United American Application Packet

Thank you for your interest in the United American Medicare Supplement plan!

This packet provides you with access to the policy Outline of Coverage, printable application in addition to a link to the Choosing a Medigap Policy Guide.

Should you decide to apply by secure upload/mail/fax/email, the printable application needs to be reviewed and signed by an Agent before it can be submitted to United American. You may email, fax or mail it in to CDA Insurance:

- Fax: 1.541.284.2994
- Email: cs@cda-insurance.com
- Secure File Upload: Click here
- Mail: CDA Insurance LLC
  PO Box 26540
  Eugene, Oregon 97402

Other Important Information
Download Medicare's Choosing a Medigap Policy Guide (.pdf) Download Policy Outline (.pdf) Download Application (.pdf)

Our website: https://medicare-oregon.com

If you should have any questions on the application, please call us at 1.800.884.2343 or 1.541.434.9613.

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 June 1, 2010

Benefit Plans A, B, C, D, F, HDF, G, 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 in your state.

BASIC BENEFITS:
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of the Part B coinsurance or copayments.
Blood: First three pints of blood each year.
Hospice: Part A coinsurance.

A*	B*	C*	D*	F*	F *,**	G*
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance		Basic, including 100% Part B coinsurance
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible
		Part B Deductible		Part B Deductible		
				Part B Excess (100%)		Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency

K*	L*	M	N*
Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Foreign Travel Emergency	Foreign Travel Emergency
Out-of-pocket limit $5560; paid at 100% after limit reached	Out-of-pocket limit $2780; paid at 100% after limit reached		

* Denotes plans available by United American Insurance Company.

** Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2300 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed $2300. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

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	5/1/2013
B	1932	966	483	161	5F0	1/1/2017
C	2037	1019	510	170	5F4	5/1/2013
F	2296	1148	574	192	5FC	1/1/2019
HDF	364	182	91	31	5FG	4/1/2014
K	1159	580	290	97	5FO	4/1/2014
L	1628	814	407	136	5FS	4/1/2014

Standard

Plan	A	SA	Q	M	Plan Code	Effective Date
A	1478	739	370	124	5EY	5/1/2013
B	2223	1112	556	186	5F2	1/1/2017
C	2344	1172	586	196	5F6	5/1/2013
F	2642	1321	661	221	5FE	1/1/2019
HDF	419	210	105	35	5FI	4/1/2014
K	1333	667	334	112	5FQ	4/1/2014
L	1873	937	469	157	5FU	4/1/2014

Female

Preferred

Plan	A	SA	Q	M	Plan Code	Effective Date
A	1118	559	280	94	5EX	5/1/2013
B	1681	841	421	141	5F1	1/1/2017
C	1772	886	443	148	5F5	5/1/2013
F	1997	999	500	167	5FD	1/1/2019
HDF	317	159	80	27	5FH	4/1/2014
K	1008	504	252	84	5FP	4/1/2014
L	1416	708	354	118	5FT	4/1/2014

Standard

Plan	A	SA	Q	M	Plan Code	Effective Date
A	1285	643	322	108	5EZ	5/1/2013
B	1932	966	483	161	5F3	1/1/2017
C	2037	1019	510	170	5F7	5/1/2013
F	2296	1148	574	192	5FF	1/1/2019
HDF	364	182	91	31	5FJ	4/1/2014
K	1159	580	290	97	5FR	4/1/2014
L	1628	814	407	136	5FV	4/1/2014

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

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	5/1/2013
B	1932	966	483	161	5F0	1/1/2017
C	2037	1019	510	170	5F4	5/1/2013
D	1956	978	489	163	5F8	1/1/2017
F	2296	1148	574	192	5FC	1/1/2019
HDF	364	182	91	31	5FG	4/1/2014
G	1996	998	499	167	5FK	1/1/2017
K	1159	580	290	97	5FO	4/1/2014
L	1628	814	407	136	5FS	4/1/2014
N	1818	909	455	152	5FW	1/1/2019

Standard

Plan	A	SA	Q	M	Plan Code	Effective Date
A	1478	739	370	124	5EY	5/1/2013
B	2223	1112	556	186	5F2	1/1/2017
C	2344	1172	586	196	5F6	5/1/2013
D	2250	1125	563	188	5FA	1/1/2017
F	2642	1321	661	221	5FE	1/1/2019
HDF	419	210	105	35	5FI	4/1/2014
G	2297	1149	575	192	5FM	1/1/2017
K	1333	667	334	112	5FQ	4/1/2014
L	1873	937	469	157	5FU	4/1/2014
N	2092	1046	523	175	5FY	1/1/2019

Female

Preferred

Plan	A	SA	Q	M	Plan Code	Effective Date
A	1118	559	280	94	5EX	5/1/2013
B	1681	841	421	141	5F1	1/1/2017
C	1772	886	443	148	5F5	5/1/2013
D	1701	851	426	142	5F9	1/1/2017
F	1997	999	500	167	5FD	1/1/2019
HDF	317	159	80	27	5FH	4/1/2014
G	1736	868	434	145	5FL	1/1/2017
K	1008	504	252	84	5FP	4/1/2014
L	1416	708	354	118	5FT	4/1/2014
N	1581	791	396	132	5FX	1/1/2019

Standard

Plan	A	SA	Q	M	Plan Code	Effective Date
A	1285	643	322	108	5EZ	5/1/2013
B	1932	966	483	161	5F3	1/1/2017
C	2037	1019	510	170	5F7	5/1/2013
D	1956	978	489	163	5FB	1/1/2017
F	2296	1148	574	192	5FF	1/1/2019
HDF	364	182	91	31	5FJ	4/1/2014
G	1996	998	499	167	5FN	1/1/2017
K	1159	580	290	97	5FR	4/1/2014
L	1628	814	407	136	5FV	4/1/2014
N	1818	909	455	152	5FZ	1/1/2019

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

PLAN A

Male

Preferred Effective Date: 5/1/2013 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: 5/1/2013 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: 5/1/2013 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: 5/1/2013 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: 1/1/2017 Plan Code: 5AM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1932	966	483	161
66	2039	1020	510	170
67	2130	1065	533	178
68	2216	1108	554	185
69	2308	1154	577	193
70	2400	1200	600	200
71	2470	1235	618	206
72	2509	1255	628	210
73	2556	1278	639	213
74	2592	1296	648	216
75	2626	1313	657	219
76	2647	1324	662	221
77	2651	1326	663	221
78	2655	1328	664	222
79	2661	1331	666	222
80+	2661	1331	666	222

Standard Effective Date: 1/1/2017 Plan Code: 5AO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2223	1112	556	186
66	2346	1173	587	196
67	2451	1226	613	205
68	2550	1275	638	213
69	2656	1328	664	222
70	2762	1381	691	231
71	2843	1422	711	237
72	2887	1444	722	241
73	2941	1471	736	246
74	2983	1492	746	249
75	3022	1511	756	252
76	3045	1523	762	254
77	3050	1525	763	255
78	3055	1528	764	255
79	3063	1532	766	256
80+	3063	1532	766	256

Female

Preferred Effective Date: 1/1/2017 Plan Code: 5AN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1681	841	421	141
66	1773	887	444	148
67	1852	926	463	155
68	1928	964	482	161
69	2008	1004	502	168
70	2087	1044	522	174
71	2149	1075	538	180
72	2182	1091	546	182
73	2223	1112	556	186
74	2255	1128	564	188
75	2284	1142	571	191
76	2302	1151	576	192
77	2306	1153	577	193
78	2309	1155	578	193
79	2315	1158	579	193
80+	2315	1158	579	193

Standard Effective Date: 1/1/2017 Plan Code: 5AP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1932	966	483	161
66	2039	1020	510	170
67	2130	1065	533	178
68	2216	1108	554	185
69	2308	1154	577	193
70	2400	1200	600	200
71	2470	1235	618	206
72	2509	1255	628	210
73	2556	1278	639	213
74	2592	1296	648	216
75	2626	1313	657	219
76	2647	1324	662	221
77	2651	1326	663	221
78	2655	1328	664	222
79	2661	1331	666	222
80+	2661	1331	666	222

PLAN C

Male

Preferred Effective Date: 5/1/2013 Plan Code: 5B4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2037	1019	510	170
66	2146	1073	537	179
67	2241	1121	561	187
68	2338	1169	585	195
69	2446	1223	612	204
70	2554	1277	639	213
71	2644	1322	661	221
72	2704	1352	676	226
73	2773	1387	694	232
74	2830	1415	708	236
75	2884	1442	721	241
76	2924	1462	731	244
77	2972	1486	743	248
78	3021	1511	756	252
79	3071	1536	768	256
80+	3156	1578	789	263

Standard Effective Date: 5/1/2013 Plan Code: 5B6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2344	1172	586	196
66	2469	1235	618	206
67	2578	1289	645	215
68	2690	1345	673	225
69	2814	1407	704	235
70	2939	1470	735	245
71	3043	1522	761	254
72	3112	1556	778	260
73	3190	1595	798	266
74	3257	1629	815	272
75	3318	1659	830	277
76	3365	1683	842	281
77	3420	1710	855	285
78	3477	1739	870	290
79	3533	1767	884	295
80+	3632	1816	908	303

Female

Preferred Effective Date: 5/1/2013 Plan Code: 5B5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1772	886	443	148
66	1866	933	467	156
67	1949	975	488	163
68	2034	1017	509	170
69	2127	1064	532	178
70	2221	1111	556	186
71	2300	1150	575	192
72	2352	1176	588	196
73	2412	1206	603	201
74	2462	1231	616	206
75	2508	1254	627	209
76	2544	1272	636	212
77	2585	1293	647	216
78	2628	1314	657	219
79	2671	1336	668	223
80+	2745	1373	687	229

Standard Effective Date: 5/1/2013 Plan Code: 5B7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2037	1019	510	170
66	2146	1073	537	179
67	2241	1121	561	187
68	2338	1169	585	195
69	2446	1223	612	204
70	2554	1277	639	213
71	2644	1322	661	221
72	2704	1352	676	226
73	2773	1387	694	232
74	2830	1415	708	236
75	2884	1442	721	241
76	2924	1462	731	244
77	2972	1486	743	248
78	3021	1511	756	252
79	3071	1536	768	256
80+	3156	1578	789	263

PLAN D

Male

Preferred Effective Date: 1/1/2017 Plan Code: 5BM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1956	978	489	163
66	2070	1035	518	173
67	2170	1085	543	181
68	2272	1136	568	190
69	2384	1192	596	199
70	2496	1248	624	208
71	2591	1296	648	216
72	2655	1328	664	222
73	2726	1363	682	228
74	2785	1393	697	233
75	2840	1420	710	237
76	2883	1442	721	241
77	2934	1467	734	245
78	2985	1493	747	249
79	3036	1518	759	253
80+	3125	1563	782	261

Standard Effective Date: 1/1/2017 Plan Code: 5BO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2250	1125	563	188
66	2382	1191	596	199
67	2497	1249	625	209
68	2614	1307	654	218
69	2743	1372	686	229
70	2872	1436	718	240
71	2982	1491	746	249
72	3055	1528	764	255
73	3136	1568	784	262
74	3205	1603	802	268
75	3268	1634	817	273
76	3317	1659	830	277
77	3376	1688	844	282
78	3435	1718	859	287
79	3494	1747	874	292
80+	3596	1798	899	300

Female

Preferred Effective Date: 1/1/2017 Plan Code: 5BN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1701	851	426	142
66	1800	900	450	150
67	1888	944	472	158
68	1976	988	494	165
69	2074	1037	519	173
70	2171	1086	543	181
71	2254	1127	564	188
72	2309	1155	578	193
73	2371	1186	593	198
74	2423	1212	606	202
75	2470	1235	618	206
76	2507	1254	627	209
77	2552	1276	638	213
78	2597	1299	650	217
79	2641	1321	661	221
80+	2718	1359	680	227

Standard Effective Date: 1/1/2017 Plan Code: 5BP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1956	978	489	163
66	2070	1035	518	173
67	2170	1085	543	181
68	2272	1136	568	190
69	2384	1192	596	199
70	2496	1248	624	208
71	2591	1296	648	216
72	2655	1328	664	222
73	2726	1363	682	228
74	2785	1393	697	233
75	2840	1420	710	237
76	2883	1442	721	241
77	2934	1467	734	245
78	2985	1493	747	249
79	3036	1518	759	253
80+	3125	1563	782	261

PLAN F

Male

Preferred Effective Date: 1/1/2019 Plan Code: 5C4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2296	1148	574	192
66	2417	1209	605	202
67	2523	1262	631	211
68	2632	1316	658	220
69	2753	1377	689	230
70	2874	1437	719	240
71	2975	1488	744	248
72	3044	1522	761	254
73	3120	1560	780	260
74	3185	1593	797	266
75	3244	1622	811	271
76	3288	1644	822	274
77	3344	1672	836	279
78	3398	1699	850	284
79	3454	1727	864	288
80+	3549	1775	888	296

Standard Effective Date: 1/1/2019 Plan Code: 5C6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2642	1321	661	221
66	2781	1391	696	232
67	2903	1452	726	242
68	3028	1514	757	253
69	3168	1584	792	264
70	3307	1654	827	276
71	3424	1712	856	286
72	3503	1752	876	292
73	3590	1795	898	300
74	3665	1833	917	306
75	3732	1866	933	311
76	3784	1892	946	316
77	3848	1924	962	321
78	3911	1956	978	326
79	3975	1988	994	332
80+	4084	2042	1021	341

Female

Preferred Effective Date: 1/1/2019 Plan Code: 5C5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1997	999	500	167
66	2102	1051	526	176
67	2194	1097	549	183
68	2289	1145	573	191
69	2395	1198	599	200
70	2500	1250	625	209
71	2588	1294	647	216
72	2648	1324	662	221
73	2714	1357	679	227
74	2770	1385	693	231
75	2821	1411	706	236
76	2860	1430	715	239
77	2909	1455	728	243
78	2956	1478	739	247
79	3004	1502	751	251
80+	3087	1544	772	258

Standard Effective Date: 1/1/2019 Plan Code: 5C7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2296	1148	574	192
66	2417	1209	605	202
67	2523	1262	631	211
68	2632	1316	658	220
69	2753	1377	689	230
70	2874	1437	719	240
71	2975	1488	744	248
72	3044	1522	761	254
73	3120	1560	780	260
74	3185	1593	797	266
75	3244	1622	811	271
76	3288	1644	822	274
77	3344	1672	836	279
78	3398	1699	850	284
79	3454	1727	864	288
80+	3549	1775	888	296

PLAN HDF

Male

Preferred Effective Date: 4/1/2014 Plan Code: 5CM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	364	182	91	31
66	394	197	99	33
67	421	211	106	36
68	440	220	110	37
69	459	230	115	39
70	480	240	120	40
71	497	249	125	42
72	521	261	131	44
73	548	274	137	46
74	572	286	143	48
75	597	299	150	50
76	606	303	152	51
77	616	308	154	52
78	626	313	157	53
79	635	318	159	53
80+	654	327	164	55

Standard Effective Date: 4/1/2014 Plan Code: 5CO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	419	210	105	35
66	454	227	114	38
67	484	242	121	41
68	506	253	127	43
69	528	264	132	44
70	552	276	138	46
71	571	286	143	48
72	600	300	150	50
73	630	315	158	53
74	659	330	165	55
75	687	344	172	58
76	697	349	175	59
77	709	355	178	60
78	720	360	180	60
79	731	366	183	61
80+	752	376	188	63

Female

Preferred Effective Date: 4/1/2014 Plan Code: 5CN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	317	159	80	27
66	343	172	86	29
67	366	183	92	31
68	383	192	96	32
69	399	200	100	34
70	417	209	105	35
71	432	216	108	36
72	453	227	114	38
73	477	239	120	40
74	498	249	125	42
75	519	260	130	44
76	527	264	132	44
77	536	268	134	45
78	544	272	136	46
79	553	277	139	47
80+	569	285	143	48

Standard Effective Date: 4/1/2014 Plan Code: 5CP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	364	182	91	31
66	394	197	99	33
67	421	211	106	36
68	440	220	110	37
69	459	230	115	39
70	480	240	120	40
71	497	249	125	42
72	521	261	131	44
73	548	274	137	46
74	572	286	143	48
75	597	299	150	50
76	606	303	152	51
77	616	308	154	52
78	626	313	157	53
79	635	318	159	53
80+	654	327	164	55

PLAN G

Male

Preferred Effective Date: 1/1/2017 Plan Code: 5D4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1996	998	499	167
66	2113	1057	529	177
67	2214	1107	554	185
68	2316	1158	579	193
69	2430	1215	608	203
70	2544	1272	636	212
71	2639	1320	660	220
72	2705	1353	677	226
73	2777	1389	695	232
74	2838	1419	710	237
75	2893	1447	724	242
76	2936	1468	734	245
77	2988	1494	747	249
78	3040	1520	760	254
79	3092	1546	773	258
80+	3183	1592	796	266

Standard Effective Date: 1/1/2017 Plan Code: 5D6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2297	1149	575	192
66	2431	1216	608	203
67	2548	1274	637	213
68	2666	1333	667	223
69	2796	1398	699	233
70	2927	1464	732	244
71	3037	1519	760	254
72	3113	1557	779	260
73	3195	1598	799	267
74	3265	1633	817	273
75	3329	1665	833	278
76	3379	1690	845	282
77	3439	1720	860	287
78	3498	1749	875	292
79	3558	1779	890	297
80+	3662	1831	916	306

Female

Preferred Effective Date: 1/1/2017 Plan Code: 5D5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1736	868	434	145
66	1838	919	460	154
67	1926	963	482	161
68	2015	1008	504	168
69	2113	1057	529	177
70	2213	1107	554	185
71	2296	1148	574	192
72	2353	1177	589	197
73	2415	1208	604	202
74	2468	1234	617	206
75	2517	1259	630	210
76	2554	1277	639	213
77	2599	1300	650	217
78	2644	1322	661	221
79	2689	1345	673	225
80+	2768	1384	692	231

Standard Effective Date: 1/1/2017 Plan Code: 5D7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1996	998	499	167
66	2113	1057	529	177
67	2214	1107	554	185
68	2316	1158	579	193
69	2430	1215	608	203
70	2544	1272	636	212
71	2639	1320	660	220
72	2705	1353	677	226
73	2777	1389	695	232
74	2838	1419	710	237
75	2893	1447	724	242
76	2936	1468	734	245
77	2988	1494	747	249
78	3040	1520	760	254
79	3092	1546	773	258
80+	3183	1592	796	266

PLAN K

Male

Preferred Effective Date: 4/1/2014 Plan Code: P44

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1159	580	290	97
66	1246	623	312	104
67	1320	660	330	110
68	1388	694	347	116
69	1461	731	366	122
70	1542	771	386	129
71	1585	793	397	133
72	1614	807	404	135
73	1649	825	413	138
74	1675	838	419	140
75	1715	858	429	143
76	1739	870	435	145
77	1754	877	439	147
78	1771	886	443	148
79	1782	891	446	149
80+	1804	902	451	151

Standard Effective Date: 4/1/2014 Plan Code: P46

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1333	667	334	112
66	1434	717	359	120
67	1519	760	380	127
68	1598	799	400	134
69	1681	841	421	141
70	1775	888	444	148
71	1824	912	456	152
72	1857	929	465	155
73	1898	949	475	159
74	1927	964	482	161
75	1974	987	494	165
76	2001	1001	501	167
77	2018	1009	505	169
78	2038	1019	510	170
79	2051	1026	513	171
80+	2076	1038	519	173

Female

Preferred Effective Date: 4/1/2014 Plan Code: P45

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1008	504	252	84
66	1084	542	271	91
67	1148	574	287	96
68	1208	604	302	101
69	1271	636	318	106
70	1341	671	336	112
71	1379	690	345	115
72	1404	702	351	117
73	1434	717	359	120
74	1457	729	365	122
75	1492	746	373	125
76	1512	756	378	126
77	1525	763	382	128
78	1540	770	385	129
79	1551	776	388	130
80+	1569	785	393	131

Standard Effective Date: 4/1/2014 Plan Code: P47

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1159	580	290	97
66	1246	623	312	104
67	1320	660	330	110
68	1388	694	347	116
69	1461	731	366	122
70	1542	771	386	129
71	1585	793	397	133
72	1614	807	404	135
73	1649	825	413	138
74	1675	838	419	140
75	1715	858	429	143
76	1739	870	435	145
77	1754	877	439	147
78	1771	886	443	148
79	1782	891	446	149
80+	1804	902	451	151

PLAN L

Male

Preferred Effective Date: 4/1/2014 Plan Code: P60

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1628	814	407	136
66	1750	875	438	146
67	1860	930	465	155
68	1954	977	489	163
69	2054	1027	514	172
70	2170	1085	543	181
71	2228	1114	557	186
72	2273	1137	569	190
73	2321	1161	581	194
74	2362	1181	591	197
75	2413	1207	604	202
76	2448	1224	612	204
77	2470	1235	618	206
78	2491	1246	623	208
79	2506	1253	627	209
80+	2535	1268	634	212

Standard Effective Date: 4/1/2014 Plan Code: P62

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1873	937	469	157
66	2014	1007	504	168
67	2141	1071	536	179
68	2249	1125	563	188
69	2363	1182	591	197
70	2497	1249	625	209
71	2564	1282	641	214
72	2615	1308	654	218
73	2671	1336	668	223
74	2719	1360	680	227
75	2776	1388	694	232
76	2817	1409	705	235
77	2843	1422	711	237
78	2866	1433	717	239
79	2883	1442	721	241
80+	2918	1459	730	244

Female

Preferred Effective Date: 4/1/2014 Plan Code: P61

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1416	708	354	118
66	1523	762	381	127
67	1618	809	405	135
68	1700	850	425	142
69	1786	893	447	149
70	1888	944	472	158
71	1938	969	485	162
72	1977	989	495	165
73	2019	1010	505	169
74	2055	1028	514	172
75	2099	1050	525	175
76	2129	1065	533	178
77	2149	1075	538	180
78	2166	1083	542	181
79	2179	1090	545	182
80+	2205	1103	552	184

Standard Effective Date: 4/1/2014 Plan Code: P63

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1628	814	407	136
66	1750	875	438	146
67	1860	930	465	155
68	1954	977	489	163
69	2054	1027	514	172
70	2170	1085	543	181
71	2228	1114	557	186
72	2273	1137	569	190
73	2321	1161	581	194
74	2362	1181	591	197
75	2413	1207	604	202
76	2448	1224	612	204
77	2470	1235	618	206
78	2491	1246	623	208
79	2506	1253	627	209
80+	2535	1268	634	212

PLAN N

Male

Preferred Effective Date: 1/1/2019 Plan Code: 5DM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1818	909	455	152
66	1921	961	481	161
67	2015	1008	504	168
68	2110	1055	528	176
69	2220	1110	555	185
70	2327	1164	582	194
71	2419	1210	605	202
72	2481	1241	621	207
73	2553	1277	639	213
74	2611	1306	653	218
75	2669	1335	668	223
76	2714	1357	679	227
77	2767	1384	692	231
78	2825	1413	707	236
79	2879	1440	720	240
80+	2978	1489	745	249

Standard Effective Date: 1/1/2019 Plan Code: 5DO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2092	1046	523	175
66	2211	1106	553	185
67	2319	1160	580	194
68	2429	1215	608	203
69	2555	1278	639	213
70	2678	1339	670	224
71	2784	1392	696	232
72	2855	1428	714	238
73	2937	1469	735	245
74	3005	1503	752	251
75	3071	1536	768	256
76	3123	1562	781	261
77	3184	1592	796	266
78	3251	1626	813	271
79	3313	1657	829	277
80+	3426	1713	857	286

Female

Preferred Effective Date: 1/1/2019 Plan Code: 5DN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1581	791	396	132
66	1671	836	418	140
67	1753	877	439	147
68	1836	918	459	153
69	1931	966	483	161
70	2024	1012	506	169
71	2104	1052	526	176
72	2158	1079	540	180
73	2220	1110	555	185
74	2271	1136	568	190
75	2322	1161	581	194
76	2361	1181	591	197
77	2407	1204	602	201
78	2457	1229	615	205
79	2505	1253	627	209
80+	2590	1295	648	216

Standard Effective Date: 1/1/2019 Plan Code: 5DP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1818	909	455	152
66	1921	961	481	161
67	2015	1008	504	168
68	2110	1055	528	176
69	2220	1110	555	185
70	2327	1164	582	194
71	2419	1210	605	202
72	2481	1241	621	207
73	2553	1277	639	213
74	2611	1306	653	218
75	2669	1335	668	223
76	2714	1357	679	227
77	2767	1384	692	231
78	2825	1413	707	236
79	2879	1440	720	240
80+	2978	1489	745	249

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 $1364	$0	$1364 (Part A Deductible)
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	$0	Up to $170.50 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 $185 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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 $1364	$1364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	$0	Up to $170.50 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 $185 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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 $1364	$1364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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 $185 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 $185 of Medicare Approved Amounts*	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$185 (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 $1364	$1364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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 D

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $185 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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 $2300 deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $2300. 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 $2300 DEDUCTIBLE, ** PLAN PAYS	IN ADDITION TO $2300 DEDUCTIBLE, ** YOU PAY
HOSPITALIZATION *			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1364	$1364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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 $185 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 $2300 deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $2300. 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 $2300 DEDUCTIBLE, ** PLAN PAYS	IN ADDITION TO $2300 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 $185 of Medicare Approved Amounts*	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$185 (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
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 $1364	$1364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $185 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 $185 of Medicare Approved Amounts*	$0	$0	$185 (Part B Deductible)
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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 K

* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $5560 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 $1364	$682 (50% of Part A Deductible)	$682 (50% of Part A Deductible)♦
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $85.25 a day (50% of Part A Coinsurance)	Up to $85.25 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 $185 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 $185 of Medicare Approved Amounts ****	$0	$0	$185 (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 $5560)*
BLOOD			
First 3 pints	$0	50%	50% ♦
Next $185 of Medicare Approved Amounts ****	$0	$0	$185 (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 $185 of Medicare Approved Amounts *****	$0	$0	$185 (Part B Deductible) ♦
Remainder of Medicare Approved Amounts	80%	10%	10% ♦

* This plan limits your annual out-of-pocket payment for Medicare-approved amounts $5560 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 $2780 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 $1364	$1023 (75% of Part A Deductible)	$341 (25% of Part A Deductible) ♦
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $127.88 a day (75% of Part A Coinsurance)	Up to $42.62 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 $185 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 $185 of Medicare Approved Amounts ****	$0	$0	$185 (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 $2780)*
BLOOD			
First 3 pints	$0	75%	25% ♦
Next $185 of Medicare Approved Amounts ****	$0	$0	$185 (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 $185 of Medicare Approved Amounts *****	$0	$0	$185 (Part B Deductible) ♦
Remainder of Medicare Approved Amounts	80%	15%	5% ♦

* This plan limits your annual out-of-pocket payment for Medicare-approved amounts $2780 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 $1364	$1364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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 $185 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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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