UNITED AMERICAN INSURANCE COMPANY

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

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

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

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

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

Benefits	Plans Available to All Applicants								Medicare First Eligible Before 2020 Only	
	A^	B^	D^	G^1^	K^	L^	M	N^	C^	F^1^
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓copays apply (3)	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2025(2)					$7,220(2)	$3,610(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 $2,870 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	1285	643	322	108	5EW	05/01/2013
B	2490	1245	623	208	5F0	04/01/2024
C	2525	1263	632	211	5F4	04/01/2024
D	2448	1224	612	204	5F8	04/01/2024
F	3004	1502	751	251	5FC	04/01/2024
HDF	437	219	110	37	5FG	04/01/2024
G	2426	1213	607	203	5FK	04/01/2024
HDG	437	219	110	37	5I6	04/01/2024
K	1228	614	307	103	5FO	01/15/2020
L	1725	863	432	144	5FS	01/15/2020

Standard

Plan	A	SA	Q	M	Plan Code	Effective Date
A	1478	739	370	124	5EY	05/01/2013
B	2865	1433	717	239	5F2	04/01/2024
C	2905	1453	727	243	5F6	04/01/2024
D	2817	1409	705	235	5FA	04/01/2024
F	3457	1729	865	289	5FE	04/01/2024
HDF	503	252	126	42	5FI	04/01/2024
G	2792	1396	698	233	5FM	04/01/2024
HDG	503	252	126	42	5I8	04/01/2024
K	1413	707	354	118	5FQ	01/15/2020
L	1985	993	497	166	5FU	01/15/2020

Female

Preferred

Plan	A	SA	Q	M	Plan Code	Effective Date
A	1118	559	280	94	5EX	05/01/2013
B	2166	1083	542	181	5F1	04/01/2024
C	2196	1098	549	183	5F5	04/01/2024
D	2129	1065	533	178	5F9	04/01/2024
F	2613	1307	654	218	5FD	04/01/2024
HDF	380	190	95	32	5FH	04/01/2024
G	2111	1056	528	176	5FL	04/01/2024
HDG	380	190	95	32	5I7	04/01/2024
K	1068	534	267	89	5FP	01/15/2020
L	1500	750	375	125	5FT	01/15/2020

Standard

Plan	A	SA	Q	M	Plan Code	Effective Date
A	1285	643	322	108	5EZ	05/01/2013
B	2490	1245	623	208	5F3	04/01/2024
C	2525	1263	632	211	5F7	04/01/2024
D	2448	1224	612	204	5FB	04/01/2024
F	3004	1502	751	251	5FF	04/01/2024
HDF	437	219	110	37	5FJ	04/01/2024
G	2426	1213	607	203	5FN	04/01/2024
HDG	437	219	110	37	5I9	04/01/2024
K	1228	614	307	103	5FR	01/15/2020
L	1725	863	432	144	5FV	01/15/2020

*** NOTE: In OREGON, 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	1285	643	322	108	5EW	05/01/2013
B	2490	1245	623	208	5F0	04/01/2024
C	2525	1263	632	211	5F4	04/01/2024
D	2448	1224	612	204	5F8	04/01/2024
F	3004	1502	751	251	5FC	04/01/2024
HDF	437	219	110	37	5FG	04/01/2024
G	2426	1213	607	203	5FK	04/01/2024
HDG	437	219	110	37	5I6	04/01/2024
K	1228	614	307	103	5FO	01/15/2020
L	1725	863	432	144	5FS	01/15/2020
N	2158	1079	540	180	5FW	04/01/2024

Standard

Plan	A	SA	Q	M	Plan Code	Effective Date
A	1478	739	370	124	5EY	05/01/2013
B	2865	1433	717	239	5F2	04/01/2024
C	2905	1453	727	243	5F6	04/01/2024
D	2817	1409	705	235	5FA	04/01/2024
F	3457	1729	865	289	5FE	04/01/2024
HDF	503	252	126	42	5FI	04/01/2024
G	2792	1396	698	233	5FM	04/01/2024
HDG	503	252	126	42	5I8	04/01/2024
K	1413	707	354	118	5FQ	01/15/2020
L	1985	993	497	166	5FU	01/15/2020
N	2484	1242	621	207	5FY	04/01/2024

Female

Preferred

Plan	A	SA	Q	M	Plan Code	Effective Date
A	1118	559	280	94	5EX	05/01/2013
B	2166	1083	542	181	5F1	04/01/2024
C	2196	1098	549	183	5F5	04/01/2024
D	2129	1065	533	178	5F9	04/01/2024
F	2613	1307	654	218	5FD	04/01/2024
HDF	380	190	95	32	5FH	04/01/2024
G	2111	1056	528	176	5FL	04/01/2024
HDG	380	190	95	32	5I7	04/01/2024
K	1068	534	267	89	5FP	01/15/2020
L	1500	750	375	125	5FT	01/15/2020
N	1878	939	470	157	5FX	04/01/2024

Standard

Plan	A	SA	Q	M	Plan Code	Effective Date
A	1285	643	322	108	5EZ	05/01/2013
B	2490	1245	623	208	5F3	04/01/2024
C	2525	1263	632	211	5F7	04/01/2024
D	2448	1224	612	204	5FB	04/01/2024
F	3004	1502	751	251	5FF	04/01/2024
HDF	437	219	110	37	5FJ	04/01/2024
G	2426	1213	607	203	5FN	04/01/2024
HDG	437	219	110	37	5I9	04/01/2024
K	1228	614	307	103	5FR	01/15/2020
L	1725	863	432	144	5FV	01/15/2020
N	2158	1079	540	180	5FZ	04/01/2024

*** NOTE: In OREGON, 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: 05/01/2013 Plan Code: 5A4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1285	643	322	108
66	1350	675	338	113
67	1402	701	351	117
68	1452	726	363	121
69	1505	753	377	126
70	1558	779	390	130
71	1598	799	400	134
72	1609	805	403	135
73	1629	815	408	136
74	1638	819	410	137
75	1650	825	413	138
76	1650	825	413	138
77	1650	825	413	138
78	1650	825	413	138
79	1650	825	413	138
80+	1650	825	413	138

Standard Effective Date: 05/01/2013 Plan Code: 5A6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1478	739	370	124
66	1553	777	389	130
67	1614	807	404	135
68	1671	836	418	140
69	1732	866	433	145
70	1793	897	449	150
71	1839	920	460	154
72	1852	926	463	155
73	1874	937	469	157
74	1885	943	472	158
75	1899	950	475	159
76	1899	950	475	159
77	1899	950	475	159
78	1899	950	475	159
79	1899	950	475	159
80+	1899	950	475	159

Female

Preferred Effective Date: 05/01/2013 Plan Code: 5A5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1118	559	280	94
66	1174	587	294	98
67	1220	610	305	102
68	1263	632	316	106
69	1309	655	328	110
70	1355	678	339	113
71	1390	695	348	116
72	1400	700	350	117
73	1417	709	355	119
74	1425	713	357	119
75	1435	718	359	120
76	1435	718	359	120
77	1435	718	359	120
78	1435	718	359	120
79	1435	718	359	120
80+	1435	718	359	120

Standard Effective Date: 05/01/2013 Plan Code: 5A7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1285	643	322	108
66	1350	675	338	113
67	1402	701	351	117
68	1452	726	363	121
69	1505	753	377	126
70	1558	779	390	130
71	1598	799	400	134
72	1609	805	403	135
73	1629	815	408	136
74	1638	819	410	137
75	1650	825	413	138
76	1650	825	413	138
77	1650	825	413	138
78	1650	825	413	138
79	1650	825	413	138
80+	1650	825	413	138

PLAN B

Male

Preferred Effective Date: 04/01/2024 Plan Code: 5AM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2490	1245	623	208
66	2627	1314	657	219
67	2745	1373	687	229
68	2855	1428	714	238
69	2973	1487	744	248
70	3092	1546	773	258
71	3183	1592	796	266
72	3232	1616	808	270
73	3294	1647	824	275
74	3340	1670	835	279
75	3384	1692	846	282
76	3410	1705	853	285
77	3415	1708	854	285
78	3421	1711	856	286
79	3430	1715	858	286
80+	3430	1715	858	286

Standard Effective Date: 04/01/2024 Plan Code: 5AO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2865	1433	717	239
66	3023	1512	756	252
67	3159	1580	790	264
68	3285	1643	822	274
69	3422	1711	856	286
70	3558	1779	890	297
71	3662	1831	916	306
72	3719	1860	930	310
73	3790	1895	948	316
74	3843	1922	961	321
75	3895	1948	974	325
76	3924	1962	981	327
77	3930	1965	983	328
78	3936	1968	984	328
79	3948	1974	987	329
80+	3948	1974	987	329

Female

Preferred Effective Date: 04/01/2024 Plan Code: 5AN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2166	1083	542	181
66	2285	1143	572	191
67	2388	1194	597	199
68	2483	1242	621	207
69	2586	1293	647	216
70	2689	1345	673	225
71	2768	1384	692	231
72	2811	1406	703	235
73	2865	1433	717	239
74	2905	1453	727	243
75	2944	1472	736	246
76	2966	1483	742	248
77	2971	1486	743	248
78	2976	1488	744	248
79	2984	1492	746	249
80+	2984	1492	746	249

Standard Effective Date: 04/01/2024 Plan Code: 5AP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2490	1245	623	208
66	2627	1314	657	219
67	2745	1373	687	229
68	2855	1428	714	238
69	2973	1487	744	248
70	3092	1546	773	258
71	3183	1592	796	266
72	3232	1616	808	270
73	3294	1647	824	275
74	3340	1670	835	279
75	3384	1692	846	282
76	3410	1705	853	285
77	3415	1708	854	285
78	3421	1711	856	286
79	3430	1715	858	286
80+	3430	1715	858	286

PLAN C

Male

Preferred Effective Date: 04/01/2024 Plan Code: 5B4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2525	1263	632	211
66	2660	1330	665	222
67	2778	1389	695	232
68	2899	1450	725	242
69	3032	1516	758	253
70	3164	1582	791	264
71	3279	1640	820	274
72	3354	1677	839	280
73	3437	1719	860	287
74	3508	1754	877	293
75	3575	1788	894	298
76	3626	1813	907	303
77	3684	1842	921	307
78	3745	1873	937	313
79	3807	1904	952	318
80+	3912	1956	978	326

Standard Effective Date: 04/01/2024 Plan Code: 5B6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2905	1453	727	243
66	3061	1531	766	256
67	3197	1599	800	267
68	3336	1668	834	278
69	3489	1745	873	291
70	3642	1821	911	304
71	3773	1887	944	315
72	3859	1930	965	322
73	3955	1978	989	330
74	4037	2019	1010	337
75	4113	2057	1029	343
76	4172	2086	1043	348
77	4239	2120	1060	354
78	4310	2155	1078	360
79	4381	2191	1096	366
80+	4502	2251	1126	376

Female

Preferred Effective Date: 04/01/2024 Plan Code: 5B5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2196	1098	549	183
66	2314	1157	579	193
67	2416	1208	604	202
68	2521	1261	631	211
69	2637	1319	660	220
70	2753	1377	689	230
71	2852	1426	713	238
72	2917	1459	730	244
73	2990	1495	748	250
74	3052	1526	763	255
75	3109	1555	778	260
76	3154	1577	789	263
77	3204	1602	801	267
78	3258	1629	815	272
79	3312	1656	828	276
80+	3403	1702	851	284

Standard Effective Date: 04/01/2024 Plan Code: 5B7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2525	1263	632	211
66	2660	1330	665	222
67	2778	1389	695	232
68	2899	1450	725	242
69	3032	1516	758	253
70	3164	1582	791	264
71	3279	1640	820	274
72	3354	1677	839	280
73	3437	1719	860	287
74	3508	1754	877	293
75	3575	1788	894	298
76	3626	1813	907	303
77	3684	1842	921	307
78	3745	1873	937	313
79	3807	1904	952	318
80+	3912	1956	978	326

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

PLAN D

Male

Preferred Effective Date: 04/01/2024 Plan Code: 5BM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2448	1224	612	204
66	2592	1296	648	216
67	2717	1359	680	227
68	2844	1422	711	237
69	2984	1492	746	249
70	3124	1562	781	261
71	3245	1623	812	271
72	3325	1663	832	278
73	3412	1706	853	285
74	3486	1743	872	291
75	3555	1778	889	297
76	3609	1805	903	301
77	3673	1837	919	307
78	3738	1869	935	312
79	3800	1900	950	317
80+	3912	1956	978	326

Standard Effective Date: 04/01/2024 Plan Code: 5BO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2817	1409	705	235
66	2983	1492	746	249
67	3127	1564	782	261
68	3273	1637	819	273
69	3434	1717	859	287
70	3595	1798	899	300
71	3734	1867	934	312
72	3826	1913	957	319
73	3927	1964	982	328
74	4011	2006	1003	335
75	4091	2046	1023	341
76	4153	2077	1039	347
77	4227	2114	1057	353
78	4302	2151	1076	359
79	4373	2187	1094	365
80+	4502	2251	1126	376

Female

Preferred Effective Date: 04/01/2024 Plan Code: 5BN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2129	1065	533	178
66	2255	1128	564	188
67	2363	1182	591	197
68	2474	1237	619	207
69	2596	1298	649	217
70	2717	1359	680	227
71	2822	1411	706	236
72	2892	1446	723	241
73	2968	1484	742	248
74	3032	1516	758	253
75	3093	1547	774	258
76	3139	1570	785	262
77	3195	1598	799	267
78	3252	1626	813	271
79	3305	1653	827	276
80+	3403	1702	851	284

Standard Effective Date: 04/01/2024 Plan Code: 5BP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2448	1224	612	204
66	2592	1296	648	216
67	2717	1359	680	227
68	2844	1422	711	237
69	2984	1492	746	249
70	3124	1562	781	261
71	3245	1623	812	271
72	3325	1663	832	278
73	3412	1706	853	285
74	3486	1743	872	291
75	3555	1778	889	297
76	3609	1805	903	301
77	3673	1837	919	307
78	3738	1869	935	312
79	3800	1900	950	317
80+	3912	1956	978	326

PLAN F

Male

Preferred Effective Date: 04/01/2024 Plan Code: 5C4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3004	1502	751	251
66	3163	1582	791	264
67	3301	1651	826	276
68	3444	1722	861	287
69	3602	1801	901	301
70	3761	1881	941	314
71	3893	1947	974	325
72	3984	1992	996	332
73	4083	2042	1021	341
74	4168	2084	1042	348
75	4244	2122	1061	354
76	4303	2152	1076	359
77	4376	2188	1094	365
78	4447	2224	1112	371
79	4520	2260	1130	377
80+	4646	2323	1162	388

Standard Effective Date: 04/01/2024 Plan Code: 5C6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3457	1729	865	289
66	3640	1820	910	304
67	3799	1900	950	317
68	3964	1982	991	331
69	4145	2073	1037	346
70	4329	2165	1083	361
71	4480	2240	1120	374
72	4584	2292	1146	382
73	4698	2349	1175	392
74	4797	2399	1200	400
75	4884	2442	1221	407
76	4952	2476	1238	413
77	5035	2518	1259	420
78	5118	2559	1280	427
79	5201	2601	1301	434
80+	5346	2673	1337	446

Female

Preferred Effective Date: 04/01/2024 Plan Code: 5C5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2613	1307	654	218
66	2752	1376	688	230
67	2872	1436	718	240
68	2996	1498	749	250
69	3134	1567	784	262
70	3272	1636	818	273
71	3386	1693	847	283
72	3465	1733	867	289
73	3552	1776	888	296
74	3626	1813	907	303
75	3692	1846	923	308
76	3743	1872	936	312
77	3806	1903	952	318
78	3868	1934	967	323
79	3932	1966	983	328
80+	4041	2021	1011	337

Standard Effective Date: 04/01/2024 Plan Code: 5C7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3004	1502	751	251
66	3163	1582	791	264
67	3301	1651	826	276
68	3444	1722	861	287
69	3602	1801	901	301
70	3761	1881	941	314
71	3893	1947	974	325
72	3984	1992	996	332
73	4083	2042	1021	341
74	4168	2084	1042	348
75	4244	2122	1061	354
76	4303	2152	1076	359
77	4376	2188	1094	365
78	4447	2224	1112	371
79	4520	2260	1130	377
80+	4646	2323	1162	388

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

PLAN HDF

Male

Preferred — Effective Date: 04/01/2024 — Plan Code: 5CM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	437	219	110	37
66	472	236	118	40
67	504	252	126	42
68	528	264	132	44
69	551	276	138	46
70	575	288	144	48
71	596	298	149	50
72	625	313	157	53
73	657	329	165	55
74	686	343	172	58
75	716	358	179	60
76	726	363	182	61
77	739	370	185	62
78	751	376	188	63
79	763	382	191	64
80+	784	392	196	66

Standard — Effective Date: 04/01/2024 — Plan Code: 5CO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	503	252	126	42
66	543	272	136	46
67	580	290	145	49
68	607	304	152	51
69	634	317	159	53
70	661	331	166	56
71	686	343	172	58
72	719	360	180	60
73	756	378	189	63
74	789	395	198	66
75	823	412	206	69
76	836	418	209	70
77	850	425	213	71
78	864	432	216	72
79	878	439	220	74
80+	902	451	226	76

Female

Preferred — Effective Date: 04/01/2024 — Plan Code: 5CN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	380	190	95	32
66	411	206	103	35
67	438	219	110	37
68	459	230	115	39
69	479	240	120	40
70	500	250	125	42
71	518	259	130	44
72	543	272	136	46
73	571	286	143	48
74	596	298	149	50
75	622	311	156	52
76	632	316	158	53
77	643	322	161	54
78	653	327	164	55
79	663	332	166	56
80+	682	341	171	57

Standard — Effective Date: 04/01/2024 — Plan Code: 5CP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	437	219	110	37
66	472	236	118	40
67	504	252	126	42
68	528	264	132	44
69	551	276	138	46
70	575	288	144	48
71	596	298	149	50
72	625	313	157	53
73	657	329	165	55
74	686	343	172	58
75	716	358	179	60
76	726	363	182	61
77	739	370	185	62
78	751	376	188	63
79	763	382	191	64
80+	784	392	196	66

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

PLAN G

Male

Preferred Effective Date: 04/01/2024 Plan Code: 5D4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2426	1213	607	203
66	2566	1283	642	214
67	2690	1345	673	225
68	2814	1407	704	235
69	2953	1477	739	247
70	3091	1546	773	258
71	3207	1604	802	268
72	3286	1643	822	274
73	3375	1688	844	282
74	3449	1725	863	288
75	3516	1758	879	293
76	3568	1784	892	298
77	3630	1815	908	303
78	3693	1847	924	308
79	3757	1879	940	314
80+	3867	1934	967	323

Standard Effective Date: 04/01/2024 Plan Code: 5D6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2792	1396	698	233
66	2953	1477	739	247
67	3096	1548	774	258
68	3238	1619	810	270
69	3398	1699	850	284
70	3557	1779	890	297
71	3691	1846	923	308
72	3782	1891	946	316
73	3884	1942	971	324
74	3968	1984	992	331
75	4046	2023	1012	338
76	4106	2053	1027	343
77	4177	2089	1045	349
78	4250	2125	1063	355
79	4324	2162	1081	361
80+	4450	2225	1113	371

Female

Preferred Effective Date: 04/01/2024 Plan Code: 5D5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2111	1056	528	176
66	2232	1116	558	186
67	2340	1170	585	195
68	2448	1224	612	204
69	2569	1285	643	215
70	2689	1345	673	225
71	2790	1395	698	233
72	2859	1430	715	239
73	2936	1468	734	245
74	3000	1500	750	250
75	3058	1529	765	255
76	3104	1552	776	259
77	3158	1579	790	264
78	3212	1606	803	268
79	3268	1634	817	273
80+	3364	1682	841	281

Standard Effective Date: 04/01/2024 Plan Code: 5D7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2426	1213	607	203
66	2566	1283	642	214
67	2690	1345	673	225
68	2814	1407	704	235
69	2953	1477	739	247
70	3091	1546	773	258
71	3207	1604	802	268
72	3286	1643	822	274
73	3375	1688	844	282
74	3449	1725	863	288
75	3516	1758	879	293
76	3568	1784	892	298
77	3630	1815	908	303
78	3693	1847	924	308
79	3757	1879	940	314
80+	3867	1934	967	323

PLAN HDG

Male

Preferred Effective Date: 04/01/2024 Plan Code: 5HO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	437	219	110	37
66	472	236	118	40
67	504	252	126	42
68	528	264	132	44
69	551	276	138	46
70	575	288	144	48
71	596	298	149	50
72	625	313	157	53
73	657	329	165	55
74	686	343	172	58
75	716	358	179	60
76	726	363	182	61
77	739	370	185	62
78	751	376	188	63
79	763	382	191	64
80+	784	392	196	66

Standard Effective Date: 04/01/2024 Plan Code: 5HQ

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	503	252	126	42
66	543	272	136	46
67	580	290	145	49
68	607	304	152	51
69	634	317	159	53
70	661	331	166	56
71	686	343	172	58
72	719	360	180	60
73	756	378	189	63
74	789	395	198	66
75	823	412	206	69
76	836	418	209	70
77	850	425	213	71
78	864	432	216	72
79	878	439	220	74
80+	902	451	226	76

Female

Preferred Effective Date: 04/01/2024 Plan Code: 5HP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	380	190	95	32
66	411	206	103	35
67	438	219	110	37
68	459	230	115	39
69	479	240	120	40
70	500	250	125	42
71	518	259	130	44
72	543	272	136	46
73	571	286	143	48
74	596	298	149	50
75	622	311	156	52
76	632	316	158	53
77	643	322	161	54
78	653	327	164	55
79	663	332	166	56
80+	682	341	171	57

Standard Effective Date: 04/01/2024 Plan Code: 5HR

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	437	219	110	37
66	472	236	118	40
67	504	252	126	42
68	528	264	132	44
69	551	276	138	46
70	575	288	144	48
71	596	298	149	50
72	625	313	157	53
73	657	329	165	55
74	686	343	172	58
75	716	358	179	60
76	726	363	182	61
77	739	370	185	62
78	751	376	188	63
79	763	382	191	64
80+	784	392	196	66

PLAN K

Male

Preferred Effective Date: 01/15/2020 Plan Code: P44

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1228	614	307	103
66	1321	661	331	111
67	1399	700	350	117
68	1472	736	368	123
69	1549	775	388	130
70	1635	818	409	137
71	1680	840	420	140
72	1711	856	428	143
73	1748	874	437	146
74	1775	888	444	148
75	1818	909	455	152
76	1843	922	461	154
77	1859	930	465	155
78	1876	938	469	157
79	1889	945	473	158
80+	1912	956	478	160

Standard Effective Date: 01/15/2020 Plan Code: P46

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1413	707	354	118
66	1520	760	380	127
67	1610	805	403	135
68	1694	847	424	142
69	1782	891	446	149
70	1882	941	471	157
71	1933	967	484	162
72	1969	985	493	165
73	2012	1006	503	168
74	2043	1022	511	171
75	2092	1046	523	175
76	2121	1061	531	177
77	2140	1070	535	179
78	2159	1080	540	180
79	2174	1087	544	182
80+	2200	1100	550	184

Female

Preferred Effective Date: 01/15/2020 Plan Code: P45

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1068	534	267	89
66	1149	575	288	96
67	1217	609	305	102
68	1280	640	320	107
69	1347	674	337	113
70	1422	711	356	119
71	1461	731	366	122
72	1488	744	372	124
73	1521	761	381	127
74	1544	772	386	129
75	1581	791	396	132
76	1603	802	401	134
77	1617	809	405	135
78	1632	816	408	136
79	1643	822	411	137
80+	1663	832	416	139

Standard Effective Date: 01/15/2020 Plan Code: P47

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1228	614	307	103
66	1321	661	331	111
67	1399	700	350	117
68	1472	736	368	123
69	1549	775	388	130
70	1635	818	409	137
71	1680	840	420	140
72	1711	856	428	143
73	1748	874	437	146
74	1775	888	444	148
75	1818	909	455	152
76	1843	922	461	154
77	1859	930	465	155
78	1876	938	469	157
79	1889	945	473	158
80+	1912	956	478	160

PLAN L

Male

Preferred Effective Date: 01/15/2020 Plan Code: P60

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1725	863	432	144
66	1855	928	464	155
67	1973	987	494	165
68	2072	1036	518	173
69	2177	1089	545	182
70	2300	1150	575	192
71	2361	1181	591	197
72	2409	1205	603	201
73	2460	1230	615	205
74	2504	1252	626	209
75	2558	1279	640	214
76	2595	1298	649	217
77	2619	1310	655	219
78	2640	1320	660	220
79	2656	1328	664	222
80+	2687	1344	672	224

Standard Effective Date: 01/15/2020 Plan Code: P62

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1985	993	497	166
66	2135	1068	534	178
67	2270	1135	568	190
68	2384	1192	596	199
69	2505	1253	627	209
70	2647	1324	662	221
71	2717	1359	680	227
72	2773	1387	694	232
73	2830	1415	708	236
74	2882	1441	721	241
75	2943	1472	736	246
76	2986	1493	747	249
77	3014	1507	754	252
78	3038	1519	760	254
79	3057	1529	765	255
80+	3092	1546	773	258

Female

Preferred Effective Date: 01/15/2020 Plan Code: P61

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1500	750	375	125
66	1614	807	404	135
67	1716	858	429	143
68	1802	901	451	151
69	1893	947	474	158
70	2001	1001	501	167
71	2054	1027	514	172
72	2096	1048	524	175
73	2139	1070	535	179
74	2179	1090	545	182
75	2225	1113	557	186
76	2257	1129	565	189
77	2278	1139	570	190
78	2296	1148	574	192
79	2310	1155	578	193
80+	2337	1169	585	195

Standard Effective Date: 01/15/2020 Plan Code: P63

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1725	863	432	144
66	1855	928	464	155
67	1973	987	494	165
68	2072	1036	518	173
69	2177	1089	545	182
70	2300	1150	575	192
71	2361	1181	591	197
72	2409	1205	603	201
73	2460	1230	615	205
74	2504	1252	626	209
75	2558	1279	640	214
76	2595	1298	649	217
77	2619	1310	655	219
78	2640	1320	660	220
79	2656	1328	664	222
80+	2687	1344	672	224

PLAN N

Male

Preferred Effective Date: 04/01/2024 Plan Code: 5DM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2158	1079	540	180
66	2282	1141	571	191
67	2394	1197	599	200
68	2509	1255	628	210
69	2638	1319	660	220
70	2765	1383	692	231
71	2874	1437	719	240
72	2946	1473	737	246
73	3031	1516	758	253
74	3103	1552	776	259
75	3170	1585	793	265
76	3223	1612	806	269
77	3286	1643	822	274
78	3356	1678	839	280
79	3421	1711	856	286
80+	3536	1768	884	295

Standard Effective Date: 04/01/2024 Plan Code: 5DO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2484	1242	621	207
66	2626	1313	657	219
67	2755	1378	689	230
68	2887	1444	722	241
69	3036	1518	759	253
70	3182	1591	796	266
71	3307	1654	827	276
72	3390	1695	848	283
73	3488	1744	872	291
74	3570	1785	893	298
75	3648	1824	912	304
76	3709	1855	928	310
77	3782	1891	946	316
78	3862	1931	966	322
79	3936	1968	984	328
80+	4069	2035	1018	340

Female

Preferred Effective Date: 04/01/2024 Plan Code: 5DN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1878	939	470	157
66	1985	993	497	166
67	2083	1042	521	174
68	2182	1091	546	182
69	2295	1148	574	192
70	2405	1203	602	201
71	2500	1250	625	209
72	2562	1281	641	214
73	2637	1319	660	220
74	2699	1350	675	225
75	2757	1379	690	230
76	2804	1402	701	234
77	2859	1430	715	239
78	2919	1460	730	244
79	2976	1488	744	248
80+	3076	1538	769	257

Standard Effective Date: 04/01/2024 Plan Code: 5DP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2158	1079	540	180
66	2282	1141	571	191
67	2394	1197	599	200
68	2509	1255	628	210
69	2638	1319	660	220
70	2765	1383	692	231
71	2874	1437	719	240
72	2946	1473	737	246
73	3031	1516	758	253
74	3103	1552	776	259
75	3170	1585	793	265
76	3223	1612	806	269
77	3286	1643	822	274
78	3356	1678	839	280
79	3421	1711	856	286
80+	3536	1768	884	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 $1676	$0	$1676 (Part A Deductible)
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	$0	Up to $209.50 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 A
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $257 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 $257 of Medicare-Approved Amounts*	$0	$0	$257 (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 $257 of Medicare-Approved Amounts*	$0	$0	$257 (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 $257 of Medicare-Approved Amounts*	$0	$0	$257 (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 $1676	$1676 (Part A Deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	$0	Up to $209.50 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 $257 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 $257 of Medicare-Approved Amounts*	$0	$0	$257 (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 $257 of Medicare-Approved Amounts*	$0	$0	$257 (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 $257 of Medicare-Approved Amounts*	$0	$0	$257 (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 $1676	$1676 (Part A Deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	Up to $209.50 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 $257 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 $257 of Medicare-Approved Amounts*	$0	$257 (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 $257 of Medicare-Approved Amounts*	$0	$257 (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 $257 of Medicare-Approved Amounts*	$0	$257 (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 $1676	$1676 (Part A Deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	Up to $209.50 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 $257 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 $257 of Medicare-Approved Amounts*	$0	$0	$257 (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 $257 of Medicare-Approved Amounts*	$0	$0	$257 (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 $257 of Medicare-Approved Amounts*	$0	$0	$257 (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 $2870 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2870. 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, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2870 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2870 DEDUCTIBLE,** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1676	$1676 (Part A Deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	Up to $209.50 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 $257 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 $2870 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2870. 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 $2870 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2870 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 $257 of Medicare-Approved Amounts*	$0	$257 (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 $257 of Medicare-Approved Amounts*	$0	$257 (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 $257 of Medicare-Approved Amounts*	$0	$257 (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 $2870 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2870. 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 $2870 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2870 DEDUCTIBLE,** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1676	$1676 (Part A Deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	Up to $209.50 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 $257 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 $2870 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2870. 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 $2870 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2870 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 $257 of Medicare-Approved Amounts*	$0	$0	$257 (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 $257 of Medicare-Approved Amounts*	$0	$0	$257 (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 $257 of Medicare-Approved Amounts*	$0	$0	$257 (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 $7220 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 the 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 $1676	$838 (50% of Part A Deductible)	$838 (50% of Part A Deductible) ♦
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	Up to $104.75 a day (50% of Part A Coinsurance)	Up to $104.75 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 $257 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 $257 of Medicare-Approved Amounts ****	$0	$0	$257 (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 $7220)*
BLOOD			
First 3 pints	$0	50%	50%♦
Next $257 of Medicare-Approved Amounts ****	$0	$0	$257 (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 $257 of Medicare-Approved Amounts *****	$0	$0	$257 (Part B Deductible)♦
Remainder of Medicare-Approved Amounts	80%	10%	10%♦

* This plan limits your annual out-of-pocket payment for Medicare-approved amounts $7220 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 $3610 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 the 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 $1676	$1257 (75% of Part A Deductible)	$419 (25% of Part A Deductible) ♦
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	Up to $157.12 a day (75% of Part A Coinsurance)	Up to $52.38 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 $257 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 $257 of Medicare-Approved Amounts ****	$0	$0	$257 (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 $3610)*
BLOOD			
First 3 pints	$0	75%	25% ♦
Next $257 of Medicare-Approved Amounts ****	$0	$0	$257 (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 $257 of Medicare-Approved Amounts *****	$0	$0	$257 (Part B Deductible) ♦
Remainder of Medicare-Approved Amounts	80%	15%	5% ♦

* This plan limits your annual out-of-pocket payment for Medicare-approved amounts $3610 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 $1676	$1676 (Part A Deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	Up to $209.50 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 $257 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 $257 of Medicare-Approved Amounts*	$0	$0	$257 (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 $257 of Medicare-Approved Amounts*	$0	$0	$257 (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 $257 of Medicare-Approved Amounts*	$0	$0	$257 (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