UNITED AMERICAN INSURANCE COMPANY

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

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

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

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

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

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

* Denotes plans available by United American Insurance Company

[1] Plans F and G also have a high deductible option which 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.

UNDER AGE 65 GUARANTEED ISSUE PERIOD (G/I) *

Male

Preferred

Plan	A	SA	Q	M	Plan Code	Effective Date
A	2255	1128	564	188	5EW	01/01/2020
B	3954	1977	989	330	5F0	01/01/2024
C	4593	2297	1149	383	5F4	01/01/2024
D	4403	2202	1101	367	5F8	01/01/2024
F	4654	2327	1164	388	5FC	01/01/2024
HDF	835	418	209	70	5FG	01/01/2024
G	4037	2019	1010	337	5FK	01/01/2024
HDG	835	418	209	70	5I6	01/01/2024
K	1643	822	411	137	5FO	01/01/2020
L	2306	1153	577	193	5FS	01/01/2020

Standard

Plan	A	SA	Q	M	Plan Code	Effective Date
A	2594	1297	649	217	5EY	01/01/2020
B	4550	2275	1138	380	5F2	01/01/2024
C	5286	2643	1322	441	5F6	01/01/2024
D	5067	2534	1267	423	5FA	01/01/2024
F	5356	2678	1339	447	5FE	01/01/2024
HDF	961	481	241	81	5FI	01/01/2024
G	4646	2323	1162	388	5FM	01/01/2024
HDG	961	481	241	81	5I8	01/01/2024
K	1890	945	473	158	5FQ	01/01/2020
L	2653	1327	664	222	5FU	01/01/2020

Female

Preferred

Plan	A	SA	Q	M	Plan Code	Effective Date
A	1961	981	491	164	5EX	01/01/2020
B	3439	1720	860	287	5F1	01/01/2024
C	3996	1998	999	333	5F5	01/01/2024
D	3830	1915	958	320	5F9	01/01/2024
F	4049	2025	1013	338	5FD	01/01/2024
HDF	726	363	182	61	5FH	01/01/2024
G	3512	1756	878	293	5FL	01/01/2024
HDG	726	363	182	61	5I7	01/01/2024
K	1429	715	358	120	5FP	01/01/2020
L	2006	1003	502	168	5FT	01/01/2020

Standard

Plan	A	SA	Q	M	Plan Code	Effective Date
A	2255	1128	564	188	5EZ	01/01/2020
B	3954	1977	989	330	5F3	01/01/2024
C	4593	2297	1149	383	5F7	01/01/2024
D	4403	2202	1101	367	5FB	01/01/2024
F	4654	2327	1164	388	5FF	01/01/2024
HDF	835	418	209	70	5FJ	01/01/2024
G	4037	2019	1010	337	5FN	01/01/2024
HDG	835	418	209	70	5I9	01/01/2024
K	1643	822	411	137	5FR	01/01/2020
L	2306	1153	577	193	5FV	01/01/2020

*** NOTE: In SOUTH DAKOTA, once the policyholder reaches age 65, rates for their policy will change to reflect the rates of the corresponding overage plan.**

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

UNDER AGE 65 DURING OPEN ENROLLMENT (O/E) *

Male

Preferred

Plan	A	SA	Q	M	Plan Code	Effective Date
A	2255	1128	564	188	5EW	01/01/2020
B	3954	1977	989	330	5F0	01/01/2024
C	4593	2297	1149	383	5F4	01/01/2024
D	4403	2202	1101	367	5F8	01/01/2024
F	4654	2327	1164	388	5FC	01/01/2024
HDF	835	418	209	70	5FG	01/01/2024
G	4037	2019	1010	337	5FK	01/01/2024
HDG	835	418	209	70	5I6	01/01/2024
K	1643	822	411	137	5FO	01/01/2020
L	2306	1153	577	193	5FS	01/01/2020
N	4020	2010	1005	335	5FW	01/01/2024

Standard

Plan	A	SA	Q	M	Plan Code	Effective Date
A	2594	1297	649	217	5EY	01/01/2020
B	4550	2275	1138	380	5F2	01/01/2024
C	5286	2643	1322	441	5F6	01/01/2024
D	5067	2534	1267	423	5FA	01/01/2024
F	5356	2678	1339	447	5FE	01/01/2024
HDF	961	481	241	81	5FI	01/01/2024
G	4646	2323	1162	388	5FM	01/01/2024
HDG	961	481	241	81	5I8	01/01/2024
K	1890	945	473	158	5FQ	01/01/2020
L	2653	1327	664	222	5FU	01/01/2020
N	4626	2313	1157	386	5FY	01/01/2024

Female

Preferred

Plan	A	SA	Q	M	Plan Code	Effective Date
A	1961	981	491	164	5EX	01/01/2020
B	3439	1720	860	287	5F1	01/01/2024
C	3996	1998	999	333	5F5	01/01/2024
D	3830	1915	958	320	5F9	01/01/2024
F	4049	2025	1013	338	5FD	01/01/2024
HDF	726	363	182	61	5FH	01/01/2024
G	3512	1756	878	293	5FL	01/01/2024
HDG	726	363	182	61	5I7	01/01/2024
K	1429	715	358	120	5FP	01/01/2020
L	2006	1003	502	168	5FT	01/01/2020
N	3497	1749	875	292	5FX	01/01/2024

Standard

Plan	A	SA	Q	M	Plan Code	Effective Date
A	2255	1128	564	188	5EZ	01/01/2020
B	3954	1977	989	330	5F3	01/01/2024
C	4593	2297	1149	383	5F7	01/01/2024
D	4403	2202	1101	367	5FB	01/01/2024
F	4654	2327	1164	388	5FF	01/01/2024
HDF	835	418	209	70	5FJ	01/01/2024
G	4037	2019	1010	337	5FN	01/01/2024
HDG	835	418	209	70	5I9	01/01/2024
K	1643	822	411	137	5FR	01/01/2020
L	2306	1153	577	193	5FV	01/01/2020
N	4020	2010	1005	335	5FZ	01/01/2024

*** NOTE: In SOUTH DAKOTA, once the policyholder reaches age 65, rates for their policy will change to reflect the rates of the corresponding overage plan.**

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

PLAN A

Male

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1759	880	440	147
66	1848	924	462	154
67	1923	962	481	161
68	1990	995	498	166
69	2067	1034	517	173
70	2135	1068	534	178
71	2189	1095	548	183
72	2208	1104	552	184
73	2233	1117	559	187
74	2241	1121	561	187
75	2255	1128	564	188
76	2255	1128	564	188
77	2255	1128	564	188
78	2255	1128	564	188
79	2255	1128	564	188
80+	2255	1128	564	188

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2024	1012	506	169
66	2126	1063	532	178
67	2213	1107	554	185
68	2290	1145	573	191
69	2378	1189	595	199
70	2457	1229	615	205
71	2519	1260	630	210
72	2540	1270	635	212
73	2570	1285	643	215
74	2578	1289	645	215
75	2594	1297	649	217
76	2594	1297	649	217
77	2594	1297	649	217
78	2594	1297	649	217
79	2594	1297	649	217
80+	2594	1297	649	217

Female

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1530	765	383	128
66	1607	804	402	134
67	1673	837	419	140
68	1731	866	433	145
69	1798	899	450	150
70	1857	929	465	155
71	1904	952	476	159
72	1920	960	480	160
73	1943	972	486	162
74	1949	975	488	163
75	1961	981	491	164
76	1961	981	491	164
77	1961	981	491	164
78	1961	981	491	164
79	1961	981	491	164
80+	1961	981	491	164

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1759	880	440	147
66	1848	924	462	154
67	1923	962	481	161
68	1990	995	498	166
69	2067	1034	517	173
70	2135	1068	534	178
71	2189	1095	548	183
72	2208	1104	552	184
73	2233	1117	559	187
74	2241	1121	561	187
75	2255	1128	564	188
76	2255	1128	564	188
77	2255	1128	564	188
78	2255	1128	564	188
79	2255	1128	564	188
80+	2255	1128	564	188

PLAN B

Male

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2915	1458	729	243
66	3078	1539	770	257
67	3219	1610	805	269
68	3341	1671	836	279
69	3486	1743	872	291
70	3618	1809	905	302
71	3725	1863	932	311
72	3787	1894	947	316
73	3853	1927	964	322
74	3899	1950	975	325
75	3954	1977	989	330
76	3984	1992	996	332
77	3985	1993	997	333
78	3987	1994	997	333
79	3989	1995	998	333
80+	3989	1995	998	333

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3354	1677	839	280
66	3542	1771	886	296
67	3704	1852	926	309
68	3844	1922	961	321
69	4011	2006	1003	335
70	4164	2082	1041	347
71	4287	2144	1072	358
72	4358	2179	1090	364
73	4434	2217	1109	370
74	4487	2244	1122	374
75	4550	2275	1138	380
76	4584	2292	1146	382
77	4585	2293	1147	383
78	4588	2294	1147	383
79	4590	2295	1148	383
80+	4590	2295	1148	383

Female

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2535	1268	634	212
66	2677	1339	670	224
67	2800	1400	700	234
68	2906	1453	727	243
69	3032	1516	758	253
70	3147	1574	787	263
71	3240	1620	810	270
72	3294	1647	824	275
73	3352	1676	838	280
74	3392	1696	848	283
75	3439	1720	860	287
76	3465	1733	867	289
77	3466	1733	867	289
78	3468	1734	867	289
79	3470	1735	868	290
80+	3470	1735	868	290

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2915	1458	729	243
66	3078	1539	770	257
67	3219	1610	805	269
68	3341	1671	836	279
69	3486	1743	872	291
70	3618	1809	905	302
71	3725	1863	932	311
72	3787	1894	947	316
73	3853	1927	964	322
74	3899	1950	975	325
75	3954	1977	989	330
76	3984	1992	996	332
77	3985	1993	997	333
78	3987	1994	997	333
79	3989	1995	998	333
80+	3989	1995	998	333

PLAN C

Male

Preferred Effective Date: 01/01/2024 Plan Code: 5B4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3254	1627	814	272
66	3431	1716	858	286
67	3586	1793	897	299
68	3733	1867	934	312
69	3916	1958	979	327
70	4082	2041	1021	341
71	4224	2112	1056	352
72	4328	2164	1082	361
73	4432	2216	1108	370
74	4512	2256	1128	376
75	4593	2297	1149	383
76	4661	2331	1166	389
77	4731	2366	1183	395
78	4806	2403	1202	401
79	4875	2438	1219	407
80+	5000	2500	1250	417

Standard Effective Date: 01/01/2024 Plan Code: 5B6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3745	1873	937	313
66	3949	1975	988	330
67	4127	2064	1032	344
68	4295	2148	1074	358
69	4507	2254	1127	376
70	4697	2349	1175	392
71	4861	2431	1216	406
72	4980	2490	1245	415
73	5100	2550	1275	425
74	5193	2597	1299	433
75	5286	2643	1322	441
76	5363	2682	1341	447
77	5444	2722	1361	454
78	5531	2766	1383	461
79	5610	2805	1403	468
80+	5754	2877	1439	480

Female

Preferred Effective Date: 01/01/2024 Plan Code: 5B5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2831	1416	708	236
66	2985	1493	747	249
67	3120	1560	780	260
68	3247	1624	812	271
69	3407	1704	852	284
70	3551	1776	888	296
71	3674	1837	919	307
72	3764	1882	941	314
73	3855	1928	964	322
74	3925	1963	982	328
75	3996	1998	999	333
76	4054	2027	1014	338
77	4115	2058	1029	343
78	4181	2091	1046	349
79	4241	2121	1061	354
80+	4350	2175	1088	363

Standard Effective Date: 01/01/2024 Plan Code: 5B7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3254	1627	814	272
66	3431	1716	858	286
67	3586	1793	897	299
68	3733	1867	934	312
69	3916	1958	979	327
70	4082	2041	1021	341
71	4224	2112	1056	352
72	4328	2164	1082	361
73	4432	2216	1108	370
74	4512	2256	1128	376
75	4593	2297	1149	383
76	4661	2331	1166	389
77	4731	2366	1183	395
78	4806	2403	1202	401
79	4875	2438	1219	407
80+	5000	2500	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: 01/01/2024 Plan Code: 5BM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3043	1522	761	254
66	3220	1610	805	269
67	3384	1692	846	282
68	3530	1765	883	295
69	3713	1857	929	310
70	3884	1942	971	324
71	4027	2014	1007	336
72	4131	2066	1033	345
73	4236	2118	1059	353
74	4319	2160	1080	360
75	4403	2202	1101	367
76	4469	2235	1118	373
77	4543	2272	1136	379
78	4617	2309	1155	385
79	4687	2344	1172	391
80+	4812	2406	1203	401

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3501	1751	876	292
66	3705	1853	927	309
67	3895	1948	974	325
68	4062	2031	1016	339
69	4273	2137	1069	357
70	4470	2235	1118	373
71	4635	2318	1159	387
72	4754	2377	1189	397
73	4874	2437	1219	407
74	4970	2485	1243	415
75	5067	2534	1267	423
76	5142	2571	1286	429
77	5228	2614	1307	436
78	5313	2657	1329	443
79	5394	2697	1349	450
80+	5538	2769	1385	462

Female

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2647	1324	662	221
66	2801	1401	701	234
67	2944	1472	736	246
68	3070	1535	768	256
69	3230	1615	808	270
70	3379	1690	845	282
71	3503	1752	876	292
72	3593	1797	899	300
73	3684	1842	921	307
74	3757	1879	940	314
75	3830	1915	958	320
76	3887	1944	972	324
77	3952	1976	988	330
78	4016	2008	1004	335
79	4077	2039	1020	340
80+	4186	2093	1047	349

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3043	1522	761	254
66	3220	1610	805	269
67	3384	1692	846	282
68	3530	1765	883	295
69	3713	1857	929	310
70	3884	1942	971	324
71	4027	2014	1007	336
72	4131	2066	1033	345
73	4236	2118	1059	353
74	4319	2160	1080	360
75	4403	2202	1101	367
76	4469	2235	1118	373
77	4543	2272	1136	379
78	4617	2309	1155	385
79	4687	2344	1172	391
80+	4812	2406	1203	401

PLAN F

Male

Preferred Effective Date: 01/01/2024 Plan Code: 5C4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3299	1650	825	275
66	3478	1739	870	290
67	3635	1818	909	303
68	3786	1893	947	316
69	3968	1984	992	331
70	4133	2067	1034	345
71	4278	2139	1070	357
72	4382	2191	1096	366
73	4483	2242	1121	374
74	4569	2285	1143	381
75	4654	2327	1164	388
76	4717	2359	1180	394
77	4792	2396	1198	400
78	4864	2432	1216	406
79	4938	2469	1235	412
80+	5058	2529	1265	422

Standard Effective Date: 01/01/2024 Plan Code: 5C6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3796	1898	949	317
66	4003	2002	1001	334
67	4184	2092	1046	349
68	4357	2179	1090	364
69	4566	2283	1142	381
70	4756	2378	1189	397
71	4923	2462	1231	411
72	5043	2522	1261	421
73	5159	2580	1290	430
74	5258	2629	1315	439
75	5356	2678	1339	447
76	5428	2714	1357	453
77	5515	2758	1379	460
78	5597	2799	1400	467
79	5683	2842	1421	474
80+	5821	2911	1456	486

Female

Preferred Effective Date: 01/01/2024 Plan Code: 5C5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2870	1435	718	240
66	3026	1513	757	253
67	3162	1581	791	264
68	3293	1647	824	275
69	3451	1726	863	288
70	3595	1798	899	300
71	3722	1861	931	311
72	3812	1906	953	318
73	3900	1950	975	325
74	3974	1987	994	332
75	4049	2025	1013	338
76	4103	2052	1026	342
77	4168	2084	1042	348
78	4231	2116	1058	353
79	4296	2148	1074	358
80+	4400	2200	1100	367

Standard Effective Date: 01/01/2024 Plan Code: 5C7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3299	1650	825	275
66	3478	1739	870	290
67	3635	1818	909	303
68	3786	1893	947	316
69	3968	1984	992	331
70	4133	2067	1034	345
71	4278	2139	1070	357
72	4382	2191	1096	366
73	4483	2242	1121	374
74	4569	2285	1143	381
75	4654	2327	1164	388
76	4717	2359	1180	394
77	4792	2396	1198	400
78	4864	2432	1216	406
79	4938	2469	1235	412
80+	5058	2529	1265	422

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

PLAN HDF

Male

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	512	256	128	43
66	553	277	139	47
67	594	297	149	50
68	617	309	155	52
69	648	324	162	54
70	673	337	169	57
71	698	349	175	59
72	733	367	184	62
73	769	385	193	65
74	803	402	201	67
75	835	418	209	70
76	848	424	212	71
77	863	432	216	72
78	876	438	219	73
79	889	445	223	75
80+	914	457	229	77

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	589	295	148	50
66	637	319	160	54
67	683	342	171	57
68	710	355	178	60
69	746	373	187	63
70	774	387	194	65
71	804	402	201	67
72	843	422	211	71
73	885	443	222	74
74	924	462	231	77
75	961	481	241	81
76	976	488	244	82
77	993	497	249	83
78	1008	504	252	84
79	1023	512	256	86
80+	1052	526	263	88

Female

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	445	223	112	38
66	481	241	121	41
67	517	259	130	44
68	537	269	135	45
69	564	282	141	47
70	585	293	147	49
71	608	304	152	51
72	637	319	160	54
73	669	335	168	56
74	699	350	175	59
75	726	363	182	61
76	738	369	185	62
77	751	376	188	63
78	762	381	191	64
79	773	387	194	65
80+	795	398	199	67

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	512	256	128	43
66	553	277	139	47
67	594	297	149	50
68	617	309	155	52
69	648	324	162	54
70	673	337	169	57
71	698	349	175	59
72	733	367	184	62
73	769	385	193	65
74	803	402	201	67
75	835	418	209	70
76	848	424	212	71
77	863	432	216	72
78	876	438	219	73
79	889	445	223	75
80+	914	457	229	77

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

PLAN G

Male

Preferred Effective Date: 01/01/2024 Plan Code: 5D4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2795	1398	699	233
66	2959	1480	740	247
67	3106	1553	777	259
68	3242	1621	811	271
69	3407	1704	852	284
70	3562	1781	891	297
71	3694	1847	924	308
72	3788	1894	947	316
73	3885	1943	972	324
74	3961	1981	991	331
75	4037	2019	1010	337
76	4099	2050	1025	342
77	4164	2082	1041	347
78	4232	2116	1058	353
79	4300	2150	1075	359
80+	4409	2205	1103	368

Standard Effective Date: 01/01/2024 Plan Code: 5D6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3216	1608	804	268
66	3406	1703	852	284
67	3574	1787	894	298
68	3731	1866	933	311
69	3921	1961	981	327
70	4099	2050	1025	342
71	4251	2126	1063	355
72	4359	2180	1090	364
73	4471	2236	1118	373
74	4558	2279	1140	380
75	4646	2323	1162	388
76	4717	2359	1180	394
77	4792	2396	1198	400
78	4871	2436	1218	406
79	4948	2474	1237	413
80+	5073	2537	1269	423

Female

Preferred Effective Date: 01/01/2024 Plan Code: 5D5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2431	1216	608	203
66	2574	1287	644	215
67	2702	1351	676	226
68	2820	1410	705	235
69	2964	1482	741	247
70	3098	1549	775	259
71	3213	1607	804	268
72	3295	1648	824	275
73	3380	1690	845	282
74	3446	1723	862	288
75	3512	1756	878	293
76	3566	1783	892	298
77	3622	1811	906	302
78	3682	1841	921	307
79	3740	1870	935	312
80+	3835	1918	959	320

Standard Effective Date: 01/01/2024 Plan Code: 5D7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2795	1398	699	233
66	2959	1480	740	247
67	3106	1553	777	259
68	3242	1621	811	271
69	3407	1704	852	284
70	3562	1781	891	297
71	3694	1847	924	308
72	3788	1894	947	316
73	3885	1943	972	324
74	3961	1981	991	331
75	4037	2019	1010	337
76	4099	2050	1025	342
77	4164	2082	1041	347
78	4232	2116	1058	353
79	4300	2150	1075	359
80+	4409	2205	1103	368

PLAN HDG

Male

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	512	256	128	43
66	553	277	139	47
67	594	297	149	50
68	617	309	155	52
69	648	324	162	54
70	673	337	169	57
71	698	349	175	59
72	733	367	184	62
73	769	385	193	65
74	803	402	201	67
75	835	418	209	70
76	848	424	212	71
77	863	432	216	72
78	876	438	219	73
79	889	445	223	75
80+	914	457	229	77

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	589	295	148	50
66	637	319	160	54
67	683	342	171	57
68	710	355	178	60
69	746	373	187	63
70	774	387	194	65
71	804	402	201	67
72	843	422	211	71
73	885	443	222	74
74	924	462	231	77
75	961	481	241	81
76	976	488	244	82
77	993	497	249	83
78	1008	504	252	84
79	1023	512	256	86
80+	1052	526	263	88

Female

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	445	223	112	38
66	481	241	121	41
67	517	259	130	44
68	537	269	135	45
69	564	282	141	47
70	585	293	147	49
71	608	304	152	51
72	637	319	160	54
73	669	335	168	56
74	699	350	175	59
75	726	363	182	61
76	738	369	185	62
77	751	376	188	63
78	762	381	191	64
79	773	387	194	65
80+	795	398	199	67

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	512	256	128	43
66	553	277	139	47
67	594	297	149	50
68	617	309	155	52
69	648	324	162	54
70	673	337	169	57
71	698	349	175	59
72	733	367	184	62
73	769	385	193	65
74	803	402	201	67
75	835	418	209	70
76	848	424	212	71
77	863	432	216	72
78	876	438	219	73
79	889	445	223	75
80+	914	457	229	77

PLAN K

Male

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1109	555	278	93
66	1193	597	299	100
67	1261	631	316	106
68	1325	663	332	111
69	1392	696	348	116
70	1472	736	368	123
71	1512	756	378	126
72	1541	771	386	129
73	1576	788	394	132
74	1605	803	402	134
75	1643	822	411	137
76	1671	836	418	140
77	1690	845	423	141
78	1706	853	427	143
79	1717	859	430	144
80+	1752	876	438	146

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1276	638	319	107
66	1373	687	344	115
67	1451	726	363	121
68	1525	763	382	128
69	1601	801	401	134
70	1694	847	424	142
71	1740	870	435	145
72	1773	887	444	148
73	1814	907	454	152
74	1847	924	462	154
75	1890	945	473	158
76	1923	962	481	161
77	1944	972	486	162
78	1963	982	491	164
79	1976	988	494	165
80+	2016	1008	504	168

Female

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	964	482	241	81
66	1038	519	260	87
67	1097	549	275	92
68	1153	577	289	97
69	1210	605	303	101
70	1280	640	320	107
71	1315	658	329	110
72	1341	671	336	112
73	1371	686	343	115
74	1396	698	349	117
75	1429	715	358	120
76	1454	727	364	122
77	1470	735	368	123
78	1484	742	371	124
79	1494	747	374	125
80+	1524	762	381	127

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1109	555	278	93
66	1193	597	299	100
67	1261	631	316	106
68	1325	663	332	111
69	1392	696	348	116
70	1472	736	368	123
71	1512	756	378	126
72	1541	771	386	129
73	1576	788	394	132
74	1605	803	402	134
75	1643	822	411	137
76	1671	836	418	140
77	1690	845	423	141
78	1706	853	427	143
79	1717	859	430	144
80+	1752	876	438	146

PLAN L

Male

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1552	776	388	130
66	1668	834	417	139
67	1772	886	443	148
68	1859	930	465	155
69	1956	978	489	163
70	2068	1034	517	173
71	2126	1063	532	178
72	2167	1084	542	181
73	2213	1107	554	185
74	2253	1127	564	188
75	2306	1153	577	193
76	2340	1170	585	195
77	2373	1187	594	198
78	2394	1197	599	200
79	2417	1209	605	202
80+	2463	1232	616	206

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1786	893	447	149
66	1920	960	480	160
67	2039	1020	510	170
68	2140	1070	535	179
69	2250	1125	563	188
70	2379	1190	595	199
71	2447	1224	612	204
72	2494	1247	624	208
73	2546	1273	637	213
74	2593	1297	649	217
75	2653	1327	664	222
76	2693	1347	674	225
77	2731	1366	683	228
78	2755	1378	689	230
79	2781	1391	696	232
80+	2834	1417	709	237

Female

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1350	675	338	113
66	1451	726	363	121
67	1541	771	386	129
68	1617	809	405	135
69	1701	851	426	142
70	1799	900	450	150
71	1850	925	463	155
72	1885	943	472	158
73	1925	963	482	161
74	1960	980	490	164
75	2006	1003	502	168
76	2035	1018	509	170
77	2064	1032	516	172
78	2083	1042	521	174
79	2102	1051	526	176
80+	2142	1071	536	179

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1552	776	388	130
66	1668	834	417	139
67	1772	886	443	148
68	1859	930	465	155
69	1956	978	489	163
70	2068	1034	517	173
71	2126	1063	532	178
72	2167	1084	542	181
73	2213	1107	554	185
74	2253	1127	564	188
75	2306	1153	577	193
76	2340	1170	585	195
77	2373	1187	594	198
78	2394	1197	599	200
79	2417	1209	605	202
80+	2463	1232	616	206

PLAN N

Male

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2738	1369	685	229
66	2899	1450	725	242
67	3048	1524	762	254
68	3192	1596	798	266
69	3357	1679	840	280
70	3513	1757	879	293
71	3647	1824	912	304
72	3753	1877	939	313
73	3851	1926	963	321
74	3929	1965	983	328
75	4020	2010	1005	335
76	4081	2041	1021	341
77	4161	2081	1041	347
78	4238	2119	1060	354
79	4313	2157	1079	360
80+	4449	2225	1113	371

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3151	1576	788	263
66	3336	1668	834	278
67	3508	1754	877	293
68	3673	1837	919	307
69	3863	1932	966	322
70	4042	2021	1011	337
71	4197	2099	1050	350
72	4319	2160	1080	360
73	4432	2216	1108	370
74	4521	2261	1131	377
75	4626	2313	1157	386
76	4696	2348	1174	392
77	4788	2394	1197	399
78	4877	2439	1220	407
79	4963	2482	1241	414
80+	5120	2560	1280	427

Female

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2382	1191	596	199
66	2521	1261	631	211
67	2651	1326	663	221
68	2777	1389	695	232
69	2920	1460	730	244
70	3055	1528	764	255
71	3173	1587	794	265
72	3265	1633	817	273
73	3350	1675	838	280
74	3418	1709	855	285
75	3497	1749	875	292
76	3550	1775	888	296
77	3619	1810	905	302
78	3686	1843	922	308
79	3751	1876	938	313
80+	3870	1935	968	323

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2738	1369	685	229
66	2899	1450	725	242
67	3048	1524	762	254
68	3192	1596	798	266
69	3357	1679	840	280
70	3513	1757	879	293
71	3647	1824	912	304
72	3753	1877	939	313
73	3851	1926	963	321
74	3929	1965	983	328
75	4020	2010	1005	335
76	4081	2041	1021	341
77	4161	2081	1041	347
78	4238	2119	1060	354
79	4313	2157	1079	360
80+	4449	2225	1113	371

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