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

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

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. Western United Life Assurance Company offers five of the twelve plans available.

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	G[1]	K	L	M	N	C	F	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 2020[2]						$5,560[2]	$2,780[2]					

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of $2,300 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.

WESTERN UNITED LIFE ASSURANCE COMPANY
ANNUAL PREFERRED 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	6,131	N/A	N/A	N/A	N/A	7,050	N/A	N/A	N/A	N/A
65	1,461	1,913	1,897	1,408	1,212	1,680	2,200	2,182	1,618	1,393
66	1,461	1,913	1,897	1,408	1,212	1,680	2,200	2,182	1,618	1,393
67	1,461	1,913	1,897	1,408	1,212	1,680	2,200	2,182	1,618	1,393
68	1,512	1,974	1,957	1,460	1,256	1,739	2,269	2,250	1,679	1,444
69	1,562	2,036	2,019	1,513	1,299	1,796	2,340	2,322	1,740	1,494
70	1,614	2,097	2,080	1,566	1,344	1,855	2,412	2,392	1,801	1,546
71	1,655	2,157	2,138	1,615	1,387	1,904	2,480	2,459	1,857	1,595
72	1,700	2,220	2,201	1,668	1,433	1,955	2,553	2,532	1,918	1,649
73	1,744	2,282	2,263	1,721	1,479	2,007	2,624	2,602	1,980	1,701
74	1,794	2,352	2,331	1,780	1,530	2,063	2,705	2,682	2,046	1,760
75	1,852	2,431	2,410	1,845	1,587	2,128	2,795	2,772	2,121	1,825
76	1,898	2,508	2,487	1,908	1,643	2,183	2,885	2,860	2,195	1,890
77	1,946	2,587	2,566	1,972	1,701	2,238	2,977	2,952	2,268	1,956
78	1,995	2,669	2,647	2,037	1,761	2,293	3,069	3,044	2,343	2,024
79	2,049	2,757	2,733	2,108	1,824	2,355	3,170	3,144	2,424	2,098
80	2,103	2,848	2,823	2,181	1,889	2,418	3,274	3,247	2,508	2,174
81	2,155	2,945	2,920	2,259	1,962	2,479	3,386	3,357	2,598	2,256
82	2,209	3,044	3,018	2,338	2,037	2,540	3,501	3,470	2,690	2,343
83	2,265	3,150	3,123	2,423	2,116	2,605	3,623	3,591	2,787	2,433
84	2,323	3,257	3,229	2,511	2,197	2,671	3,746	3,713	2,886	2,525
85	2,384	3,372	3,342	2,601	2,282	2,743	3,878	3,843	2,991	2,623
86	2,440	3,477	3,446	2,685	2,358	2,806	3,998	3,963	3,088	2,712
87	2,496	3,585	3,552	2,771	2,439	2,871	4,122	4,087	3,187	2,805
88	2,555	3,696	3,662	2,859	2,521	2,938	4,249	4,212	3,288	2,900
89	2,615	3,809	3,775	2,949	2,606	3,005	4,380	4,341	3,393	2,997
90	2,674	3,926	3,890	3,043	2,691	3,075	4,515	4,474	3,499	3,095
91	2,725	4,032	3,996	3,127	2,772	3,133	4,638	4,595	3,596	3,188
92	2,774	4,137	4,099	3,211	2,852	3,190	4,759	4,715	3,692	3,278
93	2,825	4,245	4,206	3,297	2,933	3,248	4,883	4,836	3,791	3,373
94	2,875	4,356	4,316	3,383	3,015	3,306	5,009	4,962	3,890	3,468
95	2,926	4,468	4,427	3,473	3,100	3,366	5,139	5,090	3,994	3,566
96	2,977	4,543	4,501	3,532	3,153	3,423	5,226	5,178	4,061	3,626
97	3,027	4,621	4,578	3,592	3,207	3,482	5,315	5,265	4,131	3,688
98	3,079	4,701	4,656	3,654	3,261	3,540	5,405	5,355	4,202	3,750
99	3,131	4,780	4,734	3,716	3,317	3,600	5,497	5,445	4,274	3,815

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	7,050	N/A	N/A	N/A	N/A	8,108	N/A	N/A	N/A	N/A
65	1,680	2,200	2,182	1,618	1,393	1,932	2,531	2,508	1,861	1,602
66	1,680	2,200	2,182	1,618	1,393	1,932	2,531	2,508	1,861	1,602
67	1,680	2,200	2,182	1,618	1,393	1,932	2,531	2,508	1,861	1,602
68	1,739	2,269	2,250	1,679	1,444	1,999	2,610	2,588	1,931	1,660
69	1,796	2,340	2,322	1,740	1,494	2,065	2,692	2,669	2,001	1,718
70	1,855	2,412	2,392	1,801	1,546	2,135	2,773	2,750	2,071	1,777
71	1,904	2,480	2,459	1,857	1,595	2,189	2,852	2,828	2,137	1,834
72	1,955	2,553	2,532	1,918	1,649	2,248	2,935	2,911	2,206	1,895
73	2,007	2,624	2,602	1,980	1,701	2,307	3,018	2,993	2,276	1,956
74	2,063	2,705	2,682	2,046	1,760	2,373	3,110	3,084	2,353	2,023
75	2,128	2,795	2,772	2,121	1,825	2,449	3,215	3,188	2,440	2,098
76	2,183	2,885	2,860	2,195	1,890	2,511	3,318	3,290	2,522	2,174
77	2,238	2,977	2,952	2,268	1,956	2,574	3,423	3,394	2,607	2,249
78	2,293	3,069	3,044	2,343	2,024	2,638	3,530	3,500	2,694	2,328
79	2,355	3,170	3,144	2,424	2,098	2,709	3,647	3,615	2,788	2,413
80	2,418	3,274	3,247	2,508	2,174	2,781	3,765	3,734	2,884	2,499
81	2,479	3,386	3,357	2,598	2,256	2,850	3,893	3,862	2,988	2,595
82	2,540	3,501	3,470	2,690	2,343	2,921	4,027	3,992	3,093	2,694
83	2,605	3,623	3,591	2,787	2,433	2,996	4,166	4,129	3,205	2,797
84	2,671	3,746	3,713	2,886	2,525	3,072	4,308	4,270	3,320	2,904
85	2,743	3,878	3,843	2,991	2,623	3,153	4,459	4,419	3,440	3,016
86	2,806	3,998	3,963	3,088	2,712	3,227	4,599	4,557	3,551	3,120
87	2,871	4,122	4,087	3,187	2,805	3,302	4,741	4,699	3,665	3,226
88	2,938	4,249	4,212	3,288	2,900	3,379	4,887	4,844	3,780	3,334
89	3,005	4,380	4,341	3,393	2,997	3,457	5,038	4,993	3,901	3,445
90	3,075	4,515	4,474	3,499	3,095	3,536	5,191	5,145	4,023	3,561
91	3,133	4,638	4,595	3,596	3,188	3,604	5,333	5,285	4,136	3,667
92	3,190	4,759	4,715	3,692	3,278	3,670	5,472	5,422	4,246	3,771
93	3,248	4,883	4,836	3,791	3,373	3,735	5,615	5,563	4,360	3,879
94	3,306	5,009	4,962	3,890	3,468	3,802	5,760	5,707	4,475	3,989
95	3,366	5,139	5,090	3,994	3,566	3,870	5,909	5,854	4,593	4,100
96	3,423	5,226	5,178	4,061	3,626	3,936	6,010	5,954	4,671	4,171
97	3,482	5,315	5,265	4,131	3,688	4,004	6,112	6,054	4,750	4,241
98	3,540	5,405	5,355	4,202	3,750	4,071	6,216	6,157	4,831	4,313
99	3,600	5,497	5,445	4,274	3,815	4,141	6,321	6,262	4,914	4,386

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 Plan A	Female Plan C	Female Plan F	Female Plan G	Female Plan N	Male Plan A	Male Plan C	Male Plan F	Male Plan G	Male Plan N
0-64	5,547	N/A	N/A	N/A	N/A	6,378	N/A	N/A	N/A	N/A
65	1,321	1,731	1,717	1,274	1,096	1,520	1,990	1,974	1,464	1,261
66	1,321	1,731	1,717	1,274	1,096	1,520	1,990	1,974	1,464	1,261
67	1,321	1,731	1,717	1,274	1,096	1,520	1,990	1,974	1,464	1,261
68	1,368	1,786	1,771	1,321	1,136	1,573	2,053	2,036	1,519	1,306
69	1,414	1,842	1,827	1,369	1,175	1,625	2,118	2,100	1,574	1,352
70	1,460	1,897	1,882	1,416	1,216	1,679	2,182	2,164	1,629	1,398
71	1,497	1,951	1,934	1,461	1,255	1,722	2,244	2,225	1,681	1,443
72	1,538	2,008	1,991	1,510	1,297	1,769	2,309	2,290	1,736	1,492
73	1,578	2,064	2,047	1,557	1,339	1,815	2,374	2,354	1,792	1,539
74	1,624	2,128	2,109	1,610	1,384	1,867	2,447	2,426	1,852	1,592
75	1,676	2,199	2,180	1,669	1,435	1,926	2,529	2,508	1,919	1,651
76	1,718	2,270	2,251	1,726	1,487	1,975	2,611	2,588	1,986	1,710
77	1,760	2,341	2,322	1,784	1,539	2,024	2,693	2,670	2,052	1,770
78	1,805	2,415	2,395	1,843	1,593	2,075	2,777	2,754	2,119	1,832
79	1,853	2,495	2,473	1,908	1,650	2,131	2,868	2,844	2,194	1,898
80	1,903	2,576	2,555	1,973	1,709	2,188	2,962	2,937	2,270	1,967
81	1,949	2,665	2,642	2,043	1,776	2,243	3,064	3,037	2,350	2,042
82	1,999	2,754	2,730	2,116	1,843	2,298	3,167	3,140	2,434	2,119
83	2,049	2,850	2,825	2,193	1,914	2,357	3,278	3,249	2,521	2,201
84	2,101	2,947	2,921	2,271	1,987	2,417	3,390	3,359	2,612	2,285
85	2,157	3,050	3,024	2,353	2,064	2,481	3,508	3,477	2,707	2,373
86	2,208	3,145	3,118	2,429	2,134	2,538	3,618	3,585	2,794	2,454
87	2,258	3,243	3,214	2,507	2,207	2,597	3,730	3,697	2,883	2,537
88	2,311	3,344	3,314	2,587	2,281	2,658	3,845	3,810	2,974	2,624
89	2,366	3,447	3,415	2,669	2,358	2,719	3,962	3,927	3,069	2,711
90	2,420	3,552	3,520	2,753	2,435	2,783	4,085	4,048	3,165	2,801
91	2,465	3,648	3,616	2,829	2,508	2,835	4,196	4,157	3,254	2,884
92	2,510	3,743	3,709	2,905	2,580	2,886	4,305	4,266	3,340	2,966
93	2,556	3,841	3,806	2,983	2,653	2,938	4,418	4,376	3,430	3,051
94	2,601	3,942	3,905	3,061	2,727	2,992	4,532	4,490	3,520	3,138
95	2,648	4,042	4,005	3,143	2,804	3,046	4,649	4,606	3,614	3,226
96	2,693	4,111	4,073	3,196	2,853	3,097	4,728	4,684	3,675	3,280
97	2,739	4,181	4,142	3,250	2,901	3,150	4,809	4,763	3,737	3,336
98	2,785	4,253	4,212	3,306	2,951	3,202	4,891	4,845	3,802	3,392
99	2,833	4,324	4,284	3,362	3,001	3,258	4,973	4,927	3,867	3,451

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	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	6,378	N/A	N/A	N/A	N/A	7,336	N/A	N/A	N/A	N/A
65	1,520	1,990	1,974	1,464	1,261	1,748	2,290	2,270	1,683	1,450
66	1,520	1,990	1,974	1,464	1,261	1,748	2,290	2,270	1,683	1,450
67	1,520	1,990	1,974	1,464	1,261	1,748	2,290	2,270	1,683	1,450
68	1,573	2,053	2,036	1,519	1,306	1,809	2,362	2,342	1,747	1,502
69	1,625	2,118	2,100	1,574	1,352	1,869	2,436	2,415	1,811	1,554
70	1,679	2,182	2,164	1,629	1,398	1,931	2,509	2,488	1,873	1,607
71	1,722	2,244	2,225	1,681	1,443	1,981	2,580	2,558	1,933	1,660
72	1,769	2,309	2,290	1,736	1,492	2,034	2,655	2,633	1,996	1,715
73	1,815	2,374	2,354	1,792	1,539	2,087	2,730	2,708	2,060	1,770
74	1,867	2,447	2,426	1,852	1,592	2,147	2,814	2,790	2,129	1,831
75	1,926	2,529	2,508	1,919	1,651	2,215	2,909	2,884	2,208	1,898
76	1,975	2,611	2,588	1,986	1,710	2,271	3,002	2,976	2,282	1,967
77	2,024	2,693	2,670	2,052	1,770	2,328	3,097	3,070	2,359	2,035
78	2,075	2,777	2,754	2,119	1,832	2,386	3,194	3,166	2,438	2,106
79	2,131	2,868	2,844	2,194	1,898	2,451	3,299	3,271	2,522	2,183
80	2,188	2,962	2,937	2,270	1,967	2,517	3,407	3,378	2,610	2,261
81	2,243	3,064	3,037	2,350	2,042	2,578	3,523	3,494	2,704	2,347
82	2,298	3,167	3,140	2,434	2,119	2,643	3,643	3,612	2,799	2,438
83	2,357	3,278	3,249	2,521	2,201	2,710	3,770	3,735	2,899	2,531
84	2,417	3,390	3,359	2,612	2,285	2,780	3,898	3,864	3,004	2,628
85	2,481	3,508	3,477	2,707	2,373	2,853	4,035	3,999	3,112	2,728
86	2,538	3,618	3,585	2,794	2,454	2,919	4,161	4,123	3,213	2,822
87	2,597	3,730	3,697	2,883	2,537	2,988	4,289	4,251	3,316	2,918
88	2,658	3,845	3,810	2,974	2,624	3,057	4,421	4,382	3,420	3,016
89	2,719	3,962	3,927	3,069	2,711	3,127	4,558	4,517	3,529	3,117
90	2,783	4,085	4,048	3,165	2,801	3,200	4,697	4,655	3,639	3,221
91	2,835	4,196	4,157	3,254	2,884	3,260	4,825	4,781	3,742	3,317
92	2,886	4,305	4,266	3,340	2,966	3,320	4,950	4,906	3,842	3,411
93	2,938	4,418	4,376	3,430	3,051	3,379	5,081	5,033	3,944	3,509
94	2,992	4,532	4,490	3,520	3,138	3,440	5,212	5,163	4,049	3,609
95	3,046	4,649	4,606	3,614	3,226	3,502	5,347	5,296	4,155	3,710
96	3,097	4,728	4,684	3,675	3,280	3,562	5,438	5,387	4,227	3,773
97	3,150	4,809	4,763	3,737	3,336	3,622	5,530	5,478	4,298	3,837
98	3,202	4,891	4,845	3,802	3,392	3,683	5,624	5,571	4,371	3,903
99	3,258	4,973	4,927	3,867	3,451	3,747	5,719	5,666	4,446	3,968

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	5,138	N/A	N/A	N/A	N/A	5,908	N/A	N/A	N/A	N/A
65	1,224	1,603	1,590	1,180	1,016	1,408	1,844	1,829	1,356	1,168
66	1,224	1,603	1,590	1,180	1,016	1,408	1,844	1,829	1,356	1,168
67	1,224	1,603	1,590	1,180	1,016	1,408	1,844	1,829	1,356	1,168
68	1,267	1,654	1,640	1,223	1,052	1,457	1,902	1,886	1,407	1,210
69	1,309	1,706	1,692	1,268	1,089	1,505	1,962	1,946	1,458	1,252
70	1,353	1,757	1,743	1,312	1,126	1,555	2,021	2,005	1,509	1,295
71	1,387	1,808	1,792	1,353	1,162	1,595	2,079	2,061	1,557	1,337
72	1,425	1,860	1,844	1,398	1,201	1,639	2,139	2,122	1,608	1,382
73	1,462	1,912	1,896	1,442	1,240	1,682	2,199	2,181	1,660	1,426
74	1,504	1,971	1,954	1,492	1,282	1,729	2,267	2,248	1,715	1,475
75	1,552	2,037	2,020	1,546	1,330	1,784	2,343	2,323	1,778	1,529
76	1,591	2,102	2,085	1,599	1,377	1,830	2,418	2,397	1,839	1,584
77	1,631	2,168	2,151	1,653	1,426	1,875	2,495	2,474	1,901	1,639
78	1,672	2,237	2,218	1,707	1,476	1,922	2,572	2,551	1,963	1,697
79	1,717	2,311	2,291	1,767	1,529	1,974	2,657	2,635	2,032	1,758
80	1,763	2,387	2,366	1,828	1,583	2,027	2,744	2,721	2,102	1,822
81	1,806	2,468	2,447	1,893	1,645	2,078	2,838	2,813	2,177	1,891
82	1,852	2,551	2,529	1,960	1,707	2,129	2,934	2,908	2,255	1,963
83	1,898	2,640	2,617	2,031	1,773	2,183	3,036	3,010	2,336	2,039
84	1,947	2,730	2,706	2,104	1,841	2,239	3,140	3,112	2,419	2,116
85	1,998	2,826	2,801	2,180	1,912	2,299	3,250	3,221	2,507	2,198
86	2,045	2,914	2,888	2,250	1,976	2,351	3,351	3,321	2,588	2,273
87	2,092	3,004	2,977	2,322	2,044	2,406	3,455	3,425	2,671	2,350
88	2,141	3,098	3,069	2,396	2,113	2,462	3,561	3,530	2,755	2,431
89	2,191	3,193	3,164	2,472	2,184	2,519	3,670	3,638	2,843	2,512
90	2,241	3,290	3,260	2,550	2,255	2,578	3,784	3,750	2,932	2,594
91	2,284	3,379	3,349	2,621	2,323	2,626	3,887	3,851	3,014	2,672
92	2,325	3,467	3,436	2,691	2,390	2,673	3,988	3,951	3,094	2,747
93	2,367	3,558	3,525	2,763	2,458	2,722	4,092	4,053	3,177	2,827
94	2,409	3,651	3,617	2,835	2,526	2,771	4,198	4,159	3,260	2,907
95	2,453	3,744	3,710	2,911	2,598	2,821	4,307	4,266	3,348	2,988
96	2,495	3,808	3,773	2,960	2,643	2,869	4,380	4,339	3,404	3,039
97	2,537	3,873	3,837	3,010	2,688	2,918	4,455	4,412	3,462	3,091
98	2,580	3,940	3,902	3,062	2,733	2,966	4,530	4,488	3,522	3,142
99	2,624	4,006	3,968	3,114	2,780	3,018	4,607	4,564	3,582	3,197

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 Plan A	Female Plan C	Female Plan F	Female Plan G	Female Plan N	Male Plan A	Male Plan C	Male Plan F	Male Plan G	Male Plan N
0-64	5,908	N/A	N/A	N/A	N/A	6,795	N/A	N/A	N/A	N/A
65	1,408	1,844	1,829	1,356	1,168	1,619	2,121	2,102	1,559	1,343
66	1,408	1,844	1,829	1,356	1,168	1,619	2,121	2,102	1,559	1,343
67	1,408	1,844	1,829	1,356	1,168	1,619	2,121	2,102	1,559	1,343
68	1,457	1,902	1,886	1,407	1,210	1,676	2,188	2,169	1,618	1,391
69	1,505	1,962	1,946	1,458	1,252	1,731	2,256	2,237	1,677	1,440
70	1,555	2,021	2,005	1,509	1,295	1,789	2,324	2,305	1,735	1,489
71	1,595	2,079	2,061	1,557	1,337	1,835	2,390	2,370	1,791	1,537
72	1,639	2,139	2,122	1,608	1,382	1,884	2,460	2,439	1,849	1,588
73	1,682	2,199	2,181	1,660	1,426	1,933	2,529	2,508	1,908	1,639
74	1,729	2,267	2,248	1,715	1,475	1,989	2,607	2,585	1,972	1,696
75	1,784	2,343	2,323	1,778	1,529	2,052	2,695	2,672	2,045	1,758
76	1,830	2,418	2,397	1,839	1,584	2,104	2,781	2,757	2,114	1,822
77	1,875	2,495	2,474	1,901	1,639	2,157	2,869	2,844	2,185	1,885
78	1,922	2,572	2,551	1,963	1,697	2,211	2,959	2,933	2,258	1,951
79	1,974	2,657	2,635	2,032	1,758	2,270	3,056	3,030	2,336	2,022
80	2,027	2,744	2,721	2,102	1,822	2,331	3,156	3,129	2,417	2,094
81	2,078	2,838	2,813	2,177	1,891	2,388	3,263	3,237	2,504	2,174
82	2,129	2,934	2,908	2,255	1,963	2,448	3,375	3,346	2,592	2,258
83	2,183	3,036	3,010	2,336	2,039	2,511	3,492	3,460	2,686	2,344
84	2,239	3,140	3,112	2,419	2,116	2,575	3,611	3,579	2,783	2,434
85	2,299	3,250	3,221	2,507	2,198	2,643	3,737	3,704	2,883	2,527
86	2,351	3,351	3,321	2,588	2,273	2,704	3,854	3,819	2,976	2,614
87	2,406	3,455	3,425	2,671	2,350	2,768	3,973	3,938	3,071	2,703
88	2,462	3,561	3,530	2,755	2,431	2,832	4,096	4,059	3,168	2,794
89	2,519	3,670	3,638	2,843	2,512	2,897	4,222	4,184	3,269	2,887
90	2,578	3,784	3,750	2,932	2,594	2,964	4,351	4,312	3,371	2,984
91	2,626	3,887	3,851	3,014	2,672	3,020	4,470	4,429	3,466	3,073
92	2,673	3,988	3,951	3,094	2,747	3,076	4,586	4,544	3,559	3,160
93	2,722	4,092	4,053	3,177	2,827	3,130	4,706	4,662	3,654	3,251
94	2,771	4,198	4,159	3,260	2,907	3,186	4,828	4,783	3,751	3,343
95	2,821	4,307	4,266	3,348	2,988	3,244	4,953	4,906	3,849	3,436
96	2,869	4,380	4,339	3,404	3,039	3,299	5,037	4,990	3,915	3,495
97	2,918	4,455	4,412	3,462	3,091	3,355	5,122	5,074	3,981	3,554
98	2,966	4,530	4,488	3,522	3,142	3,412	5,210	5,160	4,049	3,615
99	3,018	4,607	4,564	3,582	3,197	3,471	5,298	5,248	4,118	3,676

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 onetime $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. Western United Life Assurance Company will not change premium rates for a Medicare supplement policy, unless the rates, rating schedule, and supporting documentation have been approved by the Commissioner of the Texas Department Insurance.

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

DISCOSURES

Use this outline to compare benefits 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.

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 $1364	$0	$1364 (Part A deductible)
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	$0	Up to $170.50 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 $185 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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 $1364	$1364 (Part A deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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 $185 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 $185 of Medicare Approved Amounts*	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$185 (Part B deductible)	$0
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

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 $1364	$1364 (Part A deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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 $185 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 $185 of Medicare Approved Amounts*	$0	$185 (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 $185 of Medicare Approved amounts*	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$185 (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 $1364	$1364 (Part A deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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 $185 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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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	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 $185 of Medicare Approved Amounts*	$0	$0	$185 (Unless Part B deductible has been met)
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 $1364	$1364 (Part A deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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 $185 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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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	100%	$0	$0
— Durable medical equipment First $185 of Medicare Approved Amounts*	$0	$0	$185 (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.