MEDICAL PLAN 1 SUMMARY

Underwritten by United American Insurance Company

Part B Deductible	$50
Office Visit Co-Pay	$10
Emergency Room Co-Pay	$65

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD			
Services	**Medicare Pays**	**Plan Pays**	**You Pay**
Hospitalization*: Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but $1,216	$1,216 (Part A Deductible)	**$0**
61st through 90th day	All but $304 per day	$304 per day	**$0**
91st day and after: While using 60 lifetime reserve days:	All but $608 per day	$608 per day	**$0**
Once lifetime reserve days are used: Additional 365 days:	$0	100% of Medicare-Eligible expenses	**$0**
Beyond 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 through 100th day	All but $152 per day	Up to $152 per 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 that you are terminally ill and you elect to receive these services.			
Available as long as your doctor certifies that you are terminally ill and you elect to receive these services.	All but very limited co-payment/ co-insurance for outpatient drugs and inpatient respite care	Medicare co-payment/ co-insurance	**$0**

MEDICAL PLAN 1 SUMMARY

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MEDICARE (PART B) – MEDICAL SERVICES-PER CALENDAR YEAR			
Services	**Medicare Pays**	**Plan Pays**	**You Pay**
Medical Expenses: In or Out of the Hospital and Outpatient Hospital Treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First $147 of Participant Charges**	$0	$97 (Part B Deductible)	**$50 (Part B Deductible)**
Office Visit Co-Pay			**$10**
ER Co-Pay			**$65**
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	**$0**
Part B Excess Charges (above Medicare-approved amounts)	$0	All Costs	**$0**
Blood:			
First 3 pints	$0	All Costs	**$0**
Additional Amounts	$0	$97 (Part B Deductible)	**$50 (Part B Deductible)**
Office Visit Co-Pay			**$10**
ER Co-Pay			**$65**
Remainder of Medicare-approved amounts	80%	20%	**$0**
Clinical Laboratory Services:			
Blood tests for Diagnostic Services	100%	$0	$0
MEDICARE PARTS A & B			
Services	**Medicare Pays**	**Plan Pays**	**You Pay**
Home Health Care: Medicare Approved Services			
Medically necessary skilled care services and medical supplies	100%	$0	**$0**
Durable Medical equipment First $147 of Medicare-approved amounts**	$0	$97 (Part B Deductible)	**$50 (Part B Deductible)**
Office Visit Co-Pay			**$10**
ER Co-Pay			**$65**
Remainder of Medicare-approved amounts	80%	20%	**$0**

MEDICAL PLAN 1 SUMMARY

Underwritten by United American Insurance Company

OTHER BENEFITS NOT COVERED BY MEDICARE			
Services	**Medicare Pays**	**Plan Pays**	**You Pay**
Foreign Travel Emergency: Medically necessary emergency 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 of $50,000	**20% and amounts over the $50,000 lifetime maximum**

* 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.

** Once you have been billed $147 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Medicare Part B Deductible will have been met for the calendar year.

The summary of benefits described herein is for illustrative purposes only. In case of differences or errors, the Group Policy governs.