UNITED AMERICAN INSURANCE COMPANY

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

Benefit Chart of Medicare Supplement Plans Sold on or After June 1, 2010

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

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state.

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

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

K	L	M	N*
Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Foreign Travel Emergency	Foreign Travel Emergency
Out-of-pocket limit $4940; paid at 100% after limit reached	Out-of-pocket limit $2470; paid at 100% after limit reached		

* Denotes plans available by United American Insurance Company.

** Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2180 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed $2180. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

PREMIUM INFORMATION

We, United American Insurance Company, can only raise your premium if we raise the premium for all policies like yours in this State.

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.

PLAN A – AREA 4 *(ZIP 331-333, 340)*

PREFERRED

MALE

ISSUE AGE	Effective Date: 09-01-12		Plan Code: 5E0	
	Annual	Semi Annual	Quarterly	Monthly
65	2339	1170	585	195
66	2472	1236	618	206
67	2472	1236	618	206
68	2472	1236	618	206
69	2472	1236	618	206
70	2711	1356	678	226
71	2711	1356	678	226
72	2711	1356	678	226
73	2711	1356	678	226
74	2711	1356	678	226
75	2866	1433	717	239
76	2866	1433	717	239
77	2866	1433	717	239
78	2866	1433	717	239
79	2866	1433	717	239
80+	2866	1433	717	239

FEMALE

ISSUE AGE	Effective Date: 09-01-12		Plan Code: 5E1	
	Annual	Semi Annual	Quarterly	Monthly
65	2035	1018	509	170
66	2150	1075	538	179
67	2150	1075	538	179
68	2150	1075	538	179
69	2150	1075	538	179
70	2358	1179	590	197
71	2358	1179	590	197
72	2358	1179	590	197
73	2358	1179	590	197
74	2358	1179	590	197
75	2493	1247	623	208
76	2493	1247	623	208
77	2493	1247	623	208
78	2493	1247	623	208
79	2493	1247	623	208
80+	2493	1247	623	208

STANDARD

MALE

ISSUE AGE	Effective Date: 09-01-12		Plan Code: 5E2	
	Annual	Semi Annual	Quarterly	Monthly
65	2692	1346	673	224
66	2845	1423	711	237
67	2845	1423	711	237
68	2845	1423	711	237
69	2845	1423	711	237
70	3119	1560	780	260
71	3119	1560	780	260
72	3119	1560	780	260
73	3119	1560	780	260
74	3119	1560	780	260
75	3298	1649	825	275
76	3298	1649	825	275
77	3298	1649	825	275
78	3298	1649	825	275
79	3298	1649	825	275
80+	3298	1649	825	275

FEMALE

ISSUE AGE	Effective Date: 09-01-12		Plan Code: 5E3	
	Annual	Semi Annual	Quarterly	Monthly
65	2339	1170	585	195
66	2472	1236	618	206
67	2472	1236	618	206
68	2472	1236	618	206
69	2472	1236	618	206
70	2711	1356	678	226
71	2711	1356	678	226
72	2711	1356	678	226
73	2711	1356	678	226
74	2711	1356	678	226
75	2866	1433	717	239
76	2866	1433	717	239
77	2866	1433	717	239
78	2866	1433	717	239
79	2866	1433	717	239
80+	2866	1433	717	239

PLAN B – AREA 4 *(ZIP 331-333, 340)*

MALE

PREFERRED

ISSUE AGE	Effective Date: 09-01-12		Plan Code: 5E4	
	Annual	Semi Annual	Quarterly	Monthly
65	3178	1589	795	265
66	3372	1686	843	281
67	3372	1686	843	281
68	3372	1686	843	281
69	3372	1686	843	281
70	3736	1868	934	311
71	3736	1868	934	311
72	3736	1868	934	311
73	3736	1868	934	311
74	3736	1868	934	311
75	4024	2012	1006	335
76	4024	2012	1006	335
77	4024	2012	1006	335
78	4024	2012	1006	335
79	4024	2012	1006	335
80+	4032	2016	1008	336

STANDARD

ISSUE AGE	Effective Date: 09-01-12		Plan Code: 5E6	
	Annual	Semi Annual	Quarterly	Monthly
65	3658	1829	915	305
66	3880	1940	970	323
67	3880	1940	970	323
68	3880	1940	970	323
69	3880	1940	970	323
70	4299	2150	1075	358
71	4299	2150	1075	358
72	4299	2150	1075	358
73	4299	2150	1075	358
74	4299	2150	1075	358
75	4631	2316	1158	386
76	4631	2316	1158	386
77	4631	2316	1158	386
78	4631	2316	1158	386
79	4631	2316	1158	386
80+	4640	2320	1160	387

FEMALE

ISSUE AGE	Effective Date: 09-01-12		Plan Code: 5E5	
	Annual	Semi Annual	Quarterly	Monthly
65	2765	1383	691	230
66	2933	1467	733	244
67	2933	1467	733	244
68	2933	1467	733	244
69	2933	1467	733	244
70	3250	1625	813	271
71	3250	1625	813	271
72	3250	1625	813	271
73	3250	1625	813	271
74	3250	1625	813	271
75	3500	1750	875	292
76	3500	1750	875	292
77	3500	1750	875	292
78	3500	1750	875	292
79	3500	1750	875	292
80+	3507	1754	877	292

ISSUE AGE	Effective Date: 09-01-12		Plan Code: 5E7	
	Annual	Semi Annual	Quarterly	Monthly
65	3178	1589	795	265
66	3372	1686	843	281
67	3372	1686	843	281
68	3372	1686	843	281
69	3372	1686	843	281
70	3736	1868	934	311
71	3736	1868	934	311
72	3736	1868	934	311
73	3736	1868	934	311
74	3736	1868	934	311
75	4024	2012	1006	335
76	4024	2012	1006	335
77	4024	2012	1006	335
78	4024	2012	1006	335
79	4024	2012	1006	335
80+	4032	2016	1008	336

PLAN C – AREA 4 *(ZIP 331-333, 340)*

MALE

PREFERRED

ISSUE AGE	Effective Date: 09-01-12		Plan Code: 5E8	
	Annual	Semi Annual	Quarterly	Monthly
65	3554	1777	889	296
66	3783	1892	946	315
67	3783	1892	946	315
68	3783	1892	946	315
69	3783	1892	946	315
70	4245	2123	1061	354
71	4245	2123	1061	354
72	4245	2123	1061	354
73	4245	2123	1061	354
74	4245	2123	1061	354
75	4707	2354	1177	392
76	4707	2354	1177	392
77	4707	2354	1177	392
78	4707	2354	1177	392
79	4707	2354	1177	392
80+	4934	2467	1234	411

STANDARD

ISSUE AGE	Effective Date: 09-01-12		Plan Code: 5EA	
	Annual	Semi Annual	Quarterly	Monthly
65	4090	2045	1023	341
66	4354	2177	1089	363
67	4354	2177	1089	363
68	4354	2177	1089	363
69	4354	2177	1089	363
70	4885	2443	1221	407
71	4885	2443	1221	407
72	4885	2443	1221	407
73	4885	2443	1221	407
74	4885	2443	1221	407
75	5417	2709	1354	451
76	5417	2709	1354	451
77	5417	2709	1354	451
78	5417	2709	1354	451
79	5417	2709	1354	451
80+	5678	2839	1420	473

FEMALE

PREFERRED

ISSUE AGE	Effective Date: 09-01-12		Plan Code: 5E9	
	Annual	Semi Annual	Quarterly	Monthly
65	3091	1546	773	258
66	3291	1646	823	274
67	3291	1646	823	274
68	3291	1646	823	274
69	3291	1646	823	274
70	3692	1846	923	308
71	3692	1846	923	308
72	3692	1846	923	308
73	3692	1846	923	308
74	3692	1846	923	308
75	4095	2048	1024	341
76	4095	2048	1024	341
77	4095	2048	1024	341
78	4095	2048	1024	341
79	4095	2048	1024	341
80+	4292	2146	1073	358

STANDARD

ISSUE AGE	Effective Date: 09-01-12		Plan Code: 5EB	
	Annual	Semi Annual	Quarterly	Monthly
65	3554	1777	889	296
66	3783	1892	946	315
67	3783	1892	946	315
68	3783	1892	946	315
69	3783	1892	946	315
70	4245	2123	1061	354
71	4245	2123	1061	354
72	4245	2123	1061	354
73	4245	2123	1061	354
74	4245	2123	1061	354
75	4707	2354	1177	392
76	4707	2354	1177	392
77	4707	2354	1177	392
78	4707	2354	1177	392
79	4707	2354	1177	392
80+	4934	2467	1234	411

PLAN D – AREA 4 *(ZIP 331-333, 340)*

MALE

PREFERRED

ISSUE AGE	Effective Date: 09-01-12		Plan Code: 5EC	
	Annual	Semi Annual	Quarterly	Monthly
65	3358	1679	840	280
66	3587	1794	897	299
67	3587	1794	897	299
68	3587	1794	897	299
69	3587	1794	897	299
70	4049	2025	1012	337
71	4049	2025	1012	337
72	4049	2025	1012	337
73	4049	2025	1012	337
74	4049	2025	1012	337
75	4513	2257	1128	376
76	4513	2257	1128	376
77	4513	2257	1128	376
78	4513	2257	1128	376
79	4513	2257	1128	376
80+	4741	2371	1185	395

STANDARD

ISSUE AGE	Effective Date: 09-01-12		Plan Code: 5EE	
	Annual	Semi Annual	Quarterly	Monthly
65	3864	1932	966	322
66	4128	2064	1032	344
67	4128	2064	1032	344
68	4128	2064	1032	344
69	4128	2064	1032	344
70	4659	2330	1165	388
71	4659	2330	1165	388
72	4659	2330	1165	388
73	4659	2330	1165	388
74	4659	2330	1165	388
75	5193	2597	1298	433
76	5193	2597	1298	433
77	5193	2597	1298	433
78	5193	2597	1298	433
79	5193	2597	1298	433
80+	5455	2728	1364	455

FEMALE

PREFERRED

ISSUE AGE	Effective Date: 09-01-12		Plan Code: 5ED	
	Annual	Semi Annual	Quarterly	Monthly
65	2921	1461	730	243
66	3120	1560	780	260
67	3120	1560	780	260
68	3120	1560	780	260
69	3120	1560	780	260
70	3522	1761	881	294
71	3522	1761	881	294
72	3522	1761	881	294
73	3522	1761	881	294
74	3522	1761	881	294
75	3925	1963	981	327
76	3925	1963	981	327
77	3925	1963	981	327
78	3925	1963	981	327
79	3925	1963	981	327
80+	4124	2062	1031	344

STANDARD

ISSUE AGE	Effective Date: 09-01-12		Plan Code: 5EF	
	Annual	Semi Annual	Quarterly	Monthly
65	3358	1679	840	280
66	3587	1794	897	299
67	3587	1794	897	299
68	3587	1794	897	299
69	3587	1794	897	299
70	4049	2025	1012	337
71	4049	2025	1012	337
72	4049	2025	1012	337
73	4049	2025	1012	337
74	4049	2025	1012	337
75	4513	2257	1128	376
76	4513	2257	1128	376
77	4513	2257	1128	376
78	4513	2257	1128	376
79	4513	2257	1128	376
80+	4741	2371	1185	395

PLAN F – AREA 4 *(ZIP 331-333, 340)*

PREFERRED

MALE

ISSUE AGE	Effective Date: 09-01-12		Plan Code: 5EG	
	Annual	Semi Annual	Quarterly	Monthly
65	3569	1785	892	297
66	3799	1900	950	317
67	3799	1900	950	317
68	3799	1900	950	317
69	3799	1900	950	317
70	4259	2130	1065	355
71	4259	2130	1065	355
72	4259	2130	1065	355
73	4259	2130	1065	355
74	4259	2130	1065	355
75	4723	2362	1181	394
76	4723	2362	1181	394
77	4723	2362	1181	394
78	4723	2362	1181	394
79	4723	2362	1181	394
80+	4951	2476	1238	413

FEMALE

ISSUE AGE	Effective Date: 09-01-12		Plan Code: 5EH	
	Annual	Semi Annual	Quarterly	Monthly
65	3105	1553	776	259
66	3304	1652	826	275
67	3304	1652	826	275
68	3304	1652	826	275
69	3304	1652	826	275
70	3704	1852	926	309
71	3704	1852	926	309
72	3704	1852	926	309
73	3704	1852	926	309
74	3704	1852	926	309
75	4108	2054	1027	342
76	4108	2054	1027	342
77	4108	2054	1027	342
78	4108	2054	1027	342
79	4108	2054	1027	342
80+	4306	2153	1077	359

STANDARD

MALE

ISSUE AGE	Effective Date: 09-01-12		Plan Code: 5EI	
	Annual	Semi Annual	Quarterly	Monthly
65	4107	2054	1027	342
66	4371	2186	1093	364
67	4371	2186	1093	364
68	4371	2186	1093	364
69	4371	2186	1093	364
70	4901	2451	1225	408
71	4901	2451	1225	408
72	4901	2451	1225	408
73	4901	2451	1225	408
74	4901	2451	1225	408
75	5435	2718	1359	453
76	5435	2718	1359	453
77	5435	2718	1359	453
78	5435	2718	1359	453
79	5435	2718	1359	453
80+	5697	2849	1424	475

FEMALE

ISSUE AGE	Effective Date: 09-01-12		Plan Code: 5EJ	
	Annual	Semi Annual	Quarterly	Monthly
65	3569	1785	892	297
66	3799	1900	950	317
67	3799	1900	950	317
68	3799	1900	950	317
69	3799	1900	950	317
70	4259	2130	1065	355
71	4259	2130	1065	355
72	4259	2130	1065	355
73	4259	2130	1065	355
74	4259	2130	1065	355
75	4723	2362	1181	394
76	4723	2362	1181	394
77	4723	2362	1181	394
78	4723	2362	1181	394
79	4723	2362	1181	394
80+	4951	2476	1238	413

PLAN HDF – AREA 4 *(ZIP 331-333, 340)*

MALE

PREFERRED

ISSUE AGE	Effective Date: 01-01-14		Plan Code: 5EK	
	Annual	Semi Annual	Quarterly	Monthly
65	906	453	227	76
66	977	489	244	81
67	977	489	244	81
68	977	489	244	81
69	977	489	244	81
70	1165	583	291	97
71	1165	583	291	97
72	1165	583	291	97
73	1165	583	291	97
74	1165	583	291	97
75	1499	750	375	125
76	1499	750	375	125
77	1499	750	375	125
78	1499	750	375	125
79	1499	750	375	125
80+	1664	832	416	139

STANDARD

ISSUE AGE	Effective Date: 01-01-14		Plan Code: 5EM	
	Annual	Semi Annual	Quarterly	Monthly
65	1043	522	261	87
66	1124	562	281	94
67	1124	562	281	94
68	1124	562	281	94
69	1124	562	281	94
70	1341	671	335	112
71	1341	671	335	112
72	1341	671	335	112
73	1341	671	335	112
74	1341	671	335	112
75	1726	863	432	144
76	1726	863	432	144
77	1726	863	432	144
78	1726	863	432	144
79	1726	863	432	144
80+	1914	957	479	160

FEMALE

PREFERRED

ISSUE AGE	Effective Date: 01-01-14		Plan Code: 5EL	
	Annual	Semi Annual	Quarterly	Monthly
65	788	394	197	66
66	849	425	212	71
67	849	425	212	71
68	849	425	212	71
69	849	425	212	71
70	1013	507	253	84
71	1013	507	253	84
72	1013	507	253	84
73	1013	507	253	84
74	1013	507	253	84
75	1304	652	326	109
76	1304	652	326	109
77	1304	652	326	109
78	1304	652	326	109
79	1304	652	326	109
80+	1447	724	362	121

STANDARD

ISSUE AGE	Effective Date: 01-01-14		Plan Code: 5EN	
	Annual	Semi Annual	Quarterly	Monthly
65	906	453	227	76
66	977	489	244	81
67	977	489	244	81
68	977	489	244	81
69	977	489	244	81
70	1165	583	291	97
71	1165	583	291	97
72	1165	583	291	97
73	1165	583	291	97
74	1165	583	291	97
75	1499	750	375	125
76	1499	750	375	125
77	1499	750	375	125
78	1499	750	375	125
79	1499	750	375	125
80+	1664	832	416	139

PLAN G – AREA 4 *(ZIP 331-333, 340)*

MALE

PREFERRED

ISSUE AGE	Effective Date: 09-01-12		Plan Code: 5EO	
	Annual	Semi Annual	Quarterly	Monthly
65	3371	1686	843	281
66	3601	1801	900	300
67	3601	1801	900	300
68	3601	1801	900	300
69	3601	1801	900	300
70	4061	2031	1015	338
71	4061	2031	1015	338
72	4061	2031	1015	338
73	4061	2031	1015	338
74	4061	2031	1015	338
75	4524	2262	1131	377
76	4524	2262	1131	377
77	4524	2262	1131	377
78	4524	2262	1131	377
79	4524	2262	1131	377
80+	4752	2376	1188	396

STANDARD

ISSUE AGE	Effective Date: 09-01-12		Plan Code: 5EQ	
	Annual	Semi Annual	Quarterly	Monthly
65	3879	1940	970	323
66	4144	2072	1036	345
67	4144	2072	1036	345
68	4144	2072	1036	345
69	4144	2072	1036	345
70	4674	2337	1169	390
71	4674	2337	1169	390
72	4674	2337	1169	390
73	4674	2337	1169	390
74	4674	2337	1169	390
75	5206	2603	1302	434
76	5206	2603	1302	434
77	5206	2603	1302	434
78	5206	2603	1302	434
79	5206	2603	1302	434
80+	5469	2735	1367	456

FEMALE

PREFERRED

ISSUE AGE	Effective Date: 09-01-12		Plan Code: 5EP	
	Annual	Semi Annual	Quarterly	Monthly
65	2932	1466	733	244
66	3133	1567	783	261
67	3133	1567	783	261
68	3133	1567	783	261
69	3133	1567	783	261
70	3533	1767	883	294
71	3533	1767	883	294
72	3533	1767	883	294
73	3533	1767	883	294
74	3533	1767	883	294
75	3935	1968	984	328
76	3935	1968	984	328
77	3935	1968	984	328
78	3935	1968	984	328
79	3935	1968	984	328
80+	4134	2067	1034	345

STANDARD

ISSUE AGE	Effective Date: 09-01-12		Plan Code: 5ER	
	Annual	Semi Annual	Quarterly	Monthly
65	3371	1686	843	281
66	3601	1801	900	300
67	3601	1801	900	300
68	3601	1801	900	300
69	3601	1801	900	300
70	4061	2031	1015	338
71	4061	2031	1015	338
72	4061	2031	1015	338
73	4061	2031	1015	338
74	4061	2031	1015	338
75	4524	2262	1131	377
76	4524	2262	1131	377
77	4524	2262	1131	377
78	4524	2262	1131	377
79	4524	2262	1131	377
80+	4752	2376	1188	396

PLAN N – AREA 4 *(ZIP 331-333, 340)*

MALE

PREFERRED

ISSUE AGE	Effective Date: 09-01-12		Plan Code: 5ES	
	Annual	Semi Annual	Quarterly	Monthly
65	2861	1431	715	238
66	3060	1530	765	255
67	3060	1530	765	255
68	3060	1530	765	255
69	3060	1530	765	255
70	3463	1732	866	289
71	3463	1732	866	289
72	3463	1732	866	289
73	3463	1732	866	289
74	3463	1732	866	289
75	3883	1942	971	324
76	3883	1942	971	324
77	3883	1942	971	324
78	3883	1942	971	324
79	3883	1942	971	324
80+	4108	2054	1027	342

STANDARD

ISSUE AGE	Effective Date: 09-01-12		Plan Code: 5EU	
	Annual	Semi Annual	Quarterly	Monthly
65	3292	1646	823	274
66	3522	1761	881	294
67	3522	1761	881	294
68	3522	1761	881	294
69	3522	1761	881	294
70	3985	1993	996	332
71	3985	1993	996	332
72	3985	1993	996	332
73	3985	1993	996	332
74	3985	1993	996	332
75	4469	2235	1117	372
76	4469	2235	1117	372
77	4469	2235	1117	372
78	4469	2235	1117	372
79	4469	2235	1117	372
80+	4727	2364	1182	394

FEMALE

PREFERRED

ISSUE AGE	Effective Date: 09-01-12		Plan Code: 5ET	
	Annual	Semi Annual	Quarterly	Monthly
65	2488	1244	622	207
66	2662	1331	666	222
67	2662	1331	666	222
68	2662	1331	666	222
69	2662	1331	666	222
70	3012	1506	753	251
71	3012	1506	753	251
72	3012	1506	753	251
73	3012	1506	753	251
74	3012	1506	753	251
75	3378	1689	845	282
76	3378	1689	845	282
77	3378	1689	845	282
78	3378	1689	845	282
79	3378	1689	845	282
80+	3573	1787	893	298

STANDARD

ISSUE AGE	Effective Date: 09-01-12		Plan Code: 5EV	
	Annual	Semi Annual	Quarterly	Monthly
65	2861	1431	715	238
66	3060	1530	765	255
67	3060	1530	765	255
68	3060	1530	765	255
69	3060	1530	765	255
70	3463	1732	866	289
71	3463	1732	866	289
72	3463	1732	866	289
73	3463	1732	866	289
74	3463	1732	866	289
75	3883	1942	971	324
76	3883	1942	971	324
77	3883	1942	971	324
78	3883	1942	971	324
79	3883	1942	971	324
80+	4108	2054	1027	342

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 $1260	$0	$1260 (Part A Deductible)
61st thru 90th day	All but $315 a day	$315 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $630 a day	$630 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 $157.50 a day	$0	Up to $157.50 a day
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

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

* Once you have been billed $147 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 $147 of Medicare Approved Amounts*	$0	$0	$147 (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 $147 of Medicare Approved Amounts*	$0	$0	$147 (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 $147 of Medicare Approved Amounts*	$0	$0	$147 (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 $1260	$1260 (Part A Deductible)	$0
61st thru 90th day	All but $315 a day	$315 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $630 a day	$630 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 $157.50 a day	$0	Up to $157.50 a day
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

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

* Once you have been billed $147 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 $147 of Medicare Approved Amounts*	$0	$0	$147 (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 $147 of Medicare Approved Amounts*	$0	$0	$147 (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 $147 of Medicare Approved Amounts*	$0	$0	$147 (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 $1260	$1260 (Part A Deductible)	$0
61st thru 90th day	All but $315 a day	$315 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $630 a day	$630 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 $157.50 a day	Up to $157.50 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicar'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 C
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $147 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 $147 of Medicare Approved Amounts*	$0	$147 (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 $147 of Medicare Approved Amounts*	$0	$147 (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 $147 of Medicare Approved Amounts*	$0	$147 (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 $1260	$1260 (Part A Deductible)	$0
61st thru 90th day	All but $315 a day	$315 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $630 a day	$630 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 $157.50 a day	Up to $157.50 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicar'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 $147 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 $147 of Medicare Approved Amounts*	$0	$0	$147 (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 $147 of Medicare Approved Amounts*	$0	$0	$147 (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 $147 of Medicare Approved Amounts*	$0	$0	$147 (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 $2180 deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $2180. 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 $2180 DEDUCTIBLE, ** PLAN PAYS	IN ADDITION TO $2180 DEDUCTIBLE, ** YOU PAY
HOSPITALIZATION *			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1260	$1260 (Part A Deductible)	$0
61st thru 90th day	All but $315 a day	$315 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $630 a day	$630 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 $157.50 a day	Up to $157.50 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

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

* Once you have been billed $147 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 $2180 deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $2180. 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 $2180 DEDUCTIBLE, ** PLAN PAYS	IN ADDITION TO $2180 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 $147 of Medicare Approved Amounts*	$0	$147 (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 $147 of Medicare Approved Amounts*	$0	$147 (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 $147 of Medicare Approved Amounts*	$0	$147 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION *			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1260	$1260 (Part A Deductible)	$0
61st thru 90th day	All but $315 a day	$315 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $630 a day	$630 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 $157.50 a day	Up to $157.50 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

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

* Once you have been billed $147 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 $147 of Medicare Approved Amounts*	$0	$0	$147 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $147 of Medicare Approved Amounts*	$0	$0	$147 (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 $147 of Medicare Approved Amounts*	$0	$0	$147 (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 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 $1260	$1260 (Part A Deductible)	$0
61st thru 90th day	All but $315 a day	$315 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $630 a day	$630 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 $157.50 a day	Up to $157.50 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN N

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

* Once you have been billed $147 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 $147 of Medicare Approved Amounts*	$0	$0	$147 (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 $147 of Medicare Approved Amounts*	$0	$0	$147 (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 $147 of Medicare Approved Amounts*	$0	$0	$147 (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