NEW JERSEY

2023 ProCare® RATE SHEETS

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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
$ 239	$ 120	$ 60	$ 20

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 Period (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: 03/01/2024 — Plan Code: 5A4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2209	1105	553	185
66	2263	1132	566	189
67	2310	1155	578	193
68	2371	1186	593	198
69	2434	1217	609	203
70	2502	1251	626	209
71	2556	1278	639	213
72	2593	1297	649	217
73	2705	1353	677	226
74	2825	1413	707	236
75	2945	1473	737	246
76	3057	1529	765	255
77	3112	1556	778	260
78	3112	1556	778	260
79	3112	1556	778	260
80+	3112	1556	778	260

Standard — Effective Date: 03/01/2024 — Plan Code: 5A6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2542	1271	636	212
66	2604	1302	651	217
67	2659	1330	665	222
68	2729	1365	683	228
69	2801	1401	701	234
70	2880	1440	720	240
71	2942	1471	736	246
72	2984	1492	746	249
73	3113	1557	779	260
74	3251	1626	813	271
75	3389	1695	848	283
76	3518	1759	880	294
77	3582	1791	896	299
78	3582	1791	896	299
79	3582	1791	896	299
80+	3582	1791	896	299

Female

Preferred — Effective Date: 03/01/2024 — Plan Code: 5A5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1921	961	481	161
66	1968	984	492	164
67	2009	1005	503	168
68	2062	1031	516	172
69	2116	1058	529	177
70	2176	1088	544	182
71	2223	1112	556	186
72	2255	1128	564	188
73	2353	1177	589	197
74	2456	1228	614	205
75	2561	1281	641	214
76	2658	1329	665	222
77	2707	1354	677	226
78	2707	1354	677	226
79	2707	1354	677	226
80+	2707	1354	677	226

Standard — Effective Date: 03/01/2024 — Plan Code: 5A7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2209	1105	553	185
66	2263	1132	566	189
67	2310	1155	578	193
68	2371	1186	593	198
69	2434	1217	609	203
70	2502	1251	626	209
71	2556	1278	639	213
72	2593	1297	649	217
73	2705	1353	677	226
74	2825	1413	707	236
75	2945	1473	737	246
76	3057	1529	765	255
77	3112	1556	778	260
78	3112	1556	778	260
79	3112	1556	778	260
80+	3112	1556	778	260

PLAN C

Male

Preferred Effective Date: 03/01/2024 Plan Code: 5B4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3353	1677	839	280
66	3466	1733	867	289
67	3582	1791	896	299
68	3703	1852	926	309
69	3826	1913	957	319
70	3954	1977	989	330
71	4083	2042	1021	341
72	4221	2111	1056	352
73	4364	2182	1091	364
74	4508	2254	1127	376
75	4656	2328	1164	388
76	4808	2404	1202	401
77	4968	2484	1242	414
78	5139	2570	1285	429
79	5306	2653	1327	443
80+	5482	2741	1371	457

Standard Effective Date: 03/01/2024 Plan Code: 5B6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3859	1930	965	322
66	3989	1995	998	333
67	4122	2061	1031	344
68	4262	2131	1066	356
69	4403	2202	1101	367
70	4551	2276	1138	380
71	4699	2350	1175	392
72	4857	2429	1215	405
73	5022	2511	1256	419
74	5187	2594	1297	433
75	5358	2679	1340	447
76	5534	2767	1384	462
77	5718	2859	1430	477
78	5914	2957	1479	493
79	6106	3053	1527	509
80+	6309	3155	1578	526

Female

Preferred Effective Date: 03/01/2024 Plan Code: 5B5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2916	1458	729	243
66	3014	1507	754	252
67	3115	1558	779	260
68	3220	1610	805	269
69	3327	1664	832	278
70	3439	1720	860	287
71	3551	1776	888	296
72	3671	1836	918	306
73	3795	1898	949	317
74	3920	1960	980	327
75	4049	2025	1013	338
76	4182	2091	1046	349
77	4321	2161	1081	361
78	4469	2235	1118	373
79	4614	2307	1154	385
80+	4767	2384	1192	398

Standard Effective Date: 03/01/2024 Plan Code: 5B7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3353	1677	839	280
66	3466	1733	867	289
67	3582	1791	896	299
68	3703	1852	926	309
69	3826	1913	957	319
70	3954	1977	989	330
71	4083	2042	1021	341
72	4221	2111	1056	352
73	4364	2182	1091	364
74	4508	2254	1127	376
75	4656	2328	1164	388
76	4808	2404	1202	401
77	4968	2484	1242	414
78	5139	2570	1285	429
79	5306	2653	1327	443
80+	5482	2741	1371	457

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

PLAN D

Male

Preferred Effective Date: 03/01/2024 Plan Code: 5BM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2608	1304	652	218
66	2703	1352	676	226
67	2804	1402	701	234
68	2908	1454	727	243
69	3014	1507	754	252
70	3125	1563	782	261
71	3236	1618	809	270
72	3356	1678	839	280
73	3480	1740	870	290
74	3604	1802	901	301
75	3733	1867	934	312
76	3864	1932	966	322
77	4003	2002	1001	334
78	4150	2075	1038	346
79	4296	2148	1074	358
80+	4447	2224	1112	371

Standard Effective Date: 03/01/2024 Plan Code: 5BO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3001	1501	751	251
66	3111	1556	778	260
67	3227	1614	807	269
68	3347	1674	837	279
69	3468	1734	867	289
70	3597	1799	900	300
71	3724	1862	931	311
72	3863	1932	966	322
73	4005	2003	1002	334
74	4148	2074	1037	346
75	4296	2148	1074	358
76	4447	2224	1112	371
77	4607	2304	1152	384
78	4776	2388	1194	398
79	4944	2472	1236	412
80+	5118	2559	1280	427

Female

Preferred Effective Date: 03/01/2024 Plan Code: 5BN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2268	1134	567	189
66	2351	1176	588	196
67	2439	1220	610	204
68	2529	1265	633	211
69	2621	1311	656	219
70	2718	1359	680	227
71	2814	1407	704	235
72	2919	1460	730	244
73	3026	1513	757	253
74	3135	1568	784	262
75	3247	1624	812	271
76	3361	1681	841	281
77	3481	1741	871	291
78	3609	1805	903	301
79	3736	1868	934	312
80+	3868	1934	967	323

Standard Effective Date: 03/01/2024 Plan Code: 5BP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2608	1304	652	218
66	2703	1352	676	226
67	2804	1402	701	234
68	2908	1454	727	243
69	3014	1507	754	252
70	3125	1563	782	261
71	3236	1618	809	270
72	3356	1678	839	280
73	3480	1740	870	290
74	3604	1802	901	301
75	3733	1867	934	312
76	3864	1932	966	322
77	4003	2002	1001	334
78	4150	2075	1038	346
79	4296	2148	1074	358
80+	4447	2224	1112	371

PLAN F

Male

Preferred — Effective Date: 03/01/2024 — Plan Code: 5C4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3370	1685	843	281
66	3481	1741	871	291
67	3598	1799	900	300
68	3719	1860	930	310
69	3840	1920	960	320
70	3971	1986	993	331
71	4099	2050	1025	342
72	4236	2118	1059	353
73	4379	2190	1095	365
74	4522	2261	1131	377
75	4673	2337	1169	390
76	4824	2412	1206	402
77	4984	2492	1246	416
78	5155	2578	1289	430
79	5323	2662	1331	444
80+	5497	2749	1375	459

Standard — Effective Date: 03/01/2024 — Plan Code: 5C6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3879	1940	970	324
66	4006	2003	1002	334
67	4141	2071	1036	346
68	4280	2140	1070	357
69	4419	2210	1105	369
70	4569	2285	1143	381
71	4718	2359	1180	394
72	4875	2438	1219	407
73	5039	2520	1260	420
74	5204	2602	1301	434
75	5378	2689	1345	449
76	5552	2776	1388	463
77	5736	2868	1434	478
78	5933	2967	1484	495
79	6126	3063	1532	511
80+	6326	3163	1582	528

Female

Preferred — Effective Date: 03/01/2024 — Plan Code: 5C5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2931	1466	733	245
66	3027	1514	757	253
67	3129	1565	783	261
68	3234	1617	809	270
69	3339	1670	835	279
70	3453	1727	864	288
71	3565	1783	892	298
72	3684	1842	921	307
73	3808	1904	952	318
74	3932	1966	983	328
75	4064	2032	1016	339
76	4196	2098	1049	350
77	4335	2168	1084	362
78	4483	2242	1121	374
79	4629	2315	1158	386
80+	4780	2390	1195	399

Standard — Effective Date: 03/01/2024 — Plan Code: 5C7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3370	1685	843	281
66	3481	1741	871	291
67	3598	1799	900	300
68	3719	1860	930	310
69	3840	1920	960	320
70	3971	1986	993	331
71	4099	2050	1025	342
72	4236	2118	1059	353
73	4379	2190	1095	365
74	4522	2261	1131	377
75	4673	2337	1169	390
76	4824	2412	1206	402
77	4984	2492	1246	416
78	5155	2578	1289	430
79	5323	2662	1331	444
80+	5497	2749	1375	459

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PLAN HDF

Male

Preferred — Effective Date: 03/01/2024 — Plan Code: 5CM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	826	413	207	69
66	848	424	212	71
67	872	436	218	73
68	905	453	227	76
69	933	467	234	78
70	966	483	242	81
71	998	499	250	84
72	1018	509	255	85
73	1068	534	267	89
74	1123	562	281	94
75	1180	590	295	99
76	1233	617	309	103
77	1269	635	318	106
78	1283	642	321	107
79	1295	648	324	108
80+	1358	679	340	114

Standard — Effective Date: 03/01/2024 — Plan Code: 5CO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	950	475	238	80
66	976	488	244	82
67	1004	502	251	84
68	1042	521	261	87
69	1074	537	269	90
70	1111	556	278	93
71	1148	574	287	96
72	1172	586	293	98
73	1229	615	308	103
74	1293	647	324	108
75	1358	679	340	114
76	1419	710	355	119
77	1461	731	366	122
78	1477	739	370	124
79	1491	746	373	125
80+	1562	781	391	131

Female

Preferred — Effective Date: 03/01/2024 — Plan Code: 5CN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	718	359	180	60
66	738	369	185	62
67	758	379	190	64
68	787	394	197	66
69	812	406	203	68
70	840	420	210	70
71	868	434	217	73
72	885	443	222	74
73	928	464	232	78
74	977	489	245	82
75	1026	513	257	86
76	1072	536	268	90
77	1104	552	276	92
78	1116	558	279	93
79	1126	563	282	94
80+	1181	591	296	99

Standard — Effective Date: 03/01/2024 — Plan Code: 5CP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	826	413	207	69
66	848	424	212	71
67	872	436	218	73
68	905	453	227	76
69	933	467	234	78
70	966	483	242	81
71	998	499	250	84
72	1018	509	255	85
73	1068	534	267	89
74	1123	562	281	94
75	1180	590	295	99
76	1233	617	309	103
77	1269	635	318	106
78	1283	642	321	107
79	1295	648	324	108
80+	1358	679	340	114

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

PLAN G

Male

Preferred — Effective Date: 03/01/2024 — Plan Code: 5D4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2612	1306	653	218
66	2708	1354	677	226
67	2810	1405	703	235
68	2913	1457	729	243
69	3018	1509	755	252
70	3131	1566	783	261
71	3240	1620	810	270
72	3362	1681	841	281
73	3484	1742	871	291
74	3610	1805	903	301
75	3739	1870	935	312
76	3870	1935	968	323
77	4007	2004	1002	334
78	4154	2077	1039	347
79	4300	2150	1075	359
80+	4453	2227	1114	372

Standard — Effective Date: 03/01/2024 — Plan Code: 5D6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3006	1503	752	251
66	3116	1558	779	260
67	3233	1617	809	270
68	3352	1676	838	280
69	3473	1737	869	290
70	3603	1802	901	301
71	3729	1865	933	311
72	3869	1935	968	323
73	4010	2005	1003	335
74	4154	2077	1039	347
75	4303	2152	1076	359
76	4453	2227	1114	372
77	4612	2306	1153	385
78	4781	2391	1196	399
79	4949	2475	1238	413
80+	5124	2562	1281	427

Female

Preferred — Effective Date: 03/01/2024 — Plan Code: 5D5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2271	1136	568	190
66	2355	1178	589	197
67	2443	1222	611	204
68	2533	1267	634	212
69	2625	1313	657	219
70	2723	1362	681	227
71	2818	1409	705	235
72	2923	1462	731	244
73	3030	1515	758	253
74	3139	1570	785	262
75	3251	1626	813	271
76	3365	1683	842	281
77	3485	1743	872	291
78	3613	1807	904	302
79	3740	1870	935	312
80+	3872	1936	968	323

Standard — Effective Date: 03/01/2024 — Plan Code: 5D7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2612	1306	653	218
66	2708	1354	677	226
67	2810	1405	703	235
68	2913	1457	729	243
69	3018	1509	755	252
70	3131	1566	783	261
71	3240	1620	810	270
72	3362	1681	841	281
73	3484	1742	871	291
74	3610	1805	903	301
75	3739	1870	935	312
76	3870	1935	968	323
77	4007	2004	1002	334
78	4154	2077	1039	347
79	4300	2150	1075	359
80+	4453	2227	1114	372

PLAN HDG

Male

Preferred Effective Date: 03/01/2024 Plan Code: 5HO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	826	413	207	69
66	848	424	212	71
67	872	436	218	73
68	905	453	227	76
69	933	467	234	78
70	966	483	242	81
71	998	499	250	84
72	1018	509	255	85
73	1068	534	267	89
74	1123	562	281	94
75	1180	590	295	99
76	1233	617	309	103
77	1269	635	318	106
78	1283	642	321	107
79	1295	648	324	108
80+	1358	679	340	114

Standard Effective Date: 03/01/2024 Plan Code: 5HQ

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	950	475	238	80
66	976	488	244	82
67	1004	502	251	84
68	1042	521	261	87
69	1074	537	269	90
70	1111	556	278	93
71	1148	574	287	96
72	1172	586	293	98
73	1229	615	308	103
74	1293	647	324	108
75	1358	679	340	114
76	1419	710	355	119
77	1461	731	366	122
78	1477	739	370	124
79	1491	746	373	125
80+	1562	781	391	131

Female

Preferred Effective Date: 03/01/2024 Plan Code: 5HP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	718	359	180	60
66	738	369	185	62
67	758	379	190	64
68	787	394	197	66
69	812	406	203	68
70	840	420	210	70
71	868	434	217	73
72	885	443	222	74
73	928	464	232	78
74	977	489	245	82
75	1026	513	257	86
76	1072	536	268	90
77	1104	552	276	92
78	1116	558	279	93
79	1126	563	282	94
80+	1181	591	296	99

Standard Effective Date: 03/01/2024 Plan Code: 5HR

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	826	413	207	69
66	848	424	212	71
67	872	436	218	73
68	905	453	227	76
69	933	467	234	78
70	966	483	242	81
71	998	499	250	84
72	1018	509	255	85
73	1068	534	267	89
74	1123	562	281	94
75	1180	590	295	99
76	1233	617	309	103
77	1269	635	318	106
78	1283	642	321	107
79	1295	648	324	108
80+	1358	679	340	114

PLAN N

Male

Preferred — Effective Date: 03/01/2024 — Plan Code: 5DM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2152	1076	538	180
66	2235	1118	559	187
67	2324	1162	581	194
68	2414	1207	604	202
69	2508	1254	627	209
70	2604	1302	651	217
71	2703	1352	676	226
72	2806	1403	702	234
73	2915	1458	729	243
74	3022	1511	756	252
75	3136	1568	784	262
76	3253	1627	814	272
77	3371	1686	843	281
78	3502	1751	876	292
79	3629	1815	908	303
80+	3762	1881	941	314

Standard — Effective Date: 03/01/2024 — Plan Code: 5DO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2477	1239	620	207
66	2572	1286	643	215
67	2675	1338	669	223
68	2779	1390	695	232
69	2886	1443	722	241
70	2997	1499	750	250
71	3111	1556	778	260
72	3230	1615	808	270
73	3355	1678	839	280
74	3478	1739	870	290
75	3609	1805	903	301
76	3744	1872	936	312
77	3880	1940	970	324
78	4031	2016	1008	336
79	4176	2088	1044	348
80+	4330	2165	1083	361

Female

Preferred — Effective Date: 03/01/2024 — Plan Code: 5DN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1872	936	468	156
66	1944	972	486	162
67	2021	1011	506	169
68	2100	1050	525	175
69	2181	1091	546	182
70	2265	1133	567	189
71	2351	1176	588	196
72	2441	1221	611	204
73	2535	1268	634	212
74	2628	1314	657	219
75	2727	1364	682	228
76	2829	1415	708	236
77	2932	1466	733	245
78	3046	1523	762	254
79	3156	1578	789	263
80+	3272	1636	818	273

Standard — Effective Date: 03/01/2024 — Plan Code: 5DP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2152	1076	538	180
66	2235	1118	559	187
67	2324	1162	581	194
68	2414	1207	604	202
69	2508	1254	627	209
70	2604	1302	651	217
71	2703	1352	676	226
72	2806	1403	702	234
73	2915	1458	729	243
74	3022	1511	756	252
75	3136	1568	784	262
76	3253	1627	814	272
77	3371	1686	843	281
78	3502	1751	876	292
79	3629	1815	908	303
80+	3762	1881	941	314

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

Male

Preferred						
Plan	A	SA	Q	M	Plan Code	Effective Date
C	3353	1677	839	280	5F4	03/01/2024
D	2608	1304	652	218	5F8	03/01/2024

Female

Preferred						
Plan	A	SA	Q	M	Plan Code	Effective Date
C	2916	1458	729	243	5F5	03/01/2024
D	2268	1134	567	189	5F9	03/01/2024

*** 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	3353	1677	839	280	5F4	03/01/2024
D	2608	1304	652	218	5F8	03/01/2024

Female

Preferred						
Plan	A	SA	Q	M	Plan Code	Effective Date
C	2916	1458	729	243	5F5	03/01/2024
D	2268	1134	567	189	5F9	03/01/2024

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.

ProCare®

Medicare Supplement Insurance Policies

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

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ProCare®

Medicare Supplement Insurance Policies

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, August 2022.

Freedom to Choose & Nationwide Acceptance

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

Strength of Tradition

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

Assurance of Service

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

Financial Strength

For more than 45 consecutive years, UA has earned the A (Excellent) or higher Financial Strength Rating from A.M. Best Company (rating as of 8/23).❖

UA has been rated AA – (Very Strong) for Financial Strength by Standard & Poor's (rating as of 10/22).❖

❖ 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■					$7,060	$3,530			

▼ Plans F and G also have a high deductible option which requires first paying a plan deductible of *($2,800 in 2024)* before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High Deductible Plan G does not cover the Medicare Part B deductible. However, High Deductible Plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

■ Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit *($7,060 for Plan K, $3,530 for Plan L in 2024)*. The out-of-pocket annual limit does NOT include the charges from your provider that exceed Medicare-approved amounts, called 'excess charges'. You will be responsible for paying excess charges. The out-of-pocket annual limit may increase each year for inflation.

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

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

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.

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) __ __ - __ __ - __ __ __ __

   (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? **Yes No** ○ ○

   (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:

	Yes	No
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 $ _,___.__

63782

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.)

United American Insurance Company Since 1947

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.

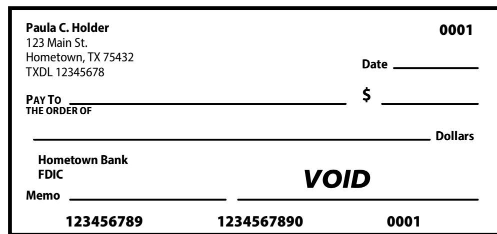
Payor's Last Name

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

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UAI1756 **0615**

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)

______________________________ (Applicant's Signature)

Type or print name & address of Agent or Broker:

____

____

______________________________ (Date)

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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)

______________________________ (Applicant's Signature)

Type or print name & address of Agent or Broker:

____

____

______________________________ (Date)

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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.

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

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.

2024 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	**$1,632** DEDUCTIBLE
61-90 DAYS	All eligible expenses after patient pays a per-day coinsurance	**$408** A DAY COINSURANCE as much as: **$12,240**
91-150 DAYS	All eligible expenses after patient pays a per-day coinsurance (These are Lifetime Reserve Days that may never be used again)	**$816** A DAY COINSURANCE as much as: **$48,960**
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 **$204** A DAY COINSURANCE as much as: **$16,320**
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

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2024 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	**$240** 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 2024, 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.*

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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 2024[2]					$7,060[2]	$3,530[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 $2,800 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	3134	1567	784	262	5F4	03/01/2023
D	2437	1219	610	204	5F8	03/01/2023

Female

Preferred						
Plan	A	SA	Q	M	Plan Code	Effective Date
C	2725	1363	682	228	5F5	03/01/2023
D	2119	1060	530	177	5F9	03/01/2023

*** 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	3134	1567	784	262	5F4	03/01/2023
D	2437	1219	610	204	5F8	03/01/2023

Female						
Preferred						
Plan	A	SA	Q	M	Plan Code	Effective Date
C	2725	1363	682	228	5F5	03/01/2023
D	2119	1060	530	177	5F9	03/01/2023

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: 03/01/2023 — Plan Code: 5A4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2064	1032	516	172
66	2115	1058	529	177
67	2159	1080	540	180
68	2217	1109	555	185
69	2275	1138	569	190
70	2339	1170	585	195
71	2389	1195	598	200
72	2423	1212	606	202
73	2528	1264	632	211
74	2640	1320	660	220
75	2753	1377	689	230
76	2857	1429	715	239
77	2908	1454	727	243
78	2908	1454	727	243
79	2908	1454	727	243
80+	2908	1454	727	243

Standard — Effective Date: 03/01/2023 — Plan Code: 5A6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2376	1188	594	198
66	2434	1217	609	203
67	2484	1242	621	207
68	2551	1276	638	213
69	2618	1309	655	219
70	2692	1346	673	225
71	2749	1375	688	230
72	2788	1394	697	233
73	2910	1455	728	243
74	3038	1519	760	254
75	3168	1584	792	264
76	3288	1644	822	274
77	3347	1674	837	279
78	3347	1674	837	279
79	3347	1674	837	279
80+	3347	1674	837	279

Female

Preferred — Effective Date: 03/01/2023 — Plan Code: 5A5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1795	898	449	150
66	1839	920	460	154
67	1877	939	470	157
68	1928	964	482	161
69	1978	989	495	165
70	2034	1017	509	170
71	2077	1039	520	174
72	2107	1054	527	176
73	2199	1100	550	184
74	2296	1148	574	192
75	2394	1197	599	200
76	2484	1242	621	207
77	2529	1265	633	211
78	2529	1265	633	211
79	2529	1265	633	211
80+	2529	1265	633	211

Standard — Effective Date: 03/01/2023 — Plan Code: 5A7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2064	1032	516	172
66	2115	1058	529	177
67	2159	1080	540	180
68	2217	1109	555	185
69	2275	1138	569	190
70	2339	1170	585	195
71	2389	1195	598	200
72	2423	1212	606	202
73	2528	1264	632	211
74	2640	1320	660	220
75	2753	1377	689	230
76	2857	1429	715	239
77	2908	1454	727	243
78	2908	1454	727	243
79	2908	1454	727	243
80+	2908	1454	727	243

PLAN C

Male

Preferred — Effective Date: 03/01/2023 — Plan Code: 5B4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3134	1567	784	262
66	3239	1620	810	270
67	3348	1674	837	279
68	3460	1730	865	289
69	3575	1788	894	298
70	3696	1848	924	308
71	3816	1908	954	318
72	3945	1973	987	329
73	4078	2039	1020	340
74	4212	2106	1053	351
75	4351	2176	1088	363
76	4494	2247	1124	375
77	4643	2322	1161	387
78	4803	2402	1201	401
79	4959	2480	1240	414
80+	5123	2562	1281	427

Standard — Effective Date: 03/01/2023 — Plan Code: 5B6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3607	1804	902	301
66	3728	1864	932	311
67	3853	1927	964	322
68	3982	1991	996	332
69	4115	2058	1029	343
70	4253	2127	1064	355
71	4392	2196	1098	366
72	4540	2270	1135	379
73	4693	2347	1174	392
74	4848	2424	1212	404
75	5007	2504	1252	418
76	5171	2586	1293	431
77	5343	2672	1336	446
78	5527	2764	1382	461
79	5707	2854	1427	476
80+	5896	2948	1474	492

Female

Preferred — Effective Date: 03/01/2023 — Plan Code: 5B5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2725	1363	682	228
66	2817	1409	705	235
67	2911	1456	728	243
68	3009	1505	753	251
69	3109	1555	778	260
70	3214	1607	804	268
71	3319	1660	830	277
72	3431	1716	858	286
73	3546	1773	887	296
74	3663	1832	916	306
75	3784	1892	946	316
76	3908	1954	977	326
77	4038	2019	1010	337
78	4177	2089	1045	349
79	4312	2156	1078	360
80+	4455	2228	1114	372

Standard — Effective Date: 03/01/2023 — Plan Code: 5B7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3134	1567	784	262
66	3239	1620	810	270
67	3348	1674	837	279
68	3460	1730	865	289
69	3575	1788	894	298
70	3696	1848	924	308
71	3816	1908	954	318
72	3945	1973	987	329
73	4078	2039	1020	340
74	4212	2106	1053	351
75	4351	2176	1088	363
76	4494	2247	1124	375
77	4643	2322	1161	387
78	4803	2402	1201	401
79	4959	2480	1240	414
80+	5123	2562	1281	427

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

PLAN D

Male

Preferred — Effective Date: 03/01/2023 — Plan Code: 5BM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2437	1219	610	204
66	2526	1263	632	211
67	2621	1311	656	219
68	2718	1359	680	227
69	2816	1408	704	235
70	2921	1461	731	244
71	3024	1512	756	252
72	3137	1569	785	262
73	3252	1626	813	271
74	3368	1684	842	281
75	3489	1745	873	291
76	3612	1806	903	301
77	3741	1871	936	312
78	3878	1939	970	324
79	4015	2008	1004	335
80+	4156	2078	1039	347

Standard — Effective Date: 03/01/2023 — Plan Code: 5BO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2804	1402	701	234
66	2907	1454	727	243
67	3016	1508	754	252
68	3128	1564	782	261
69	3241	1621	811	271
70	3362	1681	841	281
71	3481	1741	871	291
72	3610	1805	903	301
73	3743	1872	936	312
74	3876	1938	969	323
75	4016	2008	1004	335
76	4157	2079	1040	347
77	4305	2153	1077	359
78	4463	2232	1116	372
79	4620	2310	1155	385
80+	4783	2392	1196	399

Female

Preferred — Effective Date: 03/01/2023 — Plan Code: 5BN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2119	1060	530	177
66	2197	1099	550	184
67	2279	1140	570	190
68	2364	1182	591	197
69	2449	1225	613	205
70	2540	1270	635	212
71	2630	1315	658	220
72	2728	1364	682	228
73	2828	1414	707	236
74	2929	1465	733	245
75	3035	1518	759	253
76	3141	1571	786	262
77	3253	1627	814	272
78	3373	1687	844	282
79	3491	1746	873	291
80+	3615	1808	904	302

Standard — Effective Date: 03/01/2023 — Plan Code: 5BP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2437	1219	610	204
66	2526	1263	632	211
67	2621	1311	656	219
68	2718	1359	680	227
69	2816	1408	704	235
70	2921	1461	731	244
71	3024	1512	756	252
72	3137	1569	785	262
73	3252	1626	813	271
74	3368	1684	842	281
75	3489	1745	873	291
76	3612	1806	903	301
77	3741	1871	936	312
78	3878	1939	970	324
79	4015	2008	1004	335
80+	4156	2078	1039	347

PLAN F

Male

Preferred — Effective Date: 03/01/2023 — Plan Code: 5C4

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3150	1575	788	263
66	3253	1627	814	272
67	3363	1682	841	281
68	3475	1738	869	290
69	3588	1794	897	299
70	3711	1856	928	310
71	3831	1916	958	320
72	3959	1980	990	330
73	4092	2046	1023	341
74	4226	2113	1057	353
75	4367	2184	1092	364
76	4509	2255	1128	376
77	4658	2329	1165	389
78	4818	2409	1205	402
79	4975	2488	1244	415
80+	5137	2569	1285	429

Standard — Effective Date: 03/01/2023 — Plan Code: 5C6

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3625	1813	907	303
66	3744	1872	936	312
67	3870	1935	968	323
68	4000	2000	1000	334
69	4129	2065	1033	345
70	4270	2135	1068	356
71	4409	2205	1103	368
72	4556	2278	1139	380
73	4709	2355	1178	393
74	4864	2432	1216	406
75	5026	2513	1257	419
76	5189	2595	1298	433
77	5361	2681	1341	447
78	5545	2773	1387	463
79	5725	2863	1432	478
80+	5912	2956	1478	493

Female

Preferred — Effective Date: 03/01/2023 — Plan Code: 5C5

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2739	1370	685	229
66	2829	1415	708	236
67	2924	1462	731	244
68	3022	1511	756	252
69	3120	1560	780	260
70	3227	1614	807	269
71	3332	1666	833	278
72	3443	1722	861	287
73	3559	1780	890	297
74	3675	1838	919	307
75	3798	1899	950	317
76	3921	1961	981	327
77	4051	2026	1013	338
78	4190	2095	1048	350
79	4326	2163	1082	361
80+	4467	2234	1117	373

Standard — Effective Date: 03/01/2023 — Plan Code: 5C7

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	3150	1575	788	263
66	3253	1627	814	272
67	3363	1682	841	281
68	3475	1738	869	290
69	3588	1794	897	299
70	3711	1856	928	310
71	3831	1916	958	320
72	3959	1980	990	330
73	4092	2046	1023	341
74	4226	2113	1057	353
75	4367	2184	1092	364
76	4509	2255	1128	376
77	4658	2329	1165	389
78	4818	2409	1205	402
79	4975	2488	1244	415
80+	5137	2569	1285	429

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

PLAN HDF

Male

Preferred — Effective Date: 03/01/2023 — Plan Code: 5CM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	772	386	193	65
66	793	397	199	67
67	815	408	204	68
68	846	423	212	71
69	872	436	218	73
70	902	451	226	76
71	932	466	233	78
72	952	476	238	80
73	998	499	250	84
74	1050	525	263	88
75	1103	552	276	92
76	1152	576	288	96
77	1187	594	297	99
78	1200	600	300	100
79	1210	605	303	101
80+	1268	634	317	106

Standard — Effective Date: 03/01/2023 — Plan Code: 5CO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	889	445	223	75
66	912	456	228	76
67	938	469	235	79
68	974	487	244	82
69	1004	502	251	84
70	1038	519	260	87
71	1073	537	269	90
72	1095	548	274	92
73	1148	574	287	96
74	1209	605	303	101
75	1269	635	318	106
76	1326	663	332	111
77	1366	683	342	114
78	1381	691	346	116
79	1393	697	349	117
80+	1460	730	365	122

Female

Preferred — Effective Date: 03/01/2023 — Plan Code: 5CN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	672	336	168	56
66	689	345	173	58
67	709	355	178	60
68	736	368	184	62
69	758	379	190	64
70	785	393	197	66
71	811	406	203	68
72	828	414	207	69
73	868	434	217	73
74	913	457	229	77
75	959	480	240	80
76	1002	501	251	84
77	1032	516	258	86
78	1043	522	261	87
79	1053	527	264	88
80+	1103	552	276	92

Standard — Effective Date: 03/01/2023 — Plan Code: 5CP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	772	386	193	65
66	793	397	199	67
67	815	408	204	68
68	846	423	212	71
69	872	436	218	73
70	902	451	226	76
71	932	466	233	78
72	952	476	238	80
73	998	499	250	84
74	1050	525	263	88
75	1103	552	276	92
76	1152	576	288	96
77	1187	594	297	99
78	1200	600	300	100
79	1210	605	303	101
80+	1268	634	317	106

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

PLAN G

Male

Preferred	Effective Date: 03/01/2023		Plan Code: 5D4	
Attained Age	**Annual**	**Semi Annual**	**Quarterly**	**Monthly**
65	2441	1221	611	204
66	2530	1265	633	211
67	2626	1313	657	219
68	2723	1362	681	227
69	2820	1410	705	235
70	2926	1463	732	244
71	3029	1515	758	253
72	3141	1571	786	262
73	3256	1628	814	272
74	3373	1687	844	282
75	3494	1747	874	292
76	3616	1808	904	302
77	3745	1873	937	313
78	3883	1942	971	324
79	4019	2010	1005	335
80+	4162	2081	1041	347

Standard	Effective Date: 03/01/2023		Plan Code: 5D6	
Attained Age	**Annual**	**Semi Annual**	**Quarterly**	**Monthly**
65	2809	1405	703	235
66	2912	1456	728	243
67	3022	1511	756	252
68	3133	1567	784	262
69	3246	1623	812	271
70	3367	1684	842	281
71	3486	1743	872	291
72	3615	1808	904	302
73	3748	1874	937	313
74	3882	1941	971	324
75	4021	2011	1006	336
76	4162	2081	1041	347
77	4310	2155	1078	360
78	4468	2234	1117	373
79	4625	2313	1157	386
80+	4790	2395	1198	400

Female

Preferred	Effective Date: 03/01/2023		Plan Code: 5D5	
Attained Age	**Annual**	**Semi Annual**	**Quarterly**	**Monthly**
65	2123	1062	531	177
66	2201	1101	551	184
67	2284	1142	571	191
68	2368	1184	592	198
69	2453	1227	614	205
70	2544	1272	636	212
71	2634	1317	659	220
72	2732	1366	683	228
73	2832	1416	708	236
74	2934	1467	734	245
75	3038	1519	760	254
76	3145	1573	787	263
77	3257	1629	815	272
78	3376	1688	844	282
79	3495	1748	874	292
80+	3619	1810	905	302

Standard	Effective Date: 03/01/2023		Plan Code: 5D7	
Attained Age	**Annual**	**Semi Annual**	**Quarterly**	**Monthly**
65	2441	1221	611	204
66	2530	1265	633	211
67	2626	1313	657	219
68	2723	1362	681	227
69	2820	1410	705	235
70	2926	1463	732	244
71	3029	1515	758	253
72	3141	1571	786	262
73	3256	1628	814	272
74	3373	1687	844	282
75	3494	1747	874	292
76	3616	1808	904	302
77	3745	1873	937	313
78	3883	1942	971	324
79	4019	2010	1005	335
80+	4162	2081	1041	347

PLAN HDG

Male

Preferred — Effective Date: 03/01/2023 — Plan Code: 5HO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	772	386	193	65
66	793	397	199	67
67	815	408	204	68
68	846	423	212	71
69	872	436	218	73
70	902	451	226	76
71	932	466	233	78
72	952	476	238	80
73	998	499	250	84
74	1050	525	263	88
75	1103	552	276	92
76	1152	576	288	96
77	1187	594	297	99
78	1200	600	300	100
79	1210	605	303	101
80+	1268	634	317	106

Standard — Effective Date: 03/01/2023 — Plan Code: 5HQ

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	889	445	223	75
66	912	456	228	76
67	938	469	235	79
68	974	487	244	82
69	1004	502	251	84
70	1038	519	260	87
71	1073	537	269	90
72	1095	548	274	92
73	1148	574	287	96
74	1209	605	303	101
75	1269	635	318	106
76	1326	663	332	111
77	1366	683	342	114
78	1381	691	346	116
79	1393	697	349	117
80+	1460	730	365	122

Female

Preferred — Effective Date: 03/01/2023 — Plan Code: 5HP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	672	336	168	56
66	689	345	173	58
67	709	355	178	60
68	736	368	184	62
69	758	379	190	64
70	785	393	197	66
71	811	406	203	68
72	828	414	207	69
73	868	434	217	73
74	913	457	229	77
75	959	480	240	80
76	1002	501	251	84
77	1032	516	258	86
78	1043	522	261	87
79	1053	527	264	88
80+	1103	552	276	92

Standard — Effective Date: 03/01/2023 — Plan Code: 5HR

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	772	386	193	65
66	793	397	199	67
67	815	408	204	68
68	846	423	212	71
69	872	436	218	73
70	902	451	226	76
71	932	466	233	78
72	952	476	238	80
73	998	499	250	84
74	1050	525	263	88
75	1103	552	276	92
76	1152	576	288	96
77	1187	594	297	99
78	1200	600	300	100
79	1210	605	303	101
80+	1268	634	317	106

PLAN N

Male

Preferred | **Effective Date:** 03/01/2023 | **Plan Code:** 5DM

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2012	1006	503	168
66	2089	1045	523	175
67	2172	1086	543	181
68	2256	1128	564	188
69	2343	1172	586	196
70	2434	1217	609	203
71	2526	1263	632	211
72	2623	1312	656	219
73	2724	1362	681	227
74	2825	1413	707	236
75	2931	1466	733	245
76	3040	1520	760	254
77	3151	1576	788	263
78	3274	1637	819	273
79	3392	1696	848	283
80+	3516	1758	879	293

Standard | **Effective Date:** 03/01/2023 | **Plan Code:** 5DO

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2315	1158	579	193
66	2404	1202	601	201
67	2499	1250	625	209
68	2597	1299	650	217
69	2697	1349	675	225
70	2801	1401	701	234
71	2907	1454	727	243
72	3018	1509	755	252
73	3134	1567	784	262
74	3251	1626	813	271
75	3373	1687	844	282
76	3499	1750	875	292
77	3626	1813	907	303
78	3767	1884	942	314
79	3903	1952	976	326
80+	4047	2024	1012	338

Female

Preferred | **Effective Date:** 03/01/2023 | **Plan Code:** 5DN

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	1749	875	438	146
66	1817	909	455	152
67	1889	945	473	158
68	1962	981	491	164
69	2038	1019	510	170
70	2116	1058	529	177
71	2197	1099	550	184
72	2281	1141	571	191
73	2369	1185	593	198
74	2456	1228	614	205
75	2549	1275	638	213
76	2644	1322	661	221
77	2740	1370	685	229
78	2847	1424	712	238
79	2950	1475	738	246
80+	3058	1529	765	255

Standard | **Effective Date:** 03/01/2023 | **Plan Code:** 5DP

Attained Age	Annual	Semi Annual	Quarterly	Monthly
65	2012	1006	503	168
66	2089	1045	523	175
67	2172	1086	543	181
68	2256	1128	564	188
69	2343	1172	586	196
70	2434	1217	609	203
71	2526	1263	632	211
72	2623	1312	656	219
73	2724	1362	681	227
74	2825	1413	707	236
75	2931	1466	733	245
76	3040	1520	760	254
77	3151	1576	788	263
78	3274	1637	819	273
79	3392	1696	848	283
80+	3516	1758	879	293

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 $1632	$0	$1632 (Part A Deductible)
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	$0	Up to $204 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 $240 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 $240 of Medicare-Approved Amounts*	$0	$0	$240 (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 $240 of Medicare-Approved Amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
– Tests for diagnostic services	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $240 of Medicare-Approved Amounts*	$0	$0	$240 (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 $1632	$1632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 $240 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 $240 of Medicare-Approved Amounts*	$0	$240 (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 $240 of Medicare-Approved Amounts*	$0	$240 (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 $240 of Medicare-Approved Amounts*	$0	$240 (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 $1632	$1632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 $240 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 $240 of Medicare-Approved Amounts*	$0	$0	$240 (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 $240 of Medicare-Approved Amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
– Tests for diagnostic services	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $240 of Medicare-Approved Amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 $2800 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2800. 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 $2800 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2800 DEDUCTIBLE,** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1632	$1632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 $240 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 $2800 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2800. 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 $2800 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2800 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 $240 of Medicare-Approved Amounts*	$0	$240 (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 $240 of Medicare-Approved Amounts*	$0	$240 (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 $240 of Medicare-Approved Amounts*	$0	$240 (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 $2800 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2800. 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 $2800 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2800 DEDUCTIBLE,** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1632	$1632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 $240 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 $2800 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2800. 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 $2800 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2800 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 $240 of Medicare-Approved Amounts*	$0	$0	$240 (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 $240 of Medicare-Approved Amounts*	$0	$0	$240 (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

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2800 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2800 DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $240 of Medicare-Approved Amounts*	$0	$0	$240 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2800 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2800 DEDUCTIBLE,** YOU PAY
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 $1632	$1632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 $240 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 $240 of Medicare-Approved Amounts*	$0	$0	$240 (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 $240 of Medicare-Approved Amounts*	$0	$0	$240 (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 $240 of Medicare-Approved Amounts*	$0	$0	$240 (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