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 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 2021(2)					$6,220(2)	$3,110(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 $2,370 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	2171	1086	543	181	5F0	01/15/2021
C	2202	1101	551	184	5F4	01/15/2021
D	2135	1068	534	178	5F8	01/15/2021
F	2572	1286	643	215	5FC	01/15/2020
HDF	364	182	91	31	5FG	04/01/2014
G	2076	1038	519	173	5FK	01/15/2020
HDG	364	182	91	31	5I6	01/01/2020
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	2499	1250	625	209	5F2	01/15/2021
C	2534	1267	634	212	5F6	01/15/2021
D	2457	1229	615	205	5FA	01/15/2021
F	2959	1480	740	247	5FE	01/15/2020
HDF	419	210	105	35	5FI	04/01/2014
G	2389	1195	598	200	5FM	01/15/2020
HDG	419	210	105	35	5I8	01/01/2020
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	1889	945	473	158	5F1	01/15/2021
C	1916	958	479	160	5F5	01/15/2021
D	1857	929	465	155	5F9	01/15/2021
F	2237	1119	560	187	5FD	01/15/2020
HDF	317	159	80	27	5FH	04/01/2014
G	1806	903	452	151	5FL	01/15/2020
HDG	317	159	80	27	5I7	01/01/2020
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	2171	1086	543	181	5F3	01/15/2021
C	2202	1101	551	184	5F7	01/15/2021
D	2135	1068	534	178	5FB	01/15/2021
F	2572	1286	643	215	5FF	01/15/2020
HDF	364	182	91	31	5FJ	04/01/2014
G	2076	1038	519	173	5FN	01/15/2020
HDG	364	182	91	31	5I9	01/01/2020
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	2171	1086	543	181	5F0	01/15/2021
C	2202	1101	551	184	5F4	01/15/2021
D	2135	1068	534	178	5F8	01/15/2021
F	2572	1286	643	215	5FC	01/15/2020
HDF	364	182	91	31	5FG	04/01/2014
G	2076	1038	519	173	5FK	01/15/2020
HDG	364	182	91	31	5I6	01/01/2020
K	1228	614	307	103	5FO	01/15/2020
L	1725	863	432	144	5FS	01/15/2020
N	2042	1021	511	171	5FW	01/15/2021

Standard

Plan	A	SA	Q	M	Plan Code	Effective Date
A	1478	739	370	124	5EY	05/01/2013
B	2499	1250	625	209	5F2	01/15/2021
C	2534	1267	634	212	5F6	01/15/2021
D	2457	1229	615	205	5FA	01/15/2021
F	2959	1480	740	247	5FE	01/15/2020
HDF	419	210	105	35	5FI	04/01/2014
G	2389	1195	598	200	5FM	01/15/2020
HDG	419	210	105	35	5I8	01/01/2020
K	1413	707	354	118	5FQ	01/15/2020
L	1985	993	497	166	5FU	01/15/2020
N	2350	1175	588	196	5FY	01/15/2021

Female

Preferred

Plan	A	SA	Q	M	Plan Code	Effective Date
A	1118	559	280	94	5EX	05/01/2013
B	1889	945	473	158	5F1	01/15/2021
C	1916	958	479	160	5F5	01/15/2021
D	1857	929	465	155	5F9	01/15/2021
F	2237	1119	560	187	5FD	01/15/2020
HDF	317	159	80	27	5FH	04/01/2014
G	1806	903	452	151	5FL	01/15/2020
HDG	317	159	80	27	5I7	01/01/2020
K	1068	534	267	89	5FP	01/15/2020
L	1500	750	375	125	5FT	01/15/2020
N	1776	888	444	148	5FX	01/15/2021

Standard

Plan	A	SA	Q	M	Plan Code	Effective Date
A	1285	643	322	108	5EZ	05/01/2013
B	2171	1086	543	181	5F3	01/15/2021
C	2202	1101	551	184	5F7	01/15/2021
D	2135	1068	534	178	5FB	01/15/2021
F	2572	1286	643	215	5FF	01/15/2020
HDF	364	182	91	31	5FJ	04/01/2014
G	2076	1038	519	173	5FN	01/15/2020
HDG	364	182	91	31	5I9	01/01/2020
K	1228	614	307	103	5FR	01/15/2020
L	1725	863	432	144	5FV	01/15/2020
N	2042	1021	511	171	5FZ	01/15/2021

*** 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: 01/15/2021 Plan Code: 5AM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2171	1086	543	181
66	2291	1146	573	191
67	2393	1197	599	200
68	2491	1246	623	208
69	2593	1297	649	217
70	2697	1349	675	225
71	2776	1388	694	232
72	2818	1409	705	235
73	2872	1436	718	240
74	2912	1456	728	243
75	2951	1476	738	246
76	2974	1487	744	248
77	2979	1490	745	249
78	2983	1492	746	249
79	2991	1496	748	250
80+	2991	1496	748	250

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2499	1250	625	209
66	2636	1318	659	220
67	2754	1377	689	230
68	2866	1433	717	239
69	2984	1492	746	249
70	3103	1552	776	259
71	3194	1597	799	267
72	3243	1622	811	271
73	3305	1653	827	276
74	3351	1676	838	280
75	3396	1698	849	283
76	3423	1712	856	286
77	3428	1714	857	286
78	3433	1717	859	287
79	3442	1721	861	287
80+	3442	1721	861	287

Female

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1889	945	473	158
66	1993	997	499	167
67	2082	1041	521	174
68	2166	1083	542	181
69	2256	1128	564	188
70	2346	1173	587	196
71	2414	1207	604	202
72	2452	1226	613	205
73	2498	1249	625	209
74	2533	1267	634	212
75	2567	1284	642	214
76	2587	1294	647	216
77	2591	1296	648	216
78	2595	1298	649	217
79	2602	1301	651	217
80+	2602	1301	651	217

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2171	1086	543	181
66	2291	1146	573	191
67	2393	1197	599	200
68	2491	1246	623	208
69	2593	1297	649	217
70	2697	1349	675	225
71	2776	1388	694	232
72	2818	1409	705	235
73	2872	1436	718	240
74	2912	1456	728	243
75	2951	1476	738	246
76	2974	1487	744	248
77	2979	1490	745	249
78	2983	1492	746	249
79	2991	1496	748	250
80+	2991	1496	748	250

PLAN C

Male

Preferred Effective Date: 01/15/2021 Plan Code: 5B4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2202	1101	551	184
66	2320	1160	580	194
67	2422	1211	606	202
68	2528	1264	632	211
69	2644	1322	661	221
70	2761	1381	691	231
71	2860	1430	715	239
72	2924	1462	731	244
73	2998	1499	750	250
74	3060	1530	765	255
75	3117	1559	780	260
76	3162	1581	791	264
77	3214	1607	804	268
78	3267	1634	817	273
79	3320	1660	830	277
80+	3412	1706	853	285

Standard Effective Date: 01/15/2021 Plan Code: 5B6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2534	1267	634	212
66	2669	1335	668	223
67	2787	1394	697	233
68	2909	1455	728	243
69	3043	1522	761	254
70	3177	1589	795	265
71	3291	1646	823	275
72	3365	1683	842	281
73	3450	1725	863	288
74	3521	1761	881	294
75	3587	1794	897	299
76	3639	1820	910	304
77	3698	1849	925	309
78	3760	1880	940	314
79	3821	1911	956	319
80+	3927	1964	982	328

Female

Preferred Effective Date: 01/15/2021 Plan Code: 5B5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1916	958	479	160
66	2018	1009	505	169
67	2107	1054	527	176
68	2199	1100	550	184
69	2300	1150	575	192
70	2401	1201	601	201
71	2488	1244	622	208
72	2544	1272	636	212
73	2608	1304	652	218
74	2662	1331	666	222
75	2712	1356	678	226
76	2751	1376	688	230
77	2795	1398	699	233
78	2842	1421	711	237
79	2888	1444	722	241
80+	2968	1484	742	248

Standard Effective Date: 01/15/2021 Plan Code: 5B7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2202	1101	551	184
66	2320	1160	580	194
67	2422	1211	606	202
68	2528	1264	632	211
69	2644	1322	661	221
70	2761	1381	691	231
71	2860	1430	715	239
72	2924	1462	731	244
73	2998	1499	750	250
74	3060	1530	765	255
75	3117	1559	780	260
76	3162	1581	791	264
77	3214	1607	804	268
78	3267	1634	817	273
79	3320	1660	830	277
80+	3412	1706	853	285

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

PLAN D

Male

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2135	1068	534	178
66	2260	1130	565	189
67	2370	1185	593	198
68	2480	1240	620	207
69	2603	1302	651	217
70	2724	1362	681	227
71	2829	1415	708	236
72	2900	1450	725	242
73	2977	1489	745	249
74	3041	1521	761	254
75	3100	1550	775	259
76	3147	1574	787	263
77	3203	1602	801	267
78	3260	1630	815	272
79	3315	1658	829	277
80+	3412	1706	853	285

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2457	1229	615	205
66	2601	1301	651	217
67	2727	1364	682	228
68	2854	1427	714	238
69	2995	1498	749	250
70	3135	1568	784	262
71	3256	1628	814	272
72	3337	1669	835	279
73	3425	1713	857	286
74	3499	1750	875	292
75	3568	1784	892	298
76	3622	1811	906	302
77	3686	1843	922	308
78	3751	1876	938	313
79	3815	1908	954	318
80+	3927	1964	982	328

Female

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1857	929	465	155
66	1966	983	492	164
67	2061	1031	516	172
68	2157	1079	540	180
69	2264	1132	566	189
70	2370	1185	593	198
71	2461	1231	616	206
72	2522	1261	631	211
73	2589	1295	648	216
74	2645	1323	662	221
75	2697	1349	675	225
76	2738	1369	685	229
77	2786	1393	697	233
78	2835	1418	709	237
79	2884	1442	721	241
80+	2968	1484	742	248

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2135	1068	534	178
66	2260	1130	565	189
67	2370	1185	593	198
68	2480	1240	620	207
69	2603	1302	651	217
70	2724	1362	681	227
71	2829	1415	708	236
72	2900	1450	725	242
73	2977	1489	745	249
74	3041	1521	761	254
75	3100	1550	775	259
76	3147	1574	787	263
77	3203	1602	801	267
78	3260	1630	815	272
79	3315	1658	829	277
80+	3412	1706	853	285

PLAN F

Male

Preferred Effective Date: 01/15/2020 Plan Code: 5C4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2572	1286	643	215
66	2707	1354	677	226
67	2825	1413	707	236
68	2948	1474	737	246
69	3083	1542	771	257
70	3219	1610	805	269
71	3332	1666	833	278
72	3409	1705	853	285
73	3494	1747	874	292
74	3567	1784	892	298
75	3632	1816	908	303
76	3682	1841	921	307
77	3745	1873	937	313
78	3806	1903	952	318
79	3868	1934	967	323
80+	3975	1988	994	332

Standard Effective Date: 01/15/2020 Plan Code: 5C6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2959	1480	740	247
66	3116	1558	779	260
67	3251	1626	813	271
68	3392	1696	848	283
69	3548	1774	887	296
70	3704	1852	926	309
71	3834	1917	959	320
72	3923	1962	981	327
73	4021	2011	1006	336
74	4105	2053	1027	343
75	4180	2090	1045	349
76	4238	2119	1060	354
77	4310	2155	1078	360
78	4380	2190	1095	365
79	4451	2226	1113	371
80+	4574	2287	1144	382

Female

Preferred Effective Date: 01/15/2020 Plan Code: 5C5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2237	1119	560	187
66	2355	1178	589	197
67	2457	1229	615	205
68	2564	1282	641	214
69	2682	1341	671	224
70	2800	1400	700	234
71	2898	1449	725	242
72	2965	1483	742	248
73	3040	1520	760	254
74	3103	1552	776	259
75	3160	1580	790	264
76	3203	1602	801	267
77	3258	1629	815	272
78	3311	1656	828	276
79	3365	1683	842	281
80+	3458	1729	865	289

Standard Effective Date: 01/15/2020 Plan Code: 5C7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2572	1286	643	215
66	2707	1354	677	226
67	2825	1413	707	236
68	2948	1474	737	246
69	3083	1542	771	257
70	3219	1610	805	269
71	3332	1666	833	278
72	3409	1705	853	285
73	3494	1747	874	292
74	3567	1784	892	298
75	3632	1816	908	303
76	3682	1841	921	307
77	3745	1873	937	313
78	3806	1903	952	318
79	3868	1934	967	323
80+	3975	1988	994	332

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

PLAN HDF

Male

Preferred Effective Date: 04/01/2014 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: 04/01/2014 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: 04/01/2014 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: 04/01/2014 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

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

PLAN G

Male

Preferred Effective Date: 01/15/2020 Plan Code: 5D4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2076	1038	519	173
66	2197	1099	550	184
67	2303	1152	576	192
68	2409	1205	603	201
69	2527	1264	632	211
70	2645	1323	662	221
71	2745	1373	687	229
72	2813	1407	704	235
73	2888	1444	722	241
74	2951	1476	738	246
75	3009	1505	753	251
76	3053	1527	764	255
77	3108	1554	777	259
78	3161	1581	791	264
79	3216	1608	804	268
80+	3310	1655	828	276

Standard Effective Date: 01/15/2020 Plan Code: 5D6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2389	1195	598	200
66	2528	1264	632	211
67	2650	1325	663	221
68	2773	1387	694	232
69	2908	1454	727	243
70	3044	1522	761	254
71	3159	1580	790	264
72	3237	1619	810	270
73	3323	1662	831	277
74	3396	1698	849	283
75	3462	1731	866	289
76	3514	1757	879	293
77	3576	1788	894	298
78	3638	1819	910	304
79	3701	1851	926	309
80+	3809	1905	953	318

Female

Preferred Effective Date: 01/15/2020 Plan Code: 5D5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1806	903	452	151
66	1911	956	478	160
67	2003	1002	501	167
68	2096	1048	524	175
69	2198	1099	550	184
70	2301	1151	576	192
71	2388	1194	597	199
72	2447	1224	612	204
73	2512	1256	628	210
74	2567	1284	642	214
75	2617	1309	655	219
76	2656	1328	664	222
77	2703	1352	676	226
78	2750	1375	688	230
79	2797	1399	700	234
80+	2879	1440	720	240

Standard Effective Date: 01/15/2020 Plan Code: 5D7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2076	1038	519	173
66	2197	1099	550	184
67	2303	1152	576	192
68	2409	1205	603	201
69	2527	1264	632	211
70	2645	1323	662	221
71	2745	1373	687	229
72	2813	1407	704	235
73	2888	1444	722	241
74	2951	1476	738	246
75	3009	1505	753	251
76	3053	1527	764	255
77	3108	1554	777	259
78	3161	1581	791	264
79	3216	1608	804	268
80+	3310	1655	828	276

PLAN HDG

Male

Preferred Effective Date: 01/01/2020 Plan Code: 5HO

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: 01/01/2020 Plan Code: 5HQ

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: 01/01/2020 Plan Code: 5HP

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: 01/01/2020 Plan Code: 5HR

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 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: 01/15/2021 Plan Code: 5DM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2042	1021	511	171
66	2158	1079	540	180
67	2264	1132	566	189
68	2372	1186	593	198
69	2495	1248	624	208
70	2616	1308	654	218
71	2718	1359	680	227
72	2787	1394	697	233
73	2868	1434	717	239
74	2935	1468	734	245
75	2999	1500	750	250
76	3049	1525	763	255
77	3109	1555	778	260
78	3174	1587	794	265
79	3235	1618	809	270
80+	3345	1673	837	279

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2350	1175	588	196
66	2484	1242	621	207
67	2605	1303	652	218
68	2730	1365	683	228
69	2871	1436	718	240
70	3010	1505	753	251
71	3128	1564	782	261
72	3208	1604	802	268
73	3300	1650	825	275
74	3377	1689	845	282
75	3451	1726	863	288
76	3509	1755	878	293
77	3578	1789	895	299
78	3653	1827	914	305
79	3723	1862	931	311
80+	3849	1925	963	321

Female

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1776	888	444	148
66	1878	939	470	157
67	1969	985	493	165
68	2063	1032	516	172
69	2170	1085	543	181
70	2275	1138	569	190
71	2364	1182	591	197
72	2425	1213	607	203
73	2494	1247	624	208
74	2553	1277	639	213
75	2609	1305	653	218
76	2652	1326	663	221
77	2704	1352	676	226
78	2761	1381	691	231
79	2814	1407	704	235
80+	2910	1455	728	243

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

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2042	1021	511	171
66	2158	1079	540	180
67	2264	1132	566	189
68	2372	1186	593	198
69	2495	1248	624	208
70	2616	1308	654	218
71	2718	1359	680	227
72	2787	1394	697	233
73	2868	1434	717	239
74	2935	1468	734	245
75	2999	1500	750	250
76	3049	1525	763	255
77	3109	1555	778	260
78	3174	1587	794	265
79	3235	1618	809	270
80+	3345	1673	837	279

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 $1484	$0	$1484 (Part A Deductible)
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	$0	Up to $185.50 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 $203 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 $203 of Medicare-Approved Amounts*	$0	$0	$203 (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 $203 of Medicare-Approved Amounts*	$0	$0	$203 (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 $203 of Medicare-Approved Amounts*	$0	$0	$203 (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 $1484	$1484 (Part A Deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	$0	Up to $185.50 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 $203 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 $203 of Medicare-Approved Amounts*	$0	$0	$203 (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 $203 of Medicare-Approved Amounts*	$0	$0	$203 (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 $203 of Medicare-Approved Amounts*	$0	$0	$203 (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 $1484	$1484 (Part A Deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $185.50 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 $203 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 $203 of Medicare-Approved Amounts*	$0	$203 (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 $203 of Medicare-Approved Amounts*	$0	$203 (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 $203 of Medicare-Approved Amounts*	$0	$203 (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 $1484	$1484 (Part A Deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $185.50 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 $203 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 $203 of Medicare-Approved Amounts*	$0	$0	$203 (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 $203 of Medicare-Approved Amounts*	$0	$0	$203 (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 $203 of Medicare-Approved Amounts*	$0	$0	$203 (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 $2370 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2370. 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 $2370 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2370 DEDUCTIBLE,** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1484	$1484 (Part A Deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $185.50 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 $203 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 $2370 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2370. 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 $2370 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2370 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 $203 of Medicare-Approved Amounts*	$0	$203 (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 $203 of Medicare-Approved Amounts*	$0	$203 (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 $203 of Medicare-Approved Amounts*	$0	$203 (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 $2370 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2370. 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 $2370 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2370 DEDUCTIBLE,** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1484	$1484 (Part A Deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $185.50 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 $203 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 $2370 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2370. 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 $2370 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2370 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 $203 of Medicare-Approved Amounts*	$0	$0	$203 (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 $203 of Medicare-Approved Amounts*	$0	$0	$203 (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 $203 of Medicare-Approved Amounts*	$0	$0	$203 (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 $6220 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 $1484	$742 (50% of Part A Deductible)	$742 (50% of Part A Deductible) ♦
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $92.75 a day (50% of Part A Coinsurance)	Up to $92.75 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 $203 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 $203 of Medicare-Approved Amounts ****	$0	$0	$203 (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 $6220)*
BLOOD			
First 3 pints	$0	50%	50%♦
Next $203 of Medicare-Approved Amounts ****	$0	$0	$203 (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 $203 of Medicare-Approved Amounts *****	$0	$0	$203 (Part B Deductible)♦
Remainder of Medicare-Approved Amounts	80%	10%	10%♦

* This plan limits your annual out-of-pocket payment for Medicare-approved amounts $6220 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 $3110 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 $1484	$1113 (75% of Part A Deductible)	$371 (25% of Part A Deductible) ♦
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $139.13 a day (75% of Part A Coinsurance)	Up to $46.38 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 $203 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 $203 of Medicare-Approved Amounts ****	$0	$0	$203 (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 $3110)*
BLOOD			
First 3 pints	$0	75%	25% ♦
Next $203 of Medicare-Approved Amounts ****	$0	$0	$203 (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 $203 of Medicare-Approved Amounts *****	$0	$0	$203 (Part B Deductible) ♦
Remainder of Medicare-Approved Amounts	80%	15%	5% ♦

* This plan limits your annual out-of-pocket payment for Medicare-approved amounts $3110 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 $1484	$1484 (Part A Deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $185.50 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 $203 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 $203 of Medicare-Approved Amounts*	$0	$0	$203 (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 $203 of Medicare-Approved Amounts*	$0	$0	$203 (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 $203 of Medicare-Approved Amounts*	$0	$0	$203 (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