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.

PLAN A

Male

Preferred Effective Date: 01/01/2017 Plan Code: 5A4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1617	809	405	135
66	1700	850	425	142
67	1773	887	444	148
68	1839	920	460	154
69	1912	956	478	160
70	1984	992	496	166
71	2041	1021	511	171
72	2065	1033	517	173
73	2075	1038	519	173
74	2075	1038	519	173
75	2076	1038	519	173
76	2076	1038	519	173
77	2076	1038	519	173
78	2076	1038	519	173
79	2076	1038	519	173
80+	2076	1038	519	173

Standard Effective Date: 01/01/2017 Plan Code: 5A6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1861	931	466	156
66	1957	979	490	164
67	2041	1021	511	171
68	2116	1058	529	177
69	2200	1100	550	184
70	2283	1142	571	191
71	2348	1174	587	196
72	2377	1189	595	199
73	2388	1194	597	199
74	2388	1194	597	199
75	2389	1195	598	200
76	2389	1195	598	200
77	2389	1195	598	200
78	2389	1195	598	200
79	2389	1195	598	200
80+	2389	1195	598	200

Female

Preferred Effective Date: 01/01/2017 Plan Code: 5A5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1407	704	352	118
66	1479	740	370	124
67	1542	771	386	129
68	1599	800	400	134
69	1663	832	416	139
70	1725	863	432	144
71	1775	888	444	148
72	1796	898	449	150
73	1804	902	451	151
74	1804	902	451	151
75	1805	903	452	151
76	1805	903	452	151
77	1805	903	452	151
78	1805	903	452	151
79	1805	903	452	151
80+	1805	903	452	151

Standard Effective Date: 01/01/2017 Plan Code: 5A7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1617	809	405	135
66	1700	850	425	142
67	1773	887	444	148
68	1839	920	460	154
69	1912	956	478	160
70	1984	992	496	166
71	2041	1021	511	171
72	2065	1033	517	173
73	2075	1038	519	173
74	2075	1038	519	173
75	2076	1038	519	173
76	2076	1038	519	173
77	2076	1038	519	173
78	2076	1038	519	173
79	2076	1038	519	173
80+	2076	1038	519	173

PLAN B

Male

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2285	1143	572	191
66	2413	1207	604	202
67	2529	1265	633	211
68	2636	1318	659	220
69	2753	1377	689	230
70	2863	1432	716	239
71	2958	1479	740	247
72	3016	1508	754	252
73	3052	1526	763	255
74	3076	1538	769	257
75	3103	1552	776	259
76	3109	1555	778	260
77	3109	1555	778	260
78	3109	1555	778	260
79	3109	1555	778	260
80+	3109	1555	778	260

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2630	1315	658	220
66	2777	1389	695	232
67	2911	1456	728	243
68	3033	1517	759	253
69	3168	1584	792	264
70	3295	1648	824	275
71	3404	1702	851	284
72	3471	1736	868	290
73	3513	1757	879	293
74	3540	1770	885	295
75	3571	1786	893	298
76	3578	1789	895	299
77	3578	1789	895	299
78	3578	1789	895	299
79	3578	1789	895	299
80+	3578	1789	895	299

Female

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1988	994	497	166
66	2099	1050	525	175
67	2200	1100	550	184
68	2292	1146	573	191
69	2394	1197	599	200
70	2490	1245	623	208
71	2572	1286	643	215
72	2623	1312	656	219
73	2654	1327	664	222
74	2675	1338	669	223
75	2698	1349	675	225
76	2704	1352	676	226
77	2704	1352	676	226
78	2704	1352	676	226
79	2704	1352	676	226
80+	2704	1352	676	226

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2285	1143	572	191
66	2413	1207	604	202
67	2529	1265	633	211
68	2636	1318	659	220
69	2753	1377	689	230
70	2863	1432	716	239
71	2958	1479	740	247
72	3016	1508	754	252
73	3052	1526	763	255
74	3076	1538	769	257
75	3103	1552	776	259
76	3109	1555	778	260
77	3109	1555	778	260
78	3109	1555	778	260
79	3109	1555	778	260
80+	3109	1555	778	260

PLAN C

Male

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3533	1767	884	295
66	3726	1863	932	311
67	3901	1951	976	326
68	4075	2038	1019	340
69	4277	2139	1070	357
70	4462	2231	1116	372
71	4638	2319	1160	387
72	4758	2379	1190	397
73	4846	2423	1212	404
74	4912	2456	1228	410
75	4982	2491	1246	416
76	5023	2512	1256	419
77	5086	2543	1272	424
78	5149	2575	1288	430
79	5212	2606	1303	435
80+	5336	2668	1334	445

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	4066	2033	1017	339
66	4288	2144	1072	358
67	4489	2245	1123	375
68	4689	2345	1173	391
69	4922	2461	1231	411
70	5136	2568	1284	428
71	5337	2669	1335	445
72	5475	2738	1369	457
73	5577	2789	1395	465
74	5653	2827	1414	472
75	5734	2867	1434	478
76	5781	2891	1446	482
77	5854	2927	1464	488
78	5925	2963	1482	494
79	5998	2999	1500	500
80+	6140	3070	1535	512

Female

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3073	1537	769	257
66	3240	1620	810	270
67	3392	1696	848	283
68	3544	1772	886	296
69	3719	1860	930	310
70	3881	1941	971	324
71	4033	2017	1009	337
72	4138	2069	1035	345
73	4214	2107	1054	352
74	4272	2136	1068	356
75	4333	2167	1084	362
76	4368	2184	1092	364
77	4423	2212	1106	369
78	4478	2239	1120	374
79	4533	2267	1134	378
80+	4640	2320	1160	387

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3533	1767	884	295
66	3726	1863	932	311
67	3901	1951	976	326
68	4075	2038	1019	340
69	4277	2139	1070	357
70	4462	2231	1116	372
71	4638	2319	1160	387
72	4758	2379	1190	397
73	4846	2423	1212	404
74	4912	2456	1228	410
75	4982	2491	1246	416
76	5023	2512	1256	419
77	5086	2543	1272	424
78	5149	2575	1288	430
79	5212	2606	1303	435
80+	5336	2668	1334	445

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

PLAN D

Male

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3163	1582	791	264
66	3352	1676	838	280
67	3521	1761	881	294
68	3690	1845	923	308
69	3878	1939	970	324
70	4063	2032	1016	339
71	4224	2112	1056	352
72	4348	2174	1087	363
73	4430	2215	1108	370
74	4496	2248	1124	375
75	4561	2281	1141	381
76	4601	2301	1151	384
77	4661	2331	1166	389
78	4721	2361	1181	394
79	4786	2393	1197	399
80+	4900	2450	1225	409

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3640	1820	910	304
66	3858	1929	965	322
67	4052	2026	1013	338
68	4247	2124	1062	354
69	4463	2232	1116	372
70	4676	2338	1169	390
71	4861	2431	1216	406
72	5003	2502	1251	417
73	5099	2550	1275	425
74	5174	2587	1294	432
75	5249	2625	1313	438
76	5295	2648	1324	442
77	5364	2682	1341	447
78	5433	2717	1359	453
79	5508	2754	1377	459
80+	5639	2820	1410	470

Female

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2751	1376	688	230
66	2915	1458	729	243
67	3062	1531	766	256
68	3209	1605	803	268
69	3373	1687	844	282
70	3533	1767	884	295
71	3673	1837	919	307
72	3781	1891	946	316
73	3853	1927	964	322
74	3910	1955	978	326
75	3967	1984	992	331
76	4001	2001	1001	334
77	4054	2027	1014	338
78	4106	2053	1027	343
79	4162	2081	1041	347
80+	4261	2131	1066	356

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3163	1582	791	264
66	3352	1676	838	280
67	3521	1761	881	294
68	3690	1845	923	308
69	3878	1939	970	324
70	4063	2032	1016	339
71	4224	2112	1056	352
72	4348	2174	1087	363
73	4430	2215	1108	370
74	4496	2248	1124	375
75	4561	2281	1141	381
76	4601	2301	1151	384
77	4661	2331	1166	389
78	4721	2361	1181	394
79	4786	2393	1197	399
80+	4900	2450	1225	409

PLAN F

Male

Preferred Effective Date: 01/15/2021 Plan Code: 5C4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3073	1537	769	257
66	3239	1620	810	270
67	3393	1697	849	283
68	3541	1771	886	296
69	3714	1857	929	310
70	3878	1939	970	324
71	4024	2012	1006	336
72	4133	2067	1034	345
73	4208	2104	1052	351
74	4266	2133	1067	356
75	4325	2163	1082	361
76	4359	2180	1090	364
77	4416	2208	1104	368
78	4472	2236	1118	373
79	4526	2263	1132	378
80+	4632	2316	1158	386

Standard Effective Date: 01/15/2021 Plan Code: 5C6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3536	1768	884	295
66	3728	1864	932	311
67	3905	1953	977	326
68	4075	2038	1019	340
69	4274	2137	1069	357
70	4463	2232	1116	372
71	4631	2316	1158	386
72	4756	2378	1189	397
73	4843	2422	1211	404
74	4909	2455	1228	410
75	4977	2489	1245	415
76	5017	2509	1255	419
77	5082	2541	1271	424
78	5147	2574	1287	429
79	5209	2605	1303	435
80+	5331	2666	1333	445

Female

Preferred Effective Date: 01/15/2021 Plan Code: 5C5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2672	1336	668	223
66	2817	1409	705	235
67	2951	1476	738	246
68	3079	1540	770	257
69	3230	1615	808	270
70	3373	1687	844	282
71	3500	1750	875	292
72	3594	1797	899	300
73	3659	1830	915	305
74	3710	1855	928	310
75	3761	1881	941	314
76	3791	1896	948	316
77	3841	1921	961	321
78	3889	1945	973	325
79	3936	1968	984	328
80+	4028	2014	1007	336

Standard Effective Date: 01/15/2021 Plan Code: 5C7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3073	1537	769	257
66	3239	1620	810	270
67	3393	1697	849	283
68	3541	1771	886	296
69	3714	1857	929	310
70	3878	1939	970	324
71	4024	2012	1006	336
72	4133	2067	1034	345
73	4208	2104	1052	351
74	4266	2133	1067	356
75	4325	2163	1082	361
76	4359	2180	1090	364
77	4416	2208	1104	368
78	4472	2236	1118	373
79	4526	2263	1132	378
80+	4632	2316	1158	386

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

PLAN HDF

Male

Preferred Effective Date: 01/01/2014 Plan Code: 5CM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	423	212	106	36
66	460	230	115	39
67	493	247	124	42
68	516	258	129	43
69	540	270	135	45
70	564	282	141	47
71	585	293	147	49
72	618	309	155	52
73	642	321	161	54
74	668	334	167	56
75	694	347	174	58
76	700	350	175	59
77	724	362	181	61
78	749	375	188	63
79	772	386	193	65
80+	818	409	205	69

Standard Effective Date: 01/01/2014 Plan Code: 5CO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	487	244	122	41
66	529	265	133	45
67	567	284	142	48
68	593	297	149	50
69	622	311	156	52
70	649	325	163	55
71	674	337	169	57
72	711	356	178	60
73	739	370	185	62
74	769	385	193	65
75	798	399	200	67
76	806	403	202	68
77	833	417	209	70
78	861	431	216	72
79	889	445	223	75
80+	942	471	236	79

Female

Preferred Effective Date: 01/01/2014 Plan Code: 5CN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	368	184	92	31
66	400	200	100	34
67	429	215	108	36
68	448	224	112	38
69	470	235	118	40
70	490	245	123	41
71	509	255	128	43
72	537	269	135	45
73	559	280	140	47
74	581	291	146	49
75	603	302	151	51
76	609	305	153	51
77	630	315	158	53
78	651	326	163	55
79	672	336	168	56
80+	712	356	178	60

Standard Effective Date: 01/01/2014 Plan Code: 5CP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	423	212	106	36
66	460	230	115	39
67	493	247	124	42
68	516	258	129	43
69	540	270	135	45
70	564	282	141	47
71	585	293	147	49
72	618	309	155	52
73	642	321	161	54
74	668	334	167	56
75	694	347	174	58
76	700	350	175	59
77	724	362	181	61
78	749	375	188	63
79	772	386	193	65
80+	818	409	205	69

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

PLAN G

Male

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2753	1377	689	230
66	2914	1457	729	243
67	3062	1531	766	256
68	3204	1602	801	267
69	3370	1685	843	281
70	3528	1764	882	294
71	3671	1836	918	306
72	3776	1888	944	315
73	3849	1925	963	321
74	3904	1952	976	326
75	3960	1980	990	330
76	3995	1998	999	333
77	4049	2025	1013	338
78	4102	2051	1026	342
79	4156	2078	1039	347
80+	4255	2128	1064	355

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3168	1584	792	264
66	3353	1677	839	280
67	3524	1762	881	294
68	3687	1844	922	308
69	3879	1940	970	324
70	4060	2030	1015	339
71	4225	2113	1057	353
72	4346	2173	1087	363
73	4430	2215	1108	370
74	4493	2247	1124	375
75	4557	2279	1140	380
76	4598	2299	1150	384
77	4660	2330	1165	389
78	4720	2360	1180	394
79	4783	2392	1196	399
80+	4897	2449	1225	409

Female

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2394	1197	599	200
66	2534	1267	634	212
67	2663	1332	666	222
68	2786	1393	697	233
69	2931	1466	733	245
70	3068	1534	767	256
71	3192	1596	798	266
72	3284	1642	821	274
73	3347	1674	837	279
74	3395	1698	849	283
75	3444	1722	861	287
76	3474	1737	869	290
77	3521	1761	881	294
78	3567	1784	892	298
79	3615	1808	904	302
80+	3701	1851	926	309

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2753	1377	689	230
66	2914	1457	729	243
67	3062	1531	766	256
68	3204	1602	801	267
69	3370	1685	843	281
70	3528	1764	882	294
71	3671	1836	918	306
72	3776	1888	944	315
73	3849	1925	963	321
74	3904	1952	976	326
75	3960	1980	990	330
76	3995	1998	999	333
77	4049	2025	1013	338
78	4102	2051	1026	342
79	4156	2078	1039	347
80+	4255	2128	1064	355

PLAN HDG

Male

Preferred Effective Date: 02/15/2023 Plan Code: 5HO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	461	231	116	39
66	502	251	126	42
67	537	269	135	45
68	562	281	141	47
69	589	295	148	50
70	614	307	154	52
71	638	319	160	54
72	673	337	169	57
73	700	350	175	59
74	728	364	182	61
75	756	378	189	63
76	764	382	191	64
77	789	395	198	66
78	816	408	204	68
79	842	421	211	71
80+	892	446	223	75

Standard Effective Date: 02/15/2023 Plan Code: 5HQ

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	530	265	133	45
66	577	289	145	49
67	618	309	155	52
68	646	323	162	54
69	677	339	170	57
70	707	354	177	59
71	734	367	184	62
72	775	388	194	65
73	806	403	202	68
74	838	419	210	70
75	870	435	218	73
76	879	440	220	74
77	908	454	227	76
78	939	470	235	79
79	969	485	243	81
80+	1027	514	257	86

Female

Preferred Effective Date: 02/15/2023 Plan Code: 5HP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	401	201	101	34
66	436	218	109	37
67	467	234	117	39
68	488	244	122	41
69	512	256	128	43
70	534	267	134	45
71	555	278	139	47
72	586	293	147	49
73	609	305	153	51
74	633	317	159	53
75	658	329	165	55
76	664	332	166	56
77	686	343	172	58
78	710	355	178	60
79	732	366	183	61
80+	776	388	194	65

Standard Effective Date: 02/15/2023 Plan Code: 5HR

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	461	231	116	39
66	502	251	126	42
67	537	269	135	45
68	562	281	141	47
69	589	295	148	50
70	614	307	154	52
71	638	319	160	54
72	673	337	169	57
73	700	350	175	59
74	728	364	182	61
75	756	378	189	63
76	764	382	191	64
77	789	395	198	66
78	816	408	204	68
79	842	421	211	71
80+	892	446	223	75

PLAN K

Male

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1400	700	350	117
66	1504	752	376	126
67	1595	798	399	133
68	1675	838	419	140
69	1759	880	440	147
70	1864	932	466	156
71	1912	956	478	160
72	1948	974	487	163
73	1988	994	497	166
74	2023	1012	506	169
75	2065	1033	517	173
76	2092	1046	523	175
77	2108	1054	527	176
78	2124	1062	531	177
79	2137	1069	535	179
80+	2161	1081	541	181

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1612	806	403	135
66	1730	865	433	145
67	1835	918	459	153
68	1928	964	482	161
69	2025	1013	507	169
70	2146	1073	537	179
71	2200	1100	550	184
72	2242	1121	561	187
73	2288	1144	572	191
74	2329	1165	583	195
75	2377	1189	595	199
76	2408	1204	602	201
77	2426	1213	607	203
78	2445	1223	612	204
79	2460	1230	615	205
80+	2487	1244	622	208

Female

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1218	609	305	102
66	1308	654	327	109
67	1387	694	347	116
68	1457	729	365	122
69	1530	765	383	128
70	1621	811	406	136
71	1663	832	416	139
72	1694	847	424	142
73	1729	865	433	145
74	1760	880	440	147
75	1796	898	449	150
76	1819	910	455	152
77	1833	917	459	153
78	1847	924	462	154
79	1859	930	465	155
80+	1879	940	470	157

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1400	700	350	117
66	1504	752	376	126
67	1595	798	399	133
68	1675	838	419	140
69	1759	880	440	147
70	1864	932	466	156
71	1912	956	478	160
72	1948	974	487	163
73	1988	994	497	166
74	2023	1012	506	169
75	2065	1033	517	173
76	2092	1046	523	175
77	2108	1054	527	176
78	2124	1062	531	177
79	2137	1069	535	179
80+	2161	1081	541	181

PLAN L

Male

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1966	983	492	164
66	2117	1059	530	177
67	2240	1120	560	187
68	2357	1179	590	197
69	2479	1240	620	207
70	2617	1309	655	219
71	2690	1345	673	225
72	2740	1370	685	229
73	2796	1398	699	233
74	2847	1424	712	238
75	2902	1451	726	242
76	2941	1471	736	246
77	2964	1482	741	247
78	2989	1495	748	250
79	3004	1502	751	251
80+	3034	1517	759	253

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2263	1132	566	189
66	2436	1218	609	203
67	2578	1289	645	215
68	2713	1357	679	227
69	2853	1427	714	238
70	3012	1506	753	251
71	3096	1548	774	258
72	3153	1577	789	263
73	3217	1609	805	269
74	3277	1639	820	274
75	3340	1670	835	279
76	3384	1692	846	282
77	3411	1706	853	285
78	3440	1720	860	287
79	3457	1729	865	289
80+	3492	1746	873	291

Female

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1710	855	428	143
66	1841	921	461	154
67	1948	974	487	163
68	2050	1025	513	171
69	2156	1078	539	180
70	2276	1138	569	190
71	2340	1170	585	195
72	2383	1192	596	199
73	2431	1216	608	203
74	2476	1238	619	207
75	2524	1262	631	211
76	2557	1279	640	214
77	2578	1289	645	215
78	2599	1300	650	217
79	2612	1306	653	218
80+	2639	1320	660	220

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1966	983	492	164
66	2117	1059	530	177
67	2240	1120	560	187
68	2357	1179	590	197
69	2479	1240	620	207
70	2617	1309	655	219
71	2690	1345	673	225
72	2740	1370	685	229
73	2796	1398	699	233
74	2847	1424	712	238
75	2902	1451	726	242
76	2941	1471	736	246
77	2964	1482	741	247
78	2989	1495	748	250
79	3004	1502	751	251
80+	3034	1517	759	253

PLAN N

Male

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2986	1493	747	249
66	3164	1582	791	264
67	3330	1665	833	278
68	3494	1747	874	292
69	3680	1840	920	307
70	3855	1928	964	322
71	4020	2010	1005	335
72	4143	2072	1036	346
73	4227	2114	1057	353
74	4294	2147	1074	358
75	4363	2182	1091	364
76	4408	2204	1102	368
77	4478	2239	1120	374
78	4545	2273	1137	379
79	4616	2308	1154	385
80+	4751	2376	1188	396

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3436	1718	859	287
66	3641	1821	911	304
67	3833	1917	959	320
68	4021	2011	1006	336
69	4235	2118	1059	353
70	4436	2218	1109	370
71	4626	2313	1157	386
72	4768	2384	1192	398
73	4865	2433	1217	406
74	4942	2471	1236	412
75	5021	2511	1256	419
76	5073	2537	1269	423
77	5153	2577	1289	430
78	5231	2616	1308	436
79	5312	2656	1328	443
80+	5468	2734	1367	456

Female

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2597	1299	650	217
66	2752	1376	688	230
67	2896	1448	724	242
68	3038	1519	760	254
69	3200	1600	800	267
70	3352	1676	838	280
71	3496	1748	874	292
72	3603	1802	901	301
73	3676	1838	919	307
74	3734	1867	934	312
75	3794	1897	949	317
76	3833	1917	959	320
77	3894	1947	974	325
78	3953	1977	989	330
79	4014	2007	1004	335
80+	4132	2066	1033	345

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2986	1493	747	249
66	3164	1582	791	264
67	3330	1665	833	278
68	3494	1747	874	292
69	3680	1840	920	307
70	3855	1928	964	322
71	4020	2010	1005	335
72	4143	2072	1036	346
73	4227	2114	1057	353
74	4294	2147	1074	358
75	4363	2182	1091	364
76	4408	2204	1102	368
77	4478	2239	1120	374
78	4545	2273	1137	379
79	4616	2308	1154	385
80+	4751	2376	1188	396

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