United American insurance company

NEW JERSEY

ProCare®

Medicare Supplement Insurance Policies

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

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

United American's ProCare® 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 2025.

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 50 consecutive years, UA has earned the A (Excellent) or higher Financial Strength Rating from A.M. Best Company (rating as of 11/25).❖

UA has been rated AA – (Very Strong) for Financial Strength by S&P Global (rating as of 10/25).❖

❖ 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.

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, MSL06, 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.

ProCare®

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

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.

	Plans Available to All Applicants							Medicare First Eligible Before 2020 Only	
Medicare Plans / Benefits	A	B	D	G▼	K■	L■	N●	C	F▼
Basic Benefits									
Hospitalization (Part A Coinsurance)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medical Expenses (Part B Coinsurance)	100%	100%	100%	100%	50%	75%	Copay●	100%	100%
Blood	✓	✓	✓	✓	50%	75%	✓	✓	✓
Hospice	✓	✓	✓	✓	50%	75%	✓	✓	✓
Skilled Nursing Facility Coinsurance			✓	✓	50%	75%	✓	✓	✓
Part A Deductible		✓	✓	✓	50%	75%	✓	✓	✓
Part B Deductible								✓	✓
Excess Doctor Charges				100%					100%
Foreign Travel Emergency			✓	✓			✓	✓	✓
Out-of-Pocket Annual Limit■					$8,000	$4,000			

▼ Plans F and G also have a high deductible option which requires first paying a plan deductible of *($2,950 in 2026)* 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 *($8,000 for Plan K, $4,000 for Plan L in 2026)*. 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 Medicare 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*.

ProCare®

Medicare Supplement Insurance Policies

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

30-Day review period

If after receiving your ProCare policy you want to cancel for any reason, simply return your policy and I.D. card to our Home Office within the 30-day period. Any premium, less any claims paid, is refunded.

Effective Date of Coverage

When the policy applied for has been issued.

Limitations and Exclusions

No benefits are payable for: any expense which you are not legally obligated to pay; or, any services that are not medically necessary as determined by Medicare, or are not furnished at the direction of, and under the supervision of, a physician; or any portion of any expense for which payment is made by Medicare; or custodial or intermediate level care, or rest cures; or, any type of expense not eligible for coverage under Medicare, except as provided under the Foreign Travel Emergency benefit.

Pre-existing Conditions

With the exception of open enrollment/ guaranteed issue periods, loss due to injury or sickness for which medical advice or treatment was recommended or given by a physician within 6 months prior to policy effective date is not covered unless the loss is incurred more than 60 days *(6 months for underage 65 disability*)* after the effective date. Waiting period waived if replacing a Medicare Supplement policy.

*May vary by state

I, _____,
have applied for the following policy benefits:

I understand this brochure only highlights the available policies/ features and I should refer to my Outline of Coverage and the policy for specific benefit provisions and limitations.

Applicant Notice and Conditional Receipt

I have purchased the following Medicare Supplement Plan:

❑ A ❑ C ❑ D ❑ F ❑ HDF ❑ G

❑ HDG ❑ N

My Medicare Supplement Plan is:

❑ Attained Age Rated.
Where applicable, premiums on policies with Attained Age Rates increase on each policy anniversary due to your age change, until age 81.

❑ Issue Age Rated or Community Rated.
Where applicable, premiums on policies with Issue Age Rates or Community Rates are based on age at time of issue.

All checks must be made payable to United American:
DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

Received of _____
Proposed Insured's Name

a bank draft authorization or check in the sum of $_____for _____ month(s) Medicare Supplement policy premium, other policy fees and noninsurance charges with application for Policy Form MSA10, MSC10, MSD10, MSF10, MSHDF10, MSG10, MSHDG, or MSN10.

If for any reason the policy is not issued, payment is to be refunded in full. Insurance is not effective until the policy applied for has been issued by the Home Office.

_____ _____
Date Agent's Signature

Applicant Information:
Keep this document. It highlights the benefits of your policy. It is not a contract. Your actual policy provisions will govern your benefits.

Instructions to Agent:
Complete this section and leave with the applicant. Fill in the selected plan as chosen on the application in the spaces provided above and complete the conditional receipt.

United American insurance company

3700 S Stonebridge Dr
PO Box 8080 | McKinney, TX 75070
UnitedAmerican.com

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

PART I: APPLICANT INFORMATION

Plan Code (Refer to Rate Card)

Effective Date Requested (mm-dd-yyyy)

*Medicare first eligible before 2020 only

Select Plan Applying for ○ A ○ C* ○ D ○ F* ○ HDF* ○ G ○ HDG ○ N

Mode of Premium
- ○ Annual
- ○ Semi-Annual
- ○ Quarterly
- ○ Monthly

Method of Payment
- ○ Send Premium Notices
- ○ Automatic Payment Plan

Draft Date
Day (01-28) of the Month to Draft Bank Account

Applicant's First Name

M.I.

Last Name

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 - -

Height (ft. in.)

Weight (lbs.)

Date of Birth (mm-dd-yyyy) - -

Age Last Birthday

Sex ○ Male ○ Female

E-mail Address of Proposed Insured

Application Verification Information

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:
- ○ 8 AM - Noon
- ○ Noon - 6 PM
- ○ 6 PM - 9 PM

Home Phone No. - -

Work Phone No. - -

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. **Yes No** ○ ○
   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 II: ELIGIBILITY QUESTIONS (continued)

Yes No

6. Are you within 6 months of your enrollment in Medicare Part B or otherwise qualified for open enrollment? ○ ○
(Questions 7-18 not required if the answer to question 6 is "YES".)

IF THE ANSWER TO ANY OF QUESTIONS 7-17 ARE "YES," THE APPLICANT IS NOT ELIGIBLE FOR COVERAGE:

7. Are you currently hospitalized, confined to a nursing facility or receiving Medicare approved home health care, or have you been hospitalized or received Medicare approved home health care 2 or more times in the past 12 months? ○ ○
8. Do you have emphysema, Chronic Obstructive Pulmonary Disease (COPD), or pulmonary fibrosis? ○ ○
9. Are you bedridden or do you use a wheelchair for any daily activity, or have you been diagnosed with Gaucher's Disease or any other type of lysosomal storage disorder, or have you had any type of amputation caused by disease? ○ ○
10. Have you been advised that surgery may be required within the next twelve months for cataracts? ○ ○
11. Have you been diagnosed or treated for Parkinson's disease, Multiple or Lateral Sclerosis, Alzheimer's disease, senile dementia, or organic brain disorder? ○ ○
12. Have you been treated, diagnosed or tested positive as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or ever tested positive for antibodies for the AIDS (HIV) virus? ○ ○
13. Do you have diabetes requiring more than 50 units of insulin daily? ○ ○
14. Within the past 2 years, have you been diagnosed or treated for internal cancer, melanoma, leukemia, alcoholism or drug abuse, cirrhosis, mental or nervous disorder requiring psychiatric care, or have you been advised to have kidney dialysis? ○ ○
15. Within the past 2 years, have you been diagnosed or treated for heart attack, peripheral vascular disease, congestive heart failure, heart valve disorder, stroke, or transient ischemic attacks (TIA)? ○ ○
16. Within the past 2 years, have you been diagnosed or treated for rheumatoid arthritis or crippling arthritis? ○ ○
17. Within the past year, have you been fed intravenously or through a tube, have you been medically advised to have surgery for joint replacement or for a heart condition, but not had such surgery, or have you been advised to have other surgery that has not been performed? ○ ○
18. Have you used tobacco in any form in the past 12 months? ○ ○

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? (mm-dd-yyyy) ☐☐ – ☐☐ – ☐☐☐☐ Reason for termination? _____

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? (mm-dd-yyyy) ☐☐ – ☐☐ – ☐☐☐☐ Reason for termination? _____

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 reinstituted 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 reinstituted 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 reinstituted 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 reinstituted 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).

I hereby apply to United American Insurance Company for a policy to be issued in reliance on my written answers to the above questions. The answers are, to the best of my knowledge and belief, true. I agree the policy shall not be effective unless it has actually been issued. I have received an outline of coverage for the policy applied for and a Medicare Supplement Buyers Guide.

I understand that loss due to injury or sickness for which medical advice was received or treatment was recommended or given by a physician within 6 months prior to the policy effective date is not covered unless the loss is incurred more than 60 days after the policy effective date, subject to the Time Limit on Certain Defenses provision and legal proceedings.

I authorize the MIB Inc., any insurance company, hospital, physician or other practitioner having any information available as to my diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment, to disclose such information to United American Insurance Company for the purpose of determining my eligibility for insurance and eligibility for benefits under this policy. I understand that any information obtained will not be released to any person or organization except to the MIB Inc., reinsuring companies or other persons or organizations performing business or legal services in connection with this application, with a claim or as may be otherwise lawfully required. I agree that a copy of this authorization is to be acceptable. This authorization will remain in effect for a period of 24 months from the date signed. I understand that I or an authorized representative may request a copy of this authorization. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. Information for consumers about MIB may be obtained on its website at www.mib.com.

No agent may bind, alter, change or waive any underwriting requirements or other provisions of the application or policy. Final acceptance is made by the Underwriting Department of the Company.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Application Signed at City **State** **On this Date (mm-dd-yyyy)**

_____ – _____ – _____

Amount paid with application: $ _____ , _____ . _____

for first _____ months premiums.

Applicant's Signature

Total Premium $ _____ , _____ . _____

Initials of Proposed Insured _____

(Application Continued)

PART V: AGENT CERTIFICATION

The undersigned Agent certifies that he/she has ☐ / has not ☐ personally met with the Applicant and that the Applicant has read, or had read to him/her, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

AGENT COMPLETES (Attach separate sheet, if necessary.)

1. List any other health insurance policy you have sold to the Applicant which is still in force:

_____

_____

2. List any other health insurance policy you have sold to the Applicant in the past five (5) years which is no longer in force:

_____

_____

I certify: (1) I have accurately recorded the information supplied by the Applicant, (2) I have given an outline of coverage for the policy applied for and a Medicare Supplement Buyers Guide to the Applicant.

Last Name | | | | | |

Agent No. | | | | | | |

_____
Agent's Signature

MA15(29) MAIL POLICY TO: ○ Agent ○ Insured (The Policy will be sent to Insured unless otherwise instructed.)

Initials of Proposed Insured | | |

United American insurance company

Bank Draft Authorization

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. [ ]

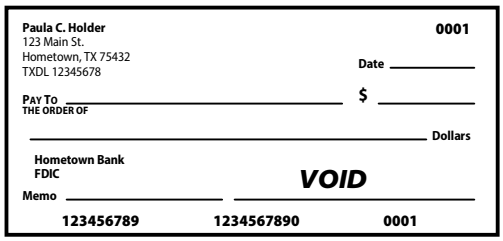
Payor's Last Name [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

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.



Bank ABA Routing Number

Account Number

Check Number

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

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 - <u>Business</u> 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)

FORM 1080-C

48656

UAI1756 **0423**

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)

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)

UNITED AMERICAN INSURANCE COMPANY

3700 S. Stonebridge Drive • McKinney, Texas 75070

Authorization for Release of Health-Related Information

This authorization is intended to comply with the HIPAA Privacy Rule

_____ _____

Name of proposed insured/patient (please print) Date of birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, other insurance company, consumer reporting agency, MIB, Inc., or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other protected health information concerning me to the United American Insurance Company (UA) and its agents, employees, and representatives. This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also may include information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that UA may: 1) underwrite my application(s) for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and/or 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with UA.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to UA to the attention of the Underwriting Department at the above address. I understand that a revocation is not effective to the extent that any of My Providers have relied on this Authorization, and that, to the extent that UA has a legal right to contest a claim under an insurance policy or to contest the policy itself, such revocation may prevent UA from completing its review of policy claims. Such revocation shall not apply to any use or disclosure of my protected health information specifically allowed without authorization by HIPAA and no action relating to this authorization shall be construed as creating any restriction on the uses that HIPAA allows without my authorization. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, UA may not be able to process my application, or if coverage has been issued, may not be able to process policy claims. I acknowledge that I have received a copy of this authorization.

_____ _____

Signature of Proposed Insured/Patient or Personal Representative Date

_____

Description of Personal Representative's Authority or Relationship to Patient

Home Office Copy

UNITED AMERICAN INSURANCE COMPANY

3700 S. Stonebridge Drive • McKinney, Texas 75070

Authorization for Release of Health-Related Information

This authorization is intended to comply with the HIPAA Privacy Rule

_____ _____

Name of proposed insured/patient (please print) Date of birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, other insurance company, consumer reporting agency, MIB, Inc., or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other protected health information concerning me to the United American Insurance Company (UA) and its agents, employees, and representatives. This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also may include information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that UA may: 1) underwrite my application(s) for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and/or 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with UA.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to UA to the attention of the Underwriting Department at the above address. I understand that a revocation is not effective to the extent that any of My Providers have relied on this Authorization, and that, to the extent that UA has a legal right to contest a claim under an insurance policy or to contest the policy itself, such revocation may prevent UA from completing its review of policy claims. Such revocation shall not apply to any use or disclosure of my protected health information specifically allowed without authorization by HIPAA and no action relating to this authorization shall be construed as creating any restriction on the uses that HIPAA allows without my authorization. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

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_____ _____

Signature of Proposed Insured/Patient or Personal Representative Date

_____

Description of Personal Representative's Authority or Relationship to Patient

Applicant Copy

Globe Life
General Agency Division

Sole Proprietorship Form

_____, is a Sole Proprietorship
Company name here

and I am the owner of the company. I authorize my premium to be paid from the company account.

_____ _____
Signature of Owner Printed Name of Owner

Note: If this policy is to be on bank draft, the bank draft authorization on the application **must** also be signed.

2026 MEDICARE PART A

Part A is Hospital Insurance for confinement in a hospital or skilled nursing facility per benefit period.

*A benefit period begins on the first day you receive service as an inpatient 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.

WHEN YOU ARE HOSPITALIZED* FOR:	MEDICARE COVERS	YOU PAY
1-60 DAYS	Most confinement costs after the required Medicare deductible	**$1,736** DEDUCTIBLE
61-90 DAYS	All eligible expenses after patient pays a per-day coinsurance	**$434** A DAY COINSURANCE as much as: **$13,020**
91-150 DAYS	All eligible expenses after patient pays a per-day coinsurance (These are Lifetime Reserve Days that may never be used again)	**$868** A DAY COINSURANCE as much as: **$52,080**
151 DAYS OR MORE	NOTHING	**YOU PAY ALL COSTS**
***SKILLED NURSING CONFINEMENT:** Following an inpatient hospital stay of at least 3 days and enter a Medicare-approved skilled nursing facility within 30 days after hospital discharge and receive skilled nursing care	All eligible expenses for the first 20 days; then all eligible expenses for days 21-100 after patient pays a per-day coinsurance	After 20 days **$217** A DAY COINSURANCE as much as: **$17,360**
HOSPICE CARE: Must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment for outpatient drugs and inpatient respite care	Medicare CO-PAYMENT
BLOOD	100% of approved amount after first 3 pints of blood.	First 3 pints

F3095
UAI0136 **1125**

2026 MEDICARE PART B

Part B is Medical Insurance and covers physician services, outpatient care, tests, and supplies — per calendar year.

ON EXPENSES INCURRED FOR:	MEDICARE COVERS	YOU PAY
ANNUAL DEDUCTIBLE	Incurred Expenses after the required Medicare deductible	**$283** ANNUAL DEDUCTIBLE
MEDICAL EXPENSES Physicians' services for inpatient and outpatient medical/surgical services; physical/speech therapy; and diagnostic tests	80% of approved amount	**20%** of approved amount*
EXCESS DOCTOR CHARGES** *(Above Medicare Approved Amounts)*	0% above approved amount	**ALL COSTS**
CLINICAL LABORATORY SERVICES	Generally 100% of approved amount	Nothing for services
HOME HEALTHCARE	100% of approved amount; 80% of approved amount for durable medical equipment	Nothing for services; 20% of approved amount* for durable medical equipment
OUTPATIENT HOSPITAL TREATMENT	Medicare payment to hospital, based on outpatient procedure payment rates	Coinsurance based on outpatient payment rates
BLOOD	80% of approved amount after first 3 pints of blood.	First 3 pints plus 20% of approved amount for additional pints

*On all Medicare-covered expenses, a doctor or other healthcare provider may agree to accept Medicare assignment. This means the patient will not be required to pay any expense in excess of Medicare's approved charge. The patient pays only 20% of the approved charge.

**Physicians who do not accept assignment of a Medicare claim are limited as to the amount they can charge for a covered service. In 2026, the most a nonparticipating physician can charge for a service covered by Medicare is 115% of the approved amount (may vary by state). *Note: In New York, the most a nonparticipating physician can charge for services covered by Medicare is 105% of the approved amount. For routine office visits covered by Medicare, a nonparticipating New York physician can charge up to 115% of the fee schedule amount.*

F3095
UAI0136 **1125**

United American insurance company

2025 ProCare® Rates – New Jersey

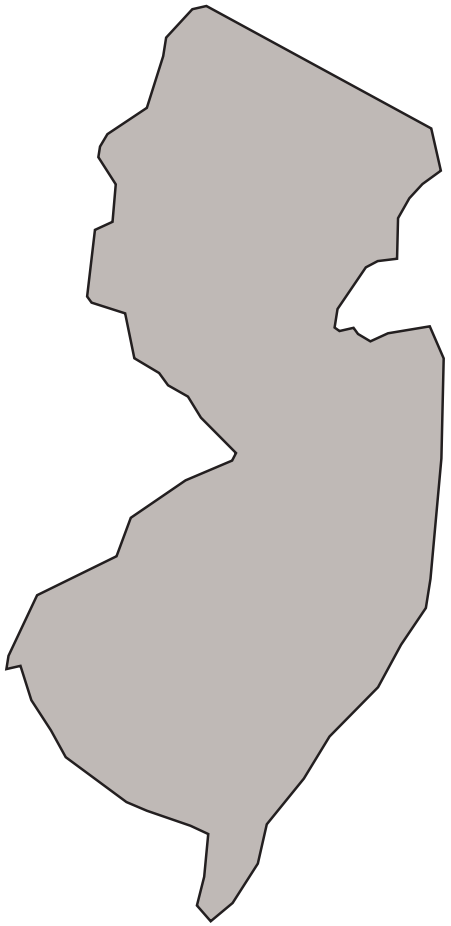
Plans C, F and HDF are only available to applicants first eligible for Medicare Part A before January 1, 2020.

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

A	SA	Q	M
$282	$141	$71	$24

Attained Age policy rates are based on the policyholder's current age. Rates increase yearly (as the policyholder's age increases) on the policy anniversary date, usually up to age 80. Any rate increases due to medical care cost increases are in addition to the increases due to aging. Plans A, C, D, F, HDF, G, HDG, and N are Attained Age rated.

Under Age 65 During Open Enrollment/Guaranteed Issue (OE/GI) policy rates available during Open Enrollment / Guaranteed Issue period for Plans C and D only. Available to applicants ages 50 thru 64.



PLAN A

Male

Preferred

Effective Date: 06/15/2026 Plan Code: 5A4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2858	1429	715	239
66	2927	1464	732	244
67	2988	1494	747	249
68	3067	1534	767	256
69	3148	1574	787	263
70	3237	1619	810	270
71	3307	1654	827	276
72	3354	1677	839	280
73	3499	1750	875	292
74	3653	1827	914	305
75	3808	1904	952	318
76	3953	1977	989	330
77	4025	2013	1007	336
78	4025	2013	1007	336
79	4025	2013	1007	336
80+	4025	2013	1007	336

Standard

Effective Date: 06/15/2026 Plan Code: 5A6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3289	1645	823	275
66	3368	1684	842	281
67	3439	1720	860	287
68	3530	1765	883	295
69	3623	1812	906	302
70	3725	1863	932	311
71	3806	1903	952	318
72	3860	1930	965	322
73	4027	2014	1007	336
74	4204	2102	1051	351
75	4383	2192	1096	366
76	4550	2275	1138	380
77	4633	2317	1159	387
78	4633	2317	1159	387
79	4633	2317	1159	387
80+	4633	2317	1159	387

Female

Preferred

Effective Date: 06/15/2026 Plan Code: 5A5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2485	1243	622	208
66	2545	1273	637	213
67	2598	1299	650	217
68	2668	1334	667	223
69	2738	1369	685	229
70	2815	1408	704	235
71	2876	1438	719	240
72	2917	1459	730	244
73	3043	1522	761	254
74	3177	1589	795	265
75	3312	1656	828	276
76	3438	1719	860	287
77	3501	1751	876	292
78	3501	1751	876	292
79	3501	1751	876	292
80+	3501	1751	876	292

Standard

Effective Date: 06/15/2026 Plan Code: 5A7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2858	1429	715	239
66	2927	1464	732	244
67	2988	1494	747	249
68	3067	1534	767	256
69	3148	1574	787	263
70	3237	1619	810	270
71	3307	1654	827	276
72	3354	1677	839	280
73	3499	1750	875	292
74	3653	1827	914	305
75	3808	1904	952	318
76	3953	1977	989	330
77	4025	2013	1007	336
78	4025	2013	1007	336
79	4025	2013	1007	336
80+	4025	2013	1007	336

PLAN C

Male

Preferred — Effective Date: 06/15/2026 — Plan Code: 5B4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	4337	2169	1085	362
66	4483	2242	1121	374
67	4633	2317	1159	387
68	4790	2395	1198	400
69	4949	2475	1238	413
70	5114	2557	1279	427
71	5281	2641	1321	441
72	5459	2730	1365	455
73	5644	2822	1411	471
74	5831	2916	1458	486
75	6022	3011	1506	502
76	6220	3110	1555	519
77	6426	3213	1607	536
78	6647	3324	1662	554
79	6862	3431	1716	572
80+	7091	3546	1773	591

Standard — Effective Date: 06/15/2026 — Plan Code: 5B6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	4991	2496	1248	416
66	5159	2580	1290	430
67	5332	2666	1333	445
68	5513	2757	1379	460
69	5695	2848	1424	475
70	5886	2943	1472	491
71	6077	3039	1520	507
72	6283	3142	1571	524
73	6495	3248	1624	542
74	6710	3355	1678	560
75	6930	3465	1733	578
76	7158	3579	1790	597
77	7395	3698	1849	617
78	7650	3825	1913	638
79	7897	3949	1975	659
80+	8160	4080	2040	680

Female

Preferred — Effective Date: 06/15/2026 — Plan Code: 5B5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3771	1886	943	315
66	3899	1950	975	325
67	4029	2015	1008	336
68	4166	2083	1042	348
69	4304	2152	1076	359
70	4448	2224	1112	371
71	4592	2296	1148	383
72	4748	2374	1187	396
73	4908	2454	1227	409
74	5071	2536	1268	423
75	5237	2619	1310	437
76	5409	2705	1353	451
77	5588	2794	1397	466
78	5781	2891	1446	482
79	5967	2984	1492	498
80+	6166	3083	1542	514

Standard — Effective Date: 06/15/2026 — Plan Code: 5B7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	4337	2169	1085	362
66	4483	2242	1121	374
67	4633	2317	1159	387
68	4790	2395	1198	400
69	4949	2475	1238	413
70	5114	2557	1279	427
71	5281	2641	1321	441
72	5459	2730	1365	455
73	5644	2822	1411	471
74	5831	2916	1458	486
75	6022	3011	1506	502
76	6220	3110	1555	519
77	6426	3213	1607	536
78	6647	3324	1662	554
79	6862	3431	1716	572
80+	7091	3546	1773	591

Only applicants first eligible for Medicare before 2020 may purchase Plans C, F, and High Deducible F.

PLAN D

Male

Preferred

Effective Date: 06/15/2026 Plan Code: 5BM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3372	1686	843	281
66	3496	1748	874	292
67	3627	1814	907	303
68	3761	1881	941	314
69	3899	1950	975	325
70	4043	2022	1011	337
71	4184	2092	1046	349
72	4340	2170	1085	362
73	4501	2251	1126	376
74	4662	2331	1166	389
75	4829	2415	1208	403
76	4998	2499	1250	417
77	5178	2589	1295	432
78	5367	2684	1342	448
79	5557	2779	1390	464
80+	5752	2876	1438	480

Standard

Effective Date: 06/15/2026 Plan Code: 5BO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3881	1941	971	324
66	4023	2012	1006	336
67	4174	2087	1044	348
68	4328	2164	1082	361
69	4487	2244	1122	374
70	4652	2326	1163	388
71	4815	2408	1204	402
72	4995	2498	1249	417
73	5180	2590	1295	432
74	5365	2683	1342	448
75	5557	2779	1390	464
76	5752	2876	1438	480
77	5959	2980	1490	497
78	6176	3088	1544	515
79	6395	3198	1599	533
80+	6620	3310	1655	552

Female

Preferred

Effective Date: 06/15/2026 Plan Code: 5BN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2933	1467	734	245
66	3040	1520	760	254
67	3154	1577	789	263
68	3271	1636	818	273
69	3390	1695	848	283
70	3516	1758	879	293
71	3639	1820	910	304
72	3774	1887	944	315
73	3914	1957	979	327
74	4054	2027	1014	338
75	4199	2100	1050	350
76	4347	2174	1087	363
77	4503	2252	1126	376
78	4667	2334	1167	389
79	4833	2417	1209	403
80+	5003	2502	1251	417

Standard

Effective Date: 06/15/2026 Plan Code: 5BP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3372	1686	843	281
66	3496	1748	874	292
67	3627	1814	907	303
68	3761	1881	941	314
69	3899	1950	975	325
70	4043	2022	1011	337
71	4184	2092	1046	349
72	4340	2170	1085	362
73	4501	2251	1126	376
74	4662	2331	1166	389
75	4829	2415	1208	403
76	4998	2499	1250	417
77	5178	2589	1295	432
78	5367	2684	1342	448
79	5557	2779	1390	464
80+	5752	2876	1438	480

PLAN F

Male

Preferred — Effective Date: 06/15/2026 — Plan Code: 5C4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	4359	2180	1090	364
66	4502	2251	1126	376
67	4654	2327	1164	388
68	4810	2405	1203	401
69	4966	2483	1242	414
70	5136	2568	1284	428
71	5302	2651	1326	442
72	5480	2740	1370	457
73	5663	2832	1416	472
74	5848	2924	1462	488
75	6043	3022	1511	504
76	6240	3120	1560	520
77	6447	3224	1612	538
78	6667	3334	1667	556
79	6884	3442	1721	574
80+	7110	3555	1778	593

Standard — Effective Date: 06/15/2026 — Plan Code: 5C6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	5017	2509	1255	419
66	5181	2591	1296	432
67	5356	2678	1339	447
68	5536	2768	1384	462
69	5715	2858	1429	477
70	5911	2956	1478	493
71	6102	3051	1526	509
72	6306	3153	1577	526
73	6517	3259	1630	544
74	6730	3365	1683	561
75	6955	3478	1739	580
76	7181	3591	1796	599
77	7420	3710	1855	619
78	7673	3837	1919	640
79	7923	3962	1981	661
80+	8182	4091	2046	682

Female

Preferred — Effective Date: 06/15/2026 — Plan Code: 5C5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3791	1896	948	316
66	3915	1958	979	327
67	4047	2024	1012	338
68	4183	2092	1046	349
69	4319	2160	1080	360
70	4466	2233	1117	373
71	4611	2306	1153	385
72	4765	2383	1192	398
73	4925	2463	1232	411
74	5086	2543	1272	424
75	5256	2628	1314	438
76	5427	2714	1357	453
77	5607	2804	1402	468
78	5798	2899	1450	484
79	5987	2994	1497	499
80+	6183	3092	1546	516

Standard — Effective Date: 06/15/2026 — Plan Code: 5C7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	4359	2180	1090	364
66	4502	2251	1126	376
67	4654	2327	1164	388
68	4810	2405	1203	401
69	4966	2483	1242	414
70	5136	2568	1284	428
71	5302	2651	1326	442
72	5480	2740	1370	457
73	5663	2832	1416	472
74	5848	2924	1462	488
75	6043	3022	1511	504
76	6240	3120	1560	520
77	6447	3224	1612	538
78	6667	3334	1667	556
79	6884	3442	1721	574
80+	7110	3555	1778	593

Only applicants first eligible for Medicare before 2020 may purchase Plans C, F, and High Deducible F.

PLAN HDF

Male

Preferred — Effective Date: 06/15/2026 — Plan Code: 5CM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1068	534	267	89
66	1098	549	275	92
67	1128	564	282	94
68	1171	586	293	98
69	1207	604	302	101
70	1248	624	312	104
71	1291	646	323	108
72	1317	659	330	110
73	1380	690	345	115
74	1453	727	364	122
75	1526	763	382	128
76	1595	798	399	133
77	1642	821	411	137
78	1659	830	415	139
79	1675	838	419	140
80+	1755	878	439	147

Standard — Effective Date: 06/15/2026 — Plan Code: 5CO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1229	615	308	103
66	1263	632	316	106
67	1298	649	325	109
68	1347	674	337	113
69	1389	695	348	116
70	1436	718	359	120
71	1486	743	372	124
72	1515	758	379	127
73	1588	794	397	133
74	1672	836	418	140
75	1756	878	439	147
76	1835	918	459	153
77	1890	945	473	158
78	1910	955	478	160
79	1928	964	482	161
80+	2020	1010	505	169

Female

Preferred — Effective Date: 06/15/2026 — Plan Code: 5CN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	928	464	232	78
66	955	478	239	80
67	981	491	246	82
68	1018	509	255	85
69	1050	525	263	88
70	1085	543	272	91
71	1123	562	281	94
72	1145	573	287	96
73	1200	600	300	100
74	1264	632	316	106
75	1327	664	332	111
76	1387	694	347	116
77	1428	714	357	119
78	1443	722	361	121
79	1457	729	365	122
80+	1526	763	382	128

Standard — Effective Date: 06/15/2026 — Plan Code: 5CP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1068	534	267	89
66	1098	549	275	92
67	1128	564	282	94
68	1171	586	293	98
69	1207	604	302	101
70	1248	624	312	104
71	1291	646	323	108
72	1317	659	330	110
73	1380	690	345	115
74	1453	727	364	122
75	1526	763	382	128
76	1595	798	399	133
77	1642	821	411	137
78	1659	830	415	139
79	1675	838	419	140
80+	1755	878	439	147

Only applicants first eligible for Medicare before 2020 may purchase Plans C, F, and High Deducible F.

PLAN G

Male

Preferred

Effective Date: 06/15/2026 Plan Code: 5D4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3379	1690	845	282
66	3502	1751	876	292
67	3634	1817	909	303
68	3768	1884	942	314
69	3903	1952	976	326
70	4049	2025	1013	338
71	4191	2096	1048	350
72	4348	2174	1087	363
73	4507	2254	1127	376
74	4670	2335	1168	390
75	4835	2418	1209	403
76	5005	2503	1252	418
77	5183	2592	1296	432
78	5373	2687	1344	448
79	5561	2781	1391	464
80+	5760	2880	1440	480

Standard

Effective Date: 06/15/2026 Plan Code: 5D6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3888	1944	972	324
66	4031	2016	1008	336
67	4183	2092	1046	349
68	4336	2168	1084	362
69	4492	2246	1123	375
70	4660	2330	1165	389
71	4823	2412	1206	402
72	5003	2502	1251	417
73	5186	2593	1297	433
74	5374	2687	1344	448
75	5564	2782	1391	464
76	5760	2880	1440	480
77	5965	2983	1492	498
78	6184	3092	1546	516
79	6400	3200	1600	534
80+	6629	3315	1658	553

Female

Preferred

Effective Date: 06/15/2026 Plan Code: 5D5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2938	1469	735	245
66	3046	1523	762	254
67	3161	1581	791	264
68	3276	1638	819	273
69	3394	1697	849	283
70	3521	1761	881	294
71	3644	1822	911	304
72	3781	1891	946	316
73	3919	1960	980	327
74	4061	2031	1016	339
75	4205	2103	1052	351
76	4352	2176	1088	363
77	4507	2254	1127	376
78	4673	2337	1169	390
79	4836	2418	1209	403
80+	5009	2505	1253	418

Standard

Effective Date: 06/15/2026 Plan Code: 5D7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3379	1690	845	282
66	3502	1751	876	292
67	3634	1817	909	303
68	3768	1884	942	314
69	3903	1952	976	326
70	4049	2025	1013	338
71	4191	2096	1048	350
72	4348	2174	1087	363
73	4507	2254	1127	376
74	4670	2335	1168	390
75	4835	2418	1209	403
76	5005	2503	1252	418
77	5183	2592	1296	432
78	5373	2687	1344	448
79	5561	2781	1391	464
80+	5760	2880	1440	480

PLAN HDG

Male

Preferred

Effective Date: 06/15/2026 Plan Code: 5HO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1068	534	267	89
66	1098	549	275	92
67	1128	564	282	94
68	1171	586	293	98
69	1207	604	302	101
70	1248	624	312	104
71	1291	646	323	108
72	1317	659	330	110
73	1380	690	345	115
74	1453	727	364	122
75	1526	763	382	128
76	1595	798	399	133
77	1642	821	411	137
78	1659	830	415	139
79	1675	838	419	140
80+	1755	878	439	147

Standard

Effective Date: 06/15/2026 Plan Code: 5HQ

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1229	615	308	103
66	1263	632	316	106
67	1298	649	325	109
68	1347	674	337	113
69	1389	695	348	116
70	1436	718	359	120
71	1486	743	372	124
72	1515	758	379	127
73	1588	794	397	133
74	1672	836	418	140
75	1756	878	439	147
76	1835	918	459	153
77	1890	945	473	158
78	1910	955	478	160
79	1928	964	482	161
80+	2020	1010	505	169

Female

Preferred

Effective Date: 06/15/2026 Plan Code: 5HP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	928	464	232	78
66	955	478	239	80
67	981	491	246	82
68	1018	509	255	85
69	1050	525	263	88
70	1085	543	272	91
71	1123	562	281	94
72	1145	573	287	96
73	1200	600	300	100
74	1264	632	316	106
75	1327	664	332	111
76	1387	694	347	116
77	1428	714	357	119
78	1443	722	361	121
79	1457	729	365	122
80+	1526	763	382	128

Standard

Effective Date: 06/15/2026 Plan Code: 5HR

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1068	534	267	89
66	1098	549	275	92
67	1128	564	282	94
68	1171	586	293	98
69	1207	604	302	101
70	1248	624	312	104
71	1291	646	323	108
72	1317	659	330	110
73	1380	690	345	115
74	1453	727	364	122
75	1526	763	382	128
76	1595	798	399	133
77	1642	821	411	137
78	1659	830	415	139
79	1675	838	419	140
80+	1755	878	439	147

PLAN N

Male

Preferred

Effective Date: 06/15/2026 Plan Code: 5DM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2783	1392	696	232
66	2890	1445	723	241
67	3006	1503	752	251
68	3123	1562	781	261
69	3245	1623	812	271
70	3369	1685	843	281
71	3496	1748	874	292
72	3629	1815	908	303
73	3770	1885	943	315
74	3909	1955	978	326
75	4056	2028	1014	338
76	4207	2104	1052	351
77	4360	2180	1090	364
78	4530	2265	1133	378
79	4694	2347	1174	392
80+	4866	2433	1217	406

Standard

Effective Date: 06/15/2026 Plan Code: 5DO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3202	1601	801	267
66	3326	1663	832	278
67	3460	1730	865	289
68	3594	1797	899	300
69	3734	1867	934	312
70	3877	1939	970	324
71	4023	2012	1006	336
72	4176	2088	1044	348
73	4338	2169	1085	362
74	4499	2250	1125	375
75	4668	2334	1167	389
76	4841	2421	1211	404
77	5018	2509	1255	419
78	5213	2607	1304	435
79	5403	2702	1351	451
80+	5600	2800	1400	467

Female

Preferred

Effective Date: 06/15/2026 Plan Code: 5DN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2420	1210	605	202
66	2513	1257	629	210
67	2614	1307	654	218
68	2716	1358	679	227
69	2822	1411	706	236
70	2930	1465	733	245
71	3040	1520	760	254
72	3156	1578	789	263
73	3278	1639	820	274
74	3400	1700	850	284
75	3528	1764	882	294
76	3658	1829	915	305
77	3792	1896	948	316
78	3940	1970	985	329
79	4083	2042	1021	341
80+	4232	2116	1058	353

Standard

Effective Date: 06/15/2026 Plan Code: 5DP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2783	1392	696	232
66	2890	1445	723	241
67	3006	1503	752	251
68	3123	1562	781	261
69	3245	1623	812	271
70	3369	1685	843	281
71	3496	1748	874	292
72	3629	1815	908	303
73	3770	1885	943	315
74	3909	1955	978	326
75	4056	2028	1014	338
76	4207	2104	1052	351
77	4360	2180	1090	364
78	4530	2265	1133	378
79	4694	2347	1174	392
80+	4866	2433	1217	406

AGE 50 - 64 GUARANTEED ISSUE PERIOD (G/I) *

Male

Preferred

Plan	A	SA	Q	M	Plan Code	Effective Date
C	4337	2169	1085	362	5F4	06/15/2026
D	3372	1686	843	281	5F8	06/15/2026

Female

Preferred

Plan	A	SA	Q	M	Plan Code	Effective Date
C	3771	1886	943	315	5F5	06/15/2026
D	2933	1467	734	245	5F9	06/15/2026

*** NOTE: In NEW JERSEY, once the policyholder reaches age 65, rates for their policy will change to reflect the rates of the corresponding overage plan.**

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

AGE 50 - 64 DURING OPEN ENROLLMENT (O/E) *

Male

Preferred						
Plan	A	SA	Q	M	Plan Code	Effective Date
C	4337	2169	1085	362	5F4	06/15/2026
D	3372	1686	843	281	5F8	06/15/2026

Female

Preferred						
Plan	A	SA	Q	M	Plan Code	Effective Date
C	3771	1886	943	315	5F5	06/15/2026
D	2933	1467	734	245	5F9	06/15/2026

Underage Coverage:

Plans C and D are available for qualified consumers aged 50-64 who are eiligible for Medicare by reason of disability.

Open Enrollment

You are eligible for Guaranteed Acceptance in Plan C if your Medicare Part B effective date is prior to 1/1/2020 and you apply:

(1) within six months of enrollment in Medicare Part B; or

(2) within six months beginning with the month in which a retroactive determination of eiligible for Medicare is made.

You are eligible for Guaranteed Acceptance in Plan D if:

(1) your Medicare Part B effective date is prior to 1/1/2020 and you apply within six months of enrollment in Medicare Part B and you are not covered by any other Medicare Supplement Plan; or

(2) your Medicare Part B effective date is on or after 1/1/2020 and you apply within 12 months of enrollment in Medicare Part B.

*** NOTE: In NEW JERSEY, once the policyholder reaches age 65, rates for their policy will change to reflect the rates of the corresponding overage plan.**

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

UNITED AMERICAN INSURANCE COMPANY

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

Benefit Chart of Medicare Supplement Plans Sold on or After January 1, 2020

Benefit Plans A, C, D, F, HDF, G, HDG, 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 [3]	✓	✓
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 2026[2]					$8,000[2]	$4,000[2]				

* Denotes plans available by United American Insurance Company

[1] Plans F and G also have a high deductible option which requires first paying a plan deductible of $2,950 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.

[2] 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.

[3] 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. Until you are age 81, your premiums will increase on each policy anniversary solely because of your age change. 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 as approved by the Commissioner of Insurance in your state. This policy provides a 31-day grace period.

AGE 50 - 64 GUARANTEED ISSUE PERIOD (G/I) *

Male

Preferred

Plan	A	SA	Q	M	Plan Code	Effective Date
C	3739	1870	935	312	5F4	06/01/2025
D	2907	1454	727	243	5F8	06/01/2025

Female

Preferred

Plan	A	SA	Q	M	Plan Code	Effective Date
C	3251	1626	813	271	5F5	06/01/2025
D	2528	1264	632	211	5F9	06/01/2025

*** NOTE: In NEW JERSEY, once the policyholder reaches age 65, rates for their policy will change to reflect the rates of the corresponding overage plan.**

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

AGE 50 - 64 DURING OPEN ENROLLMENT (O/E) *

Male

Preferred						
Plan	A	SA	Q	M	Plan Code	Effective Date
C	3739	1870	935	312	5F4	06/01/2025
D	2907	1454	727	243	5F8	06/01/2025

Female

Preferred						
Plan	A	SA	Q	M	Plan Code	Effective Date
C	3251	1626	813	271	5F5	06/01/2025
D	2528	1264	632	211	5F9	06/01/2025

Underage Coverage:

Plans C and D are available for qualified consumers aged 50-64 who are eiligible for Medicare by reason of disability.

Open Enrollment

You are eligible for Guaranteed Acceptance in Plan C if your Medicare Part B effective date is prior to 1/1/2020 and you apply:

(1) within six months of enrollment in Medicare Part B; or

(2) within six months beginning with the month in which a retroactive determination of eiligible for Medicare is made.

You are eligible for Guaranteed Acceptance in Plan D if:

(1) your Medicare Part B effective date is prior to 1/1/2020 and you apply within six months of enrollment in Medicare Part B and you are not covered by any other Medicare Supplement Plan; or

(2) your Medicare Part B effective date is on or after 1/1/2020 and you apply within 12 months of enrollment in Medicare Part B.

*** NOTE: In NEW JERSEY, once the policyholder reaches age 65, rates for their policy will change to reflect the rates of the corresponding overage plan.**

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

PLAN A

Male

Preferred — Effective Date: 06/01/2025 — Plan Code: 5A4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2464	1232	616	206
66	2523	1262	631	211
67	2575	1288	644	215
68	2644	1322	661	221
69	2714	1357	679	227
70	2790	1395	698	233
71	2850	1425	713	238
72	2891	1446	723	241
73	3017	1509	755	252
74	3149	1575	788	263
75	3283	1642	821	274
76	3408	1704	852	284
77	3470	1735	868	290
78	3470	1735	868	290
79	3470	1735	868	290
80+	3470	1735	868	290

Standard — Effective Date: 06/01/2025 — Plan Code: 5A6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2835	1418	709	237
66	2903	1452	726	242
67	2964	1482	741	247
68	3043	1522	761	254
69	3123	1562	781	261
70	3211	1606	803	268
71	3280	1640	820	274
72	3327	1664	832	278
73	3472	1736	868	290
74	3624	1812	906	302
75	3778	1889	945	315
76	3922	1961	981	327
77	3994	1997	999	333
78	3994	1997	999	333
79	3994	1997	999	333
80+	3994	1997	999	333

Female

Preferred — Effective Date: 06/01/2025 — Plan Code: 5A5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2143	1072	536	179
66	2194	1097	549	183
67	2240	1120	560	187
68	2300	1150	575	192
69	2360	1180	590	197
70	2427	1214	607	203
71	2479	1240	620	207
72	2514	1257	629	210
73	2624	1312	656	219
74	2738	1369	685	229
75	2855	1428	714	238
76	2964	1482	741	247
77	3018	1509	755	252
78	3018	1509	755	252
79	3018	1509	755	252
80+	3018	1509	755	252

Standard — Effective Date: 06/01/2025 — Plan Code: 5A7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2464	1232	616	206
66	2523	1262	631	211
67	2575	1288	644	215
68	2644	1322	661	221
69	2714	1357	679	227
70	2790	1395	698	233
71	2850	1425	713	238
72	2891	1446	723	241
73	3017	1509	755	252
74	3149	1575	788	263
75	3283	1642	821	274
76	3408	1704	852	284
77	3470	1735	868	290
78	3470	1735	868	290
79	3470	1735	868	290
80+	3470	1735	868	290

PLAN C

Male

Preferred Effective Date: 06/01/2025 Plan Code: 5B4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3739	1870	935	312
66	3864	1932	966	322
67	3994	1997	999	333
68	4130	2065	1033	345
69	4266	2133	1067	356
70	4409	2205	1103	368
71	4553	2277	1139	380
72	4706	2353	1177	393
73	4865	2433	1217	406
74	5026	2513	1257	419
75	5192	2596	1298	433
76	5361	2681	1341	447
77	5540	2770	1385	462
78	5730	2865	1433	478
79	5916	2958	1479	493
80+	6112	3056	1528	510

Standard Effective Date: 06/01/2025 Plan Code: 5B6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	4303	2152	1076	359
66	4447	2224	1112	371
67	4597	2299	1150	384
68	4752	2376	1188	396
69	4909	2455	1228	410
70	5074	2537	1269	423
71	5239	2620	1310	437
72	5416	2708	1354	452
73	5599	2800	1400	467
74	5784	2892	1446	482
75	5975	2988	1494	498
76	6170	3085	1543	515
77	6375	3188	1594	532
78	6594	3297	1649	550
79	6808	3404	1702	568
80+	7034	3517	1759	587

Female

Preferred Effective Date: 06/01/2025 Plan Code: 5B5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3251	1626	813	271
66	3361	1681	841	281
67	3474	1737	869	290
68	3591	1796	898	300
69	3710	1855	928	310
70	3834	1917	959	320
71	3959	1980	990	330
72	4093	2047	1024	342
73	4231	2116	1058	353
74	4371	2186	1093	365
75	4515	2258	1129	377
76	4663	2332	1166	389
77	4818	2409	1205	402
78	4983	2492	1246	416
79	5144	2572	1286	429
80+	5315	2658	1329	443

Standard Effective Date: 06/01/2025 Plan Code: 5B7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3739	1870	935	312
66	3864	1932	966	322
67	3994	1997	999	333
68	4130	2065	1033	345
69	4266	2133	1067	356
70	4409	2205	1103	368
71	4553	2277	1139	380
72	4706	2353	1177	393
73	4865	2433	1217	406
74	5026	2513	1257	419
75	5192	2596	1298	433
76	5361	2681	1341	447
77	5540	2770	1385	462
78	5730	2865	1433	478
79	5916	2958	1479	493
80+	6112	3056	1528	510

Only applicants first eligible for Medicare before 2020 may purchase Plans C, F, and High Deducible F.

PLAN D

Male

Preferred Effective Date: 06/01/2025 Plan Code: 5BM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2907	1454	727	243
66	3014	1507	754	252
67	3126	1563	782	261
68	3242	1621	811	271
69	3361	1681	841	281
70	3485	1743	872	291
71	3608	1804	902	301
72	3742	1871	936	312
73	3880	1940	970	324
74	4019	2010	1005	335
75	4163	2082	1041	347
76	4309	2155	1078	360
77	4464	2232	1116	372
78	4627	2314	1157	386
79	4790	2395	1198	400
80+	4959	2480	1240	414

Standard Effective Date: 06/01/2025 Plan Code: 5BO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3346	1673	837	279
66	3468	1734	867	289
67	3598	1799	900	300
68	3731	1866	933	311
69	3867	1934	967	323
70	4011	2006	1003	335
71	4152	2076	1038	346
72	4306	2153	1077	359
73	4466	2233	1117	373
74	4625	2313	1157	386
75	4791	2396	1198	400
76	4959	2480	1240	414
77	5137	2569	1285	429
78	5325	2663	1332	444
79	5513	2757	1379	460
80+	5707	2854	1427	476

Female

Preferred Effective Date: 06/01/2025 Plan Code: 5BN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2528	1264	632	211
66	2621	1311	656	219
67	2719	1360	680	227
68	2820	1410	705	235
69	2922	1461	731	244
70	3031	1516	758	253
71	3137	1569	785	262
72	3254	1627	814	272
73	3375	1688	844	282
74	3495	1748	874	292
75	3620	1810	905	302
76	3747	1874	937	313
77	3882	1941	971	324
78	4024	2012	1006	336
79	4166	2083	1042	348
80+	4312	2156	1078	360

Standard Effective Date: 06/01/2025 Plan Code: 5BP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2907	1454	727	243
66	3014	1507	754	252
67	3126	1563	782	261
68	3242	1621	811	271
69	3361	1681	841	281
70	3485	1743	872	291
71	3608	1804	902	301
72	3742	1871	936	312
73	3880	1940	970	324
74	4019	2010	1005	335
75	4163	2082	1041	347
76	4309	2155	1078	360
77	4464	2232	1116	372
78	4627	2314	1157	386
79	4790	2395	1198	400
80+	4959	2480	1240	414

PLAN F

Male

Preferred Effective Date: 06/01/2025 Plan Code: 5C4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3758	1879	940	314
66	3881	1941	971	324
67	4011	2006	1003	335
68	4147	2074	1037	346
69	4281	2141	1071	357
70	4427	2214	1107	369
71	4571	2286	1143	381
72	4723	2362	1181	394
73	4882	2441	1221	407
74	5041	2521	1261	421
75	5210	2605	1303	435
76	5380	2690	1345	449
77	5558	2779	1390	464
78	5748	2874	1437	479
79	5935	2968	1484	495
80+	6129	3065	1533	511

Standard Effective Date: 06/01/2025 Plan Code: 5C6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	4325	2163	1082	361
66	4467	2234	1117	373
67	4616	2308	1154	385
68	4772	2386	1193	398
69	4927	2464	1232	411
70	5095	2548	1274	425
71	5260	2630	1315	439
72	5436	2718	1359	453
73	5619	2810	1405	469
74	5802	2901	1451	484
75	5996	2998	1499	500
76	6191	3096	1548	516
77	6396	3198	1599	533
78	6615	3308	1654	552
79	6830	3415	1708	570
80+	7054	3527	1764	588

Female

Preferred Effective Date: 06/01/2025 Plan Code: 5C5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3268	1634	817	273
66	3375	1688	844	282
67	3488	1744	872	291
68	3606	1803	902	301
69	3723	1862	931	311
70	3850	1925	963	321
71	3975	1988	994	332
72	4108	2054	1027	343
73	4246	2123	1062	354
74	4384	2192	1096	366
75	4531	2266	1133	378
76	4678	2339	1170	390
77	4833	2417	1209	403
78	4999	2500	1250	417
79	5161	2581	1291	431
80+	5330	2665	1333	445

Standard Effective Date: 06/01/2025 Plan Code: 5C7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3758	1879	940	314
66	3881	1941	971	324
67	4011	2006	1003	335
68	4147	2074	1037	346
69	4281	2141	1071	357
70	4427	2214	1107	369
71	4571	2286	1143	381
72	4723	2362	1181	394
73	4882	2441	1221	407
74	5041	2521	1261	421
75	5210	2605	1303	435
76	5380	2690	1345	449
77	5558	2779	1390	464
78	5748	2874	1437	479
79	5935	2968	1484	495
80+	6129	3065	1533	511

Only applicants first eligible for Medicare before 2020 may purchase Plans C, F, and High Deducible F.

PLAN HDF

Male

Preferred Effective Date: 06/01/2025 Plan Code: 5CM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	920	460	230	77
66	946	473	237	79
67	972	486	243	81
68	1010	505	253	85
69	1041	521	261	87
70	1076	538	269	90
71	1113	557	279	93
72	1135	568	284	95
73	1190	595	298	100
74	1252	626	313	105
75	1316	658	329	110
76	1375	688	344	115
77	1416	708	354	118
78	1431	716	358	120
79	1445	723	362	121
80+	1513	757	379	127

Standard Effective Date: 06/01/2025 Plan Code: 5CO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1059	530	265	89
66	1089	545	273	91
67	1119	560	280	94
68	1162	581	291	97
69	1198	599	300	100
70	1238	619	310	104
71	1280	640	320	107
72	1306	653	327	109
73	1369	685	343	115
74	1441	721	361	121
75	1514	757	379	127
76	1582	791	396	132
77	1629	815	408	136
78	1646	823	412	138
79	1662	831	416	139
80+	1742	871	436	146

Female

Preferred Effective Date: 06/01/2025 Plan Code: 5CN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	800	400	200	67
66	823	412	206	69
67	845	423	212	71
68	878	439	220	74
69	905	453	227	76
70	936	468	234	78
71	968	484	242	81
72	987	494	247	83
73	1035	518	259	87
74	1089	545	273	91
75	1144	572	286	96
76	1196	598	299	100
77	1231	616	308	103
78	1244	622	311	104
79	1256	628	314	105
80+	1316	658	329	110

Standard Effective Date: 06/01/2025 Plan Code: 5CP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	920	460	230	77
66	946	473	237	79
67	972	486	243	81
68	1010	505	253	85
69	1041	521	261	87
70	1076	538	269	90
71	1113	557	279	93
72	1135	568	284	95
73	1190	595	298	100
74	1252	626	313	105
75	1316	658	329	110
76	1375	688	344	115
77	1416	708	354	118
78	1431	716	358	120
79	1445	723	362	121
80+	1513	757	379	127

Only applicants first eligible for Medicare before 2020 may purchase Plans C, F, and High Deducible F.

PLAN G

Male

Preferred Effective Date: 06/01/2025 Plan Code: 5D4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2913	1457	729	243
66	3019	1510	755	252
67	3133	1567	784	262
68	3248	1624	812	271
69	3365	1683	842	281
70	3491	1746	873	291
71	3613	1807	904	302
72	3748	1874	937	313
73	3885	1943	972	324
74	4025	2013	1007	336
75	4168	2084	1042	348
76	4314	2157	1079	360
77	4468	2234	1117	373
78	4632	2316	1158	386
79	4794	2397	1199	400
80+	4965	2483	1242	414

Standard Effective Date: 06/01/2025 Plan Code: 5D6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3352	1676	838	280
66	3474	1737	869	290
67	3605	1803	902	301
68	3738	1869	935	312
69	3872	1936	968	323
70	4017	2009	1005	335
71	4158	2079	1040	347
72	4314	2157	1079	360
73	4471	2236	1118	373
74	4633	2317	1159	387
75	4797	2399	1200	400
76	4965	2483	1242	414
77	5142	2571	1286	429
78	5331	2666	1333	445
79	5518	2759	1380	460
80+	5714	2857	1429	477

Female

Preferred Effective Date: 06/01/2025 Plan Code: 5D5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2533	1267	634	212
66	2625	1313	657	219
67	2724	1362	681	227
68	2824	1412	706	236
69	2926	1463	732	244
70	3036	1518	759	253
71	3142	1571	786	262
72	3260	1630	815	272
73	3378	1689	845	282
74	3501	1751	876	292
75	3625	1813	907	303
76	3752	1876	938	313
77	3885	1943	972	324
78	4028	2014	1007	336
79	4169	2085	1043	348
80+	4318	2159	1080	360

Standard Effective Date: 06/01/2025 Plan Code: 5D7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2913	1457	729	243
66	3019	1510	755	252
67	3133	1567	784	262
68	3248	1624	812	271
69	3365	1683	842	281
70	3491	1746	873	291
71	3613	1807	904	302
72	3748	1874	937	313
73	3885	1943	972	324
74	4025	2013	1007	336
75	4168	2084	1042	348
76	4314	2157	1079	360
77	4468	2234	1117	373
78	4632	2316	1158	386
79	4794	2397	1199	400
80+	4965	2483	1242	414

PLAN HDG

Male

Preferred Effective Date: 06/01/2025 Plan Code: 5HO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	920	460	230	77
66	946	473	237	79
67	972	486	243	81
68	1010	505	253	85
69	1041	521	261	87
70	1076	538	269	90
71	1113	557	279	93
72	1135	568	284	95
73	1190	595	298	100
74	1252	626	313	105
75	1316	658	329	110
76	1375	688	344	115
77	1416	708	354	118
78	1431	716	358	120
79	1445	723	362	121
80+	1513	757	379	127

Standard Effective Date: 06/01/2025 Plan Code: 5HQ

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1059	530	265	89
66	1089	545	273	91
67	1119	560	280	94
68	1162	581	291	97
69	1198	599	300	100
70	1238	619	310	104
71	1280	640	320	107
72	1306	653	327	109
73	1369	685	343	115
74	1441	721	361	121
75	1514	757	379	127
76	1582	791	396	132
77	1629	815	408	136
78	1646	823	412	138
79	1662	831	416	139
80+	1742	871	436	146

Female

Preferred Effective Date: 06/01/2025 Plan Code: 5HP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	800	400	200	67
66	823	412	206	69
67	845	423	212	71
68	878	439	220	74
69	905	453	227	76
70	936	468	234	78
71	968	484	242	81
72	987	494	247	83
73	1035	518	259	87
74	1089	545	273	91
75	1144	572	286	96
76	1196	598	299	100
77	1231	616	308	103
78	1244	622	311	104
79	1256	628	314	105
80+	1316	658	329	110

Standard Effective Date: 06/01/2025 Plan Code: 5HR

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	920	460	230	77
66	946	473	237	79
67	972	486	243	81
68	1010	505	253	85
69	1041	521	261	87
70	1076	538	269	90
71	1113	557	279	93
72	1135	568	284	95
73	1190	595	298	100
74	1252	626	313	105
75	1316	658	329	110
76	1375	688	344	115
77	1416	708	354	118
78	1431	716	358	120
79	1445	723	362	121
80+	1513	757	379	127

PLAN N

Male

Preferred Effective Date: 06/01/2025 Plan Code: 5DM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2399	1200	600	200
66	2492	1246	623	208
67	2592	1296	648	216
68	2693	1347	674	225
69	2797	1399	700	234
70	2904	1452	726	242
71	3014	1507	754	252
72	3129	1565	783	261
73	3250	1625	813	271
74	3370	1685	843	281
75	3497	1749	875	292
76	3627	1814	907	303
77	3759	1880	940	314
78	3905	1953	977	326
79	4047	2024	1012	338
80+	4195	2098	1049	350

Standard Effective Date: 06/01/2025 Plan Code: 5DO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2761	1381	691	231
66	2868	1434	717	239
67	2982	1491	746	249
68	3099	1550	775	259
69	3219	1610	805	269
70	3342	1671	836	279
71	3468	1734	867	289
72	3600	1800	900	300
73	3740	1870	935	312
74	3879	1940	970	324
75	4024	2012	1006	336
76	4174	2087	1044	348
77	4326	2163	1082	361
78	4494	2247	1124	375
79	4657	2329	1165	389
80+	4828	2414	1207	403

Female

Preferred Effective Date: 06/01/2025 Plan Code: 5DN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2087	1044	522	174
66	2167	1084	542	181
67	2254	1127	564	188
68	2342	1171	586	196
69	2432	1216	608	203
70	2526	1263	632	211
71	2621	1311	656	219
72	2721	1361	681	227
73	2826	1413	707	236
74	2931	1466	733	245
75	3041	1521	761	254
76	3154	1577	789	263
77	3269	1635	818	273
78	3396	1698	849	283
79	3519	1760	880	294
80+	3648	1824	912	304

Standard Effective Date: 06/01/2025 Plan Code: 5DP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2399	1200	600	200
66	2492	1246	623	208
67	2592	1296	648	216
68	2693	1347	674	225
69	2797	1399	700	234
70	2904	1452	726	242
71	3014	1507	754	252
72	3129	1565	783	261
73	3250	1625	813	271
74	3370	1685	843	281
75	3497	1749	875	292
76	3627	1814	907	303
77	3759	1880	940	314
78	3905	1953	977	326
79	4047	2024	1012	338
80+	4195	2098	1049	350

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1736	$0	$1736 (Part A Deductible)
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $868 a day	$868 a day	$0
Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0 **
– Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $217 a day	$0	Up to $217 a day
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and	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 $283 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $283 of Medicare-Approved Amounts*	$0	$0	$283 (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 $283 of Medicare-Approved Amounts*	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
– Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $283 of Medicare-Approved Amounts*	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1736	$1736 (Part A Deductible)	$0
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $868 a day	$868 a day	$0
Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0 **
– Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $217 a day	Up to $217 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment, coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

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

* Once you have been billed $283 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $283 of Medicare-Approved Amounts*	$0	$283 (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $283 of Medicare-Approved Amounts*	$0	$283 (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
– Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $283 of Medicare-Approved Amounts*	$0	$283 (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1736	$1736 (Part A Deductible)	$0
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $868 a day	$868 a day	$0
Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0 **
– Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $217 a day	Up to $217 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited coinsurance, coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

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

* Once you have been billed $283 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $283 of Medicare-Approved Amounts*	$0	$0	$283 (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 $283 of Medicare-Approved Amounts*	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
– Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $283 of Medicare-Approved Amounts*	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN F or HIGH DEDUCTIBLE PLAN F
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

** This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2950 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2950. 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 $2950 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2950 DEDUCTIBLE,** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1736	$1736 (Part A Deductible)	$0
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $868 a day	$868 a day	$0
Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0 ***
– Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $217 a day	Up to $217 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

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

* Once you have been billed $283 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 $2950 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2950. 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 $2950 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2950 DEDUCTIBLE,** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $283 of Medicare-Approved Amounts*	$0	$283 (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 $283 of Medicare-Approved Amounts*	$0	$283 (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
– Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $283 of Medicare-Approved Amounts*	$0	$283 (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 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 $2950 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2950. 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 $2950 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2950 DEDUCTIBLE,** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1736	$1736 (Part A Deductible)	$0
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $868 a day	$868 a day	$0
Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0 ***
– Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $217 a day	Up to $217 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

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

* Once you have been billed $283 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 $2950 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2950. 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 $2950 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2950 DEDUCTIBLE,** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $283 of Medicare-Approved Amounts*	$0	$0	$283 (Unless Part B Deductible has been met)
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 $283 of Medicare-Approved Amounts*	$0	$0	$283 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
– Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $283 of Medicare-Approved Amounts*	$0	$0	$283 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN N
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1736	$1736 (Part A Deductible)	$0
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $868 a day	$868 a day	$0
Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0 **
– Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $217 a day	Up to $217 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

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

* Once you have been billed $283 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as:			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $283 of Medicare-Approved Amounts*	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges(Above Medicare-Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $283 of Medicare-Approved Amounts*	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
– Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $283 of Medicare-Approved Amounts*	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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