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 2024(2)					$7,060(2)	$3,530(2)				

^ Denotes plans available by United American Insurance Company

(1) Plans F and G also have a high deductible option which requires first paying a plan deductible of $2,800 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

(2) Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

(3) Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that do not result in an inpatient admission.

PREMIUM INFORMATION

We, United American Insurance Company, can only raise your premium if we raise the premium for all policies like yours in this state. Until you are age 81, your premiums will increase on each policy anniversary solely because of your age change. Your premiums may also be increased due to increasing health costs for all policies in your class.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to United American Insurance Company, P.O. Box 8080, McKinney, Texas 75070. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, DO NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all your medical costs.

Neither United American Insurance Company nor its agents are connected with Medicare.

This Outline of Coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The Company may cancel your policy and refuse to pay claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

RENEWABILITY

This policy is guaranteed renewable for life. We have the right to change the renewal premiums for this policy in accordance with our table of premium rates applicable to all policies of this form and class. This policy provides a 31-day grace period.

UNDER AGE 65 GUARANTEED ISSUE PERIOD (G/I) *

Male

Preferred

Plan	A	SA	Q	M	Plan Code	Effective Date
A	1285	643	322	108	5EW	05/01/2013
B	2371	1186	593	198	5F0	02/01/2023
C	2404	1202	601	201	5F4	02/01/2023
D	2331	1166	583	195	5F8	02/01/2023
F	2808	1404	702	234	5FC	02/01/2023
HDF	397	199	100	34	5FG	02/01/2023
G	2267	1134	567	189	5FK	02/01/2023
HDG	397	199	100	34	5I6	02/01/2023
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	2728	1364	682	228	5F2	02/01/2023
C	2766	1383	692	231	5F6	02/01/2023
D	2683	1342	671	224	5FA	02/01/2023
F	3231	1616	808	270	5FE	02/01/2023
HDF	457	229	115	39	5FI	02/01/2023
G	2609	1305	653	218	5FM	02/01/2023
HDG	457	229	115	39	5I8	02/01/2023
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	2062	1031	516	172	5F1	02/01/2023
C	2091	1046	523	175	5F5	02/01/2023
D	2028	1014	507	169	5F9	02/01/2023
F	2442	1221	611	204	5FD	02/01/2023
HDF	346	173	87	29	5FH	02/01/2023
G	1972	986	493	165	5FL	02/01/2023
HDG	346	173	87	29	5I7	02/01/2023
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	2371	1186	593	198	5F3	02/01/2023
C	2404	1202	601	201	5F7	02/01/2023
D	2331	1166	583	195	5FB	02/01/2023
F	2808	1404	702	234	5FF	02/01/2023
HDF	397	199	100	34	5FJ	02/01/2023
G	2267	1134	567	189	5FN	02/01/2023
HDG	397	199	100	34	5I9	02/01/2023
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	2371	1186	593	198	5F0	02/01/2023
C	2404	1202	601	201	5F4	02/01/2023
D	2331	1166	583	195	5F8	02/01/2023
F	2808	1404	702	234	5FC	02/01/2023
HDF	397	199	100	34	5FG	02/01/2023
G	2267	1134	567	189	5FK	02/01/2023
HDG	397	199	100	34	5I6	02/01/2023
K	1228	614	307	103	5FO	01/15/2020
L	1725	863	432	144	5FS	01/15/2020
N	2017	1009	505	169	5FW	02/01/2023

Standard

Plan	A	SA	Q	M	Plan Code	Effective Date
A	1478	739	370	124	5EY	05/01/2013
B	2728	1364	682	228	5F2	02/01/2023
C	2766	1383	692	231	5F6	02/01/2023
D	2683	1342	671	224	5FA	02/01/2023
F	3231	1616	808	270	5FE	02/01/2023
HDF	457	229	115	39	5FI	02/01/2023
G	2609	1305	653	218	5FM	02/01/2023
HDG	457	229	115	39	5I8	02/01/2023
K	1413	707	354	118	5FQ	01/15/2020
L	1985	993	497	166	5FU	01/15/2020
N	2322	1161	581	194	5FY	02/01/2023

Female

Preferred

Plan	A	SA	Q	M	Plan Code	Effective Date
A	1118	559	280	94	5EX	05/01/2013
B	2062	1031	516	172	5F1	02/01/2023
C	2091	1046	523	175	5F5	02/01/2023
D	2028	1014	507	169	5F9	02/01/2023
F	2442	1221	611	204	5FD	02/01/2023
HDF	346	173	87	29	5FH	02/01/2023
G	1972	986	493	165	5FL	02/01/2023
HDG	346	173	87	29	5I7	02/01/2023
K	1068	534	267	89	5FP	01/15/2020
L	1500	750	375	125	5FT	01/15/2020
N	1755	878	439	147	5FX	02/01/2023

Standard

Plan	A	SA	Q	M	Plan Code	Effective Date
A	1285	643	322	108	5EZ	05/01/2013
B	2371	1186	593	198	5F3	02/01/2023
C	2404	1202	601	201	5F7	02/01/2023
D	2331	1166	583	195	5FB	02/01/2023
F	2808	1404	702	234	5FF	02/01/2023
HDF	397	199	100	34	5FJ	02/01/2023
G	2267	1134	567	189	5FN	02/01/2023
HDG	397	199	100	34	5I9	02/01/2023
K	1228	614	307	103	5FR	01/15/2020
L	1725	863	432	144	5FV	01/15/2020
N	2017	1009	505	169	5FZ	02/01/2023

*** 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: 02/01/2023 Plan Code: 5AM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2371	1186	593	198
66	2502	1251	626	209
67	2614	1307	654	218
68	2719	1360	680	227
69	2831	1416	708	236
70	2944	1472	736	246
71	3031	1516	758	253
72	3078	1539	770	257
73	3137	1569	785	262
74	3181	1591	796	266
75	3223	1612	806	269
76	3248	1624	812	271
77	3253	1627	814	272
78	3257	1629	815	272
79	3267	1634	817	273
80+	3267	1634	817	273

Standard Effective Date: 02/01/2023 Plan Code: 5AO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2728	1364	682	228
66	2880	1440	720	240
67	3009	1505	753	251
68	3129	1565	783	261
69	3258	1629	815	272
70	3388	1694	847	283
71	3488	1744	872	291
72	3542	1771	886	296
73	3610	1805	903	301
74	3660	1830	915	305
75	3709	1855	928	310
76	3737	1869	935	312
77	3744	1872	936	312
78	3748	1874	937	313
79	3760	1880	940	314
80+	3760	1880	940	314

Female

Preferred Effective Date: 02/01/2023 Plan Code: 5AN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2062	1031	516	172
66	2177	1089	545	182
67	2274	1137	569	190
68	2365	1183	592	198
69	2463	1232	616	206
70	2561	1281	641	214
71	2637	1319	660	220
72	2677	1339	670	224
73	2728	1364	682	228
74	2767	1384	692	231
75	2804	1402	701	234
76	2825	1413	707	236
77	2830	1415	708	236
78	2833	1417	709	237
79	2842	1421	711	237
80+	2842	1421	711	237

Standard Effective Date: 02/01/2023 Plan Code: 5AP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2371	1186	593	198
66	2502	1251	626	209
67	2614	1307	654	218
68	2719	1360	680	227
69	2831	1416	708	236
70	2944	1472	736	246
71	3031	1516	758	253
72	3078	1539	770	257
73	3137	1569	785	262
74	3181	1591	796	266
75	3223	1612	806	269
76	3248	1624	812	271
77	3253	1627	814	272
78	3257	1629	815	272
79	3267	1634	817	273
80+	3267	1634	817	273

PLAN C

Male

Preferred Effective Date: 02/01/2023 Plan Code: 5B4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2404	1202	601	201
66	2533	1267	634	212
67	2645	1323	662	221
68	2761	1381	691	231
69	2888	1444	722	241
70	3014	1507	754	252
71	3123	1562	781	261
72	3193	1597	799	267
73	3273	1637	819	273
74	3342	1671	836	279
75	3405	1703	852	284
76	3453	1727	864	288
77	3508	1754	877	293
78	3567	1784	892	298
79	3626	1813	907	303
80+	3726	1863	932	311

Standard Effective Date: 02/01/2023 Plan Code: 5B6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2766	1383	692	231
66	2915	1458	729	243
67	3044	1522	761	254
68	3177	1589	795	265
69	3323	1662	831	277
70	3468	1734	867	289
71	3594	1797	899	300
72	3675	1838	919	307
73	3767	1884	942	314
74	3846	1923	962	321
75	3918	1959	980	327
76	3973	1987	994	332
77	4037	2019	1010	337
78	4105	2053	1027	343
79	4172	2086	1043	348
80+	4288	2144	1072	358

Female

Preferred Effective Date: 02/01/2023 Plan Code: 5B5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2091	1046	523	175
66	2204	1102	551	184
67	2301	1151	576	192
68	2401	1201	601	201
69	2512	1256	628	210
70	2622	1311	656	219
71	2716	1358	679	227
72	2778	1389	695	232
73	2847	1424	712	238
74	2907	1454	727	243
75	2962	1481	741	247
76	3003	1502	751	251
77	3052	1526	763	255
78	3103	1552	776	259
79	3154	1577	789	263
80+	3241	1621	811	271

Standard Effective Date: 02/01/2023 Plan Code: 5B7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2404	1202	601	201
66	2533	1267	634	212
67	2645	1323	662	221
68	2761	1381	691	231
69	2888	1444	722	241
70	3014	1507	754	252
71	3123	1562	781	261
72	3193	1597	799	267
73	3273	1637	819	273
74	3342	1671	836	279
75	3405	1703	852	284
76	3453	1727	864	288
77	3508	1754	877	293
78	3567	1784	892	298
79	3626	1813	907	303
80+	3726	1863	932	311

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

PLAN D

Male

Preferred Effective Date: 02/01/2023 Plan Code: 5BM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2331	1166	583	195
66	2468	1234	617	206
67	2588	1294	647	216
68	2708	1354	677	226
69	2842	1421	711	237
70	2975	1488	744	248
71	3090	1545	773	258
72	3167	1584	792	264
73	3250	1625	813	271
74	3320	1660	830	277
75	3386	1693	847	283
76	3437	1719	860	287
77	3498	1749	875	292
78	3560	1780	890	297
79	3619	1810	905	302
80+	3726	1863	932	311

Standard Effective Date: 02/01/2023 Plan Code: 5BO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2683	1342	671	224
66	2840	1420	710	237
67	2978	1489	745	249
68	3117	1559	780	260
69	3270	1635	818	273
70	3424	1712	856	286
71	3555	1778	889	297
72	3644	1822	911	304
73	3740	1870	935	312
74	3821	1911	956	319
75	3896	1948	974	325
76	3955	1978	989	330
77	4025	2013	1007	336
78	4096	2048	1024	342
79	4165	2083	1042	348
80+	4288	2144	1072	358

Female

Preferred Effective Date: 02/01/2023 Plan Code: 5BN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2028	1014	507	169
66	2147	1074	537	179
67	2251	1126	563	188
68	2356	1178	589	197
69	2472	1236	618	206
70	2588	1294	647	216
71	2688	1344	672	224
72	2754	1377	689	230
73	2827	1414	707	236
74	2888	1444	722	241
75	2945	1473	737	246
76	2990	1495	748	250
77	3042	1521	761	254
78	3096	1548	774	258
79	3148	1574	787	263
80+	3241	1621	811	271

Standard Effective Date: 02/01/2023 Plan Code: 5BP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2331	1166	583	195
66	2468	1234	617	206
67	2588	1294	647	216
68	2708	1354	677	226
69	2842	1421	711	237
70	2975	1488	744	248
71	3090	1545	773	258
72	3167	1584	792	264
73	3250	1625	813	271
74	3320	1660	830	277
75	3386	1693	847	283
76	3437	1719	860	287
77	3498	1749	875	292
78	3560	1780	890	297
79	3619	1810	905	302
80+	3726	1863	932	311

PLAN F

Male

Preferred Effective Date: 02/01/2023 Plan Code: 5C4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2808	1404	702	234
66	2956	1478	739	247
67	3085	1543	772	258
68	3219	1610	805	269
69	3366	1683	842	281
70	3516	1758	879	293
71	3639	1820	910	304
72	3723	1862	931	311
73	3816	1908	954	318
74	3896	1948	974	325
75	3967	1984	992	331
76	4021	2011	1006	336
77	4089	2045	1023	341
78	4157	2079	1040	347
79	4224	2112	1056	352
80+	4341	2171	1086	362

Standard Effective Date: 02/01/2023 Plan Code: 5C6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3231	1616	808	270
66	3402	1701	851	284
67	3551	1776	888	296
68	3704	1852	926	309
69	3874	1937	969	323
70	4046	2023	1012	338
71	4187	2094	1047	349
72	4284	2142	1071	357
73	4391	2196	1098	366
74	4483	2242	1121	374
75	4565	2283	1142	381
76	4627	2314	1157	386
77	4706	2353	1177	393
78	4783	2392	1196	399
79	4861	2431	1216	406
80+	4996	2498	1249	417

Female

Preferred Effective Date: 02/01/2023 Plan Code: 5C5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2442	1221	611	204
66	2571	1286	643	215
67	2684	1342	671	224
68	2800	1400	700	234
69	2928	1464	732	244
70	3058	1529	765	255
71	3165	1583	792	264
72	3238	1619	810	270
73	3319	1660	830	277
74	3389	1695	848	283
75	3450	1725	863	288
76	3498	1749	875	292
77	3557	1779	890	297
78	3616	1808	904	302
79	3674	1837	919	307
80+	3776	1888	944	315

Standard Effective Date: 02/01/2023 Plan Code: 5C7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2808	1404	702	234
66	2956	1478	739	247
67	3085	1543	772	258
68	3219	1610	805	269
69	3366	1683	842	281
70	3516	1758	879	293
71	3639	1820	910	304
72	3723	1862	931	311
73	3816	1908	954	318
74	3896	1948	974	325
75	3967	1984	992	331
76	4021	2011	1006	336
77	4089	2045	1023	341
78	4157	2079	1040	347
79	4224	2112	1056	352
80+	4341	2171	1086	362

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

PLAN HDF

Male

Preferred — Effective Date: 02/01/2023 — Plan Code: 5CM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	397	199	100	34
66	429	215	108	36
67	458	229	115	39
68	480	240	120	40
69	501	251	126	42
70	522	261	131	44
71	541	271	136	46
72	568	284	142	48
73	597	299	150	50
74	624	312	156	52
75	650	325	163	55
76	660	330	165	55
77	672	336	168	56
78	682	341	171	57
79	693	347	174	58
80+	712	356	178	60

Standard — Effective Date: 02/01/2023 — Plan Code: 5CO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	457	229	115	39
66	494	247	124	42
67	527	264	132	44
68	552	276	138	46
69	576	288	144	48
70	601	301	151	51
71	623	312	156	52
72	654	327	164	55
73	687	344	172	58
74	718	359	180	60
75	748	374	187	63
76	760	380	190	64
77	773	387	194	65
78	785	393	197	66
79	798	399	200	67
80+	820	410	205	69

Female

Preferred — Effective Date: 02/01/2023 — Plan Code: 5CN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	346	173	87	29
66	373	187	94	32
67	399	200	100	34
68	417	209	105	35
69	436	218	109	37
70	454	227	114	38
71	471	236	118	40
72	494	247	124	42
73	519	260	130	44
74	543	272	136	46
75	566	283	142	48
76	574	287	144	48
77	584	292	146	49
78	594	297	149	50
79	603	302	151	51
80+	620	310	155	52

Standard — Effective Date: 02/01/2023 — Plan Code: 5CP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	397	199	100	34
66	429	215	108	36
67	458	229	115	39
68	480	240	120	40
69	501	251	126	42
70	522	261	131	44
71	541	271	136	46
72	568	284	142	48
73	597	299	150	50
74	624	312	156	52
75	650	325	163	55
76	660	330	165	55
77	672	336	168	56
78	682	341	171	57
79	693	347	174	58
80+	712	356	178	60

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

PLAN G

Male

Preferred Effective Date: 02/01/2023 Plan Code: 5D4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2267	1134	567	189
66	2399	1200	600	200
67	2514	1257	629	210
68	2630	1315	658	220
69	2760	1380	690	230
70	2889	1445	723	241
71	2998	1499	750	250
72	3072	1536	768	256
73	3154	1577	789	263
74	3223	1612	806	269
75	3286	1643	822	274
76	3334	1667	834	278
77	3393	1697	849	283
78	3452	1726	863	288
79	3512	1756	878	293
80+	3614	1807	904	302

Standard Effective Date: 02/01/2023 Plan Code: 5D6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2609	1305	653	218
66	2760	1380	690	230
67	2893	1447	724	242
68	3027	1514	757	253
69	3176	1588	794	265
70	3324	1662	831	277
71	3450	1725	863	288
72	3535	1768	884	295
73	3629	1815	908	303
74	3709	1855	928	310
75	3782	1891	946	316
76	3837	1919	960	320
77	3905	1953	977	326
78	3972	1986	993	331
79	4041	2021	1011	337
80+	4159	2080	1040	347

Female

Preferred Effective Date: 02/01/2023 Plan Code: 5D5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1972	986	493	165
66	2087	1044	522	174
67	2187	1094	547	183
68	2288	1144	572	191
69	2401	1201	601	201
70	2513	1257	629	210
71	2608	1304	652	218
72	2672	1336	668	223
73	2743	1372	686	229
74	2804	1402	701	234
75	2859	1430	715	239
76	2900	1450	725	242
77	2951	1476	738	246
78	3003	1502	751	251
79	3055	1528	764	255
80+	3144	1572	786	262

Standard Effective Date: 02/01/2023 Plan Code: 5D7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2267	1134	567	189
66	2399	1200	600	200
67	2514	1257	629	210
68	2630	1315	658	220
69	2760	1380	690	230
70	2889	1445	723	241
71	2998	1499	750	250
72	3072	1536	768	256
73	3154	1577	789	263
74	3223	1612	806	269
75	3286	1643	822	274
76	3334	1667	834	278
77	3393	1697	849	283
78	3452	1726	863	288
79	3512	1756	878	293
80+	3614	1807	904	302

PLAN HDG

Male

Preferred Effective Date: 02/01/2023 Plan Code: 5HO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	397	199	100	34
66	429	215	108	36
67	458	229	115	39
68	480	240	120	40
69	501	251	126	42
70	522	261	131	44
71	541	271	136	46
72	568	284	142	48
73	597	299	150	50
74	624	312	156	52
75	650	325	163	55
76	660	330	165	55
77	672	336	168	56
78	682	341	171	57
79	693	347	174	58
80+	712	356	178	60

Standard Effective Date: 02/01/2023 Plan Code: 5HQ

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	457	229	115	39
66	494	247	124	42
67	527	264	132	44
68	552	276	138	46
69	576	288	144	48
70	601	301	151	51
71	623	312	156	52
72	654	327	164	55
73	687	344	172	58
74	718	359	180	60
75	748	374	187	63
76	760	380	190	64
77	773	387	194	65
78	785	393	197	66
79	798	399	200	67
80+	820	410	205	69

Female

Preferred Effective Date: 02/01/2023 Plan Code: 5HP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	346	173	87	29
66	373	187	94	32
67	399	200	100	34
68	417	209	105	35
69	436	218	109	37
70	454	227	114	38
71	471	236	118	40
72	494	247	124	42
73	519	260	130	44
74	543	272	136	46
75	566	283	142	48
76	574	287	144	48
77	584	292	146	49
78	594	297	149	50
79	603	302	151	51
80+	620	310	155	52

Standard Effective Date: 02/01/2023 Plan Code: 5HR

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	397	199	100	34
66	429	215	108	36
67	458	229	115	39
68	480	240	120	40
69	501	251	126	42
70	522	261	131	44
71	541	271	136	46
72	568	284	142	48
73	597	299	150	50
74	624	312	156	52
75	650	325	163	55
76	660	330	165	55
77	672	336	168	56
78	682	341	171	57
79	693	347	174	58
80+	712	356	178	60

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: 02/01/2023 Plan Code: 5DM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2017	1009	505	169
66	2133	1067	534	178
67	2237	1119	560	187
68	2344	1172	586	196
69	2465	1233	617	206
70	2585	1293	647	216
71	2686	1343	672	224
72	2753	1377	689	230
73	2832	1416	708	236
74	2900	1450	725	242
75	2963	1482	741	247
76	3013	1507	754	252
77	3072	1536	768	256
78	3136	1568	784	262
79	3197	1599	800	267
80+	3304	1652	826	276

Standard Effective Date: 02/01/2023 Plan Code: 5DO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2322	1161	581	194
66	2454	1227	614	205
67	2575	1288	644	215
68	2698	1349	675	225
69	2837	1419	710	237
70	2974	1487	744	248
71	3091	1546	773	258
72	3168	1584	792	264
73	3259	1630	815	272
74	3337	1669	835	279
75	3409	1705	853	285
76	3467	1734	867	289
77	3535	1768	884	295
78	3608	1804	902	301
79	3678	1839	920	307
80+	3803	1902	951	317

Female

Preferred Effective Date: 02/01/2023 Plan Code: 5DN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1755	878	439	147
66	1855	928	464	155
67	1946	973	487	163
68	2039	1020	510	170
69	2144	1072	536	179
70	2248	1124	562	188
71	2336	1168	584	195
72	2395	1198	599	200
73	2464	1232	616	206
74	2522	1261	631	211
75	2577	1289	645	215
76	2621	1311	656	219
77	2672	1336	668	223
78	2728	1364	682	228
79	2780	1390	695	232
80+	2874	1437	719	240

Standard Effective Date: 02/01/2023 Plan Code: 5DP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2017	1009	505	169
66	2133	1067	534	178
67	2237	1119	560	187
68	2344	1172	586	196
69	2465	1233	617	206
70	2585	1293	647	216
71	2686	1343	672	224
72	2753	1377	689	230
73	2832	1416	708	236
74	2900	1450	725	242
75	2963	1482	741	247
76	3013	1507	754	252
77	3072	1536	768	256
78	3136	1568	784	262
79	3197	1599	800	267
80+	3304	1652	826	276

PLAN A
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1632	$0	$1632 (Part A Deductible)
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0 **
– Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	$0	Up to $204 a day
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and 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 $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved Amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $240 of Medicare-Approved Amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
– Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $240 of Medicare-Approved Amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

PLAN B
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1632	$1632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0 **
– Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	$0	Up to $204 a day
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you the balance based on any difference between its billed charges and the amount Medicare would have paid.

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

* Once you have been billed $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved Amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $240 of Medicare-Approved Amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
– Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $240 of Medicare-Approved Amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

PLAN C
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1632	$1632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0 **
– Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment, coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you the balance based on any difference between its billed charges and the amount Medicare would have paid.

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

* Once you have been billed $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved Amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $240 of Medicare-Approved Amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
– Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $240 of Medicare-Approved Amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN D
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1632	$1632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0 **
– Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited coinsurance, coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you the balance based on any difference between its billed charges and the amount Medicare would have paid.

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

* Once you have been billed $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved Amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges(Above Medicare-Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $240 of Medicare-Approved Amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
– Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $240 of Medicare-Approved Amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN F or HIGH DEDUCTIBLE PLAN F
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2800 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2800. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2800 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2800 DEDUCTIBLE,** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1632	$1632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0 ***
– Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

*** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F or HIGH DEDUCTIBLE PLAN F
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

** This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2800 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2800. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2800 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2800 DEDUCTIBLE,** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved Amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $240 of Medicare-Approved Amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
– Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $240 of Medicare-Approved Amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G or HIGH DEDUCTIBLE PLAN G
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** This high deductible plan pays the same benefits as Plan G after one has paid a calendar year $2800 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2800 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2800 DEDUCTIBLE,** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1632	$1632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0 ***
– Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

*** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G or HIGH DEDUCTIBLE PLAN G
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

** This high deductible plan pays the same benefits as Plan G after one has paid a calendar year $2800 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2800 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2800 DEDUCTIBLE,** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved Amounts*	$0	$0	$240 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $240 of Medicare-Approved Amounts*	$0	$0	$240 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
– Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $240 of Medicare-Approved Amounts*	$0	$0	$240 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN K

* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $7060 each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit DOES NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying 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 $1632	$816 (50% of Part A Deductible)	$816 (50% of Part A Deductible) ♦
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0 ***
– Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE**			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $102 a day (50% of Part A Coinsurance)	Up to $102 a day (50% of Part A Coinsurance) ♦
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	50%	50% ♦
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	50% of copayment/ coinsurance	50% of copayment/ coinsurance ♦

*** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you the balance based on any difference between its billed charges and the amount Medicare would have paid.

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

**** Once you have been billed $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved Amounts ****	$0	$0	$240 (Part B Deductible) ****♦
Preventive Benefits for Medicare-Covered Services	Generally 80% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 10%	Generally 10%♦
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All Costs (and they do not count toward annual out-of-pocket limit of $7060)*
BLOOD			
First 3 pints	$0	50%	50%♦
Next $240 of Medicare-Approved Amounts ****	$0	$0	$240 (Part B Deductible) ****♦
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 10%	Generally 10%♦
CLINICAL LABORATORY SERVICES			
– Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $240 of Medicare-Approved Amounts *****	$0	$0	$240 (Part B Deductible)♦
Remainder of Medicare-Approved Amounts	80%	10%	10%♦

* This plan limits your annual out-of-pocket payment for Medicare-approved amounts $7060 per year. **However, this limit DOES NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

***** Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN L

* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $3530 each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit DOES NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying 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 $1632	$1224 (75% of Part A Deductible)	$408 (25% of Part A Deductible) ♦
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0 ***
– Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE**			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $153 a day (75% of Part A Coinsurance)	Up to $51 a day (25% of Part A Coinsurance) ♦
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	75%	25% ♦
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	75% of copayment/ coinsurance	25% of copayment/ coinsurance ♦

*** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you the balance based on any difference between its billed charges and the amount Medicare would have paid.

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

**** Once you have been billed $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved Amounts ****	$0	$0	$240 (Part B Deductible) **** ♦
Preventive Benefits for Medicare-Covered Services	Generally 80% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 15%	Generally 5% ♦
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All Costs (and they do not count toward annual out-of-pocket limit of $3530)*
BLOOD			
First 3 pints	$0	75%	25% ♦
Next $240 of Medicare-Approved Amounts ****	$0	$0	$240 (Part B Deductible) **** ♦
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 15%	Generally 5% ♦
CLINICAL LABORATORY SERVICES			
– Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $240 of Medicare-Approved Amounts *****	$0	$0	$240 (Part B Deductible) ♦
Remainder of Medicare-Approved Amounts	80%	15%	5% ♦

* This plan limits your annual out-of-pocket payment for Medicare-approved amounts $3530 per year. **However, this limit DOES NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

***** Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN N
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1632	$1632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0 **
– Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

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

* Once you have been billed $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved Amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges(Above Medicare-Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $240 of Medicare-Approved Amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
– Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $240 of Medicare-Approved Amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum