3833	1917	959	320
71	3959	1980	990	330
72	4035	2018	1009	337
73	4150	2075	1038	346
74	4247	2124	1062	354
75	4335	2168	1084	362
76	4408	2204	1102	368
77	4478	2239	1120	374
78	4539	2270	1135	379
79	4605	2303	1152	384
80+	4703	2352	1176	392

PLAN HDG

Male

Preferred Effective Date: 03/01/2023 Plan Code: 5HO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	465	233	117	39
66	498	249	125	42
67	532	266	133	45
68	551	276	138	46
69	572	286	143	48
70	595	298	149	50
71	613	307	154	52
72	640	320	160	54
73	674	337	169	57
74	705	353	177	59
75	737	369	185	62
76	750	375	188	63
77	759	380	190	64
78	784	392	196	66
79	812	406	203	68
80+	855	428	214	72

Standard Effective Date: 03/01/2023 Plan Code: 5HQ

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	535	268	134	45
66	574	287	144	48
67	612	306	153	51
68	634	317	159	53
69	659	330	165	55
70	685	343	172	58
71	706	353	177	59
72	737	369	185	62
73	776	388	194	65
74	811	406	203	68
75	848	424	212	71
76	863	432	216	72
77	874	437	219	73
78	902	451	226	76
79	934	467	234	78
80+	984	492	246	82

Female

Preferred Effective Date: 03/01/2023 Plan Code: 5HP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	404	202	101	34
66	433	217	109	37
67	462	231	116	39
68	479	240	120	40
69	498	249	125	42
70	517	259	130	44
71	533	267	134	45
72	557	279	140	47
73	587	294	147	49
74	613	307	154	52
75	641	321	161	54
76	652	326	163	55
77	660	330	165	55
78	682	341	171	57
79	706	353	177	59
80+	743	372	186	62

Standard Effective Date: 03/01/2023 Plan Code: 5HR

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	465	233	117	39
66	498	249	125	42
67	532	266	133	45
68	551	276	138	46
69	572	286	143	48
70	595	298	149	50
71	613	307	154	52
72	640	320	160	54
73	674	337	169	57
74	705	353	177	59
75	737	369	185	62
76	750	375	188	63
77	759	380	190	64
78	784	392	196	66
79	812	406	203	68
80+	855	428	214	72

PLAN K

Male

Preferred Effective Date: 03/15/2020 Plan Code: P44

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1327	664	332	111
66	1424	712	356	119
67	1506	753	377	126
68	1581	791	396	132
69	1665	833	417	139
70	1764	882	441	147
71	1811	906	453	151
72	1840	920	460	154
73	1881	941	471	157
74	1915	958	479	160
75	1958	979	490	164
76	1986	993	497	166
77	2008	1004	502	168
78	2030	1015	508	170
79	2043	1022	511	171
80+	2082	1041	521	174

Standard Effective Date: 03/15/2020 Plan Code: P46

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1528	764	382	128
66	1639	820	410	137
67	1733	867	434	145
68	1819	910	455	152
69	1916	958	479	160
70	2030	1015	508	170
71	2084	1042	521	174
72	2117	1059	530	177
73	2164	1082	541	181
74	2204	1102	551	184
75	2253	1127	564	188
76	2285	1143	572	191
77	2311	1156	578	193
78	2336	1168	584	195
79	2351	1176	588	196
80+	2397	1199	600	200

Female

Preferred Effective Date: 03/15/2020 Plan Code: P45

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1154	577	289	97
66	1238	619	310	104
67	1309	655	328	110
68	1375	688	344	115
69	1448	724	362	121
70	1534	767	384	128
71	1575	788	394	132
72	1600	800	400	134
73	1635	818	409	137
74	1665	833	417	139
75	1703	852	426	142
76	1727	864	432	144
77	1747	874	437	146
78	1765	883	442	148
79	1776	888	444	148
80+	1811	906	453	151

Standard Effective Date: 03/15/2020 Plan Code: P47

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1327	664	332	111
66	1424	712	356	119
67	1506	753	377	126
68	1581	791	396	132
69	1665	833	417	139
70	1764	882	441	147
71	1811	906	453	151
72	1840	920	460	154
73	1881	941	471	157
74	1915	958	479	160
75	1958	979	490	164
76	1986	993	497	166
77	2008	1004	502	168
78	2030	1015	508	170
79	2043	1022	511	171
80+	2082	1041	521	174

PLAN L

Male

Preferred Effective Date: 03/15/2020 Plan Code: P60

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1861	931	466	156
66	2003	1002	501	167
67	2114	1057	529	177
68	2223	1112	556	186
69	2338	1169	585	195
70	2473	1237	619	207
71	2542	1271	636	212
72	2585	1293	647	216
73	2643	1322	661	221
74	2690	1345	673	225
75	2745	1373	687	229
76	2787	1394	697	233
77	2821	1411	706	236
78	2851	1426	713	238
79	2870	1435	718	240
80+	2922	1461	731	244

Standard Effective Date: 03/15/2020 Plan Code: P62

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2142	1071	536	179
66	2305	1153	577	193
67	2432	1216	608	203
68	2559	1280	640	214
69	2691	1346	673	225
70	2847	1424	712	238
71	2926	1463	732	244
72	2975	1488	744	248
73	3042	1521	761	254
74	3096	1548	774	258
75	3159	1580	790	264
76	3207	1604	802	268
77	3247	1624	812	271
78	3282	1641	821	274
79	3303	1652	826	276
80+	3363	1682	841	281

Female

Preferred Effective Date: 03/15/2020 Plan Code: P61

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1619	810	405	135
66	1742	871	436	146
67	1838	919	460	154
68	1933	967	484	162
69	2033	1017	509	170
70	2151	1076	538	180
71	2211	1106	553	185
72	2248	1124	562	188
73	2299	1150	575	192
74	2340	1170	585	195
75	2387	1194	597	199
76	2424	1212	606	202
77	2454	1227	614	205
78	2480	1240	620	207
79	2496	1248	624	208
80+	2541	1271	636	212

Standard Effective Date: 03/15/2020 Plan Code: P63

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1861	931	466	156
66	2003	1002	501	167
67	2114	1057	529	177
68	2223	1112	556	186
69	2338	1169	585	195
70	2473	1237	619	207
71	2542	1271	636	212
72	2585	1293	647	216
73	2643	1322	661	221
74	2690	1345	673	225
75	2745	1373	687	229
76	2787	1394	697	233
77	2821	1411	706	236
78	2851	1426	713	238
79	2870	1435	718	240
80+	2922	1461	731	244

PLAN N

Male

Preferred Effective Date: 01/01/2022 Plan Code: 5DM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2356	1178	589	197
66	2511	1256	628	210
67	2657	1329	665	222
68	2806	1403	702	234
69	2970	1485	743	248
70	3136	1568	784	262
71	3283	1642	821	274
72	3395	1698	849	283
73	3488	1744	872	291
74	3565	1783	892	298
75	3638	1819	910	304
76	3693	1847	924	308
77	3765	1883	942	314
78	3833	1917	959	320
79	3907	1954	977	326
80+	4025	2013	1007	336

Standard Effective Date: 01/01/2022 Plan Code: 5DO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2711	1356	678	226
66	2889	1445	723	241
67	3058	1529	765	255
68	3229	1615	808	270
69	3418	1709	855	285
70	3608	1804	902	301
71	3778	1889	945	315
72	3907	1954	977	326
73	4014	2007	1004	335
74	4102	2051	1026	342
75	4186	2093	1047	349
76	4250	2125	1063	355
77	4332	2166	1083	361
78	4411	2206	1103	368
79	4496	2248	1124	375
80+	4632	2316	1158	386

Female

Preferred Effective Date: 01/01/2022 Plan Code: 5DN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2049	1025	513	171
66	2184	1092	546	182
67	2311	1156	578	193
68	2440	1220	610	204
69	2584	1292	646	216
70	2728	1364	682	228
71	2856	1428	714	238
72	2953	1477	739	247
73	3034	1517	759	253
74	3101	1551	776	259
75	3164	1582	791	264
76	3212	1606	803	268
77	3275	1638	819	273
78	3334	1667	834	278
79	3398	1699	850	284
80+	3501	1751	876	292

Standard Effective Date: 01/01/2022 Plan Code: 5DP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2356	1178	589	197
66	2511	1256	628	210
67	2657	1329	665	222
68	2806	1403	702	234
69	2970	1485	743	248
70	3136	1568	784	262
71	3283	1642	821	274
72	3395	1698	849	283
73	3488	1744	872	291
74	3565	1783	892	298
75	3638	1819	910	304
76	3693	1847	924	308
77	3765	1883	942	314
78	3833	1917	959	320
79	3907	1954	977	326
80+	4025	2013	1007	336

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