Western United Life Application Packet

Thank you for your interest in the Western United Life Medicare Supplement plan!

Attached is a copy of the policy Outline of Coverage and we have supplied you with a link to a printable copy of the Enrollment.

Should you decide to apply by upload/mail/fax/email, the printable application needs to be reviewed and signed by an Agent before it can be submitted to Western United. You may upload, email, fax or mail it in to CDA Insurance:

- Fax: 1.541.284.2994
- Email: cs@cda-insurance.com
- Secure File Upload: Click here
- Mail: CDA Insurance LLC
  PO Box 26540
  Eugene, Oregon 97402

Other Important Information
Download Medicare's Choosing a Medigap Policy Guide (.pdf) Download Policy Outline (.pdf) Download Application (.pdf)

Our website: http://www.medicare-texas.net

If you should have any questions on the application, please call us at 1.800.884.2343 or 1.541.434.9613.

WESTERN UNITED LIFE ASSURANCE COMPANY
Outline of Medicare Supplement Coverage-Cover Page
Benefit Plans A, C, F, G, AND N

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A." Some plans may not be available in your state. Western United Life Assurance Company offers five of the eleven plans available.

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 Part B coinsurance or co-payments.
Blood: First three pints of blood each year.
Hospice: Part A coinsurance

A	B	C	D	F F*	G	K	L	M	N
Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance*	Basic Benefits, including 100% Part B coinsurance	Hospitalization and preventative care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventative care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out-of-pocket limit $4620; paid at 100% after limit reached	Out-of-pocket limit $2310; paid at 100% after limit reached		

***Plans F also have an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2200 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2200. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare Deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

WESTERN UNITED LIFE ASSURANCE COMPANY
ANNUAL PREFERRED ATTAINED AGE PREMIUMS
FOR USE IN TEXAS ZIP CODES
770-773, 775

Attained Age	Female					Male				
	Plan A	Plan C	Plan F	Plan G	Plan N	Plan A	Plan C	Plan F	Plan G	Plan N
0-64	5,625	N/A	N/A	N/A	N/A	6,468	N/A	N/A	N/A	N/A
65	1,340	1,756	1,773	1,341	1,169	1,541	2,018	2,039	1,541	1,344
66	1,340	1,756	1,773	1,341	1,169	1,541	2,018	2,039	1,541	1,344
67	1,340	1,756	1,773	1,341	1,169	1,541	2,018	2,039	1,541	1,344
68	1,387	1,811	1,829	1,390	1,211	1,595	2,082	2,103	1,599	1,392
69	1,433	1,868	1,887	1,441	1,253	1,647	2,147	2,169	1,657	1,441
70	1,481	1,924	1,944	1,491	1,296	1,702	2,212	2,235	1,715	1,490
71	1,518	1,978	1,998	1,538	1,338	1,746	2,275	2,298	1,769	1,538
72	1,559	2,036	2,057	1,589	1,382	1,793	2,342	2,366	1,827	1,590
73	1,600	2,094	2,115	1,639	1,427	1,841	2,408	2,432	1,886	1,640
74	1,646	2,158	2,179	1,695	1,475	1,893	2,481	2,506	1,949	1,697
75	1,699	2,230	2,252	1,757	1,530	1,953	2,564	2,590	2,020	1,760
76	1,742	2,302	2,325	1,817	1,584	2,002	2,647	2,673	2,090	1,823
77	1,785	2,374	2,398	1,878	1,640	2,053	2,731	2,758	2,160	1,887
78	1,830	2,449	2,474	1,940	1,698	2,104	2,816	2,844	2,231	1,952
79	1,880	2,529	2,555	2,008	1,759	2,161	2,909	2,938	2,309	2,023
80	1,930	2,612	2,639	2,077	1,822	2,219	3,004	3,035	2,389	2,096
81	1,977	2,702	2,729	2,151	1,892	2,274	3,107	3,137	2,474	2,176
82	2,027	2,793	2,820	2,227	1,965	2,330	3,212	3,243	2,562	2,259
83	2,078	2,890	2,918	2,308	2,040	2,390	3,323	3,356	2,654	2,346
84	2,130	2,988	3,018	2,391	2,118	2,451	3,437	3,470	2,749	2,435
85	2,187	3,093	3,124	2,477	2,200	2,516	3,557	3,592	2,849	2,529
86	2,239	3,190	3,220	2,557	2,274	2,574	3,669	3,703	2,941	2,616
87	2,290	3,289	3,320	2,639	2,352	2,633	3,782	3,819	3,035	2,705
88	2,344	3,390	3,423	2,723	2,431	2,695	3,899	3,936	3,131	2,796
89	2,398	3,494	3,528	2,809	2,513	2,757	4,018	4,057	3,231	2,890
90	2,454	3,602	3,636	2,898	2,596	2,821	4,142	4,181	3,332	2,985
91	2,500	3,699	3,735	2,978	2,673	2,875	4,255	4,295	3,425	3,074
92	2,545	3,796	3,831	3,058	2,750	2,926	4,366	4,406	3,516	3,162
93	2,591	3,894	3,931	3,140	2,828	2,980	4,479	4,520	3,610	3,252
94	2,638	3,996	4,033	3,222	2,907	3,033	4,595	4,638	3,705	3,344
95	2,685	4,099	4,137	3,308	2,989	3,088	4,715	4,758	3,804	3,439
96	2,731	4,169	4,207	3,364	3,041	3,141	4,794	4,838	3,868	3,497
97	2,777	4,240	4,279	3,421	3,092	3,194	4,876	4,920	3,934	3,556
98	2,825	4,312	4,351	3,480	3,145	3,248	4,959	5,004	4,002	3,616
99	2,873	4,385	4,425	3,539	3,198	3,303	5,043	5,089	4,070	3,678

Premium payable other than annual will be determined according to the following factors:

Semi Annual	Quarterly	Monthly
1/2	1/4	1/12

There is a one time $25.00 policy fee.
A discount factor of .93 is applied for household discount applicants

WESTERN UNITED LIFE ASSURANCE COMPANY
ANNUAL STANDARD ATTAINED AGE PREMIUMS
FOR USE IN TEXAS ZIP CODES
770-773, 775

Attained	Female					Male				
Age	Plan A	Plan C	Plan F	Plan G	Plan N	Plan A	Plan C	Plan F	Plan G	Plan N
0-64	6,468	N/A	N/A	N/A	N/A	7,438	N/A	N/A	N/A	N/A
65	1,541	2,018	2,039	1,541	1,344	1,772	2,322	2,345	1,772	1,546
66	1,541	2,018	2,039	1,541	1,344	1,772	2,322	2,345	1,772	1,546
67	1,541	2,018	2,039	1,541	1,344	1,772	2,322	2,345	1,772	1,546
68	1,595	2,082	2,103	1,599	1,392	1,834	2,395	2,419	1,839	1,601
69	1,647	2,147	2,169	1,657	1,441	1,895	2,470	2,495	1,906	1,657
70	1,702	2,212	2,235	1,715	1,490	1,958	2,544	2,570	1,972	1,714
71	1,746	2,275	2,298	1,769	1,538	2,009	2,617	2,643	2,035	1,769
72	1,793	2,342	2,366	1,827	1,590	2,062	2,692	2,721	2,101	1,828
73	1,841	2,408	2,432	1,886	1,640	2,117	2,769	2,797	2,168	1,887
74	1,893	2,481	2,506	1,949	1,697	2,177	2,853	2,882	2,241	1,951
75	1,953	2,564	2,590	2,020	1,760	2,246	2,949	2,979	2,324	2,023
76	2,002	2,647	2,673	2,090	1,823	2,304	3,044	3,074	2,402	2,096
77	2,053	2,731	2,758	2,160	1,887	2,361	3,141	3,172	2,483	2,169
78	2,104	2,816	2,844	2,231	1,952	2,420	3,238	3,271	2,566	2,245
79	2,161	2,909	2,938	2,309	2,023	2,485	3,345	3,379	2,655	2,327
80	2,219	3,004	3,035	2,389	2,096	2,552	3,455	3,489	2,747	2,410
81	2,274	3,107	3,137	2,474	2,176	2,615	3,572	3,609	2,846	2,502
82	2,330	3,212	3,243	2,562	2,259	2,680	3,694	3,731	2,946	2,598
83	2,390	3,323	3,356	2,654	2,346	2,748	3,822	3,859	3,052	2,697
84	2,451	3,437	3,470	2,749	2,435	2,818	3,952	3,991	3,162	2,800
85	2,516	3,557	3,592	2,849	2,529	2,893	4,091	4,131	3,276	2,909
86	2,574	3,669	3,703	2,941	2,616	2,960	4,219	4,259	3,382	3,008
87	2,633	3,782	3,819	3,035	2,705	3,029	4,349	4,391	3,490	3,110
88	2,695	3,899	3,936	3,131	2,796	3,100	4,484	4,527	3,600	3,215
89	2,757	4,018	4,057	3,231	2,890	3,171	4,622	4,666	3,715	3,322
90	2,821	4,142	4,181	3,332	2,985	3,245	4,763	4,808	3,831	3,434
91	2,875	4,255	4,295	3,425	3,074	3,306	4,893	4,939	3,939	3,535
92	2,926	4,366	4,406	3,516	3,162	3,366	5,020	5,067	4,044	3,636
93	2,980	4,479	4,520	3,610	3,252	3,426	5,151	5,199	4,152	3,740
94	3,033	4,595	4,638	3,705	3,344	3,488	5,285	5,333	4,262	3,846
95	3,088	4,715	4,758	3,804	3,439	3,551	5,421	5,471	4,374	3,954
96	3,141	4,794	4,838	3,868	3,497	3,611	5,514	5,564	4,449	4,022
97	3,194	4,876	4,920	3,934	3,556	3,673	5,607	5,658	4,524	4,090
98	3,248	4,959	5,004	4,002	3,616	3,735	5,703	5,754	4,601	4,159
99	3,303	5,043	5,089	4,070	3,678	3,799	5,799	5,853	4,680	4,229

Premium payable other than annual will be determined according to the following factors:

Semi Annual	Quarterly	Monthly
1/2	1/4	1/12

There is a one time $25.00 policy fee.
A discount factor of .93 is applied for household discount applicants

WESTERN UNITED LIFE ASSURANCE COMPANY
ANNUAL PREFERRED ATTAINED AGE PREMIUMS
FOR USE IN TEXAS ZIP CODES
750-753, 760, 761, 774, 776, 777, 782, 784, 793, 794

Attained Age	Female					Male				
	Plan A	Plan C	Plan F	Plan G	Plan N	Plan A	Plan C	Plan F	Plan G	Plan N
0-64	5,089	N/A	N/A	N/A	N/A	5,852	N/A	N/A	N/A	N/A
65	1,212	1,588	1,605	1,213	1,057	1,395	1,826	1,845	1,395	1,216
66	1,212	1,588	1,605	1,213	1,057	1,395	1,826	1,845	1,395	1,216
67	1,212	1,588	1,605	1,213	1,057	1,395	1,826	1,845	1,395	1,216
68	1,255	1,639	1,655	1,258	1,095	1,443	1,884	1,903	1,447	1,260
69	1,297	1,690	1,707	1,303	1,133	1,491	1,943	1,963	1,499	1,303
70	1,340	1,740	1,758	1,349	1,172	1,540	2,002	2,023	1,551	1,348
71	1,374	1,790	1,808	1,392	1,210	1,580	2,059	2,080	1,601	1,392
72	1,411	1,842	1,861	1,437	1,250	1,623	2,119	2,140	1,653	1,438
73	1,448	1,894	1,913	1,483	1,291	1,665	2,178	2,200	1,706	1,484
74	1,490	1,952	1,971	1,533	1,335	1,713	2,245	2,268	1,763	1,535
75	1,537	2,018	2,038	1,589	1,384	1,767	2,320	2,344	1,828	1,592
76	1,576	2,082	2,103	1,644	1,434	1,812	2,395	2,419	1,891	1,649
77	1,615	2,148	2,170	1,700	1,484	1,857	2,471	2,496	1,954	1,707
78	1,656	2,215	2,238	1,756	1,536	1,904	2,548	2,574	2,019	1,766
79	1,701	2,289	2,311	1,816	1,591	1,955	2,632	2,658	2,089	1,831
80	1,746	2,364	2,387	1,879	1,648	2,007	2,718	2,746	2,161	1,896
81	1,789	2,444	2,469	1,947	1,712	2,058	2,811	2,839	2,238	1,968
82	1,834	2,527	2,552	2,015	1,777	2,108	2,906	2,935	2,318	2,043
83	1,880	2,614	2,640	2,088	1,846	2,162	3,007	3,036	2,402	2,122
84	1,928	2,704	2,730	2,163	1,916	2,217	3,109	3,140	2,487	2,203
85	1,979	2,799	2,826	2,241	1,990	2,276	3,219	3,250	2,577	2,289
86	2,025	2,886	2,914	2,313	2,058	2,328	3,319	3,351	2,661	2,366
87	2,072	2,975	3,004	2,387	2,128	2,383	3,422	3,455	2,746	2,447
88	2,120	3,068	3,097	2,463	2,199	2,439	3,527	3,562	2,833	2,530
89	2,170	3,162	3,192	2,541	2,273	2,495	3,636	3,671	2,923	2,614
90	2,220	3,259	3,290	2,622	2,348	2,553	3,748	3,783	3,014	2,701
91	2,262	3,347	3,379	2,694	2,419	2,601	3,849	3,886	3,099	2,782
92	2,303	3,434	3,467	2,766	2,488	2,648	3,950	3,986	3,182	2,860
93	2,345	3,524	3,557	2,841	2,558	2,696	4,053	4,090	3,266	2,942
94	2,386	3,616	3,649	2,916	2,631	2,745	4,157	4,196	3,353	3,026
95	2,429	3,709	3,743	2,993	2,705	2,794	4,266	4,304	3,442	3,111
96	2,471	3,772	3,807	3,044	2,751	2,841	4,338	4,378	3,500	3,164
97	2,513	3,836	3,871	3,095	2,798	2,890	4,412	4,452	3,560	3,218
98	2,556	3,902	3,937	3,148	2,845	2,938	4,487	4,528	3,620	3,272
99	2,599	3,967	4,003	3,202	2,894	2,989	4,563	4,605	3,682	3,328

Premium payable other than annual will be determined according to the following factors:

Semi Annual	Quarterly	Monthly
1/2	1/4	1/12

There is a one time $25.00 policy fee.
A discount factor of .93 is applied for household discount applicants

WESTERN UNITED LIFE ASSURANCE COMPANY
ANNUAL STANDARD ATTAINED AGE PREMIUMS
FOR USE IN TEXAS ZIP CODES
750-753, 760, 761, 774, 776, 777, 782, 784, 793, 794

Attained Age	Female					Male				
	Plan A	Plan C	Plan F	Plan G	Plan N	Plan A	Plan C	Plan F	Plan G	Plan N
0-64	5,852	N/A	N/A	N/A	N/A	6,730	N/A	N/A	N/A	N/A
65	1,395	1,826	1,845	1,395	1,216	1,604	2,100	2,121	1,604	1,398
66	1,395	1,826	1,845	1,395	1,216	1,604	2,100	2,121	1,604	1,398
67	1,395	1,826	1,845	1,395	1,216	1,604	2,100	2,121	1,604	1,398
68	1,443	1,884	1,903	1,447	1,260	1,660	2,167	2,189	1,663	1,449
69	1,491	1,943	1,963	1,499	1,303	1,715	2,234	2,257	1,724	1,499
70	1,540	2,002	2,023	1,551	1,348	1,772	2,302	2,326	1,784	1,550
71	1,580	2,059	2,080	1,601	1,392	1,817	2,367	2,391	1,841	1,601
72	1,623	2,119	2,140	1,653	1,438	1,866	2,436	2,461	1,901	1,654
73	1,665	2,178	2,200	1,706	1,484	1,915	2,505	2,531	1,962	1,707
74	1,713	2,245	2,268	1,763	1,535	1,969	2,581	2,608	2,027	1,765
75	1,767	2,320	2,344	1,828	1,592	2,032	2,669	2,695	2,102	1,831
76	1,812	2,395	2,419	1,891	1,649	2,084	2,754	2,782	2,174	1,896
77	1,857	2,471	2,496	1,954	1,707	2,137	2,841	2,870	2,247	1,963
78	1,904	2,548	2,574	2,019	1,766	2,190	2,930	2,959	2,322	2,031
79	1,955	2,632	2,658	2,089	1,831	2,249	3,027	3,057	2,403	2,105
80	2,007	2,718	2,746	2,161	1,896	2,309	3,126	3,157	2,485	2,180
81	2,058	2,811	2,839	2,238	1,968	2,366	3,232	3,265	2,575	2,264
82	2,108	2,906	2,935	2,318	2,043	2,424	3,342	3,375	2,666	2,350
83	2,162	3,007	3,036	2,402	2,122	2,486	3,458	3,491	2,762	2,441
84	2,217	3,109	3,140	2,487	2,203	2,550	3,576	3,611	2,860	2,534
85	2,276	3,219	3,250	2,577	2,289	2,617	3,701	3,737	2,964	2,632
86	2,328	3,319	3,351	2,661	2,366	2,678	3,817	3,853	3,060	2,722
87	2,383	3,422	3,455	2,746	2,447	2,741	3,935	3,973	3,158	2,814
88	2,439	3,527	3,562	2,833	2,530	2,804	4,057	4,095	3,258	2,909
89	2,495	3,636	3,671	2,923	2,614	2,869	4,182	4,222	3,361	3,006
90	2,553	3,748	3,783	3,014	2,701	2,936	4,309	4,350	3,467	3,107
91	2,601	3,849	3,886	3,099	2,782	2,992	4,427	4,469	3,563	3,199
92	2,648	3,950	3,986	3,182	2,860	3,046	4,542	4,585	3,658	3,290
93	2,696	4,053	4,090	3,266	2,942	3,100	4,661	4,703	3,756	3,384
94	2,745	4,157	4,196	3,353	3,026	3,156	4,781	4,825	3,856	3,480
95	2,794	4,266	4,304	3,442	3,111	3,213	4,905	4,950	3,958	3,578
96	2,841	4,338	4,378	3,500	3,164	3,267	4,988	5,034	4,025	3,639
97	2,890	4,412	4,452	3,560	3,218	3,323	5,073	5,120	4,094	3,700
98	2,938	4,487	4,528	3,620	3,272	3,379	5,159	5,206	4,163	3,763
99	2,989	4,563	4,605	3,682	3,328	3,437	5,247	5,295	4,234	3,827

Premium payable other than annual will be determined according to the following factors:

Semi Annual	Quarterly	Monthly
1/2	1/4	1/12

There is a one time $25.00 policy fee.
A discount factor of .93 is applied for household discount applicants

WESTERN UNITED LIFE ASSURANCE COMPANY
ANNUAL PREFERRED ATTAINED AGE PREMIUMS
FOR USE IN TEXAS ZIP CODES ALL EXCEPT
750-753, 760, 761, 770-777, 782, 784, 793, 794

Attained	Female					Male				
Age	Plan A	Plan C	Plan F	Plan G	Plan N	Plan A	Plan C	Plan F	Plan G	Plan N
0-64	4,714	N/A	N/A	N/A	N/A	5,421	N/A	N/A	N/A	N/A
65	1,123	1,471	1,486	1,124	979	1,292	1,691	1,709	1,292	1,126
66	1,123	1,471	1,486	1,124	979	1,292	1,691	1,709	1,292	1,126
67	1,123	1,471	1,486	1,124	979	1,292	1,691	1,709	1,292	1,126
68	1,162	1,518	1,533	1,165	1,015	1,337	1,745	1,763	1,340	1,167
69	1,201	1,566	1,581	1,207	1,050	1,381	1,800	1,818	1,389	1,207
70	1,241	1,612	1,629	1,250	1,086	1,426	1,854	1,874	1,437	1,249
71	1,272	1,658	1,675	1,289	1,121	1,463	1,907	1,926	1,483	1,289
72	1,307	1,706	1,724	1,331	1,158	1,503	1,962	1,983	1,531	1,332
73	1,341	1,755	1,772	1,374	1,196	1,543	2,018	2,038	1,580	1,375
74	1,380	1,808	1,826	1,420	1,236	1,587	2,079	2,101	1,633	1,422
75	1,424	1,869	1,888	1,472	1,282	1,637	2,149	2,171	1,693	1,475
76	1,460	1,929	1,948	1,522	1,328	1,678	2,218	2,240	1,751	1,528
77	1,496	1,990	2,010	1,574	1,375	1,720	2,289	2,312	1,810	1,581
78	1,534	2,052	2,073	1,626	1,423	1,764	2,360	2,384	1,870	1,636
79	1,575	2,120	2,141	1,683	1,474	1,811	2,438	2,462	1,935	1,696
80	1,617	2,189	2,211	1,741	1,527	1,859	2,518	2,543	2,002	1,756
81	1,657	2,264	2,287	1,803	1,586	1,906	2,604	2,629	2,073	1,823
82	1,698	2,341	2,364	1,866	1,646	1,953	2,692	2,718	2,147	1,893
83	1,742	2,422	2,446	1,934	1,710	2,003	2,785	2,812	2,225	1,966
84	1,786	2,504	2,529	2,004	1,775	2,054	2,880	2,908	2,304	2,041
85	1,833	2,592	2,618	2,076	1,844	2,108	2,981	3,010	2,387	2,120
86	1,876	2,673	2,699	2,143	1,906	2,157	3,075	3,104	2,465	2,192
87	1,919	2,756	2,783	2,211	1,971	2,207	3,170	3,201	2,543	2,267
88	1,964	2,842	2,869	2,282	2,037	2,259	3,267	3,299	2,624	2,343
89	2,010	2,929	2,957	2,354	2,106	2,311	3,368	3,400	2,708	2,422
90	2,057	3,018	3,047	2,429	2,175	2,365	3,472	3,504	2,792	2,502
91	2,095	3,100	3,130	2,496	2,240	2,409	3,566	3,599	2,871	2,577
92	2,133	3,181	3,211	2,563	2,305	2,453	3,659	3,692	2,947	2,650
93	2,172	3,264	3,295	2,631	2,370	2,497	3,754	3,788	3,025	2,725
94	2,211	3,349	3,380	2,701	2,437	2,542	3,851	3,887	3,106	2,803
95	2,250	3,436	3,467	2,772	2,505	2,588	3,951	3,987	3,188	2,882
96	2,289	3,494	3,526	2,820	2,548	2,632	4,018	4,055	3,242	2,930
97	2,328	3,553	3,586	2,867	2,592	2,677	4,087	4,124	3,297	2,981
98	2,367	3,614	3,647	2,916	2,636	2,722	4,156	4,194	3,354	3,031
99	2,408	3,675	3,708	2,966	2,680	2,768	4,227	4,265	3,411	3,083

Premium payable other than annual will be determined according to the following factors:

Semi Annual	Quarterly	Monthly
1/2	1/4	1/12

There is a one time $25.00 policy fee.
A discount factor of .93 is applied for household discount applicants

WESTERN UNITED LIFE ASSURANCE COMPANY
ANNUAL STANDARD ATTAINED AGE PREMIUMS
FOR USE IN TEXAS ZIP CODES ALL EXCEPT
750-753, 760, 761, 770-777, 782, 784, 793, 794

Attained Age	Female					Male				
	Plan A	Plan C	Plan F	Plan G	Plan N	Plan A	Plan C	Plan F	Plan G	Plan N
0-64	5,421	N/A	N/A	N/A	N/A	6,234	N/A	N/A	N/A	N/A
65	1,292	1,691	1,709	1,292	1,126	1,485	1,946	1,965	1,485	1,295
66	1,292	1,691	1,709	1,292	1,126	1,485	1,946	1,965	1,485	1,295
67	1,292	1,691	1,709	1,292	1,126	1,485	1,946	1,965	1,485	1,295
68	1,337	1,745	1,763	1,340	1,167	1,537	2,007	2,028	1,541	1,342
69	1,381	1,800	1,818	1,389	1,207	1,588	2,070	2,091	1,597	1,389
70	1,426	1,854	1,874	1,437	1,249	1,641	2,132	2,154	1,653	1,436
71	1,463	1,907	1,926	1,483	1,289	1,683	2,193	2,215	1,705	1,483
72	1,503	1,962	1,983	1,531	1,332	1,728	2,256	2,280	1,761	1,532
73	1,543	2,018	2,038	1,580	1,375	1,774	2,321	2,344	1,817	1,581
74	1,587	2,079	2,101	1,633	1,422	1,824	2,391	2,416	1,878	1,635
75	1,637	2,149	2,171	1,693	1,475	1,882	2,472	2,497	1,947	1,696
76	1,678	2,218	2,240	1,751	1,528	1,931	2,551	2,577	2,013	1,756
77	1,720	2,289	2,312	1,810	1,581	1,979	2,632	2,658	2,081	1,818
78	1,764	2,360	2,384	1,870	1,636	2,028	2,714	2,741	2,151	1,881
79	1,811	2,438	2,462	1,935	1,696	2,083	2,804	2,832	2,226	1,950
80	1,859	2,518	2,543	2,002	1,756	2,138	2,895	2,924	2,302	2,020
81	1,906	2,604	2,629	2,073	1,823	2,191	2,994	3,025	2,385	2,097
82	1,953	2,692	2,718	2,147	1,893	2,246	3,096	3,127	2,469	2,177
83	2,003	2,785	2,812	2,225	1,966	2,303	3,203	3,234	2,558	2,261
84	2,054	2,880	2,908	2,304	2,041	2,362	3,312	3,345	2,650	2,347
85	2,108	2,981	3,010	2,387	2,120	2,424	3,428	3,462	2,746	2,438
86	2,157	3,075	3,104	2,465	2,192	2,481	3,536	3,569	2,834	2,521
87	2,207	3,170	3,201	2,543	2,267	2,539	3,645	3,680	2,925	2,607
88	2,259	3,267	3,299	2,624	2,343	2,598	3,758	3,794	3,018	2,695
89	2,311	3,368	3,400	2,708	2,422	2,658	3,874	3,911	3,113	2,784
90	2,365	3,472	3,504	2,792	2,502	2,719	3,992	4,030	3,211	2,878
91	2,409	3,566	3,599	2,871	2,577	2,771	4,101	4,140	3,301	2,963
92	2,453	3,659	3,692	2,947	2,650	2,821	4,207	4,247	3,389	3,047
93	2,497	3,754	3,788	3,025	2,725	2,871	4,317	4,357	3,480	3,135
94	2,542	3,851	3,887	3,106	2,803	2,923	4,429	4,470	3,572	3,223
95	2,588	3,951	3,987	3,188	2,882	2,976	4,543	4,585	3,666	3,314
96	2,632	4,018	4,055	3,242	2,930	3,026	4,621	4,663	3,729	3,370
97	2,677	4,087	4,124	3,297	2,981	3,078	4,699	4,742	3,792	3,428
98	2,722	4,156	4,194	3,354	3,031	3,130	4,779	4,822	3,856	3,486
99	2,768	4,227	4,265	3,411	3,083	3,184	4,860	4,905	3,922	3,545

Premium payable other than annual will be determined according to the following factors:

Semi Annual	Quarterly	Monthly
1/2	1/4	1/12

There is a one time $25.00 policy fee.
A discount factor of .93 is applied for household discount applicants

PREMIUM INFORMATION

Western United Life Assurance Company may change your premium if a new table of rates is applicable to the policy. The change in the table of rates will apply to all covered persons in the same class on the date of change. Class is defined as attained age, underwriting class, and state of residence.

Premiums are based on your attained age, and household discount for qualified household discount applicants, and will change on Your Policy Anniversary Date.

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 Western United Life Assurance Company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to our Medicare Supplement Administrative Office at P. O. Box 924408, Houston, Texas 77292-4408. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs. Neither Western United Life Assurance 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.

LIMITATIONS AND EXCLUSIONS

We will not pay benefits for:

(a) expense incurred while this Policy is not in force, except as provided in the Extension of Benefits section;

(b) We will not pay benefits for hospital or skilled nursing facility charges incurred while this policy is not in force.

(c) that portion of any expense incurred which is paid for by Medicare;

(d) services for non-Medicare Eligible Expenses, including, but not limited to, routine exams, take home drugs and eye refractions;

(e) services for which a charge is not normally made in the absence of insurance; or

(f) loss or expense that is payable under any other Medicare Supplement Insurance Policy or certificate.

REFUND OF PREMIUMS

The Policy does contain a Pro-Rata Refund provision which provides for the refund of that part of any premium You have paid which covers the period after the death occurs.

The Policy does contain a Cancellation By Insured provision which provides for a pro-rata refund of any premium paid beyond the date of cancellation of the Policy.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

Please refer to your policy for details.

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 $1316	$0	$1316 (Part A deductible)
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $658 a day	$658 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 $164.50 a day	$0	Up to $164.50 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 co-payment/coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ 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 for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

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

*Once you have been billed $183 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 $183 of Medicare Approved Amounts*	$0	$0	$183 (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 $183 of Medicare Approved Amounts*	$0	$0	$183 (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 $183 of Medicare Approved Amounts*	$0	$0	$183 (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 $1316	$1316 (Part A deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $658 a day	$658 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 $164.50 a day	Up to $164.50 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 co-payment/coinsurance for outpatient drugs and inpatient respite care.	Medicare co-payment/ 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 for 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 $183 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 $183 of Medicare Approved Amounts*	$0	$183 (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 $183 of Medicare Approved Amounts*	$0	$183 (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 $183 of Medicare Approved Amounts*	$0	$183 (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 F

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but $1316	$1316 (Part A deductible)	$0
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $658 a day	$658 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 $164.50 a day	Up to $164.50 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 co-payment/coinsurance for outpatient drugs and inpatient respite care.	Medicare co-payment/ 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 for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F

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

*Once you have been billed $183 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 $183 of Medicare Approved Amounts*	$0	$183 (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 $183 of Medicare Approved amounts*	$0	$183 (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

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 $183 of Medicare Approved Amounts*	$0	$183 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER SERVICES – 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 G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but $1316	$1316 (Part A deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $658 a day	$658 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 $164.50 a day	Up to $164.50 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 co-payment/coinsurance for outpatient drugs and inpatient respite care.	Medicare co-payment/ 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 for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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

*Once you have been billed $183 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 $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B deductible)
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 $183 of Medicare Approved Amounts*	$0	$0	$183 (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 $183 of Medicare Approved Amounts*	$0	$0	$183 (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 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 $1316	$1316 (Part A deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $658 a day	$658 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 $164.50 a day	Up to $164.50 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 co-payment/coinsurance for outpatient drugs and inpatient respite care.	Medicare co-payment/ 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 for 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 $183 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 $183 of Medicare Approved Amounts*	$0	$0	$183 (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 co-payment 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 co-payment 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 $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First $183 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 $183 (Part B deductible) $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 Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000.	 $250 20% and amounts over the $50,000 lifetime maximum.