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 2026(2)					$8,000(2)	$4,000(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 $2,950 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	2626	1313	657	219	5F0	04/01/2025
C	2664	1332	666	222	5F4	04/01/2025
D	2582	1291	646	216	5F8	04/01/2025
F	3170	1585	793	265	5FC	04/01/2025
HDF	502	251	126	42	5FG	04/01/2025
G	2560	1280	640	214	5FK	04/01/2025
HDG	502	251	126	42	5I6	04/01/2025
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	3022	1511	756	252	5F2	04/01/2025
C	3065	1533	767	256	5F6	04/01/2025
D	2972	1486	743	248	5FA	04/01/2025
F	3648	1824	912	304	5FE	04/01/2025
HDF	578	289	145	49	5FI	04/01/2025
G	2946	1473	737	246	5FM	04/01/2025
HDG	578	289	145	49	5I8	04/01/2025
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	2284	1142	571	191	5F1	04/01/2025
C	2317	1159	580	194	5F5	04/01/2025
D	2246	1123	562	188	5F9	04/01/2025
F	2757	1379	690	230	5FD	04/01/2025
HDF	437	219	110	37	5FH	04/01/2025
G	2227	1114	557	186	5FL	04/01/2025
HDG	437	219	110	37	5I7	04/01/2025
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	2626	1313	657	219	5F3	04/01/2025
C	2664	1332	666	222	5F7	04/01/2025
D	2582	1291	646	216	5FB	04/01/2025
F	3170	1585	793	265	5FF	04/01/2025
HDF	502	251	126	42	5FJ	04/01/2025
G	2560	1280	640	214	5FN	04/01/2025
HDG	502	251	126	42	5I9	04/01/2025
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	2626	1313	657	219	5F0	04/01/2025
C	2664	1332	666	222	5F4	04/01/2025
D	2582	1291	646	216	5F8	04/01/2025
F	3170	1585	793	265	5FC	04/01/2025
HDF	502	251	126	42	5FG	04/01/2025
G	2560	1280	640	214	5FK	04/01/2025
HDG	502	251	126	42	5I6	04/01/2025
K	1228	614	307	103	5FO	01/15/2020
L	1725	863	432	144	5FS	01/15/2020
N	2277	1139	570	190	5FW	04/01/2025

Standard

Plan	A	SA	Q	M	Plan Code	Effective Date
A	1478	739	370	124	5EY	05/01/2013
B	3022	1511	756	252	5F2	04/01/2025
C	3065	1533	767	256	5F6	04/01/2025
D	2972	1486	743	248	5FA	04/01/2025
F	3648	1824	912	304	5FE	04/01/2025
HDF	578	289	145	49	5FI	04/01/2025
G	2946	1473	737	246	5FM	04/01/2025
HDG	578	289	145	49	5I8	04/01/2025
K	1413	707	354	118	5FQ	01/15/2020
L	1985	993	497	166	5FU	01/15/2020
N	2620	1310	655	219	5FY	04/01/2025

Female

Preferred

Plan	A	SA	Q	M	Plan Code	Effective Date
A	1118	559	280	94	5EX	05/01/2013
B	2284	1142	571	191	5F1	04/01/2025
C	2317	1159	580	194	5F5	04/01/2025
D	2246	1123	562	188	5F9	04/01/2025
F	2757	1379	690	230	5FD	04/01/2025
HDF	437	219	110	37	5FH	04/01/2025
G	2227	1114	557	186	5FL	04/01/2025
HDG	437	219	110	37	5I7	04/01/2025
K	1068	534	267	89	5FP	01/15/2020
L	1500	750	375	125	5FT	01/15/2020
N	1981	991	496	166	5FX	04/01/2025

Standard

Plan	A	SA	Q	M	Plan Code	Effective Date
A	1285	643	322	108	5EZ	05/01/2013
B	2626	1313	657	219	5F3	04/01/2025
C	2664	1332	666	222	5F7	04/01/2025
D	2582	1291	646	216	5FB	04/01/2025
F	3170	1585	793	265	5FF	04/01/2025
HDF	502	251	126	42	5FJ	04/01/2025
G	2560	1280	640	214	5FN	04/01/2025
HDG	502	251	126	42	5I9	04/01/2025
K	1228	614	307	103	5FR	01/15/2020
L	1725	863	432	144	5FV	01/15/2020
N	2277	1139	570	190	5FZ	04/01/2025

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

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

PLAN A

Male

Preferred

Effective Date: 05/01/2013 Plan Code: 5A4

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

Standard

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

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

Female

Preferred

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

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

Standard

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

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

PLAN B

Male

Preferred Effective Date: 04/01/2025 Plan Code: 5AM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2626	1313	657	219
66	2771	1386	693	231
67	2895	1448	724	242
68	3012	1506	753	251
69	3137	1569	785	262
70	3262	1631	816	272
71	3358	1679	840	280
72	3409	1705	853	285
73	3475	1738	869	290
74	3523	1762	881	294
75	3570	1785	893	298
76	3598	1799	900	300
77	3603	1802	901	301
78	3609	1805	903	301
79	3619	1810	905	302
80+	3619	1810	905	302

Standard Effective Date: 04/01/2025 Plan Code: 5AO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3022	1511	756	252
66	3189	1595	798	266
67	3332	1666	833	278
68	3466	1733	867	289
69	3610	1805	903	301
70	3753	1877	939	313
71	3864	1932	966	322
72	3923	1962	981	327
73	3999	2000	1000	334
74	4054	2027	1014	338
75	4109	2055	1028	343
76	4141	2071	1036	346
77	4147	2074	1037	346
78	4153	2077	1039	347
79	4165	2083	1042	348
80+	4165	2083	1042	348

Female

Preferred Effective Date: 04/01/2025 Plan Code: 5AN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2284	1142	571	191
66	2411	1206	603	201
67	2519	1260	630	210
68	2620	1310	655	219
69	2728	1364	682	228
70	2837	1419	710	237
71	2921	1461	731	244
72	2965	1483	742	248
73	3023	1512	756	252
74	3065	1533	767	256
75	3106	1553	777	259
76	3130	1565	783	261
77	3134	1567	784	262
78	3139	1570	785	262
79	3148	1574	787	263
80+	3148	1574	787	263

Standard Effective Date: 04/01/2025 Plan Code: 5AP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2626	1313	657	219
66	2771	1386	693	231
67	2895	1448	724	242
68	3012	1506	753	251
69	3137	1569	785	262
70	3262	1631	816	272
71	3358	1679	840	280
72	3409	1705	853	285
73	3475	1738	869	290
74	3523	1762	881	294
75	3570	1785	893	298
76	3598	1799	900	300
77	3603	1802	901	301
78	3609	1805	903	301
79	3619	1810	905	302
80+	3619	1810	905	302

PLAN C

Male

Preferred Effective Date: 04/01/2025 Plan Code: 5B4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2664	1332	666	222
66	2807	1404	702	234
67	2931	1466	733	245
68	3058	1529	765	255
69	3199	1600	800	267
70	3339	1670	835	279
71	3459	1730	865	289
72	3538	1769	885	295
73	3626	1813	907	303
74	3702	1851	926	309
75	3771	1886	943	315
76	3826	1913	957	319
77	3886	1943	972	324
78	3952	1976	988	330
79	4017	2009	1005	335
80+	4127	2064	1032	344

Standard Effective Date: 04/01/2025 Plan Code: 5B6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3065	1533	767	256
66	3230	1615	808	270
67	3372	1686	843	281
68	3519	1760	880	294
69	3681	1841	921	307
70	3842	1921	961	321
71	3981	1991	996	332
72	4072	2036	1018	340
73	4172	2086	1043	348
74	4260	2130	1065	355
75	4340	2170	1085	362
76	4402	2201	1101	367
77	4472	2236	1118	373
78	4547	2274	1137	379
79	4622	2311	1156	386
80+	4749	2375	1188	396

Female

Preferred Effective Date: 04/01/2025 Plan Code: 5B5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2317	1159	580	194
66	2441	1221	611	204
67	2549	1275	638	213
68	2660	1330	665	222
69	2782	1391	696	232
70	2904	1452	726	242
71	3009	1505	753	251
72	3078	1539	770	257
73	3154	1577	789	263
74	3220	1610	805	269
75	3280	1640	820	274
76	3328	1664	832	278
77	3381	1691	846	282
78	3437	1719	860	287
79	3494	1747	874	292
80+	3590	1795	898	300

Standard Effective Date: 04/01/2025 Plan Code: 5B7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2664	1332	666	222
66	2807	1404	702	234
67	2931	1466	733	245
68	3058	1529	765	255
69	3199	1600	800	267
70	3339	1670	835	279
71	3459	1730	865	289
72	3538	1769	885	295
73	3626	1813	907	303
74	3702	1851	926	309
75	3771	1886	943	315
76	3826	1913	957	319
77	3886	1943	972	324
78	3952	1976	988	330
79	4017	2009	1005	335
80+	4127	2064	1032	344

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

PLAN D

Male

Preferred Effective Date: 04/01/2025 Plan Code: 5BM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2582	1291	646	216
66	2734	1367	684	228
67	2867	1434	717	239
68	3000	1500	750	250
69	3148	1574	787	263
70	3296	1648	824	275
71	3423	1712	856	286
72	3507	1754	877	293
73	3600	1800	900	300
74	3678	1839	920	307
75	3751	1876	938	313
76	3807	1904	952	318
77	3875	1938	969	323
78	3944	1972	986	329
79	4009	2005	1003	335
80+	4127	2064	1032	344

Standard Effective Date: 04/01/2025 Plan Code: 5BO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2972	1486	743	248
66	3146	1573	787	263
67	3299	1650	825	275
68	3452	1726	863	288
69	3623	1812	906	302
70	3793	1897	949	317
71	3939	1970	985	329
72	4036	2018	1009	337
73	4143	2072	1036	346
74	4233	2117	1059	353
75	4316	2158	1079	360
76	4381	2191	1096	366
77	4459	2230	1115	372
78	4539	2270	1135	379
79	4614	2307	1154	385
80+	4749	2375	1188	396

Female

Preferred Effective Date: 04/01/2025 Plan Code: 5BN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2246	1123	562	188
66	2378	1189	595	199
67	2493	1247	624	208
68	2610	1305	653	218
69	2739	1370	685	229
70	2867	1434	717	239
71	2977	1489	745	249
72	3051	1526	763	255
73	3132	1566	783	261
74	3199	1600	800	267
75	3263	1632	816	272
76	3312	1656	828	276
77	3370	1685	843	281
78	3431	1716	858	286
79	3487	1744	872	291
80+	3590	1795	898	300

Standard Effective Date: 04/01/2025 Plan Code: 5BP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2582	1291	646	216
66	2734	1367	684	228
67	2867	1434	717	239
68	3000	1500	750	250
69	3148	1574	787	263
70	3296	1648	824	275
71	3423	1712	856	286
72	3507	1754	877	293
73	3600	1800	900	300
74	3678	1839	920	307
75	3751	1876	938	313
76	3807	1904	952	318
77	3875	1938	969	323
78	3944	1972	986	329
79	4009	2005	1003	335
80+	4127	2064	1032	344

PLAN F

Male

Preferred Effective Date: 04/01/2025 Plan Code: 5C4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3170	1585	793	265
66	3338	1669	835	279
67	3483	1742	871	291
68	3633	1817	909	303
69	3801	1901	951	317
70	3969	1985	993	331
71	4106	2053	1027	343
72	4203	2102	1051	351
73	4307	2154	1077	359
74	4398	2199	1100	367
75	4478	2239	1120	374
76	4540	2270	1135	379
77	4616	2308	1154	385
78	4692	2346	1173	391
79	4769	2385	1193	398
80+	4901	2451	1226	409

Standard Effective Date: 04/01/2025 Plan Code: 5C6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3648	1824	912	304
66	3841	1921	961	321
67	4008	2004	1002	334
68	4181	2091	1046	349
69	4374	2187	1094	365
70	4567	2284	1142	381
71	4726	2363	1182	394
72	4836	2418	1209	403
73	4957	2479	1240	414
74	5061	2531	1266	422
75	5153	2577	1289	430
76	5224	2612	1306	436
77	5312	2656	1328	443
78	5399	2700	1350	450
79	5487	2744	1372	458
80+	5640	2820	1410	470

Female

Preferred Effective Date: 04/01/2025 Plan Code: 5C5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2757	1379	690	230
66	2903	1452	726	242
67	3029	1515	758	253
68	3160	1580	790	264
69	3306	1653	827	276
70	3452	1726	863	288
71	3572	1786	893	298
72	3656	1828	914	305
73	3747	1874	937	313
74	3826	1913	957	319
75	3895	1948	974	325
76	3949	1975	988	330
77	4015	2008	1004	335
78	4081	2041	1021	341
79	4148	2074	1037	346
80+	4263	2132	1066	356

Standard Effective Date: 04/01/2025 Plan Code: 5C7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3170	1585	793	265
66	3338	1669	835	279
67	3483	1742	871	291
68	3633	1817	909	303
69	3801	1901	951	317
70	3969	1985	993	331
71	4106	2053	1027	343
72	4203	2102	1051	351
73	4307	2154	1077	359
74	4398	2199	1100	367
75	4478	2239	1120	374
76	4540	2270	1135	379
77	4616	2308	1154	385
78	4692	2346	1173	391
79	4769	2385	1193	398
80+	4901	2451	1226	409

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

PLAN HDF

Male

Preferred Effective Date: 04/01/2025 Plan Code: 5CM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	502	251	126	42
66	543	272	136	46
67	580	290	145	49
68	607	304	152	51
69	633	317	159	53
70	661	331	166	56
71	686	343	172	58
72	719	360	180	60
73	755	378	189	63
74	788	394	197	66
75	823	412	206	69
76	835	418	209	70
77	850	425	213	71
78	863	432	216	72
79	877	439	220	74
80+	901	451	226	76

Standard Effective Date: 04/01/2025 Plan Code: 5CO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	578	289	145	49
66	624	312	156	52
67	667	334	167	56
68	698	349	175	59
69	729	365	183	61
70	761	381	191	64
71	789	395	198	66
72	827	414	207	69
73	869	435	218	73
74	907	454	227	76
75	948	474	237	79
76	961	481	241	81
77	978	489	245	82
78	993	497	249	83
79	1009	505	253	85
80+	1037	519	260	87

Female

Preferred Effective Date: 04/01/2025 Plan Code: 5CN

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

Standard Effective Date: 04/01/2025 Plan Code: 5CP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	502	251	126	42
66	543	272	136	46
67	580	290	145	49
68	607	304	152	51
69	633	317	159	53
70	661	331	166	56
71	686	343	172	58
72	719	360	180	60
73	755	378	189	63
74	788	394	197	66
75	823	412	206	69
76	835	418	209	70
77	850	425	213	71
78	863	432	216	72
79	877	439	220	74
80+	901	451	226	76

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

PLAN G

Male

Preferred Effective Date: 04/01/2025 Plan Code: 5D4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2560	1280	640	214
66	2707	1354	677	226
67	2839	1420	710	237
68	2969	1485	743	248
69	3115	1558	779	260
70	3261	1631	816	272
71	3383	1692	846	282
72	3467	1734	867	289
73	3561	1781	891	297
74	3639	1820	910	304
75	3709	1855	928	310
76	3765	1883	942	314
77	3830	1915	958	320
78	3896	1948	974	325
79	3963	1982	991	331
80+	4080	2040	1020	340

Standard Effective Date: 04/01/2025 Plan Code: 5D6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2946	1473	737	246
66	3116	1558	779	260
67	3267	1634	817	273
68	3417	1709	855	285
69	3585	1793	897	299
70	3752	1876	938	313
71	3893	1947	974	325
72	3989	1995	998	333
73	4097	2049	1025	342
74	4187	2094	1047	349
75	4268	2134	1067	356
76	4332	2166	1083	361
77	4407	2204	1102	368
78	4483	2242	1121	374
79	4561	2281	1141	381
80+	4695	2348	1174	392

Female

Preferred Effective Date: 04/01/2025 Plan Code: 5D5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2227	1114	557	186
66	2355	1178	589	197
67	2469	1235	618	206
68	2583	1292	646	216
69	2710	1355	678	226
70	2836	1418	709	237
71	2943	1472	736	246
72	3016	1508	754	252
73	3097	1549	775	259
74	3165	1583	792	264
75	3226	1613	807	269
76	3275	1638	819	273
77	3331	1666	833	278
78	3389	1695	848	283
79	3448	1724	862	288
80+	3549	1775	888	296

Standard Effective Date: 04/01/2025 Plan Code: 5D7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2560	1280	640	214
66	2707	1354	677	226
67	2839	1420	710	237
68	2969	1485	743	248
69	3115	1558	779	260
70	3261	1631	816	272
71	3383	1692	846	282
72	3467	1734	867	289
73	3561	1781	891	297
74	3639	1820	910	304
75	3709	1855	928	310
76	3765	1883	942	314
77	3830	1915	958	320
78	3896	1948	974	325
79	3963	1982	991	331
80+	4080	2040	1020	340

PLAN HDG

Male

Preferred Effective Date: 04/01/2025 Plan Code: 5HO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	502	251	126	42
66	543	272	136	46
67	580	290	145	49
68	607	304	152	51
69	633	317	159	53
70	661	331	166	56
71	686	343	172	58
72	719	360	180	60
73	755	378	189	63
74	788	394	197	66
75	823	412	206	69
76	835	418	209	70
77	850	425	213	71
78	863	432	216	72
79	877	439	220	74
80+	901	451	226	76

Standard Effective Date: 04/01/2025 Plan Code: 5HQ

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	578	289	145	49
66	624	312	156	52
67	667	334	167	56
68	698	349	175	59
69	729	365	183	61
70	761	381	191	64
71	789	395	198	66
72	827	414	207	69
73	869	435	218	73
74	907	454	227	76
75	948	474	237	79
76	961	481	241	81
77	978	489	245	82
78	993	497	249	83
79	1009	505	253	85
80+	1037	519	260	87

Female

Preferred Effective Date: 04/01/2025 Plan Code: 5HP

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

Standard Effective Date: 04/01/2025 Plan Code: 5HR

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	502	251	126	42
66	543	272	136	46
67	580	290	145	49
68	607	304	152	51
69	633	317	159	53
70	661	331	166	56
71	686	343	172	58
72	719	360	180	60
73	755	378	189	63
74	788	394	197	66
75	823	412	206	69
76	835	418	209	70
77	850	425	213	71
78	863	432	216	72
79	877	439	220	74
80+	901	451	226	76

PLAN K

Male

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

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

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

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

Female

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

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

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

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

PLAN L

Male

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

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

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

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

Female

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

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

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

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

PLAN N

Male

Preferred Effective Date: 04/01/2025 Plan Code: 5DM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2277	1139	570	190
66	2408	1204	602	201
67	2526	1263	632	211
68	2647	1324	662	221
69	2783	1392	696	232
70	2917	1459	730	244
71	3032	1516	758	253
72	3108	1554	777	259
73	3198	1599	800	267
74	3273	1637	819	273
75	3344	1672	836	279
76	3401	1701	851	284
77	3467	1734	867	289
78	3540	1770	885	295
79	3609	1805	903	301
80+	3731	1866	933	311

Standard Effective Date: 04/01/2025 Plan Code: 5DO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2620	1310	655	219
66	2771	1386	693	231
67	2907	1454	727	243
68	3045	1523	762	254
69	3203	1602	801	267
70	3356	1678	839	280
71	3489	1745	873	291
72	3576	1788	894	298
73	3680	1840	920	307
74	3767	1884	942	314
75	3848	1924	962	321
76	3913	1957	979	327
77	3989	1995	998	333
78	4074	2037	1019	340
79	4153	2077	1039	347
80+	4293	2147	1074	358

Female

Preferred Effective Date: 04/01/2025 Plan Code: 5DN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1981	991	496	166
66	2095	1048	524	175
67	2197	1099	550	184
68	2302	1151	576	192
69	2421	1211	606	202
70	2537	1269	635	212
71	2637	1319	660	220
72	2703	1352	676	226
73	2781	1391	696	232
74	2847	1424	712	238
75	2909	1455	728	243
76	2958	1479	740	247
77	3016	1508	754	252
78	3080	1540	770	257
79	3139	1570	785	262
80+	3245	1623	812	271

Standard Effective Date: 04/01/2025 Plan Code: 5DP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2277	1139	570	190
66	2408	1204	602	201
67	2526	1263	632	211
68	2647	1324	662	221
69	2783	1392	696	232
70	2917	1459	730	244
71	3032	1516	758	253
72	3108	1554	777	259
73	3198	1599	800	267
74	3273	1637	819	273
75	3344	1672	836	279
76	3401	1701	851	284
77	3467	1734	867	289
78	3540	1770	885	295
79	3609	1805	903	301
80+	3731	1866	933	311

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 $1736	$0	$1736 (Part A Deductible)
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $868 a day	$868 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 $217 a day	$0	Up to $217 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 $283 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 $283 of Medicare-Approved Amounts*	$0	$0	$283 (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 $283 of Medicare-Approved Amounts*	$0	$0	$283 (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 $283 of Medicare-Approved Amounts*	$0	$0	$283 (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 $1736	$1736 (Part A Deductible)	$0
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $868 a day	$868 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 $217 a day	$0	Up to $217 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 $283 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 $283 of Medicare-Approved Amounts*	$0	$0	$283 (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 $283 of Medicare-Approved Amounts*	$0	$0	$283 (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 $283 of Medicare-Approved Amounts*	$0	$0	$283 (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 $1736	$1736 (Part A Deductible)	$0
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $868 a day	$868 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 $217 a day	Up to $217 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 $283 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 $283 of Medicare-Approved Amounts*	$0	$283 (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 $283 of Medicare-Approved Amounts*	$0	$283 (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 $283 of Medicare-Approved Amounts*	$0	$283 (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 $1736	$1736 (Part A Deductible)	$0
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $868 a day	$868 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 $217 a day	Up to $217 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 $283 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 $283 of Medicare-Approved Amounts*	$0	$0	$283 (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 $283 of Medicare-Approved Amounts*	$0	$0	$283 (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 $283 of Medicare-Approved Amounts*	$0	$0	$283 (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 $2950 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2950. 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 $2950 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2950 DEDUCTIBLE,** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1736	$1736 (Part A Deductible)	$0
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $868 a day	$868 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 $217 a day	Up to $217 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 $283 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 $2950 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2950. 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 $2950 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2950 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 $283 of Medicare-Approved Amounts*	$0	$283 (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 $283 of Medicare-Approved Amounts*	$0	$283 (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 $283 of Medicare-Approved Amounts*	$0	$283 (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 $2950 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2950. 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 $2950 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2950 DEDUCTIBLE,** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1736	$1736 (Part A Deductible)	$0
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $868 a day	$868 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 $217 a day	Up to $217 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 $283 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 $2950 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2950. 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 $2950 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2950 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 $283 of Medicare-Approved Amounts*	$0	$0	$283 (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 $283 of Medicare-Approved Amounts*	$0	$0	$283 (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 $283 of Medicare-Approved Amounts*	$0	$0	$283 (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 $8000 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 $1736	$868 (50% of Part A Deductible)	$868 (50% of Part A Deductible) ♦
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $868 a day	$868 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 $217 a day	Up to $108.50 a day (50% of Part A Coinsurance)	Up to $108.50 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 $283 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 $283 of Medicare-Approved Amounts ****	$0	$0	$283 (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 $8000)*
BLOOD			
First 3 pints	$0	50%	50%♦
Next $283 of Medicare-Approved Amounts ****	$0	$0	$283 (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 $283 of Medicare-Approved Amounts *****	$0	$0	$283 (Part B Deductible)♦
Remainder of Medicare-Approved Amounts	80%	10%	10%♦

* This plan limits your annual out-of-pocket payment for Medicare-approved amounts $8000 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 $4000 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 $1736	$1302 (75% of Part A Deductible)	$434 (25% of Part A Deductible) ♦
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $868 a day	$868 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 $217 a day	Up to $162.75 a day (75% of Part A Coinsurance)	Up to $54.25 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 $283 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 $283 of Medicare-Approved Amounts ****	$0	$0	$283 (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 $4000)*
BLOOD			
First 3 pints	$0	75%	25% ♦
Next $283 of Medicare-Approved Amounts ****	$0	$0	$283 (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 $283 of Medicare-Approved Amounts *****	$0	$0	$283 (Part B Deductible) ♦
Remainder of Medicare-Approved Amounts	80%	15%	5% ♦

* This plan limits your annual out-of-pocket payment for Medicare-approved amounts $4000 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 $1736	$1736 (Part A Deductible)	$0
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $868 a day	$868 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 $217 a day	Up to $217 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 $283 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 $283 of Medicare-Approved Amounts*	$0	$0	$283 (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 $283 of Medicare-Approved Amounts*	$0	$0	$283 (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 $283 of Medicare-Approved Amounts*	$0	$0	$283 (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