



*"We are insured, protected,  
and free to enjoy life."*

# ProCare<sup>®</sup>

## Medicare Supplement Insurance Policies

Help to reduce out-of-pocket costs  
that Medicare does not pay.

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# United American's ProCare<sup>®</sup> plans are a smart choice ...

## Why Choose United American Insurance Company?

United American is a name trusted by doctors and hospitals nationwide. Medicare was signed into law in 1966, and that year United American Insurance Company developed its first Medicare Supplement program. UA has been providing Medicare Supplement insurance ever since, and we have developed an industry-wide reputation for quality Senior insurance products. Today, UA is one of the largest nationwide underwriters of individual insurance to supplement Medicare\*, and we are proud of our legacy of quality products and superior service.

\*NAIC Medicare Experience Report by Direct Premium Earned for Total Individual Policies, September 2023.

## Freedom to Choose & Nationwide Acceptance

There is no designated physician list. There is no approval process to see a specialist. Our ProCare Medicare Supplement plans are recognized and accepted nationwide.

## Strength of Tradition

A Medicare Supplement policy from United American is protection that can never be canceled (*unless there is a material misrepresentation*) as long as premiums are paid on time.

## Assurance of Service

- Medicare Supplement coverage from United American features on-the-spot qualification in most cases.
- We're neighbors! We have an agent in your local area.

## Financial Strength

For more than 45 consecutive years, UA has earned the A (Excellent) or higher Financial Strength Rating from A.M. Best Company (rating as of 10/24).\*

UA has been rated AA – (Very Strong) for Financial Strength by Standard & Poor's (rating as of 3/24).\*

\*These ratings refer only to the financial strength of the company and are not a recommendation of the specific policy provisions, rates or practices of the insurance company.

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United American Insurance Company is not connected with or endorsed by the U.S. Government or federal Medicare program. Policies and benefits may vary by state and have some limitations and exclusions. Individual Medicare Supplement policy forms MSA10, MSB10, MSC10, MSD10, MSF10, MSHDF10, MSG10, MSHDG, MSK06, MSLO6, and MSN10 are available from our Company where state approved. Some states require these plans be available to persons eligible for Medicare due to disability or End Stage Renal Disease (ESRD). Only applicants first eligible for Medicare before 2020 may purchase Plans C, F, and HDF. This is a solicitation for insurance. You may be contacted by an agent representing United American Insurance Company. A licensed agent will provide additional information upon request.

# Choosing a Medicare Supplement Plan

We offer Medicare Supplement policies for 11 of the 12 standardized plans A, B, C, D, F/HDF, G/HDG, K, L, and N (plan availability may vary by state). All Medicare Standardized plans include the following 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 copayment.
- **Blood:** First 3 pints of blood each year.
- **Hospice:** Part A coinsurance for eligible hospice/respite care expenses.

See outline of coverage for details and exceptions.

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

Medicare Plans / Benefits	Plans Available to All Applicants							Medicare First Eligible Before 2020 Only	
	A	B	D	G <sup>▼</sup>	K <sup>■</sup>	L <sup>■</sup>	N <sup>●</sup>	C	F <sup>▼</sup>
<b>Basic Benefits</b>									
Hospitalization (Part A Coinsurance)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medical Expenses (Part B Coinsurance)	100%	100%	100%	100%	50%	75%	Copay <sup>●</sup>	100%	100%
Blood	✓	✓	✓	✓	50%	75%	✓	✓	✓
Hospice	✓	✓	✓	✓	50%	75%	✓	✓	✓
<b>Skilled Nursing Facility Coinsurance</b>			✓	✓	50%	75%	✓	✓	✓
<b>Part A Deductible</b>		✓	✓	✓	50%	75%	✓	✓	✓
<b>Part B Deductible</b>								✓	✓
<b>Excess Doctor Charges</b>				100%					100%
<b>Foreign Travel Emergency</b>			✓	✓			✓	✓	✓
<b>Out-of-Pocket Annual Limit<sup>■</sup></b>					\$7,220	\$3,610			

▼ Plans F and G also have a high deductible option which requires first paying a plan deductible of (\$2,870 in 2025) 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.

■ 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 (\$7,220 for Plan K, \$3,610 for Plan L in 2025). The out-of-pocket annual limit does NOT include the 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 may increase each year for inflation.

● Plan N pays 100% of Medical Expenses (Part B Coinsurance) except for a copayment of up to \$20 for some office visits and up to \$50 copayment for emergency room visits that do not result in an inpatient admission. The emergency room copayment is waived if the insured is admitted to any hospital, and the emergency visit is covered as a Medicare Part A expense.

Some states require designated Medicare Supplement plans also be available to people under age 65 and eligible for Medicare due to disability (different application forms may be required). Policy benefits are identical for people over or under age 65. Premiums are based on Preferred or Standard, age, sex, State/Area\*.





**United American**  
insurance company

# 2025 ProCare<sup>®</sup> Rates – Connecticut

**Plans C, F and HDF** are only available to applicants first eligible for Medicare Part A before January 1, 2020.

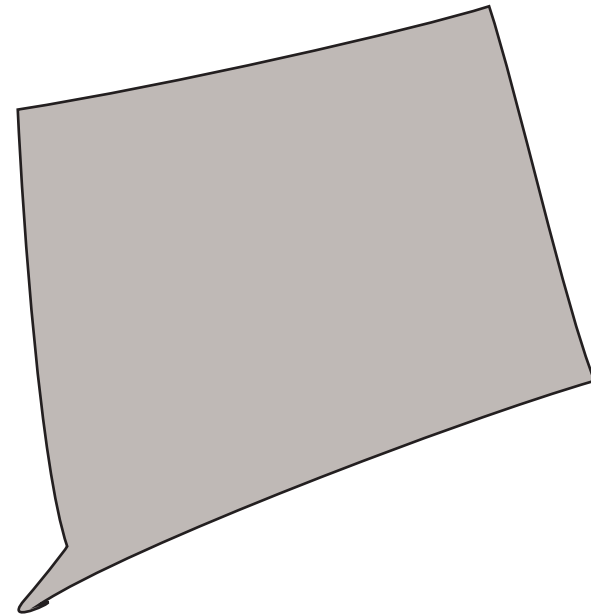
**Premium portions for Plans C and F are for Part B deductible;** subtract from the appropriate mode to calculate commission:

A	SA	Q	M
\$256	\$128	\$64	\$22

**Community Rates** policy rates are the same for all ages 65 and over. Community rates increase with medical care cost increases.

**Under Age 65 During Open Enrollment Period (OE)** policy rates available during Open Enrollment period.

**Under Age 65 During Guaranteed Issue Period (GI)** policy rates available during Guaranteed Issue period.



## COMMUNITY RATES FOR ALL AGES 65 AND OVER

Male/Female

Community						
Plan	A	SA	Q	M	Plan Code	Effective Date
A	2663	1332	666	222	5A8	02/15/2020
B	4370	2185	1093	365	5AQ	01/15/2025
C	5775	2888	1444	482	5B8	01/15/2025
D	5698	2849	1425	475	5BQ	01/15/2025
F	5116	2558	1279	427	5C8	01/15/2025
HDF	722	361	181	61	5CQ	01/15/2025
G	4923	2462	1231	411	5D8	01/15/2024
HDG	565	283	142	48	5HS	01/15/2025
K	1614	807	404	135	P87	01/01/2013
L	2397	1199	600	200	P90	02/15/2020
N	2630	1315	658	220	5DQ	01/15/2025

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

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

Male/Female

**Community**

Plan	A	SA	Q	M	Plan Code	Effective Date
A	2663	1332	666	222	5AD	02/15/2020
B	4370	2185	1093	365	5AV	01/15/2025
C	5775	2888	1444	482	5BD	01/15/2025
D	5698	2849	1425	475	5BV	01/15/2025

**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/Female

**Community**

Plan	A	SA	Q	M	Plan Code	Effective Date
A	2663	1332	666	222	5AD	02/15/2020
B	4370	2185	1093	365	5AV	01/15/2025
C	5775	2888	1444	482	5BD	01/15/2025
D	5698	2849	1425	475	5BV	01/15/2025

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



**APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE \* UNITED AMERICAN INSURANCE COMPANY  
A LEGAL RESERVE STOCK COMPANY**

**PART I: APPLICANT INFORMATION**

<b>Plan Code</b> <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/> <small>(Refer to Rate Card)</small> *Medicare first eligible before 2020 only	<b>Effective Date Requested (mm-dd-yyyy)</b> <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/>	<b>Mode of Premium</b> <input type="radio"/> Annual <input type="radio"/> Semi-Annual <input type="radio"/> Quarterly <input type="radio"/> Monthly	<b>Method of Payment</b> <input type="radio"/> Send Premium Notices <input type="radio"/> Automatic Payment Plan	<b>Draft Date</b> Day (01-28) of the Month to Draft Bank Account <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/>
<b>Select Plan Applying for</b> <input type="radio"/> A <input type="radio"/> B <input type="radio"/> C* <input type="radio"/> D <input type="radio"/> F* <input type="radio"/> HDF* <input type="radio"/> G <input type="radio"/> HDG <input type="radio"/> K <input type="radio"/> L <input type="radio"/> N				

Applicant's First Name

Last Name

M.I.

**Applicant's Mailing Address:**

Street or Route

City  State

Zip Code  County

**If Applicant's Residence Address is different from Mailing Address, show below:**

Street or Route

City  State

Zip Code  County

Social Security Number    -   -

Date of Birth (mm-dd-yyyy)   -   -      Age Last Birthday

Sex  Male  Female

Have you used tobacco in any form in the past 12 months? -----  Yes  No

E-mail Address of Proposed Insured

<b>Application Verification Information</b>	A recorded interview may be necessary as part of the underwriting of your application for insurance. The most convenient time and place for the interview is:	<input type="radio"/> 8 AM - Noon <input type="radio"/> Noon - 6 PM <input type="radio"/> 6 PM - 9 PM	Home Phone No. <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/> - <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/> - <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/> Work Phone No. <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/> - <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/> - <input style="width:20px; height:20px;" type="text"/> <input style="width:20px; height:20px;" type="text"/>
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**PART II: ELIGIBILITY QUESTIONS**

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application. **PLEASE ANSWER ALL QUESTIONS.**

**TO THE BEST OF YOUR KNOWLEDGE:**

**Yes No**

1. (a) Did you turn age 65 in the last six (6) months? -----
- (b) Did you enroll in Medicare Part B in the last six (6) months? -----
- (c) If "YES", what is the effective date? (mm-dd-yyyy)      -   -
- (d) What is your Medicare Claim Number?
- (as shown on your Medicare card omitting dashes)

2. Are you covered for medical assistance through the state Medicaid program?  
NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "NO" to this question. -----    
If you answered "YES":
- (a) Will Medicaid pay your premiums for this Medicare Supplement policy? -----
- (b) Do you receive any benefits from Medicaid OTHER THAN payment towards your Medicare Part B premium? -----

3. (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END Date" blank.
- START Date (mm-dd-yyyy)      -   -                          END Date (mm-dd-yyyy)      -   -

**Yes No**

- (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? -----
- (c) Was this your first time in this type of Medicare plan? -----
- (d) Did you drop a Medicare Supplement policy to enroll in the Medicare plan? -----
4. (a) Do you have another Medicare Supplement policy in force? -----
- (b) If so, with what company, and what plan do you have? \_\_\_\_\_
- (c) If so, do you intend to replace your current Medicare Supplement policy with this policy? -----
5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)
- (a) If so, with what company and what kind of policy?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- (b) What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END Date" blank.)
- START Date (mm-dd-yyyy)      -   -                          END Date (mm-dd-yyyy)      -   -

PART III

I. INVOLUNTARY TERMINATION OF COVERAGE:

If your previous coverage was terminated involuntarily, please provide a copy of the notice of termination of coverage and attach it to this form.

What type of coverage was terminated? \_\_\_\_\_

Date of termination?   -   -     Reason for termination? \_\_\_\_\_  
(mm-dd-yyyy)

II. VOLUNTARY TERMINATION OF COVERAGE:

If you voluntarily terminated your present coverage, please attach evidence of previous coverage to this form.

What type of coverage was terminated? \_\_\_\_\_

Date of termination?   -   -     Reason for termination? \_\_\_\_\_  
(mm-dd-yyyy)

If you voluntarily terminated coverage under a Medicare Advantage plan\* or Medicare Select policy, please answer the following questions: **Yes No**

1. Was this the first time you were ever enrolled in a Medicare Advantage plan or purchased a Medicare Select policy? -----    
If so, did you have the Medicare Advantage plan or Medicare Select policy for less than 12 months? -----
  2. Did you have a Medicare Supplement policy before applying for the Medicare Advantage plan or Medicare Select policy? -----    
If "YES", with which Company and which Medicare Supplement plan?  
\_\_\_\_\_
- Is that Company still offering that Medicare Supplement plan? -----

\* Medicare Advantage plan means a plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. 1395w-28(b)(1), and includes: (1) Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans; (2) Medical savings account plans coupled with a contribution into a Medicare Advantage plan medical savings account; and (3) Medicare Advantage private fee-for-service plans.

PART IV: APPLICANT AUTHORIZATION

- (1) You do not need more than one Medicare Supplement policy.
- (2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- (3) You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
- (4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- (5) If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
- (6) Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).





Initials of  
Proposed Insured

--	--	--

32679



**Draft date cannot be the 29th, 30th, or 31st.**

Proposed Insured's Social Security Number

			-			-					
--	--	--	---	--	--	---	--	--	--	--	--

Requested Bank Draft Day (dd)

--	--

Payor's First Name															M.I.	
Payor's Last Name																
Bank ABA Routing Number								Account Number								
Bank Name																

**Account information fields above must be complete if voided check is not attached.**

See the example check below for the location of the Bank Routing Number and Account Number.

Paula C. Holder 123 Main St. Hometown, TX 75432 TXDL 12345678	Date _____	0001
PAY TO THE ORDER OF _____	\$ _____	
Hometown Bank FDIC	<b>VOID</b>	
Memo _____		
123456789	1234567890	0001

Helpful Information for Social Security Recipients		
Social Security Benefits Paid On	Birth Date On	Draft Date
Second Wednesday	1 <sup>st</sup> – 10 <sup>th</sup>	14 <sup>th</sup>
Third Wednesday	11 <sup>th</sup> – 20 <sup>th</sup>	21 <sup>st</sup>
Fourth Wednesday	21 <sup>st</sup> – 31 <sup>st</sup>	28 <sup>th</sup>

Bank ABA Routing Number      Account Number      Check Number

As a convenience to me, I hereby request and authorize you, United American Insurance Company, McKinney, Texas, to initiate debit entries to my bank account, as recorded above, for insurance premiums and/or non-insurance product fees, as applicable, and the bank named above to debit the same to such account. I agree that your rights and treatment of such debits shall be the same as if they were checks personally signed by me. I further agree that if any such debits are dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, even if such dishonor results in the forfeiture of insurance. This authorization will remain in effect until revoked by me in writing to you, provided that you and the bank shall have a reasonable opportunity to act on such notification. All premiums and/or fees may be automatically withdrawn from my account on MONTHLY mode, unless a different mode has been selected on the application(s).

**NOTE - Business accounts are permitted only in relation to sole proprietorships, in which case a voided check and a completed Sole Proprietor form (SP 9-01) are required.**

\_\_\_\_\_  
**Payor's Signature (as it appears on bank records)**



Instructions to Agent: This form is provided for the purpose of compliance with regulations regarding the replacement of Medicare Supplement insurance. When the replacement question on the application is answered YES, this form must be dated, signed by the applicant and by the Agent, and submitted with the application, AND a copy of this form must be left with the applicant.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE  
OR MEDICARE ADVANTAGE

**UNITED AMERICAN INSURANCE COMPANY**  
3700 S. STONEBRIDGE DRIVE, P.O. BOX 8080, MCKINNEY, TEXAS 75070 (972) 529-5085

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to your application, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by United American Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER OR AGENT:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement coverage is being purchased for the following reason (check one):

- Additional benefits.
- No change in benefits, but lower premiums.
- Fewer benefits and lower premiums.
- My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

Other. (please specify) \_\_\_\_\_

- (1) Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
- (2) State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
- (3) If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. FAILURE TO INCLUDE ALL REQUESTED MATERIAL MEDICAL INFORMATION ON AN APPLICATION MAY PROVIDE A BASIS FOR THE COMPANY TO DENY ANY FUTURE CLAIMS AND TO REFUND YOUR PREMIUM AS THOUGH YOUR POLICY HAD NEVER BEEN IN FORCE. After the application has been completed and before you sign it, review it carefully to be certain that all requested information has been properly recorded.

DO NOT CANCEL YOUR PRESENT POLICY UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE THAT YOU WANT TO KEEP IT.

\_\_\_\_\_  
(Agent's Signature)

Type or print name & address of Agent or Broker:  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(Applicant's Signature)

\_\_\_\_\_  
(Date)

## Health Insurance Policy – Comparison Form

### Current Policy

Name of Company \_\_\_\_\_  
 Policy Number \_\_\_\_\_  
 Premium \_\_\_\_\_ (Mode) \_\_\_\_\_

### Proposed Policy

Name of Company **United American Insurance Company**  
 Application Number \_\_\_\_\_  
 Premium \_\_\_\_\_ (Mode) \_\_\_\_\_

Applicant's Name \_\_\_\_\_

1. Does the insurer provide a service for an automatic filing of both assigned and unassigned Part B claims?  
**Current Policy**  Yes  No      **UA Policy**  Yes  No

2. If the current policy is a standardized Medicare Supplement Plan under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), identify the plan category as A, B, C, D, F, HDF, G, HDG, K, L, M, or N.

Current Plan	ProCare Plan										
	A	B	C <sup>†</sup>	D	F <sup>†</sup>	HDF <sup>†</sup>	G	HDG	K	L	N
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**There is no need to complete the rest of this form if the current policy is a model plan.**

3. If the plan being replaced is not a Model Plan, answer the following questions for that plan only.

	Current Policy			UA Policy (Y = Yes N = No)								
	A	B	C <sup>†</sup>	D	F <sup>†</sup>	HDF <sup>†</sup>	G	HDG	K	L	N	
<b>Part A</b>												
Pays Medicare Part A Deductible?	<input type="checkbox"/> Yes <input type="checkbox"/> No	N	Y	Y	Y	Y	Y	Y	Y	50%	75%	Y
Pays all expenses after Medicare Part A is exhausted?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Has a Skilled Nursing Facility benefit?	<input type="checkbox"/> Yes <input type="checkbox"/> No	N	N	Y	Y	Y	Y	Y	Y	50%	75%	Y
<b>Part B</b>												
Pays Medicare Part B Deductible?	<input type="checkbox"/> Yes <input type="checkbox"/> No	N	N	Y	N	Y	Y	N	N	N	N	N
Pays ALL Medicare Part B coinsurance amounts?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Y	Y	Y	Y	Y	Y	Y	Y	*	*	**
Pays 100% of excess charges (amounts above Medicare approved)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	N	N	N	N	Y	Y	Y	Y	N	N	N
Has a Foreign Travel Benefit?	<input type="checkbox"/> Yes <input type="checkbox"/> No	N	N	Y	Y	Y	Y	Y	Y	N	N	Y
Is Policy Guaranteed Renewable?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
At-Home Recovery Benefit?	<input type="checkbox"/> Yes <input type="checkbox"/> No	N	N	N	N	N	N	N	N	N	N	N
Prescription Drug Benefit?	<input type="checkbox"/> Yes <input type="checkbox"/> No	N	N	N	N	N	N	N	N	N	N	N
Preventive Care Benefit?	<input type="checkbox"/> Yes <input type="checkbox"/> No	N	N	N	N	N	N	N	N	N	N	N

Other Benefits or Services (itemize) \_\_\_\_\_  
 \_\_\_\_\_

\* Once you meet out-of-pocket annual limit  
 \*\* Subject to policy copayment for office visits and emergency room visits  
 † Medicare Supplement Plan C, F, and HDF will only be available to those first eligible for Medicare Part A due to age or disability prior to January 1, 2020.

The Applicant's actual policy  was  was not made available to me for review.

Agent's Signature and Agent Number \_\_\_\_\_

Date \_\_\_\_\_

Applicant's Signature \_\_\_\_\_

Date \_\_\_\_\_

**A copy of this form must be returned with the application when a replacement is involved.**



# UNITED AMERICAN INSURANCE COMPANY

**A LEGAL RESERVE STOCK COMPANY • ADMINISTRATIVE OFFICES: MCKINNEY, TEXAS**  
3700 S. STONEBRIDGE DR., P.O. BOX 8080, MCKINNEY, TEXAS 75070 (972) 529-5085

Instructions to Agent: This form is provided for the purpose of compliance with regulations regarding the replacement of accident and sickness insurance.

When the replacement question on the application is answered YES, this form must be dated, signed by the applicant and submitted with the application AND a copy of this form must be left with the applicant.

## **NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE**

According to **(your application) (the information you have furnished)**, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by United American Insurance Company. Your new policy provides a period within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in a denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. **FAILURE TO INCLUDE ALL MATERIAL MEDICAL INFORMATION ON AN APPLICATION MAY PROVIDE A BASIS FOR THE COMPANY TO DENY ANY FUTURE CLAIMS AND TO REFUND YOUR PREMIUM AS THOUGH YOUR POLICY HAD NEVER BEEN IN FORCE.** After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

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(Date)

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(Applicant's Signature)

**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 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 <sup>3</sup>	✓	✓
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 2025 <sup>2</sup>					\$7,220 <sup>2</sup>	\$3,610 <sup>2</sup>				

\* Denotes plans available by United American Insurance Company

<sup>1</sup> Plans F and G also have a high deductible option which requires first paying a plan deductible of \$2,870 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.

<sup>2</sup> 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.

<sup>3</sup> 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. 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.

## COMMUNITY RATES FOR ALL AGES 65 AND OVER

Male/Female

Community						
Plan	A	SA	Q	M	Plan Code	Effective Date
A	2663	1332	666	222	5A8	02/15/2020
B	4142	2071	1036	346	5AQ	02/01/2023
C	5298	2649	1325	442	5B8	01/15/2024
D	5276	2638	1319	440	5BQ	01/15/2024
F	4694	2347	1174	392	5C8	01/15/2024
HDF	662	331	166	56	5CQ	01/15/2024
G	4923	2462	1231	411	5D8	01/15/2024
HDG	595	298	149	50	5HS	01/01/2020
K	1614	807	404	135	P87	01/01/2013
L	2397	1199	600	200	P90	02/15/2020
N	2481	1241	621	207	5DQ	02/15/2020

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

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

**Male/Female**

<b>Community</b>						
<b>Plan</b>	<b>A</b>	<b>SA</b>	<b>Q</b>	<b>M</b>	<b>Plan Code</b>	<b>Effective Date</b>
<b>A</b>	2663	1332	666	222	5AD	02/15/2020
<b>B</b>	4142	2071	1036	346	5AV	02/01/2023
<b>C</b>	5298	2649	1325	442	5BD	01/15/2024
<b>D</b>	5276	2638	1319	440	5BV	01/15/2024

**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/Female

Community						
Plan	A	SA	Q	M	Plan Code	Effective Date
A	2663	1332	666	222	5AD	02/15/2020
B	4142	2071	1036	346	5AV	02/01/2023
C	5298	2649	1325	442	5BD	01/15/2024
D	5276	2638	1319	440	5BV	01/15/2024

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

**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
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1676	\$0	\$1676 (Part A Deductible)
61st thru 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$838 a day	\$838 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
<b>SKILLED NURSING FACILITY CARE*</b>			
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 \$209.50 a day	\$0	Up to \$209.50 a day
101st day and after	\$0	\$0	All Costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
You must meet Medicare’s requirements, including a doctor’s certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and	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 \$257 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
<b>MEDICAL EXPENSES</b> – 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 \$257 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$257 (Part B Deductible) \$0
<b>Part B Excess Charges</b> (Above Medicare-Approved Amounts)	\$0	\$0	All Costs
<b>BLOOD</b> First 3 pints Next \$257 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$257 (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES</b> – Tests for diagnostic services	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE</b> – MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies – Durable medical equipment First \$257 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	100%   \$0 80%	\$0   \$0 20%	\$0   \$257 (Part B Deductible) \$0
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**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
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1676	\$1676 (Part A Deductible)	\$0
61st thru 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$838 a day	\$838 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
<b>SKILLED NURSING FACILITY CARE*</b>			
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 \$209.50 a day	\$0	Up to \$209.50 a day
101st day and after	\$0	\$0	All Costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
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 \$257 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
<b>MEDICAL EXPENSES</b> – 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 \$257 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$257 (Part B Deductible) \$0
<b>Part B Excess Charges</b> (Above Medicare-Approved Amounts)	\$0	\$0	All Costs
<b>BLOOD</b> First 3 pints Next \$257 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$257 (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES</b> – Tests for diagnostic services	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE</b> – MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies – Durable medical equipment First \$257 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	100%   \$0 80%	\$0   \$0 20%	\$0   \$257 (Part B Deductible) \$0
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**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
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1676	\$1676 (Part A Deductible)	\$0
61st thru 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$838 a day	\$838 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
<b>SKILLED NURSING FACILITY CARE*</b>			
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 \$209.50 a day	Up to \$209.50 a day	\$0
101st day and after	\$0	\$0	All Costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
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 respice 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 \$257 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
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as</b> Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$257 of Medicare-Approved Amounts*	\$0	\$257 (Part B Deductible)	\$0
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare-Approved Amounts)	\$0	\$0	All Costs
<b>BLOOD</b>			
First 3 pints	\$0	All Costs	\$0
Next \$257 of Medicare-Approved Amounts*	\$0	\$257 (Part B Deductible)	\$0
Remainder of Medicare-Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES</b>			
– Tests for diagnostic services	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE – MEDICARE-APPROVED SERVICES</b>			
– Medically necessary skilled care services and medical supplies	100%	\$0	\$0
– Durable medical equipment			
First \$257 of Medicare-Approved Amounts*	\$0	\$257 (Part B Deductible)	\$0
Remainder of Medicare-Approved Amounts	80%	20%	\$0

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b>			
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
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1676	\$1676 (Part A Deductible)	\$0
61st thru 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$838 a day	\$838 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
<b>SKILLED NURSING FACILITY CARE*</b>			
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 \$209.50 a day	Up to \$209.50 a day	\$0
101st day and after	\$0	\$0	All Costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
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 respice 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 \$257 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
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as</b> Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$257 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$257 (Part B Deductible) \$0
<b>Part B Excess Charges</b> (Above Medicare-Approved Amounts)	\$0	\$0	All Costs
<b>BLOOD</b> First 3 pints Next \$257 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$257 (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES</b> – Tests for diagnostic services	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE – MEDICARE-APPROVED SERVICES</b> – Medically necessary skilled care services and medical supplies – Durable medical equipment First \$257 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$257 (Part B Deductible) \$0
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**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> 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 \$2870 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$2870. 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 \$2870 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$2870 DEDUCTIBLE,** YOU PAY
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1676	\$1676 (Part A Deductible)	\$0
61st thru 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$838 a day	\$838 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
<b>SKILLED NURSING FACILITY CARE*</b>			
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 \$209.50 a day	Up to \$209.50 a day	\$0
101st day and after	\$0	\$0	All Costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
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 \$257 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 \$2870 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$2870. 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 \$2870 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$2870 DEDUCTIBLE,** YOU PAY
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as</b> Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$257 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$257 (Part B Deductible) Generally 20%	\$0 \$0
<b>Part B Excess Charges</b> (Above Medicare-Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$257 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All Costs \$257 (Part B Deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES</b> – Tests for diagnostic services	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE – MEDICARE-APPROVED SERVICES</b> – Medically necessary skilled care services and medical supplies – Durable medical equipment First \$257 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	100%   \$0 80%	\$0  \$257 (Part B Deductible) 20%	\$0  \$0 \$0
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**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> 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 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 \$2870 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are \$2870. 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 \$2870 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$2870 DEDUCTIBLE,** YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: – While using 60 lifetime reserve days Once lifetime reserve days are used: – Additional 365 days  – Beyond the Additional 365 days	All but \$1676 All but \$419 a day  All but \$838 a day  \$0  \$0	\$1676 (Part A Deductible) \$419 a day  \$838 a day  100% of Medicare-Eligible Expenses \$0	\$0 \$0  \$0  \$0 ***  All Costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21st thru 100th day 101st day and after	All approved amounts All but \$209.50 a day \$0	\$0 Up to \$209.50 a day \$0	\$0 \$0 All Costs
<b>BLOOD</b> First 3 pints Additional Amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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 \$257 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 \$2870 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are \$2870. 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 \$2870 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$2870 DEDUCTIBLE,** YOU PAY
<b>MEDICAL EXPENSES</b> – 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 \$257 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$257 (Unless Part B Deductible has been met) \$0
<b>Part B Excess Charges</b> (Above Medicare-Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$257 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$257 (Unless Part B Deductible has been met) \$0
<b>CLINICAL LABORATORY SERVICES</b> – Tests for diagnostic services	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE</b> – MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies – Durable medical equipment First \$257 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$257 (Unless Part B Deductible has been met) \$0
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**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>FOREIGN TRAVEL</b> – 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 \$7220 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 this 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 *
<b>HOSPITALIZATION**</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1676	\$838 (50% of Part A Deductible)	\$838 (50% of Part A Deductible) ♦
61st thru 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$838 a day	\$838 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
<b>SKILLED NURSING FACILITY CARE**</b>			
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 \$209.50 a day	Up to \$104.75 a day (50% of Part A Coinsurance)	Up to \$104.75 a day (50% of Part A Coinsurance) ♦
101st day and after	\$0	\$0	All Costs
<b>BLOOD</b>			
First 3 pints	\$0	50%	50% ♦
Additional Amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
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 \$257 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
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as</b> Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$257 of Medicare-Approved Amounts **** Preventive Benefits for Medicare-Covered Services  Remainder of Medicare-Approved Amounts	\$0 Generally 80% or more of Medicare-approved amounts Generally 80%	\$0 Remainder of Medicare-approved amounts Generally 10%	\$257 (Part B Deductible) **** ♦ All costs above Medicare-approved amounts  Generally 10% ♦
<b>Part B Excess Charges</b> (Above Medicare-Approved Amounts)	\$0	\$0	All Costs (and they do not count toward annual out-of-pocket limit of \$7220)*
<b>BLOOD</b> First 3 pints Next \$257 of Medicare-Approved Amounts **** Remainder of Medicare-Approved Amounts	\$0 \$0 Generally 80%	50% \$0 Generally 10%	50% ♦ \$257 (Part B Deductible) **** ♦ Generally 10% ♦
<b>CLINICAL LABORATORY SERVICES</b> – Tests for diagnostic services	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE – MEDICARE-APPROVED SERVICES</b> – Medically necessary skilled care services and medical supplies – Durable medical equipment First \$257 of Medicare-Approved Amounts ***** Remainder of Medicare-Approved Amounts	100%  \$0 80%	\$0  \$0 10%	\$0  \$257 (Part B Deductible) ♦ 10% ♦
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\* This plan limits your annual out-of-pocket payment for Medicare-approved amounts \$7220 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 \$3610 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 this 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 *
<b>HOSPITALIZATION**</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1676	\$1257 (75% of Part A Deductible)	\$419 (25% of Part A Deductible) ◆
61st thru 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$838 a day	\$838 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
<b>SKILLED NURSING FACILITY CARE**</b>			
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 \$209.50 a day	Up to \$157.12 a day (75% of Part A Coinsurance)	Up to \$52.38 a day (25% of Part A Coinsurance) ◆
101st day and after	\$0	\$0	All Costs
<b>BLOOD</b>			
First 3 pints	\$0	75%	25% ◆
Additional Amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
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 \$257 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
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as</b> Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$257 of Medicare-Approved Amounts **** Preventive Benefits for Medicare-Covered Services  Remainder of Medicare-Approved Amounts	\$0 Generally 80% or more of Medicare-approved amounts Generally 80%	\$0 Remainder of Medicare-approved amounts Generally 15%	\$257 (Part B Deductible) **** ♦ All costs above Medicare-approved amounts  Generally 5% ♦
<b>Part B Excess Charges</b> (Above Medicare-Approved Amounts)	\$0	\$0	All Costs (and they do not count toward annual out-of-pocket limit of \$3610)*
<b>BLOOD</b> First 3 pints Next \$257 of Medicare-Approved Amounts **** Remainder of Medicare-Approved Amounts	\$0 \$0 Generally 80%	75% \$0 Generally 15%	25% ♦ \$257 (Part B Deductible) **** ♦ Generally 5% ♦
<b>CLINICAL LABORATORY SERVICES</b> – Tests for diagnostic services	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE – MEDICARE-APPROVED SERVICES</b> – Medically necessary skilled care services and medical supplies – Durable medical equipment First \$257 of Medicare-Approved Amounts ***** Remainder of Medicare-Approved Amounts	100%   \$0 80%	\$0   \$0 15%	\$0   \$257 (Part B Deductible) ♦ 5% ♦
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\* This plan limits your annual out-of-pocket payment for Medicare-approved amounts \$3610 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
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1676	\$1676 (Part A Deductible)	\$0
61st thru 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$838 a day	\$838 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
<b>SKILLED NURSING FACILITY CARE*</b>			
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 \$209.50 a day	Up to \$209.50 a day	\$0
101st day and after	\$0	\$0	All Costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
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 \$257 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
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as:</b> Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$257 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$0 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.	\$257 (Part B Deductible) 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.
<b>Part B Excess Charges</b> (Above Medicare-Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next \$257 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$257 (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES</b> – Tests for diagnostic services	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE – MEDICARE-APPROVED SERVICES</b> – Medically necessary skilled care services and medical supplies – Durable medical equipment First \$257 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$257 (Part B Deductible) \$0
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**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> 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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