

UNITED AMERICAN INSURANCE COMPANY
A Nebraska Stock Company • Administrative Offices: McKinney, Texas
 Outline of Medicare Supplement Coverage - Cover Page: 1 of 2

Benefit Plans A, B, C, D, F, HDF, G, K and L

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

See Outlines of Coverage sections for details about ALL plans

BASIC BENEFITS for Plans A - J.

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.

Blood: First three pints of blood each year.

A*	B*	C*	D*	E	F*	F**	G*	H	I	J	J**
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits		Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility 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 A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible						Part B Deductible
					Part B Excess (100%)		Part B Excess (80%)		Part B Excess (100%)		Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery				At-Home Recovery		At-Home Recovery		At-Home Recovery
				Preventive Care NOT Covered by Medicare							Preventive Care NOT Covered by Medicare

* Denotes plans available by United American Insurance Company.

** Plans F and J also have an option called a high deductible Plan F and a high deductible Plan J. These high deductible plans pay the same benefits as Plans F and J after one has paid a calendar year \$1900 deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses are \$1900. 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.

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Basic Benefits for Plans K and L include similar services as plans A -J, but cost-sharing for the basic benefits is at different levels.

J	K **	L **
Basic Benefits	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 50% Hospice cost-sharing 50% of Medicare-eligible expenses for the first three pints of blood 50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 75% Hospice cost-sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services
Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT covered by Medicare		
	\$4440 Out-of-Pocket Annual Limit***	\$2220 Out-of-Pocket Annual Limit***

* Denotes plans available by United American Insurance Company.

** Plans K and L provide for different cost-sharing for items and services than Plans A - J. Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges". You will be responsible for paying excess charges.

*** The out-of-pocket annual limit will increase each year for inflation. See Outlines of Coverage for details and exceptions.

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 cost.

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.

UA Medicare Supplement Rates

PLAN A

Plan Code **HC3**

Age	Annual	Semi Annual	Quarterly	Monthly
65	1449	739	377	128
66-69	1484	757	386	131
70-74	1628	830	423	143
75-79	1756	896	457	155
80+	1970	1005	512	173

ISSUE Effective Date: 08-01-08

PLAN B

Plan Code **HC4**

Age	Annual	Semi Annual	Quarterly	Monthly
65	2007	1024	522	177
66-69	2055	1048	534	181
70-74	2253	1149	586	198
75-79	2426	1237	631	213
80+	2724	1389	708	240

ISSUE Effective Date: 08-01-08

PLAN C

Plan Code **HC5**

Age	Annual	Semi Annual	Quarterly	Monthly
65	2478	1264	644	218
66-69	2540	1295	660	224
70-74	2790	1423	725	246
75-79	3011	1536	783	265
80+	3392	1730	882	298

ISSUE Effective Date: 08-01-08

PLAN D

Plan Code **HC6**

Age	Annual	Semi Annual	Quarterly	Monthly
65	2248	1146	584	198
66-69	2302	1174	599	203
70-74	2522	1286	656	222
75-79	2719	1387	707	239
80+	3049	1555	793	268

ISSUE Effective Date: 08-01-08

PLAN F

Plan Code **HC7**

Age	Annual	Semi Annual	Quarterly	Monthly
65	2489	1269	647	219
66-69	2551	1301	663	224
70-74	2802	1429	729	247
75-79	3022	1541	786	266
80+	3398	1733	883	299

ISSUE Effective Date: 08-01-07

PLAN G

Plan Code **HC8**

Age	Annual	Semi Annual	Quarterly	Monthly
65	2327	1187	605	205
66-69	2381	1214	619	210
70-74	2613	1333	679	230
75-79	2813	1435	731	248
80+	3154	1609	820	278

ISSUE Effective Date: 08-01-08

AREA 1 RATES

AREA 1:

323-326
335-339
341-342
344
346

HIGH DEDUCTIBLE PLAN F

Plan Code **HD1**

Age	Annual	Semi Annual	Quarterly	Monthly
65	1075	548	280	95
66-69	1108	565	288	98
70-74	1163	593	302	102
75-79	1198	611	311	105
80+	1198	611	311	105

ISSUE Effective Date: 08-01-07

UA Medicare Supplement Rates

PLAN A

Plan Code **HC3**

Age	Annual	Semi Annual	Quarterly	Monthly
65	1610	821	419	142
66-69	1649	841	429	145
70-74	1809	923	470	159
75-79	1951	995	507	172
80+	2189	1116	569	193

ISSUE **Effective Date:** 08-01-08

PLAN B

Plan Code **HC4**

Age	Annual	Semi Annual	Quarterly	Monthly
65	2230	1137	580	196
66-69	2283	1164	594	201
70-74	2503	1277	651	220
75-79	2695	1374	701	237
80+	3027	1544	787	266

ISSUE **Effective Date:** 08-01-08

PLAN C

Plan Code **HC5**

Age	Annual	Semi Annual	Quarterly	Monthly
65	2753	1404	716	242
66-69	2822	1439	734	248
70-74	3100	1581	806	273
75-79	3346	1706	870	294
80+	3769	1922	980	332

ISSUE **Effective Date:** 08-01-08

PLAN D

Plan Code **HC6**

Age	Annual	Semi Annual	Quarterly	Monthly
65	2498	1274	649	220
66-69	2558	1305	665	225
70-74	2802	1429	729	247
75-79	3021	1541	785	266
80+	3388	1728	881	298

ISSUE **Effective Date:** 08-01-08

PLAN F

Plan Code **HC7**

Age	Annual	Semi Annual	Quarterly	Monthly
65	2765	1410	719	243
66-69	2834	1445	737	249
70-74	3113	1588	809	274
75-79	3358	1713	873	296
80+	3775	1925	982	332

ISSUE **Effective Date:** 08-01-07

PLAN G

Plan Code **HC8**

Age	Annual	Semi Annual	Quarterly	Monthly
65	2585	1318	672	227
66-69	2646	1349	688	233
70-74	2903	1481	755	255
75-79	3125	1594	813	275
80+	3504	1787	911	308

ISSUE **Effective Date:** 08-01-08

AREA 2 RATES

AREA 2:

320-322
327-329
343
345
347-349

HIGH DEDUCTIBLE PLAN F

Plan Code **HD1**

Age	Annual	Semi Annual	Quarterly	Monthly
65	1194	609	310	105
66-69	1231	628	320	108
70-74	1292	659	336	114
75-79	1331	679	346	117
80+	1331	679	346	117

ISSUE **Effective Date:** 08-01-07

UA Medicare Supplement Rates

PLAN A

Plan Code **HC3**

Age	Annual	Semi Annual	Quarterly	Monthly
65	1771	903	460	156
66-69	1814	925	472	160
70-74	1990	1015	517	175
75-79	2146	1094	558	189
80+	2408	1228	626	212

ISSUE Effective Date: 08-01-08

PLAN B

Plan Code **HC4**

Age	Annual	Semi Annual	Quarterly	Monthly
65	2453	1251	638	216
66-69	2511	1281	653	221
70-74	2753	1404	716	242
75-79	2965	1512	771	261
80+	3330	1698	866	293

ISSUE Effective Date: 08-01-08

PLAN C

Plan Code **HC5**

Age	Annual	Semi Annual	Quarterly	Monthly
65	3028	1544	787	266
66-69	3104	1583	807	273
70-74	3410	1739	887	300
75-79	3681	1877	957	324
80+	4146	2114	1078	365

ISSUE Effective Date: 08-01-08

PLAN D

Plan Code **HC6**

Age	Annual	Semi Annual	Quarterly	Monthly
65	2748	1401	714	242
66-69	2814	1435	732	248
70-74	3082	1572	801	271
75-79	3323	1695	864	292
80+	3727	1901	969	328

ISSUE Effective Date: 08-01-08

PLAN F

Plan Code **HC7**

Age	Annual	Semi Annual	Quarterly	Monthly
65	3042	1551	791	268
66-69	3117	1590	810	274
70-74	3424	1746	890	301
75-79	3694	1884	960	325
80+	4153	2118	1080	365

ISSUE Effective Date: 08-01-07

PLAN G

Plan Code **HC8**

Age	Annual	Semi Annual	Quarterly	Monthly
65	2844	1450	739	250
66-69	2911	1485	757	256
70-74	3193	1628	830	281
75-79	3438	1753	894	303
80+	3854	1966	1002	339

ISSUE Effective Date: 08-01-08

AREA 3 RATES

AREA 3:

330
334

HIGH DEDUCTIBLE PLAN F

Plan Code **HD1**

Age	Annual	Semi Annual	Quarterly	Monthly
65	1313	670	341	116
66-69	1354	691	352	119
70-74	1421	725	369	125
75-79	1464	747	381	129
80+	1464	747	381	129

ISSUE Effective Date: 08-01-07

UA Medicare Supplement Rates

PLAN A

Plan Code **HC3**

Age	Annual	Semi Annual	Quarterly	Monthly
65	1932	985	502	170
66-69	1979	1009	515	174
70-74	2171	1107	564	191
75-79	2341	1194	609	206
80+	2627	1340	683	231

ISSUE Effective Date: 08-01-08

PLAN B

Plan Code **HC4**

Age	Annual	Semi Annual	Quarterly	Monthly
65	2676	1365	696	235
66-69	2740	1397	712	241
70-74	3004	1532	781	264
75-79	3234	1649	841	285
80+	3632	1852	944	320

ISSUE Effective Date: 08-01-08

PLAN C

Plan Code **HC5**

Age	Annual	Semi Annual	Quarterly	Monthly
65	3304	1685	859	291
66-69	3386	1727	880	298
70-74	3720	1897	967	327
75-79	4015	2048	1044	353
80+	4523	2307	1176	398

ISSUE Effective Date: 08-01-08

PLAN D

Plan Code **HC6**

Age	Annual	Semi Annual	Quarterly	Monthly
65	2998	1529	779	264
66-69	3070	1566	798	270
70-74	3362	1715	874	296
75-79	3625	1849	943	319
80+	4066	2074	1057	358

ISSUE Effective Date: 08-01-08

PLAN F

Plan Code **HC7**

Age	Annual	Semi Annual	Quarterly	Monthly
65	3318	1692	863	292
66-69	3401	1735	884	299
70-74	3736	1905	971	329
75-79	4030	2055	1048	355
80+	4530	2310	1178	399

ISSUE Effective Date: 08-01-07

PLAN G

Plan Code **HC8**

Age	Annual	Semi Annual	Quarterly	Monthly
65	3102	1582	807	273
66-69	3175	1619	826	279
70-74	3484	1777	906	307
75-79	3750	1913	975	330
80+	4205	2145	1093	370

ISSUE Effective Date: 08-01-08

AREA 4 RATES

AREA 4:

331-333
APO-FPO
340

HIGH DEDUCTIBLE PLAN F

Plan Code **HD1**

Age	Annual	Semi Annual	Quarterly	Monthly
65	1433	731	373	126
66-69	1477	753	384	130
70-74	1550	791	403	136
75-79	1597	814	415	141
80+	1597	814	415	141

ISSUE Effective Date: 08-01-07

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 \$1024	\$0	\$1024 (Part A Deductible)
61st thru 90th day	All but \$256 a day	\$256 a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$512 a day	\$512 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 \$128 a day	\$0	Up to \$128 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			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

** **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 \$135 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 \$135 of Medicare Approved Amounts*	\$0	\$0	\$135 (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 \$135 of Medicare Approved Amounts*	\$0	\$0	\$135 (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 \$135 of Medicare Approved Amounts*	\$0	\$0	\$135 (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 \$1024	\$1024 (Part A Deductible)	\$0
61st thru 90th day	All but \$256 a day	\$256 a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$512 a day	\$512 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 \$128 a day	\$0	Up to \$128 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 Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

** **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 \$135 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 \$135 of Medicare Approved Amounts*	\$0	\$0	\$135 (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 \$135 of Medicare Approved Amounts*	\$0	\$0	\$135 (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 \$135 of Medicare Approved Amounts*	\$0	\$0	\$135 (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 \$1024	\$1024 (Part A Deductible)	\$0
61st thru 90th day	All but \$256 a day	\$256 a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$512 a day	\$512 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 \$128 a day	Up to \$128 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 Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

** **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 \$135 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 \$135 of Medicare Approved Amounts*	\$0	\$135 (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 \$135 of Medicare Approved Amounts*	\$0	\$135 (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 \$135 of Medicare Approved Amounts*	\$0	\$135 (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 \$1024	\$1024 (Part A Deductible)	\$0
61st thru 90th day	All but \$256 a day	\$256 a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$512 a day	\$512 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 \$128 a day	Up to \$128 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 Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

** **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 \$135 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 \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$135 (Part B Deductible) \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All Costs
BLOOD First 3 pints Next \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$135 (Part B Deductible) \$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 – Durable medical equipment First \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$135 (Part B Deductible) \$0
AT-HOME RECOVERY SERVICES – NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan – Benefit for each visit – Number of visits covered (must be received within 8 weeks of last Medicare Approved visit) – Calendar year maximum	\$0 0 \$0	Actual Charges to \$40 a visit Up to the number of Medicare Approved visits, not to exceed 7 each week \$1,600	Balance

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 Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
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**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 \$1900 deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are \$1900. 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 \$1900 DEDUCTIBLE, ** PLAN PAYS	IN ADDITION TO \$1900 DEDUCTIBLE, ** YOU PAY
HOSPITALIZATION *			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1024	\$1024 (Part A Deductible)	\$0
61st thru 90th day	All but \$256 a day	\$256 a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$512 a day	\$512 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 \$128 a day	Up to \$128 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			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

*** **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 \$135 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 \$1900 deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are \$1900. 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 \$1900 DEDUCTIBLE, ** PLAN PAYS	IN ADDITION TO \$1900 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 \$135 of Medicare Approved Amounts*	\$0	\$135 (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 \$135 of Medicare Approved Amounts*	\$0	\$135 (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 \$135 of Medicare Approved Amounts*	\$0	\$135 (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 \$1024	\$1024 (Part A Deductible)	\$0
61st thru 90th day	All but \$256 a day	\$256 a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$512 a day	\$512 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 \$128 a day	Up to \$128 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 Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

** **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 \$135 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 \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$135 (Part B Deductible) \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	80%	20%
BLOOD First 3 pints Next \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$135 (Part B Deductible) \$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 – Durable medical equipment First \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$135 (Part B Deductible) \$0
AT-HOME RECOVERY SERVICES – NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan – Benefit for each visit – Number of visits covered (must be received within 8 weeks of last Medicare Approved visit) – Calendar year maximum	\$0 0 \$0	Actual Charges to \$40 a visit Up to the number of Medicare Approved visits, not to exceed 7 each week \$1,600	Balance

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 Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
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PLAN K

- * You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$4440 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 \$1024	\$512 (50% of Part A Deductible)	\$512 (50% of Part A Deductible)◆
61st thru 90th day	All but \$256 a day	\$256 a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$512 a day	\$512 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 \$128 a day	Up to \$64 a day	Up to \$64 a day◆
101st day and after	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	50%	50%◆
Additional Amounts	100%	\$0	\$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	Generally, most Medicare eligible expenses for outpatient drug and inpatient respite care	50% of coinsurance or copayments	50% of coinsurance or copayments◆

- *** **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 \$135 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 \$135 of Medicare Approved Amounts **** Preventive Benefits for Medicare covered services Remainder of Medicare Approved Amounts	\$0 Generally 75% or more of Medicare approved amounts Generally 80%	\$0 Remainder of Medicare approved amounts Generally 10%	\$135 (Part B Deductible) ****◆ All costs above Medicare approved amounts 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 \$4440)*
BLOOD First 3 pints Next \$135 of Medicare Approved Amounts **** Remainder of Medicare Approved Amounts	\$0 \$0 Generally 80%	50% \$0 Generally 10%	50%◆ \$135 (Part B Deductible) ****◆ 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 – Durable medical equipment First \$135 of Medicare Approved Amounts ***** Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 10%	\$0 \$135 (Part B Deductible) ◆ 10%◆
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* This plan limits your annual out-of-pocket payment for Medicare-approved amounts \$4440 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 \$2220 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 \$1024	\$768 (75% of Part A Deductible)	\$256 (25% of Part A Deductible)♦
61st thru 90th day	All but \$256 a day	\$256 a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$512 a day	\$512 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 \$128 a day	Up to \$96 a day	Up to \$32 a day♦
101st day and after	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	75%	25%♦
Additional Amounts	100%	\$0	\$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	Generally, most Medicare eligible expenses for outpatient drug and inpatient respite care	75% of coinsurance or copayments	25% of coinsurance or copayments♦

- *** **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 \$135 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 \$135 of Medicare Approved Amounts **** Preventive Benefits for Medicare covered services Remainder of Medicare Approved Amounts	\$0 Generally 75% or more of Medicare approved amounts Generally 80%	\$0 Remainder of Medicare approved amounts Generally 15%	\$135 (Part B Deductible) ****◆ All costs above Medicare approved amounts 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 \$2220)*
BLOOD First 3 pints Next \$135 of Medicare Approved Amounts **** Remainder of Medicare Approved Amounts	\$0 \$0 Generally 80%	75% \$0 Generally 15%	25%◆ \$135 (Part B Deductible) ****◆ 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 – Durable medical equipment First \$135 of Medicare Approved Amounts ***** Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 15%	\$0 \$135 (Part B Deductible) ◆ 5%◆
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* This plan limits your annual out-of-pocket payment for Medicare-approved amounts \$2220 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*.