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.

In Colorado, it is a requirement that all plans offered by United American Insurance Company are available to under age 65 Medicare-qualified individuals.

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	2518	1259	630	210	5EW	04/15/2019
B	7597	3799	1900	634	5F0	02/15/2024
C	7788	3894	1947	649	5F4	02/15/2024
D	4935	2468	1234	412	5F8	02/15/2024
F	6352	3176	1588	530	5FC	02/15/2024
HDF	2043	1022	511	171	5FG	02/15/2024
G	4589	2295	1148	383	5FK	02/15/2024
HDG	712	356	178	60	5I6	02/15/2024
K	1958	979	490	164	5FO	05/15/2020
L	2777	1389	695	232	5FS	05/15/2020

Standard

Plan	A	SA	Q	M	Plan Code	Effective Date
A	2898	1449	725	242	5EY	04/15/2019
B	8742	4371	2186	729	5F2	02/15/2024
C	8962	4481	2241	747	5F6	02/15/2024
D	5679	2840	1420	474	5FA	02/15/2024
F	7310	3655	1828	610	5FE	02/15/2024
HDF	2351	1176	588	196	5FI	02/15/2024
G	5281	2641	1321	441	5FM	02/15/2024
HDG	820	410	205	69	5I8	02/15/2024
K	2253	1127	564	188	5FQ	05/15/2020
L	3195	1598	799	267	5FU	05/15/2020

Female

Preferred

Plan	A	SA	Q	M	Plan Code	Effective Date
A	2191	1096	548	183	5EX	04/15/2019
B	6608	3304	1652	551	5F1	02/15/2024
C	6774	3387	1694	565	5F5	02/15/2024
D	4293	2147	1074	358	5F9	02/15/2024
F	5526	2763	1382	461	5FD	02/15/2024
HDF	1777	889	445	149	5FH	02/15/2024
G	3992	1996	998	333	5FL	02/15/2024
HDG	620	310	155	52	5I7	02/15/2024
K	1703	852	426	142	5FP	05/15/2020
L	2415	1208	604	202	5FT	05/15/2020

Standard

Plan	A	SA	Q	M	Plan Code	Effective Date
A	2518	1259	630	210	5EZ	04/15/2019
B	7597	3799	1900	634	5F3	02/15/2024
C	7788	3894	1947	649	5F7	02/15/2024
D	4935	2468	1234	412	5FB	02/15/2024
F	6352	3176	1588	530	5FF	02/15/2024
HDF	2043	1022	511	171	5FJ	02/15/2024
G	4589	2295	1148	383	5FN	02/15/2024
HDG	712	356	178	60	5I9	02/15/2024
K	1958	979	490	164	5FR	05/15/2020
L	2777	1389	695	232	5FV	05/15/2020

*** NOTE: In COLORADO, 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	2518	1259	630	210	5EW	04/15/2019
B	7597	3799	1900	634	5F0	02/15/2024
C	7788	3894	1947	649	5F4	02/15/2024
D	4935	2468	1234	412	5F8	02/15/2024
F	6352	3176	1588	530	5FC	02/15/2024
HDF	2043	1022	511	171	5FG	02/15/2024
G	4589	2295	1148	383	5FK	02/15/2024
HDG	712	356	178	60	5I6	02/15/2024
K	1958	979	490	164	5FO	05/15/2020
L	2777	1389	695	232	5FS	05/15/2020
N	3537	1769	885	295	5FW	02/15/2024

Standard

Plan	A	SA	Q	M	Plan Code	Effective Date
A	2898	1449	725	242	5EY	04/15/2019
B	8742	4371	2186	729	5F2	02/15/2024
C	8962	4481	2241	747	5F6	02/15/2024
D	5679	2840	1420	474	5FA	02/15/2024
F	7310	3655	1828	610	5FE	02/15/2024
HDF	2351	1176	588	196	5FI	02/15/2024
G	5281	2641	1321	441	5FM	02/15/2024
HDG	820	410	205	69	5I8	02/15/2024
K	2253	1127	564	188	5FQ	05/15/2020
L	3195	1598	799	267	5FU	05/15/2020
N	4070	2035	1018	340	5FY	02/15/2024

Female

Preferred

Plan	A	SA	Q	M	Plan Code	Effective Date
A	2191	1096	548	183	5EX	04/15/2019
B	6608	3304	1652	551	5F1	02/15/2024
C	6774	3387	1694	565	5F5	02/15/2024
D	4293	2147	1074	358	5F9	02/15/2024
F	5526	2763	1382	461	5FD	02/15/2024
HDF	1777	889	445	149	5FH	02/15/2024
G	3992	1996	998	333	5FL	02/15/2024
HDG	620	310	155	52	5I7	02/15/2024
K	1703	852	426	142	5FP	05/15/2020
L	2415	1208	604	202	5FT	05/15/2020
N	3077	1539	770	257	5FX	02/15/2024

Standard

Plan	A	SA	Q	M	Plan Code	Effective Date
A	2518	1259	630	210	5EZ	04/15/2019
B	7597	3799	1900	634	5F3	02/15/2024
C	7788	3894	1947	649	5F7	02/15/2024
D	4935	2468	1234	412	5FB	02/15/2024
F	6352	3176	1588	530	5FF	02/15/2024
HDF	2043	1022	511	171	5FJ	02/15/2024
G	4589	2295	1148	383	5FN	02/15/2024
HDG	712	356	178	60	5I9	02/15/2024
K	1958	979	490	164	5FR	05/15/2020
L	2777	1389	695	232	5FV	05/15/2020
N	3537	1769	885	295	5FZ	02/15/2024

*** NOTE: In COLORADO, 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: 04/15/2019 Plan Code: 5A4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1466	733	367	123
66	1542	771	386	129
67	1602	801	401	134
68	1660	830	415	139
69	1724	862	431	144
70	1788	894	447	149
71	1833	917	459	153
72	1851	926	463	155
73	1881	941	471	157
74	1899	950	475	159
75	1922	961	481	161
76	1931	966	483	161
77	1931	966	483	161
78	1931	966	483	161
79	1931	966	483	161
80+	1931	966	483	161

Standard Effective Date: 04/15/2019 Plan Code: 5A6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1687	844	422	141
66	1775	888	444	148
67	1844	922	461	154
68	1910	955	478	160
69	1984	992	496	166
70	2057	1029	515	172
71	2109	1055	528	176
72	2130	1065	533	178
73	2164	1082	541	181
74	2185	1093	547	183
75	2212	1106	553	185
76	2222	1111	556	186
77	2222	1111	556	186
78	2222	1111	556	186
79	2222	1111	556	186
80+	2222	1111	556	186

Female

Preferred Effective Date: 04/15/2019 Plan Code: 5A5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1276	638	319	107
66	1341	671	336	112
67	1394	697	349	117
68	1444	722	361	121
69	1499	750	375	125
70	1555	778	389	130
71	1594	797	399	133
72	1610	805	403	135
73	1636	818	409	137
74	1652	826	413	138
75	1672	836	418	140
76	1680	840	420	140
77	1680	840	420	140
78	1680	840	420	140
79	1680	840	420	140
80+	1680	840	420	140

Standard Effective Date: 04/15/2019 Plan Code: 5A7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1466	733	367	123
66	1542	771	386	129
67	1602	801	401	134
68	1660	830	415	139
69	1724	862	431	144
70	1788	894	447	149
71	1833	917	459	153
72	1851	926	463	155
73	1881	941	471	157
74	1899	950	475	159
75	1922	961	481	161
76	1931	966	483	161
77	1931	966	483	161
78	1931	966	483	161
79	1931	966	483	161
80+	1931	966	483	161

PLAN B

Male

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2762	1381	691	231
66	2918	1459	730	244
67	3053	1527	764	255
68	3178	1589	795	265
69	3317	1659	830	277
70	3454	1727	864	288
71	3556	1778	889	297
72	3626	1813	907	303
73	3707	1854	927	309
74	3769	1885	943	315
75	3837	1919	960	320
76	3884	1942	971	324
77	3893	1947	974	325
78	3905	1953	977	326
79	3915	1958	979	327
80+	3915	1958	979	327

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3178	1589	795	265
66	3358	1679	840	280
67	3514	1757	879	293
68	3658	1829	915	305
69	3817	1909	955	319
70	3975	1988	994	332
71	4093	2047	1024	342
72	4172	2086	1043	348
73	4266	2133	1067	356
74	4337	2169	1085	362
75	4416	2208	1104	368
76	4470	2235	1118	373
77	4480	2240	1120	374
78	4493	2247	1124	375
79	4506	2253	1127	376
80+	4506	2253	1127	376

Female

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2402	1201	601	201
66	2538	1269	635	212
67	2656	1328	664	222
68	2765	1383	692	231
69	2885	1443	722	241
70	3004	1502	751	251
71	3094	1547	774	258
72	3154	1577	789	263
73	3225	1613	807	269
74	3278	1639	820	274
75	3338	1669	835	279
76	3379	1690	845	282
77	3386	1693	847	283
78	3396	1698	849	283
79	3406	1703	852	284
80+	3406	1703	852	284

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2762	1381	691	231
66	2918	1459	730	244
67	3053	1527	764	255
68	3178	1589	795	265
69	3317	1659	830	277
70	3454	1727	864	288
71	3556	1778	889	297
72	3626	1813	907	303
73	3707	1854	927	309
74	3769	1885	943	315
75	3837	1919	960	320
76	3884	1942	971	324
77	3893	1947	974	325
78	3905	1953	977	326
79	3915	1958	979	327
80+	3915	1958	979	327

PLAN C

Male

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3022	1511	756	252
66	3185	1593	797	266
67	3329	1665	833	278
68	3472	1736	868	290
69	3645	1823	912	304
70	3810	1905	953	318
71	3941	1971	986	329
72	4047	2024	1012	338
73	4163	2082	1041	347
74	4257	2129	1065	355
75	4356	2178	1089	363
76	4435	2218	1109	370
77	4513	2257	1129	377
78	4590	2295	1148	383
79	4670	2335	1168	390
80+	4799	2400	1200	400

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3478	1739	870	290
66	3665	1833	917	306
67	3831	1916	958	320
68	3995	1998	999	333
69	4195	2098	1049	350
70	4384	2192	1096	366
71	4535	2268	1134	378
72	4657	2329	1165	389
73	4791	2396	1198	400
74	4899	2450	1225	409
75	5013	2507	1254	418
76	5104	2552	1276	426
77	5194	2597	1299	433
78	5282	2641	1321	441
79	5374	2687	1344	448
80+	5522	2761	1381	461

Female

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2629	1315	658	220
66	2770	1385	693	231
67	2896	1448	724	242
68	3020	1510	755	252
69	3171	1586	793	265
70	3314	1657	829	277
71	3428	1714	857	286
72	3520	1760	880	294
73	3621	1811	906	302
74	3703	1852	926	309
75	3789	1895	948	316
76	3858	1929	965	322
77	3926	1963	982	328
78	3993	1997	999	333
79	4063	2032	1016	339
80+	4174	2087	1044	348

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3022	1511	756	252
66	3185	1593	797	266
67	3329	1665	833	278
68	3472	1736	868	290
69	3645	1823	912	304
70	3810	1905	953	318
71	3941	1971	986	329
72	4047	2024	1012	338
73	4163	2082	1041	347
74	4257	2129	1065	355
75	4356	2178	1089	363
76	4435	2218	1109	370
77	4513	2257	1129	377
78	4590	2295	1148	383
79	4670	2335	1168	390
80+	4799	2400	1200	400

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	2906	1453	727	243
66	3080	1540	770	257
67	3232	1616	808	270
68	3381	1691	846	282
69	3556	1778	889	297
70	3729	1865	933	311
71	3869	1935	968	323
72	3976	1988	994	332
73	4098	2049	1025	342
74	4195	2098	1049	350
75	4300	2150	1075	359
76	4379	2190	1095	365
77	4460	2230	1115	372
78	4542	2271	1136	379
79	4626	2313	1157	386
80+	4761	2381	1191	397

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3344	1672	836	279
66	3544	1772	886	296
67	3719	1860	930	310
68	3891	1946	973	325
69	4093	2047	1024	342
70	4292	2146	1073	358
71	4453	2227	1114	372
72	4576	2288	1144	382
73	4716	2358	1179	393
74	4828	2414	1207	403
75	4948	2474	1237	413
76	5039	2520	1260	420
77	5132	2566	1283	428
78	5227	2614	1307	436
79	5323	2662	1331	444
80+	5479	2740	1370	457

Female

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2528	1264	632	211
66	2679	1340	670	224
67	2811	1406	703	235
68	2941	1471	736	246
69	3094	1547	774	258
70	3244	1622	811	271
71	3366	1683	842	281
72	3459	1730	865	289
73	3565	1783	892	298
74	3649	1825	913	305
75	3740	1870	935	312
76	3809	1905	953	318
77	3880	1940	970	324
78	3951	1976	988	330
79	4024	2012	1006	336
80+	4141	2071	1036	346

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2906	1453	727	243
66	3080	1540	770	257
67	3232	1616	808	270
68	3381	1691	846	282
69	3556	1778	889	297
70	3729	1865	933	311
71	3869	1935	968	323
72	3976	1988	994	332
73	4098	2049	1025	342
74	4195	2098	1049	350
75	4300	2150	1075	359
76	4379	2190	1095	365
77	4460	2230	1115	372
78	4542	2271	1136	379
79	4626	2313	1157	386
80+	4761	2381	1191	397

PLAN F

Male

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2902	1451	726	242
66	3060	1530	765	255
67	3197	1599	800	267
68	3333	1667	834	278
69	3492	1746	873	291
70	3651	1826	913	305
71	3778	1889	945	315
72	3878	1939	970	324
73	3991	1996	998	333
74	4079	2040	1020	340
75	4174	2087	1044	348
76	4247	2124	1062	354
77	4323	2162	1081	361
78	4397	2199	1100	367
79	4472	2236	1118	373
80+	4596	2298	1149	383

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3339	1670	835	279
66	3521	1761	881	294
67	3678	1839	920	307
68	3836	1918	959	320
69	4019	2010	1005	335
70	4202	2101	1051	351
71	4347	2174	1087	363
72	4463	2232	1116	372
73	4593	2297	1149	383
74	4694	2347	1174	392
75	4803	2402	1201	401
76	4888	2444	1222	408
77	4975	2488	1244	415
78	5060	2530	1265	422
79	5146	2573	1287	429
80+	5288	2644	1322	441

Female

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2524	1262	631	211
66	2662	1331	666	222
67	2780	1390	695	232
68	2899	1450	725	242
69	3038	1519	760	254
70	3176	1588	794	265
71	3286	1643	822	274
72	3373	1687	844	282
73	3472	1736	868	290
74	3548	1774	887	296
75	3631	1816	908	303
76	3695	1848	924	308
77	3761	1881	941	314
78	3825	1913	957	319
79	3890	1945	973	325
80+	3997	1999	1000	334

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2902	1451	726	242
66	3060	1530	765	255
67	3197	1599	800	267
68	3333	1667	834	278
69	3492	1746	873	291
70	3651	1826	913	305
71	3778	1889	945	315
72	3878	1939	970	324
73	3991	1996	998	333
74	4079	2040	1020	340
75	4174	2087	1044	348
76	4247	2124	1062	354
77	4323	2162	1081	361
78	4397	2199	1100	367
79	4472	2236	1118	373
80+	4596	2298	1149	383

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

PLAN HDF

Male

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	570	285	143	48
66	619	310	155	52
67	662	331	166	56
68	690	345	173	58
69	724	362	181	61
70	757	379	190	64
71	783	392	196	66
72	824	412	206	69
73	869	435	218	73
74	910	455	228	76
75	954	477	239	80
76	969	485	243	81
77	989	495	248	83
78	1005	503	252	84
79	1042	521	261	87
80+	1121	561	281	94

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	656	328	164	55
66	713	357	179	60
67	762	381	191	64
68	794	397	199	67
69	833	417	209	70
70	871	436	218	73
71	901	451	226	76
72	949	475	238	80
73	1000	500	250	84
74	1047	524	262	88
75	1097	549	275	92
76	1115	558	279	93
77	1138	569	285	95
78	1156	578	289	97
79	1200	600	300	100
80+	1290	645	323	108

Female

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	496	248	124	42
66	539	270	135	45
67	576	288	144	48
68	600	300	150	50
69	630	315	158	53
70	659	330	165	55
71	681	341	171	57
72	717	359	180	60
73	756	378	189	63
74	792	396	198	66
75	830	415	208	70
76	843	422	211	71
77	860	430	215	72
78	874	437	219	73
79	907	454	227	76
80+	975	488	244	82

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	570	285	143	48
66	619	310	155	52
67	662	331	166	56
68	690	345	173	58
69	724	362	181	61
70	757	379	190	64
71	783	392	196	66
72	824	412	206	69
73	869	435	218	73
74	910	455	228	76
75	954	477	239	80
76	969	485	243	81
77	989	495	248	83
78	1005	503	252	84
79	1042	521	261	87
80+	1121	561	281	94

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	2225	1113	557	186
66	2356	1178	589	197
67	2472	1236	618	206
68	2587	1294	647	216
69	2720	1360	680	227
70	2853	1427	714	238
71	2956	1478	739	247
72	3040	1520	760	254
73	3132	1566	783	261
74	3206	1603	802	268
75	3284	1642	821	274
76	3347	1674	837	279
77	3409	1705	853	285
78	3471	1736	868	290
79	3533	1767	884	295
80+	3637	1819	910	304

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2560	1280	640	214
66	2711	1356	678	226
67	2845	1423	712	238
68	2977	1489	745	249
69	3130	1565	783	261
70	3283	1642	821	274
71	3402	1701	851	284
72	3498	1749	875	292
73	3605	1803	902	301
74	3689	1845	923	308
75	3779	1890	945	315
76	3852	1926	963	321
77	3923	1962	981	327
78	3994	1997	999	333
79	4066	2033	1017	339
80+	4185	2093	1047	349

Female

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1935	968	484	162
66	2049	1025	513	171
67	2151	1076	538	180
68	2250	1125	563	188
69	2366	1183	592	198
70	2481	1241	621	207
71	2571	1286	643	215
72	2644	1322	661	221
73	2725	1363	682	228
74	2789	1395	698	233
75	2857	1429	715	239
76	2911	1456	728	243
77	2965	1483	742	248
78	3019	1510	755	252
79	3073	1537	769	257
80+	3163	1582	791	264

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2225	1113	557	186
66	2356	1178	589	197
67	2472	1236	618	206
68	2587	1294	647	216
69	2720	1360	680	227
70	2853	1427	714	238
71	2956	1478	739	247
72	3040	1520	760	254
73	3132	1566	783	261
74	3206	1603	802	268
75	3284	1642	821	274
76	3347	1674	837	279
77	3409	1705	853	285
78	3471	1736	868	290
79	3533	1767	884	295
80+	3637	1819	910	304

PLAN HDG

Male

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	570	285	143	48
66	619	310	155	52
67	662	331	166	56
68	690	345	173	58
69	724	362	181	61
70	757	379	190	64
71	783	392	196	66
72	824	412	206	69
73	869	435	218	73
74	910	455	228	76
75	954	477	239	80
76	969	485	243	81
77	989	495	248	83
78	1005	503	252	84
79	1042	521	261	87
80+	1121	561	281	94

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	656	328	164	55
66	713	357	179	60
67	762	381	191	64
68	794	397	199	67
69	833	417	209	70
70	871	436	218	73
71	901	451	226	76
72	949	475	238	80
73	1000	500	250	84
74	1047	524	262	88
75	1097	549	275	92
76	1115	558	279	93
77	1138	569	285	95
78	1156	578	289	97
79	1200	600	300	100
80+	1290	645	323	108

Female

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	496	248	124	42
66	539	270	135	45
67	576	288	144	48
68	600	300	150	50
69	630	315	158	53
70	659	330	165	55
71	681	341	171	57
72	717	359	180	60
73	756	378	189	63
74	792	396	198	66
75	830	415	208	70
76	843	422	211	71
77	860	430	215	72
78	874	437	219	73
79	907	454	227	76
80+	975	488	244	82

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	570	285	143	48
66	619	310	155	52
67	662	331	166	56
68	690	345	173	58
69	724	362	181	61
70	757	379	190	64
71	783	392	196	66
72	824	412	206	69
73	869	435	218	73
74	910	455	228	76
75	954	477	239	80
76	969	485	243	81
77	989	495	248	83
78	1005	503	252	84
79	1042	521	261	87
80+	1121	561	281	94

PLAN K

Male

Preferred Effective Date: 05/15/2020 Plan Code: P44

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1265	633	317	106
66	1353	677	339	113
67	1434	717	359	120
68	1504	752	376	126
69	1581	791	396	132
70	1667	834	417	139
71	1714	857	429	143
72	1746	873	437	146
73	1777	889	445	149
74	1805	903	452	151
75	1848	924	462	154
76	1871	936	468	156
77	1890	945	473	158
78	1910	955	478	160
79	1930	965	483	161
80+	1958	979	490	164

Standard Effective Date: 05/15/2020 Plan Code: P46

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1455	728	364	122
66	1557	779	390	130
67	1651	826	413	138
68	1730	865	433	145
69	1819	910	455	152
70	1918	959	480	160
71	1973	987	494	165
72	2009	1005	503	168
73	2045	1023	512	171
74	2077	1039	520	174
75	2126	1063	532	178
76	2153	1077	539	180
77	2175	1088	544	182
78	2197	1099	550	184
79	2221	1111	556	186
80+	2253	1127	564	188

Female

Preferred Effective Date: 05/15/2020 Plan Code: P45

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1100	550	275	92
66	1177	589	295	99
67	1248	624	312	104
68	1308	654	327	109
69	1375	688	344	115
70	1450	725	363	121
71	1491	746	373	125
72	1519	760	380	127
73	1546	773	387	129
74	1570	785	393	131
75	1607	804	402	134
76	1628	814	407	136
77	1644	822	411	137
78	1661	831	416	139
79	1679	840	420	140
80+	1703	852	426	142

Standard Effective Date: 05/15/2020 Plan Code: P47

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1265	633	317	106
66	1353	677	339	113
67	1434	717	359	120
68	1504	752	376	126
69	1581	791	396	132
70	1667	834	417	139
71	1714	857	429	143
72	1746	873	437	146
73	1777	889	445	149
74	1805	903	452	151
75	1848	924	462	154
76	1871	936	468	156
77	1890	945	473	158
78	1910	955	478	160
79	1930	965	483	161
80+	1958	979	490	164

PLAN L

Male

Preferred Effective Date: 05/15/2020 Plan Code: P60

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1793	897	449	150
66	1925	963	482	161
67	2035	1018	509	170
68	2137	1069	535	179
69	2247	1124	562	188
70	2369	1185	593	198
71	2433	1217	609	203
72	2479	1240	620	207
73	2530	1265	633	211
74	2570	1285	643	215
75	2625	1313	657	219
76	2658	1329	665	222
77	2686	1343	672	224
78	2716	1358	679	227
79	2742	1371	686	229
80+	2777	1389	695	232

Standard Effective Date: 05/15/2020 Plan Code: P62

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2063	1032	516	172
66	2215	1108	554	185
67	2341	1171	586	196
68	2459	1230	615	205
69	2586	1293	647	216
70	2726	1363	682	228
71	2800	1400	700	234
72	2853	1427	714	238
73	2912	1456	728	243
74	2957	1479	740	247
75	3021	1511	756	252
76	3059	1530	765	255
77	3091	1546	773	258
78	3125	1563	782	261
79	3155	1578	789	263
80+	3195	1598	799	267

Female

Preferred Effective Date: 05/15/2020 Plan Code: P61

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1560	780	390	130
66	1674	837	419	140
67	1770	885	443	148
68	1859	930	465	155
69	1955	978	489	163
70	2061	1031	516	172
71	2116	1058	529	177
72	2156	1078	539	180
73	2201	1101	551	184
74	2235	1118	559	187
75	2283	1142	571	191
76	2312	1156	578	193
77	2336	1168	584	195
78	2362	1181	591	197
79	2385	1193	597	199
80+	2415	1208	604	202

Standard Effective Date: 05/15/2020 Plan Code: P63

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1793	897	449	150
66	1925	963	482	161
67	2035	1018	509	170
68	2137	1069	535	179
69	2247	1124	562	188
70	2369	1185	593	198
71	2433	1217	609	203
72	2479	1240	620	207
73	2530	1265	633	211
74	2570	1285	643	215
75	2625	1313	657	219
76	2658	1329	665	222
77	2686	1343	672	224
78	2716	1358	679	227
79	2742	1371	686	229
80+	2777	1389	695	232

PLAN N

Male

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2102	1051	526	176
66	2229	1115	558	186
67	2344	1172	586	196
68	2454	1227	614	205
69	2588	1294	647	216
70	2711	1356	678	226
71	2821	1411	706	236
72	2907	1454	727	243
73	2997	1499	750	250
74	3072	1536	768	256
75	3154	1577	789	263
76	3219	1610	805	269
77	3286	1643	822	274
78	3354	1677	839	280
79	3418	1709	855	285
80+	3537	1769	885	295

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2419	1210	605	202
66	2565	1283	642	214
67	2698	1349	675	225
68	2824	1412	706	236
69	2978	1489	745	249
70	3119	1560	780	260
71	3246	1623	812	271
72	3345	1673	837	279
73	3449	1725	863	288
74	3535	1768	884	295
75	3629	1815	908	303
76	3704	1852	926	309
77	3782	1891	946	316
78	3859	1930	965	322
79	3933	1967	984	328
80+	4070	2035	1018	340

Female

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1828	914	457	153
66	1939	970	485	162
67	2039	1020	510	170
68	2135	1068	534	178
69	2251	1126	563	188
70	2358	1179	590	197
71	2453	1227	614	205
72	2529	1265	633	211
73	2607	1304	652	218
74	2672	1336	668	223
75	2743	1372	686	229
76	2800	1400	700	234
77	2859	1430	715	239
78	2917	1459	730	244
79	2973	1487	744	248
80+	3077	1539	770	257

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2102	1051	526	176
66	2229	1115	558	186
67	2344	1172	586	196
68	2454	1227	614	205
69	2588	1294	647	216
70	2711	1356	678	226
71	2821	1411	706	236
72	2907	1454	727	243
73	2997	1499	750	250
74	3072	1536	768	256
75	3154	1577	789	263
76	3219	1610	805	269
77	3286	1643	822	274
78	3354	1677	839	280
79	3418	1709	855	285
80+	3537	1769	885	295

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