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				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.

UNDER AGE 65 GUARANTEED ISSUE PERIOD (G/I)

	Male									Fem	ale		
Non-Tob	acco Use	r					Non-Tob	acco Use	r				
	1		0	M	Plan Code	Effective Date				0	M	Plan Code	Effective Date
Plan	Α	SA	Q	IVI	Plan Code	Effective Date	Plan	Α	SA	Q	IVI	Plan Code	Effective Date
Α	4949	2475	1238	413	5EW	05/15/2023	Α	4949	2475	1238	413	5EX	05/15/2023
В	9029	4515	2258	753	5F0	05/15/2024	В	9029	4515	2258	753	5F1	05/15/2024
С	9438	4719	2360	787	5F4	05/15/2024	С	9438	4719	2360	787	5F5	05/15/2024
D	8729	4365	2183	728	5F8	05/15/2024	D	8729	4365	2183	728	5F9	05/15/2024
F	7428	3714	1857	619	5FC	05/15/2024	F	7428	3714	1857	619	5FD	05/15/2024
HDF	4234	2117	1059	353	5FG	05/15/2024	HDF	4234	2117	1059	353	5FH	05/15/2024
G	9535	4768	2384	795	5FK	05/15/2024	G	9535	4768	2384	795	5FL	05/15/2024
HDG	3920	1960	980	327	516	05/15/2024	HDG	3920	1960	980	327	517	05/15/2024
К	4332	2166	1083	361	5FO	05/15/2023	K	4332	2166	1083	361	5FP	05/15/2023
L	6048	3024	1512	504	5FS	05/15/2023	L	6048	3024	1512	504	5FT	05/15/2023
N	8598	4299	2150	717	5FW	05/15/2024	N	8598	4299	2150	717	5FX	05/15/2024
Tobacco	User						Tobacco	User					
Plan	A	SA	Q	M	Plan Code	Effective Date	Plan	Α	SA	Q	M	Plan Code	Effective Date
Α	5692	2846	1423	475	5EY	05/15/2023	Α	5692	2846	1423	475	5EZ	05/15/2023
В	10386	5193	2597	866	5F2	05/15/2024	В	10386	5193	2597	866	5F3	05/15/2024
С	10856	5428	2714	905	5F6	05/15/2024	С	10856	5428	2714	905	5F7	05/15/2024
D	10041	5021	2511	837	5FA	05/15/2024	D	10041	5021	2511	837	5FB	05/15/2024
F	8544	4272	2136	712	5FE	05/15/2024	F	8544	4272	2136	712	5FF	05/15/2024
HDF	4870	2435	1218	406	5FI	05/15/2024	HDF	4870	2435	1218	406	5FJ	05/15/2024
G	10967	5484	2742	914	5FM	05/15/2024	G	10967	5484	2742	914	5FN	05/15/2024
HDG	4509	2255	1128	376	518	05/15/2024	HDG	4509	2255	1128	376	519	05/15/2024
K	4983	2492	1246	416	5FQ	05/15/2023	K	4983	2492	1246	416	5FR	05/15/2023
L	6957	3479	1740	580	5FU	05/15/2023	L	6957	3479	1740	580	5FV	05/15/2023
N	9890	4945	2473	825	5FY	05/15/2024	N	9890	4945	2473	825	5FZ	05/15/2024

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									Fem	ale		
Non-Tob	acco Use	r					Non-Tobacco User						
Plan	Α	SA	Q	M	Plan Code	Effective Date	Plan	Α	SA	Q	M	Plan Code	Effective Date
Α	4949	2475	1238	413	5EW	05/15/2023	Α	4949	2475	1238	413	5EX	05/15/2023
В	9029	4515	2258	753	5F0	05/15/2024	В	9029	4515	2258	753	5F1	05/15/2024
С	9438	4719	2360	787	5F4	05/15/2024	С	9438	4719	2360	787	5F5	05/15/2024
D	8729	4365	2183	728	5F8	05/15/2024	D	8729	4365	2183	728	5F9	05/15/2024
F	7428	3714	1857	619	5FC	05/15/2024	F	7428	3714	1857	619	5FD	05/15/2024
HDF	4234	2117	1059	353	5FG	05/15/2024	HDF	4234	2117	1059	353	5FH	05/15/2024
G	9535	4768	2384	795	5FK	05/15/2024	G	9535	4768	2384	795	5FL	05/15/2024
HDG	3920	1960	980	327	516	05/15/2024	HDG	3920	1960	980	327	517	05/15/2024
K	4332	2166	1083	361	5FO	05/15/2023	K	4332	2166	1083	361	5FP	05/15/2023
L	6048	3024	1512	504	5FS	05/15/2023	L	6048	3024	1512	504	5FT	05/15/2023
N	8598	4299	2150	717	5FW	05/15/2024	N	8598	4299	2150	717	5FX	05/15/2024
Tobacco	Heer		ı				Tobacco	Heer					
								1					
Plan	Α	SA	Q	M	Plan Code	Effective Date	Plan	Α	SA	Q	M	Plan Code	Effective Date
Α	5692	2846	1423	475	5EY	05/15/2023	Α	5692	2846	1423	475	5EZ	05/15/2023
В	10386	5193	2597	866	5F2	05/15/2024	В	10386	5193	2597	866	5F3	05/15/2024
С	10856	5428	2714	905	5F6	05/15/2024	С	10856	5428	2714	905	5F7	05/15/2024
D	10041	5021	2511	837	5FA	05/15/2024	D	10041	5021	2511	837	5FB	05/15/2024
F	8544	4272	2136	712	5FE	05/15/2024	F	8544	4272	2136	712	5FF	05/15/2024
HDF	4870	2435	1218	406	5FI	05/15/2024	HDF	4870	2435	1218	406	5FJ	05/15/2024
G	10967	5484	2742	914	5FM	05/15/2024	G	10967	5484	2742	914	5FN	05/15/2024
HDG	4509	2255	1128	376	518	05/15/2024	HDG	4509	2255	1128	376	519	05/15/2024
K	4983	2492	1246	416	5FQ	05/15/2023	K	4983	2492	1246	416	5FR	05/15/2023
L	6957	3479	1740	580	5FU	05/15/2023	L	6957	3479	1740	580	5FV	05/15/2023
N	9890	4945	2473	825	5FY	05/15/2024	N	9890	4945	2473	825	5FZ	05/15/2024

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

PLAN A

		Male			Female					
Non-Tobacco U	ser Effectiv	e Date: 03/01/2	020 Plan Co	ode: 5A4	Non-Tobacco l	Jser Effective	e Date: 03/01/2	.020 Plan C	ode: 5A5	
Attained Age	Annual	Semi Annual	Quarterly	Monthly	Attained Age	Annual	Semi Annual	Quarterly	Monthly	
65	1302	651	326	109	65	1302	651	326	109	
66	1376	688	344	115	66	1376	688	344	115	
67	1440	720	360	120	67	1440	720	360	120	
68	1498	749	375	125	68	1498	749	375	125	
69	1561	781	391	131	69	1561	781	391	131	
70	1623	812	406	136	70	1623	812	406	136	
71	1672	836	418	140	71	1672	836	418	140	
72	1693	847	424	142	72	1693	847	424	142	
73	1702	851	426	142	73	1702	851	426	142	
74	1702	851	426	142	74	1702	851	426	142	
75	1702	851	426	142	75	1702	851	426	142	
76	1702	851	426	142	76	1702	851	426	142	
77	1702	851	426	142	77	1702	851	426	142	
78	1702	851	426	142	78	1702	851	426	142	
79	1702	851	426	142	79	1702	851	426	142	
80+	1702	851	426	142	80+	1702	851	426	142	
Tobacco User	Effectiv	e Date: 03/01/2	020 Plan Co	ode: 5A6	Tobacco User	Effective	e Date: 03/01/2	020 Plan C	ode: 5A7	
Attained Age	Annual	Semi Annual	Quarterly	Monthly	Attained Age	Annual	Semi Annual	Quarterly	Monthly	
65	1498	749	375	125	65	1498	749	375	125	
66	1583	792	396	132	66	1583	792	396	132	
67	1656	828	414	138	67	1656	828	414	138	
68	1723	862	431	144	68	1723	862	431	144	
69	1796	898	449	150	69	1796	898	449	150	
70	1867	934	467	156	70	1867	934	467	156	
71	1923	962	481	161	71	1923	962	481	161	
72	1948	974	487	163	72	1948	974	487	163	
73	1958	979	490	164	73	1958	979	490	164	
74	1958	979	490	164	74	1958	979	490	164	
75	1958	979	490	164	75	1958	979	490	164	
76	1958	979	490	164	76	1958	979	490	164	
77	1958	979	490	164	77	1958	979	490	164	
78	1958	979	490	164	78	1958	979	490	164	
79	1958	979	490	164	79	1958	979	490	164	
80+	1958	979	490	164	80+	1958	979	490	164	

PLAN B

		Male					Female		
Non-Tobacco L	Jser Effective	e Date: 05/15/2	024 Plan Co	ode: 5AM	Non-Tobacco l	Jser Effective	e Date: 05/15/2	024 Plan Co	ode: 5AN
Attained Age	Annual	Semi Annual	Quarterly	Monthly	Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2458	1229	615	205	65	2458	1229	615	205
66	2609	1305	653	218	66	2609	1305	653	218
67	2744	1372	686	229	67	2744	1372	686	229
68	2868	1434	717	239	68	2868	1434	717	239
69	3008	1504	752	251	69	3008	1504	752	251
70	3139	1570	785	262	70	3139	1570	785	262
71	3253	1627	814	272	71	3253	1627	814	272
72	3323	1662	831	277	72	3323	1662	831	277
73	3366	1683	842	281	73	3366	1683	842	281
74	3391	1696	848	283	74	3391	1696	848	283
75	3416	1708	854	285	75	3416	1708	854	285
76	3430	1715	858	286	76	3430	1715	858	286
77	3430	1715	858	286	77	3430	1715	858	286
78	3430	1715	858	286	78	3430	1715	858	286
79	3430	1715	858	286	79	3430	1715	858	286
80+	3430	1715	858	286	80+	3430	1715	858	286
Tobacco User	Effective	e Date: 05/15/2	024 Plan Co	ode: 5AO	Tobacco User	Effective	e Date: 05/15/2	024 Plan Co	ode: 5AP
Attained Age	Annual	Semi Annual	Quarterly	Monthly	Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2827	1414	707	236	65	2827	1414	707	236
66	3001	1501	751	251	66	3001	1501	751	251
67	3157	1579	790	264	67	3157	1579	790	264
68	3299	1650	825	275	68	3299	1650	825	275
69	3460	1730	865	289	69	3460	1730	865	289
70	3611	1806	903	301	70	3611	1806	903	301
71	3742	1871	936	312	71	3742	1871	936	312
72	3823	1912	956	319	72	3823	1912	956	319
73	3871	1936	968	323	73	3871	1936	968	323
74	3901	1951	976	326	74	3901	1951	976	326
75	3929	1965	983	328	75	3929	1965	983	328
76	3945	1973	987	329	76	3945	1973	987	329
77	3945	1973	987	329	77	3945	1973	987	329
78	3945	1973	987	329	78	3945	1973	987	329
79	3945	1973	987	329	79	3945	1973	987	329
80+	3945	1973	987	329	80+	3945	1973	987	329

PLAN C

					AIV C				
		Male					Female		
Non-Tobacco	User Effective	e Date: 05/15/2	024 Plan Co	ode: 5B4	Non-Tobacco l	User Effective	Date: 05/15/2	024 Plan Co	ode: 5B5
Attained Age	Annual	Semi Annual	Quarterly	Monthly	Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2796	1398	699	233	65	2796	1398	699	233
66	2963	1482	741	247	66	2963	1482	741	247
67	3109	1555	778	260	67	3109	1555	778	260
68	3258	1629	815	272	68	3258	1629	815	272
69	3432	1716	858	286	69	3432	1716	858	286
70	3596	1798	899	300	70	3596	1798	899	300
71	3745	1873	937	313	71	3745	1873	937	313
72	3855	1928	964	322	72	3855	1928	964	322
73	3928	1964	982	328	73	3928	1964	982	328
74	3986	1993	997	333	74	3986	1993	997	333
75	4038	2019	1010	337	75	4038	2019	1010	337
76	4079	2040	1020	340	76	4079	2040	1020	340
77	4138	2069	1035	345	77	4138	2069	1035	345
78	4196	2098	1049	350	78	4196	2098	1049	350
79	4257	2129	1065	355	79	4257	2129	1065	355
80+	4362	2181	1091	364	80+	4362	2181	1091	364
Tobacco User	Effective	e Date: 05/15/2	024 Plan Co	ode: 5B6	Tobacco User	Effective	Date: 05/15/2	024 Plan Co	ode: 5B7
Attained Age	Annual	Semi Annual	Quarterly	Monthly	Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3217	1609	805	269	65	3217	1609	805	269
66	3408	1704	852	284	66	3408	1704	852	284
67	3576	1788	894	298	67	3576	1788	894	298
68	3748	1874	937	313	68	3748	1874	937	313
69	3947	1974	987	329	69	3947	1974	987	329
70	4137	2069	1035	345	70	4137	2069	1035	345
71	4308	2154	1077	359	71	4308	2154	1077	359
72	4435	2218	1109	370	72	4435	2218	1109	370
73	4518	2259	1130	377	73	4518	2259	1130	377
74	4585	2293	1147	383	74	4585	2293	1147	383
75	4644	2322	1161	387	75	4644	2322	1161	387
76	4692	2346	1173	391	76	4692	2346	1173	391
77	4760	2380	1190	397	77	4760	2380	1190	397
78	4827	2414	1207	403	78	4827	2414	1207	403
79	4897	2449	1225	409	79	4897	2449	1225	409
80+	5017	2509	1255	419	80+	5017	2509	1255	419

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

PLAN D

FLAND												
		Male					Female					
Non-Tobacco l	Jser Effective	e Date: 05/15/20	024 Plan Co	ode: 5BM	Non-Tobacco L	Jser Effective	P Date: 05/15/2	024 Plan Co	ode: 5BN			
Attained Age	Annual	Semi Annual	Quarterly	Monthly	Attained Age	Annual	Semi Annual	Quarterly	Monthly			
65	2604	1302	651	217	65	2604	1302	651	217			
66	2771	1386	693	231	66	2771	1386	693	231			
67	2925	1463	732	244	67	2925	1463	732	244			
68	3077	1539	770	257	68	3077	1539	770	257			
69	3251	1626	813	271	69	3251	1626	813	271			
70	3412	1706	853	285	70	3412	1706	853	285			
71	3567	1784	892	298	71	3567	1784	892	298			
72	3679	1840	920	307	72	3679	1840	920	307			
73	3755	1878	939	313	73	3755	1878	939	313			
74	3812	1906	953	318	74	3812	1906	953	318			
75	3863	1932	966	322	75	3863	1932	966	322			
76	3906	1953	977	326	76	3906	1953	977	326			
77	3965	1983	992	331	77	3965	1983	992	331			
78	4026	2013	1007	336	78	4026	2013	1007	336			
79	4086	2043	1022	341	79	4086	2043	1022	341			
80+	4192	2096	1048	350	80+	4192	2096	1048	350			
Tobacco User	Effective	e Date: 05/15/20	024 Plan Co	ode: 5BO	Tobacco User	Effective	e Date: 05/15/2	024 Plan Co	ode: 5BP			
Attained Age	Annual	Semi Annual	Quarterly	Monthly	Attained Age	Annual	Semi Annual	Quarterly	Monthly			
65	2996	1498	749	250	65	2996	1498	749	250			
66	3187	1594	797	266	66	3187	1594	797	266			
67	3365	1683	842	281	67	3365	1683	842	281			
68	3539	1770	885	295	68	3539	1770	885	295			
69	3739	1870	935	312	69	3739	1870	935	312			
70	3925	1963	982	328	70	3925	1963	982	328			
71	4103	2052	1026	342	71	4103	2052	1026	342			
72	4232	2116	1058	353	72	4232	2116	1058	353			
73	4319	2160	1080	360	73	4319	2160	1080	360			
74	4385	2193	1097	366	74	4385	2193	1097	366			
75	4444	2222	1111	371	75	4444	2222	1111	371			
76	4492	2246	1123	375	76	4492	2246	1123	375			
77	4560	2280	1140	380	77	4560	2280	1140	380			
78	4631	2316	1158	386	78	4631	2316	1158	386			
79	4700	2350	1175	392	79	4700	2350	1175	392			
-												

PLAN F

		DA-I-		, _	AIN F		Famala		
		Male					Female		
Non-Tobacco	User Effective	P Date: 05/15/20	024 Plan Co	ode: 5C4	Non-Tobacco L	Jser Effective	P Date: 05/15/2	024 Plan Co	ode: 5C5
Attained Age	Annual	Semi Annual	Quarterly	Monthly	Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2746	1373	687	229	65	2746	1373	687	229
66	2906	1453	727	243	66	2906	1453	727	243
67	3052	1526	763	255	67	3052	1526	763	255
68	3197	1599	800	267	68	3197	1599	800	267
69	3364	1682	841	281	69	3364	1682	841	281
70	3523	1762	881	294	70	3523	1762	881	294
71	3671	1836	918	306	71	3671	1836	918	306
72	3778	1889	945	315	72	3778	1889	945	315
73	3849	1925	963	321	73	3849	1925	963	321
74	3906	1953	977	326	74	3906	1953	977	326
75	3956	1978	989	330	75	3956	1978	989	330
76	3995	1998	999	333	76	3995	1998	999	333
77	4054	2027	1014	338	77	4054	2027	1014	338
78	4112	2056	1028	343	78	4112	2056	1028	343
79	4169	2085	1043	348	79	4169	2085	1043	348
80+	4272	2136	1068	356	80+	4272	2136	1068	356
Tobacco User	Effective	Date: 05/15/2	024 Plan Co	ode: 5C6	Tobacco User	Effective	P Date: 05/15/2	024 Plan Co	ode: 5C7
Attained Age	Annual	Semi Annual	Quarterly	Monthly	Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3159	1580	790	264	65	3159	1580	790	264
66	3342	1671	836	279	66	3342	1671	836	279
67	3510	1755	878	293	67	3510	1755	878	293
68	3678	1839	920	307	68	3678	1839	920	307
69	3869	1935	968	323	69	3869	1935	968	323
70	4053	2027	1014	338	70	4053	2027	1014	338
71	4223	2112	1056	352	71	4223	2112	1056	352
72	4346	2173	1087	363	72	4346	2173	1087	363
73	4428	2214	1107	369	73	4428	2214	1107	369
74	4492	2246	1123	375	74	4492	2246	1123	375
75	4550	2275	1138	380	75	4550	2275	1138	380
76	4595	2298	1149	383	76	4595	2298	1149	383
77	4663	2332	1166	389	77	4663	2332	1166	389
78	4730	2365	1183	395	78	4730	2365	1183	395
79	4795	2398	1199	400	79	4795	2398	1199	400
80+	4914	2457	1229	410	80+	4914	2457	1229	410

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

PLAN HDF

				FLAI					
		Male					Female		
Non-Tobacco	User Effective	e Date: 05/15/2	024 Plan Co	ode: 5CM	Non-Tobacco l	User Effective	P Date: 05/15/2	024 Plan Co	ode: 5CN
Attained Age	Annual	Semi Annual	Quarterly	Monthly	Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	448	224	112	38	65	448	224	112	38
66	487	244	122	41	66	487	244	122	41
67	525	263	132	44	67	525	263	132	44
68	550	275	138	46	68	550	275	138	46
69	578	289	145	49	69	578	289	145	49
70	607	304	152	51	70	607	304	152	51
71	630	315	158	53	71	630	315	158	53
72	667	334	167	56	72	667	334	167	56
73	696	348	174	58	73	696	348	174	58
74	722	361	181	61	74	722	361	181	61
75	750	375	188	63	75	750	375	188	63
76	758	379	190	64	76	758	379	190	64
77	769	385	193	65	77	769	385	193	65
78	779	390	195	65	78	779	390	195	65
79	790	395	198	66	79	790	395	198	66
80+	811	406	203	68	80+	811	406	203	68
Tobacco User	Effective	e Date: 05/15/2	024 Plan Co	ode: 5CO	Tobacco User	Effective	Date: 05/15/2	024 Plan Co	ode: 5CP
Attained Age	Annual	Semi Annual	Quarterly	Monthly	Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	516	258	129	43	65	516	258	129	43
66	560	280	140	47	66	560	280	140	47
67	604	302	151	51	67	604	302	151	51
68	632	316	158	53	68	632	316	158	53
69	665	333	167	56	69	665	333	167	56
70	698	349	175	59	70	698	349	175	59
71	725	363	182	61	71	725	363	182	61
72	767	384	192	64	72	767	384	192	64
73	801	401	201	67	73	801	401	201	67
74	830	415	208	70	74	830	415	208	70
75	862	431	216	72	75	862	431	216	72
76	872	436	218	73	76	872	436	218	73
77	885	443	222	74	77	885	443	222	74
78	896	448	224	75	78	896	448	224	75
79	909	455	220	7.0		000	455	222	7.0
80+	932	455 466	228 233	76 78	79 80+	909 932	455 466	228 233	76 78

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

PLAN G

FLAIVO												
		Male					Female					
Non-Tobacco	User Effective	e Date: 05/15/20	024 Plan Co	ode: 5D4	Non-Tobacco l	Jser Effective	P Date: 05/15/2	024 Plan Co	ode: 5D5			
Attained Age	Annual	Semi Annual	Quarterly	Monthly	Attained Age	Annual	Semi Annual	Quarterly	Monthly			
65	2250	1125	563	188	65	2250	1125	563	188			
66	2396	1198	599	200	66	2396	1198	599	200			
67	2525	1263	632	211	67	2525	1263	632	211			
68	2656	1328	664	222	68	2656	1328	664	222			
69	2804	1402	701	234	69	2804	1402	701	234			
70	2947	1474	737	246	70	2947	1474	737	246			
71	3076	1538	769	257	71	3076	1538	769	257			
72	3173	1587	794	265	72	3173	1587	794	265			
73	3237	1619	810	270	73	3237	1619	810	270			
74	3285	1643	822	274	74	3285	1643	822	274			
75	3331	1666	833	278	75	3331	1666	833	278			
76	3367	1684	842	281	76	3367	1684	842	281			
77	3417	1709	855	285	77	3417	1709	855	285			
78	3468	1734	867	289	78	3468	1734	867	289			
79	3521	1761	881	294	79	3521	1761	881	294			
80+	3615	1808	904	302	80+	3615	1808	904	302			
Tobacco User	Effective	e Date: 05/15/20	024 Plan Co	ode: 5D6	Tobacco User	Effective	P Date: 05/15/2	024 Plan Co	ode: 5D7			
Attained Age	Annual	Semi Annual	Quarterly	Monthly	Attained Age	Annual	Semi Annual	Quarterly	Monthly			
65	2588	1294	647	216	65	2588	1294	647	216			
66	2755	1378	689	230	66	2755	1378	689	230			
67	2904	1452	726	242	67	2904	1452	726	242			
68	3055	1528	764	255	68	3055	1528	764	255			
69	3226	1613	807	269	69	3226	1613	807	269			
70	3390	1695	848	283	70	3390	1695	848	283			
71	3538	1769	885	295	71	3538	1769	885	295			
72	3649	1825	913	305	72	3649	1825	913	305			
73	3723	1862	931	311	73	3723	1862	931	311			
74	3779	1890	945	315	74	3779	1890	945	315			
75	3832	1916	958	320	75	3832	1916	958	320			
76	3873	1937	969	323	76	3873	1937	969	323			
77	3930	1965	983	328	77	3930	1965	983	328			
78	3989	1995	998	333	78	3989	1995	998	333			
79	4050	2025	1013	338	79	4050	2025	1013	338			
80+	4158	2079	1040	347	80+	4158	2079	1040	347			

PLAN HDG

				PLA	N HDG				
		Male					Female		
Non-Tobacco	User Effective	e Date: 05/15/20	024 Plan Co	ode: 5HO	Non-Tobacco	User Effective	e Date: 05/15/2	024 Plan Co	ode: 5HP
Attained Age	Annual	Semi Annual	Quarterly	Monthly	Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	448	224	112	38	65	448	224	112	38
66	487	244	122	41	66	487	244	122	41
67	525	263	132	44	67	525	263	132	44
68	550	275	138	46	68	550	275	138	46
69	578	289	145	49	69	578	289	145	49
70	607	304	152	51	70	607	304	152	51
71	630	315	158	53	71	630	315	158	53
72	667	334	167	56	72	667	334	167	56
73	696	348	174	58	73	696	348	174	58
74	722	361	181	61	74	722	361	181	61
75	750	375	188	63	75	750	375	188	63
76	758	379	190	64	76	758	379	190	64
77	769	385	193	65	77	769	385	193	65
78	779	390	195	65	78	779	390	195	65
79	790	395	198	66	79	790	395	198	66
80+	811	406	203	68	80+	811	406	203	68
Tobacco User	Effective	e Date: 05/15/20	024 Plan Co	ode: 5HQ	Tobacco User	Effective	P Date: 05/15/2	024 Plan Co	ode: 5HR
Attained Age	Annual	Semi Annual	Quarterly	Monthly	Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	516	258	129	43	65	516	258	129	43
66	560	280	140	47	66	560	280	140	47
67	604	302	151	51	67	604	302	151	51
68	632	316	158	53	68	632	316	158	53
69	665	333	167	56	69	665	333	167	56
70	698	349	175	59	70	698	349	175	59
71	725	363	182	61	71	725	363	182	61
72	767	384	192	64	72	767	384	192	64
73	801	401	201	67	73	801	401	201	67
74	830	415	208	70	74	830	415	208	70
75	862	431	216	72	75	862	431	216	72
76	872	436	218	73	76	872	436	218	73
77	885	443	222	74	77	885	443	222	74
78	896	448	224	75	78	896	448	224	75
79	909	455	228	76	79	909	455	228	76
80+	932	466	233	78	80+	932	466	233	78

PLAN K

	F LAIV IX												
		Male					Female						
Non-Tobacco	User Effective	P Date: 03/01/2	020 Plan Co	ode: P44	Non-Tobacco	Jser Effective	Date: 03/01/2	020 Plan Co	ode: P45				
Attained Age	Annual	Semi Annual	Quarterly	Monthly	Attained Age	Annual	Semi Annual	Quarterly	Monthly				
65	1069	535	268	90	65	1069	535	268	90				
66	1149	575	288	96	66	1149	575	288	96				
67	1219	610	305	102	67	1219	610	305	102				
68	1281	641	321	107	68	1281	641	321	107				
69	1343	672	336	112	69	1343	672	336	112				
70	1425	713	357	119	70	1425	713	357	119				
71	1463	732	366	122	71	1463	732	366	122				
72	1490	745	373	125	72	1490	745	373	125				
73	1522	761	381	127	73	1522	761	381	127				
74	1551	776	388	130	74	1551	776	388	130				
75	1588	794	397	133	75	1588	794	397	133				
76	1613	807	404	135	76	1613	807	404	135				
77	1633	817	409	137	77	1633	817	409	137				
78	1650	825	413	138	78	1650	825	413	138				
79	1661	831	416	139	79	1661	831	416	139				
80+	1691	846	423	141	80+	1691	846	423	141				
Tobacco User	Effective	Date: 03/01/2	020 Plan Co	ode: P46	Tobacco User	Effective	Date: 03/01/2	020 Plan Co	ode: P47				
Attained Age	Annual	Semi Annual	Quarterly	Monthly	Attained Age	Annual	Semi Annual	Quarterly	Monthly				
65	1229	615	308	103	65	1229	615	308	103				
66	1322	661	331	111	66	1322	661	331	111				
67	1403	702	351	117	67	1403	702	351	117				
68	1473	737	369	123	68	1473	737	369	123				
69	1544	772	386	129	69	1544	772	386	129				
70	1639	820	410	137	70	1639	820	410	137				
71	1683	842	421	141	71	1683	842	421	141				
72	1714	857	429	143	72	1714	857	429	143				
73	1750	875	438	146	73	1750	875	438	146				
74	1784	892	446	149	74	1784	892	446	149				
75	1826	913	457	153	75	1826	913	457	153				
76	1856	928	464	155	76	1856	928	464	155				
77	1879	940	470	157	77	1879	940	470	157				
78	1898	949	475	159	78	1898	949	475	159				
79	1910	955	478	160	79	1910	955	478	160				
80+	1945	973	487	163	80+	1945	973	487	163				

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PLAN L

	Male Female								
Non-Tobacco U	ser Effectiv	e Date: 03/01/2	020 Plan Co	ode: P60	Non-Tobacco l	Jser Effective	e Date: 03/01/2	020 Plan C	ode: P61
Attained Age	Annual	Semi Annual	Quarterly	Monthly	Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1501	751	376	126	65	1501	751	376	126
66	1613	807	404	135	66	1613	807	404	135
67	1712	856	428	143	67	1712	856	428	143
68	1799	900	450	150	68	1799	900	450	150
69	1891	946	473	158	69	1891	946	473	158
70	1999	1000	500	167	70	1999	1000	500	167
71	2054	1027	514	172	71	2054	1027	514	172
72	2095	1048	524	175	72	2095	1048	524	175
73	2141	1071	536	179	73	2141	1071	536	179
74	2178	1089	545	182	74	2178	1089	545	182
75	2228	1114	557	186	75	2228	1114	557	186
76	2262	1131	566	189	76	2262	1131	566	189
77	2292	1146	573	191	77	2292	1146	573	191
78	2317	1159	580	194	78	2317	1159	580	194
79	2334	1167	584	195	79	2334	1167	584	195
80+	2376	1188	594	198	80+	2376	1188	594	198
Tobacco User	Effectiv	e Date: 03/01/2	020 Plan Co	ode: P62	Tobacco User	Effective	e Date: 03/01/2	020 Plan C	ode: P63
Attained Age	Annual	Semi Annual	Quarterly	Monthly	Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1727	864	432	144	65	1727	864	432	144
66	1856	928	464	155	66	1856	928	464	155
67	1969	985	493	165	67	1969	985	493	165
68	2069	1035	518	173	68	2069	1035	518	173
69	2175	1088	544	182	69	2175	1088	544	182
70	2299	1150	575	192	70	2299	1150	575	192
71	2362	1181	591	197	71	2362	1181	591	197
72	2410	1205	603	201	72	2410	1205	603	201
73	2463	1232	616	206	73	2463	1232	616	206
74	2505	1253	627	209	74	2505	1253	627	209
75	2563	1282	641	214	75	2563	1282	641	214
76	2601	1301	651	217	76	2601	1301	651	217
77	2636	1318	659	220	77	2636	1318	659	220
78	2665	1333	667	223	78	2665	1333	667	223
79	2685	1343	672	224	79	2685	1343	672	224
80+	2733	1367	684	228	80+	2733	1367	684	228

PLAN N

		Male					Female		
Non-Tobacco	User Effective	Date: 05/15/20	024 Plan Co	ode: 5DM	Non-Tobacco l	Jser Effective	P Date: 05/15/2	024 Plan Co	ode: 5DN
Attained Age	Annual	Semi Annual	Quarterly	Monthly	Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2398	1199	600	200	65	2398	1199	600	200
66	2557	1279	640	214	66	2557	1279	640	214
67	2694	1347	674	225	67	2694	1347	674	225
68	2836	1418	709	237	68	2836	1418	709	237
69	2998	1499	750	250	69	2998	1499	750	250
70	3161	1581	791	264	70	3161	1581	791	264
71	3309	1655	828	276	71	3309	1655	828	276
72	3412	1706	853	285	72	3412	1706	853	285
73	3489	1745	873	291	73	3489	1745	873	291
74	3545	1773	887	296	74	3545	1773	887	296
75	3604	1802	901	301	75	3604	1802	901	301
76	3645	1823	912	304	76	3645	1823	912	304
77	3710	1855	928	310	77	3710	1855	928	310
78	3776	1888	944	315	78	3776	1888	944	315
79	3842	1921	961	321	79	3842	1921	961	321
80+	3966	1983	992	331	80+	3966	1983	992	331
Tobacco User	Effective	P Date: 05/15/20	024 Plan Co	ode: 5DO	Tobacco User	Effective	P Date: 05/15/2	024 Plan Co	ode: 5DP
Attained Age	Annual	Semi Annual	Quarterly	Monthly	Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2759	1380	690	230	65	2759	1380	690	230
66	2941	1471	736	246	66	2941	1471	736	246
67	3099	1550	775	259	67	3099	1550	775	259
68	3262	1631	816	272	68	3262	1631	816	272
69	3449	1725	863	288	69	3449	1725	863	288
70	3636	1818	909	303	70	3636	1818	909	303
71	3806	1903	952	318	71	3806	1903	952	318
72	3925	1963	982	328	72	3925	1963	982	328
73	4013	2007	1004	335	73	4013	2007	1004	335
74	4078	2039	1020	340	74	4078	2039	1020	340
75	4146	2073	1037	346	75	4146	2073	1037	346
76	4192	2096	1048	350	76	4192	2096	1048	350
77	4268	2134	1067	356	77	4268	2134	1067	356
78	4344	2172	1086	362	78	4344	2172	1086	362
79	4420	2210	1105	369	79	4420	2210	1105	369
80+	4561	2281	1141	381	80+	4561	2281	1141	381

PREMIUM INFORMATION

We, United American Insurance Company, can only raise your premium if we raise the premium for all policies like yours in this state. Until you are age 81, your premiums will increase on each policy anniversary solely because of your age change. Your premiums may also be increased due to increasing health costs for all policies in your class. We will not change our table of premium rates more often than once in a 12-month period.

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 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
	1		
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	AUL . 44.622	ta coo (D A D . L	
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	\$0 **
		Expenses	
– 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			
having been in a hospital for at least 3 days and entered			
a Medicare-Approved facility within 30 days after leaving			
the hospital	All approved apparents	\$0	ĊO.
First 20 days	All approved amounts	' '	\$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			1.0
First 3 pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's requirements, including a	All but very limited copayment,	Medicare copayment/	\$0
doctor's certification of terminal illness.	coinsurance for outpatient drugs and inpatient respite care	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 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		20% and amounts over the
		maximum benefit of \$50,000	\$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	60	¢0	\$240 (Part P Doductible)
First \$240 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0	\$0 Conorally 200/	\$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		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-APPRO	OVED SERVICES			
 Medically necessary skilled care servi 	ces and medical supplies	100%	\$0	\$0
 – Durable medical equipment 				
First \$240 of Medicare-Approved A	\mounts*	\$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	\$0 ***
		Expenses	
– 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

PLANK

* 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 91st day and after:	All but \$408 a day	\$408 a day	\$0
– While using 60 lifetime reserve days Once lifetime reserve days are used:	All but \$816 a day	\$816 a day	\$0
– 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.

PLANL

* 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	\$0 ***
D. Lil Allin Local	60	Expenses	ALL C. I
– 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* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$0 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.	\$240 (Part B Deductible) 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	20% and amounts over the
		benefit of \$50,000	\$50,000 lifetime maximum