THE ORDER OF UNITED COMMERCIAL TRAVELERS OF AMERICA
A Fraternal Benefit Society
PEOPLE HELPING PEOPLE

Home Office:
The Order of United Commercial Travelers of America
632 N. Park St., P.O. Box 159019, Columbus, OH 43215
(614) 228-3276 • Toll-free: (800) 848-0123 • Fax: (614) 228-1898
Visit our web site at www.uct.org

Outline of Medicare Supplement Coverage – Cover Page: 1 of 2

Benefit Plans A, E, F and G

These charts show the benefits included in each 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	
	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	
			At-Home Recovery				At-Home Recovery		At-Home Recovery	At-Home Recovery	
				Preventive Care NOT covered by Medicare						Preventive Care NOT covered by Medicare	

*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 or offer the same benefits as Plans F and J after one has paid a calendar year $1,900 deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses are $1,900. 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 does not include, in Plan J, the plan's separate prescription drug deductible or, in Plans F and J, the plan's separate foreign emergency deductible.

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Outline of Medicare Supplement Coverage – Cover Page 2

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 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		
Preventative Care NOT covered by Medicare		
	$4,440 Out of Pocket Annual Limit ***	$2,220 Out of Policy Annual Limit ***

**** Plans K and L provide for different cost-sharing for items and services than Plans A-J.**
Once you reach the annual limit, the plans pays 100% of the Medicare copayments, coinsurances, 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.

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Annual Premium Rates Non Smoker

	Plan A		Plan E		Plan F		Plan G	
AGE	Male	Female	Male	Female	Male	Female	Male	Female
All	1267.30	1267.30	1480.34	1480.34	1690.10	1690.10	1493.45	1493.45

Annual Premium Rates Smoker

	Plan A		Plan E		Plan F		Plan G	
AGE	Male	Female	Male	Female	Male	Female	Male	Female
All	1583.03	1583.03	1849.60	1849.60	2111.80	2111.80	1867.08	1867.08

Semi-Annual Premium Rates Non Smoker

	Plan A		Plan E		Plan F		Plan G	
AGE	Male	Female	Male	Female	Male	Female	Male	Female
All	652.66	652.66	762.37	762.37	870.40	870.40	769.13	769.13

Semi-Annual Premium Rates Smoker

	Plan A		Plan E		Plan F		Plan G	
AGE	Male	Female	Male	Female	Male	Female	Male	Female
All	815.26	815.26	952.55	952.55	1087.58	1087.58	961.55	961.55

Quarterly Premiums Rates Non Smoker

	Plan A		Plan E		Plan F		Plan G	
AGE	Male	Female	Male	Female	Male	Female	Male	Female
All	332.67	332.67	388.59	388.59	443.65	443.65	392.03	392.03

Quarterly Premiums Rates Smoker

	Plan A		Plan E		Plan F		Plan G	
AGE	Male	Female	Male	Female	Male	Female	Male	Female
All	415.55	415.55	485.52	485.52	554.35	554.35	490.11	490.11

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Monthly Premiums (EFT) Non Smoker

	Plan A		Plan E		Plan F		Plan G	
AGE	Male	Female	Male	Female	Male	Female	Male	Female
All	105.60	105.60	123.36	123.36	140.84	140.84	124.45	124.45

Monthly Premiums (EFT) Smoker

	Plan A		Plan E		Plan F		Plan G	
AGE	Male	Female	Male	Female	Male	Female	Male	Female
All	131.91	131.91	154.13	154.13	175.98	175.98	155.58	155.58

Monthly Premiums (Direct) Non Smoker

	Plan A		Plan E		Plan F		Plan G	
AGE	Male	Female	Male	Female	Male	Female	Male	Female
All	126.73	126.73	148.03	148.03	169.01	169.01	149.34	149.34

Monthly Premiums (Direct) Smoker

	Plan A		Plan E		Plan F		Plan G	
AGE	Male	Female	Male	Female	Male	Female	Male	Female
All	158.30	158.30	184.96	184.96	211.18	211.18	186.71	186.71

PREMIUM INFORMATION

We, The Order of United Commercial Travelers of America, 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: The Order of United Commercial Travelers of America, 632 North Park Street, P.O. Box 159019, Columbus, Ohio 43215-8619, or to the representative through whom the policy was purchased. 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 of your medical costs.

Neither The Order of United Commercial Travelers of America nor its agents are connected with Medicare.

This outline of coverage does not give all of the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare & 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 any 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.

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 A PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but $1,024	$0	$1,024 (Part A Deductible)
61st - 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 - 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 that 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, we stand 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 for 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 A 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

MEDICARE (PARTS A & B)

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
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 E

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 E PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but $1,024	$1,024 (Part A Deductible)	$0
61st - 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 - 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 that 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, we stand 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 for the balance based on any difference between its billed charges and the amount Medicare would have paid.**

PLAN E
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 E 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

MEDICARE (PARTS A & B)

SERVICES	MEDICARE PAYS	PLAN E PAYS	YOU PAY
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 E
OTHER BENEFITS – NOT COVERED BY MEDICARE

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
***PREVENTIVE MEDICAL CARÉ BENEFIT – NOT COVERED BY MEDICARE** Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare First $120 each calendar year Additional Charges	 $0 $0	 $120 $0	 $0 All costs

* Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare.*

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.

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but $1,024	$1,024 (Part A Deductible)	$0
61st - 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 - 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 that 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, we stand 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 for the balance based on any difference between its billed charges and the amount Medicare would have paid.**

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.

SERVICES	MEDICARE PAYS	PLAN F 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	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

MEDICARE (PARTS A & B)

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
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 G PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but $1,024	$1,024 (Part A Deductible)	$0
61st - 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 - 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 that 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, we stand 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 for 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 G 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	80%	20%
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

MEDICARE (PARTS A & B)			
SERVICES	**MEDICARE PAYS**	**PLAN G PAYS**	**YOU PAY**
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
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	$0	Actual charges to $40 a visit	Balance
- Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week.	
- Calendar year maximum	$0	$1,600	

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