

California

Medicare Supplement Life Application Booklet

Insurance Policy:
L030CA-Plan A
L035CA-Plan F
L036CA-Plan G
L039CA-Plan N



**Physicians
Mutual**[®]

Insurance for all of us.™

Physicians Life Insurance Company
Underwriting Services
2600 Dodge Street
Omaha, NE 68131-2671
1.800.228.9100

Medicare Supplement Required Forms

Completed	Does Not Apply		
<input type="checkbox"/>		PM2472—CA-0821	Medicare Supplement Checklist Home Office Copy
		M-NB-0225-AA-0719B	Application Turn in Process Order of Forms Medicare Supplement
<input type="checkbox"/>		PM2383-1	Guide to Open Enrollment and Guarantee Issue for (Rev. 0122) California Applicant's Copy
<input type="checkbox"/>		LA030-CA	Application for Medicare Supplement Home Office Copy
<input type="checkbox"/>		PM2466-0721	Acknowledgment Home Office Copy
<input type="checkbox"/>		PM2470	Agent's Statement..... Home Office Copy
<input type="checkbox"/>	<input type="checkbox"/>	PM1902A-1010	Business Owner Waiver Home Office Copy
<input type="checkbox"/>	<input type="checkbox"/>	PM2469-0719	Additional Information Regarding Current or Pending Coverage Home Office Copy
<input type="checkbox"/>	<input type="checkbox"/>	PM2471-0120	Telephone Interview for Underwritten Applications..... Home Office Copy
<input type="checkbox"/>		PM2467-0719	Third Party Designee..... Home Office Copy
<input type="checkbox"/>		PM2364	Notice of Oral Interpretation Services..... Applicant's Copy
<input type="checkbox"/>	<input type="checkbox"/>	PM2448-1-0817	Authorization for Automatic Bank Withdrawal Home Office Copy
			Home Office Copy
<input type="checkbox"/>		ALL645-0719C.....	HIPAA Authorization for Underwriting Purposes Applicant's Copy
<input type="checkbox"/>		ALL631-01/07-0414	Notice of Information Practices Under State Law..... Applicant's Copy
<input type="checkbox"/>		PM2112-0719	Receipt for Medicare Supplement Policy Applicant's Copy
<input type="checkbox"/>	<input type="checkbox"/>	PM2441-0719.....	Telephone Interview Applicant's Copy
			Home Office Copy
<input type="checkbox"/>	<input type="checkbox"/>	PM2035CA-0119	Notice to Applicant Regarding Replacement Applicant's Copy
<input type="checkbox"/>	<input type="checkbox"/>	PM2434-0719.....	Proof of Medicare Eligibility Home Office Copy
<input type="checkbox"/>		C030-CA-0122	Outline of Coverage Cover Page..... Applicant's Copy
<input type="checkbox"/>		OC030-UNI2	Plan A Outline of Coverage (Rev. 2022) ** (to be used with Policy L030CA)** Applicant's Copy



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Completed Does Not Apply

- OC035-UNI2 Plan F Outline of Coverage
(Rev. 2022) **** (to be used with Policy L035CA) **** Applicant's Copy
- OC036-UNI2 Plan G Outline of Coverage
(Rev. 2022) **** (to be used with Policy L036CA) **** Applicant's Copy
- OC039-UNI2 Plan N Outline of Coverage
(Rev. 2022) **** (to be used with Policy L039CA) **** Applicant's Copy
- Electronic Quote Summary Page (Must be submitted with
application) Home Office Copy

Medicare Supplement Checklist

Agents: Please use the following checklist and include with the application.

Application Information

- | Completed | Does Not Apply | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | | Is the applicant's information complete (name, address, age, date of birth, gender, height/weight, phone number)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Did you indicate the applicant's Medicare Number? |
| <input type="checkbox"/> | | Does the customer's check match the quote? |
| <input type="checkbox"/> | | Does the mode selected on the application match the quote? |
| <input type="checkbox"/> | <input type="checkbox"/> | If automatic bank withdrawal, is the Automatic Bank Withdrawal form complete and a voided check included? |
| <input type="checkbox"/> | <input type="checkbox"/> | If paying with business check, is Business Owner Waiver form complete? |

Coverage

- Is the appropriate Plan selected, based on when the applicant was first eligible for Medicare?
- Is the Rate structure (Attained vs. Issue Age) selected?

Health and Coverage Questions

- Are all questions answered?
- Are questions 7, 8 or 9 complete for replacements of a MA, group or other Medicare Supplement insurance?
- Did you include effective dates?
- Did you include previous coverage details?
- Did you complete the "End Date" for the other coverage?

Proof of Eligibility

- Did you include proof of Medicare Part B Eligibility or proof of Medicare Eligibility form PM2434
Note: This is not a requirement on first time open enrollment between age 64 ½ and 65 ½.
- Did you include proof that Medicare Advantage (MA) or group insurance is terminating for apps requesting guaranteed issue?
Note: Underwriting will accept a copy of the letter they sent to the MA or group insurance carrier requesting cancellation. However, proof of cancellation from MA or other carrier will be required at policy delivery.

Miscellaneous

- Did you include a copy of the Electronic Quote Summary Page?
- Did you complete an Agent Turn-in ALL-10?
- Did you include a copy of the Lead Detail sheet from Salesforce?

Application Turn in Process Order of Forms Medicare Supplement

Agents: If applicable, turn in the appropriate forms in the order listed below.

1. DO INFO
Sales Force Lead Detail Sheet (If Applicable)
2. Special Handling Information
3. Application for Medicare Supplement
4. Authorization for Automatic Bank Withdrawal
5. HIPAA Authorization for Underwriting Purposes
6. Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage
7. Proof of Medicare Eligibility (All Documents)
Disenrollment
8. Employee Discount Form
9. Third Party Designee
10. Application Checklist
Assignment of Commission Form
Acknowledgement
Agent Statement
Business Owner Waiver
Additional Information Regarding Current or Pending Coverage
Telephone Interview
11. Quote
12. Emails

GUIDE TO OPEN ENROLLMENT AND GUARANTEE ISSUE FOR CALIFORNIA

This guide provides specific requirements for Open Enrollment and Guarantee Issue of Medicare Supplement policies to be issued regardless of health history or medical conditions. The following requirements are based on California Insurance Code sections 10192.11 and 10192.12.

Open Enrollment

The issuance of a Medicare Supplement policy shall not be denied based on health status or medical conditions when any of the following requirements are met:

- The application is submitted prior to or during the six-month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B.
- An individual enrolled in Medicare by reason of disability shall be entitled to open enrollment for six months after the date of his or her enrollment in Medicare Part B, or if notified retroactively of his or her eligibility for Medicare, for six months following notice of eligibility.
- An individual enrolled in Medicare Part B is entitled to open enrollment for six months following:
 - Receipt of a notice of termination or, if no notice is received, the effective date of termination from any employer-sponsored health plan including an employer-sponsored retiree health plan*.
 - Receipt of a notice of loss of eligibility due to the divorce or death of a spouse or, if no notice is received, the effective date of loss of eligibility due to the divorce or death of a spouse, from any employer-sponsored health plan including an employer-sponsored retiree health plan*.

*employer-sponsored retiree health plan” includes any coverage for medical expenses, including, but not limited to, coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and the California Continuation Benefits Replacement Act (Cal-COBRA), that is directly or indirectly sponsored or established by an employer for employees or retirees, their spouses, dependents, or other included insureds.

 - Termination of health care services for a military retiree or the retiree's Medicare eligible spouse or dependent as a result of a military base closure or loss of access to health care services because the base no longer offers services or because the individual relocates.
- An individual enrolled in Medicare Part B is entitled to open enrollment if the individual was covered under a policy, certificate, or contract providing Medicare supplement coverage but that coverage terminated because the individual established residence at a location not served by the plan.
- An individual whose coverage was terminated by a Medicare Advantage plan shall be entitled to an additional 60-day open enrollment period to be added on to and run consecutively after any open enrollment period authorized by federal law or regulation, for any Medicare supplement coverage provided by Medicare supplement issuers and available on a guaranteed basis under state and federal law or regulation for persons terminated by their Medicare Advantage plan.
- An individual is entitled to an annual open enrollment period lasting 60 days, commencing with the individual's birthday, during which time that person may purchase any Medicare supplement policy that offers benefits equal to or lesser than those provided by the previous coverage.

- An individual enrolled in Medicare Part B is entitled to open enrollment upon being notified that, because of an increase in the individual's income or assets, he or she meets one of the following requirements:
 - He or she is no longer eligible for Medi-Cal benefits.
 - He or she is only eligible for Medi-Cal benefits with a share of cost and certifies at the time of application that he or she has not met the share of cost.

Guaranteed Issue

Individuals in the following situations are entitled to guarantee issue rights of Medicare Supplement and are not subject to a review of health history or medical conditions, provided they meet the requirements below and provide proof or documentation to demonstrate that requirements are met.

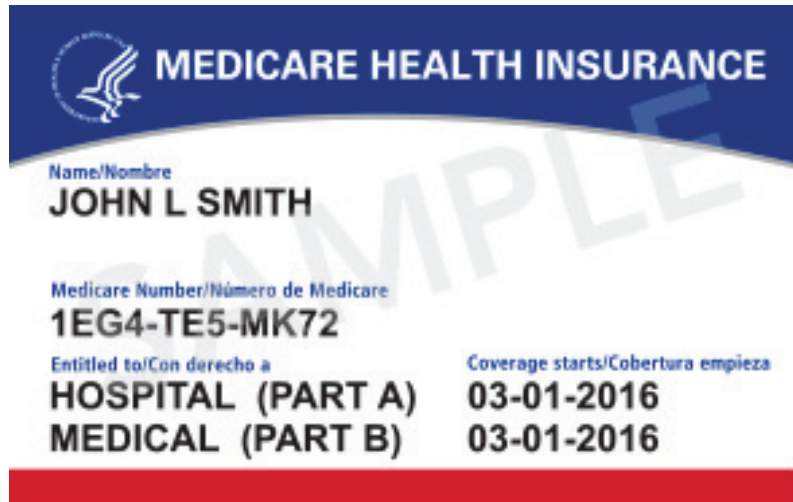
Guarantee Issue Situations

- **Termination of coverage under a group-sponsored health plan:** If you are receiving health care coverage through your or your spouse's group employer and the plan either terminates or ceases to provide all supplemental health benefits, you are entitled to a 63 day guaranteed issue period beginning on the date of termination, or notification of termination if later. You must provide proof of termination with your application.
- **Medicare Advantage (MA), PACE, Medicare Cost contract, a similar Medicare Risk Demonstration project, Medicare Select plan, or health care prepayment plan coverage ends due to the Plan termination or discontinuance in the area you reside:** Your guaranteed issue period begins upon notification of termination and ends 63 days after the date of termination, and you may select a Medicare Supplement plan from any company. If you have relocated to an area where the MA plan does not provide coverage, you are entitled to a guaranteed issue period beginning 60 days prior to your termination, and ending 63 days after your termination. You must provide documentation of termination with your application.
- **Upon becoming eligible for Medicare benefits at age 65, you enrolled in a MA plan or PACE and then disenrolled within 12 months:** You are entitled to a guaranteed issue period beginning 60 days prior to your disenrollment and ending 63 days after your disenrollment. You must provide proof of prior insurance with your application.
- **Disenroll from a Medicare Select plan, PACE, MA plan, or Medicare Cost contract within 1 year of leaving a Medicare Supplement policy for the first time:** You are entitled to a guaranteed issue period beginning 60 days prior to your disenrollment and ending 63 days after your disenrollment. This must be your first time enrolled in a Select, PACE, or MA plan. You must provide proof of prior insurance with your application.
- **Leave your plan (any plan listed above as well as any Medicare Supplement plan) as a result of fraud committed by the plan or a substantial violation of a material policy provision:** You are entitled to a guaranteed issue period beginning 60 days prior to your disenrollment/termination and ending 63 days after your disenrollment/termination. This same guaranteed issue period would apply in the case of any involuntary termination of an existing Medicare Supplement policy. You must provide proof of prior coverage and provide a determination letter stating that the plan was at fault with your application.
- **Your MA plan reduces benefits, increases the cost sharing amount, or discontinues a provider currently furnishing services to you, for other than good cause:** If any one of these events occur you are entitled to guaranteed issue of a Medicare Supplement plan from the same issuer (or by a subsidiary of the parent company of the issuer) through which you were enrolled at the time any of the above events occurred. Your guaranteed issue period begins 60 days prior to your disenrollment/termination and ends 63 days after your disenrollment/termination. If no policy is available from these sources, then you are eligible for a Medicare Supplement plan from any insurer during the annual election period for MA plans if your MA plan has increased premiums or copayments by 15% or more, or reduced any benefits; if your MA plan has discontinued a provider currently furnishing services to you for other than good cause, the guarantee issue period is the same for any insurer as with the same issuer. You must provide proof of coverage with your application.



Proof of Medicare Eligibility

Valid proof of Medicare enrollment is required to process this application. Use this form to record the information found on the applicant's Medicare Health Insurance card.



MEDICARE	HEALTH INSURANCE
Please submit the following information:	
NAME (print) _____	
MEDICARE NUMBER _____	
HOSPITAL (PART A) EFFECTIVE DATE <u> </u> <u> </u> <u> </u> — <u> </u> <u> </u> <u> </u> — <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u>	
<div style="display: flex; justify-content: space-around; width: 100%;"> M M D D Y Y Y Y </div>	
MEDICAL (PART B) EFFECTIVE DATE <u> </u> <u> </u> <u> </u> — <u> </u> <u> </u> <u> </u> — <u> </u> <u> </u> <u> </u> <u> </u> <u> </u> <u> </u>	
<div style="display: flex; justify-content: space-around; width: 100%;"> M M D D Y Y Y Y </div>	
Are both Medicare Parts A & B coverage active? YES <input type="checkbox"/> NO <input type="checkbox"/>	

I (we) certify the above information was taken directly from the applicant's Medicare card.

X _____
Applicant's Signature

Date

X _____
Agent's Signature

Date

Physicians Life Insurance Company

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. Some plans may not be available. Only applicants **first** eligible for Medicare before 2020 may purchase Plans C, F, and High Deductible F. **We currently offer Plan A, Plan F, Plan G, and Plan N.**

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%	✓	✓	✓	✓
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 2022 ²					\$6,620 ²	\$3,310 ²				

¹ Plans F and G also have a high deductible option which require first paying a plan deductible of \$2,490 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 co-payment of up to \$20 for some office visits and up to a \$50 co-payment for emergency room visits that do not result in an inpatient admission.

Automatic Bank Withdrawal Rates
ZIP Code: 900 – 908, 910 – 918, 926 – 928

Non-Tobacco – Attained Age Premiums							Tobacco – Attained Age Premiums						
Age	Plan A	Plan F	Plan G	Plan N	Age	Plan A	Plan F	Plan G	Plan N				
0-64	\$229.90	\$346.93	\$302.13	\$250.25	0-64	\$255.45	\$385.48	\$335.70	\$278.06				
65-68	\$163.99	\$204.90	\$178.43	\$147.78	65-68	\$182.21	\$227.67	\$198.26	\$164.20				
69	\$170.55	\$213.09	\$185.57	\$153.69	69	\$189.50	\$236.77	\$206.19	\$170.77				
70	\$176.94	\$221.08	\$192.53	\$159.46	70	\$196.60	\$245.65	\$213.92	\$177.18				
71	\$183.13	\$228.82	\$199.28	\$165.04	71	\$203.48	\$254.24	\$221.42	\$183.38				
72	\$189.08	\$236.25	\$205.75	\$170.40	72	\$210.09	\$262.50	\$228.61	\$189.33				
73	\$194.75	\$243.32	\$211.92	\$175.51	73	\$216.39	\$270.36	\$235.47	\$195.01				
74	\$200.11	\$250.62	\$218.29	\$180.79	74	\$222.34	\$278.47	\$242.54	\$200.88				
75	\$205.11	\$258.14	\$224.83	\$186.21	75	\$227.90	\$286.82	\$249.81	\$206.90				
76	\$209.73	\$265.89	\$231.57	\$191.80	76	\$233.03	\$295.43	\$257.30	\$213.11				
77	\$213.91	\$273.86	\$238.51	\$197.54	77	\$237.68	\$304.29	\$265.01	\$219.49				
78	\$217.66	\$282.08	\$245.66	\$203.47	78	\$241.84	\$313.42	\$272.96	\$226.08				
79	\$220.93	\$290.54	\$253.03	\$209.57	79	\$245.48	\$322.82	\$281.14	\$232.86				
80	\$223.68	\$299.26	\$260.62	\$215.86	80	\$248.53	\$332.51	\$289.58	\$239.85				
81	\$225.92	\$308.24	\$268.43	\$222.34	81	\$251.02	\$342.49	\$298.26	\$247.04				
82	\$227.61	\$317.48	\$276.50	\$229.01	82	\$252.90	\$352.76	\$307.22	\$254.46				
83	\$228.76	\$327.01	\$284.79	\$235.88	83	\$254.18	\$363.34	\$316.43	\$262.09				
84	\$229.32	\$336.82	\$293.32	\$242.96	84	\$254.80	\$374.24	\$325.91	\$269.96				
85+	\$229.90	\$346.93	\$302.13	\$250.25	85+	\$255.45	\$385.48	\$335.70	\$278.06				

See Premium Information regarding eligibility for the Household Discount (10%).

To calculate other modal premiums, first apply Household Discount, if eligible, and then for monthly premiums add \$5.00 to the A.B.W. premium, or for other modes, multiply the A.B.W. premium by the following factors: Annual-12, Semiannual-6, Quarterly-3.

**Automatic Bank Withdrawal Rates
ZIP Code: 919 – 925, 933, 935**

Non-Tobacco – Attained Age Premiums							Tobacco – Attained Age Premiums						
Age	Plan A	Plan F	Plan G	Plan N	Age	Plan A	Plan F	Plan G	Plan N				
0-64	\$203.38	\$306.90	\$267.26	\$221.37	0-64	\$225.98	\$341.00	\$296.96	\$245.97				
65-68	\$145.06	\$181.26	\$157.85	\$130.73	65-68	\$161.18	\$201.40	\$175.39	\$145.26				
69	\$150.88	\$188.50	\$164.16	\$135.95	69	\$167.64	\$209.45	\$182.40	\$151.06				
70	\$156.52	\$195.57	\$170.31	\$141.06	70	\$173.91	\$217.30	\$189.23	\$156.73				
71	\$162.00	\$202.42	\$176.28	\$146.00	71	\$180.00	\$224.91	\$195.87	\$162.22				
72	\$167.26	\$208.99	\$182.01	\$150.74	72	\$185.85	\$232.21	\$202.23	\$167.49				
73	\$172.28	\$215.25	\$187.47	\$155.26	73	\$191.42	\$239.17	\$208.30	\$172.51				
74	\$177.01	\$221.71	\$193.10	\$159.93	74	\$196.68	\$246.34	\$214.56	\$177.70				
75	\$181.45	\$228.35	\$198.88	\$164.72	75	\$201.61	\$253.72	\$220.98	\$183.02				
76	\$185.53	\$235.21	\$204.85	\$169.67	76	\$206.14	\$261.34	\$227.61	\$188.52				
77	\$189.22	\$242.26	\$210.99	\$174.75	77	\$210.25	\$269.18	\$234.43	\$194.17				
78	\$192.54	\$249.52	\$217.32	\$180.00	78	\$213.93	\$277.25	\$241.47	\$200.00				
79	\$195.43	\$257.01	\$223.83	\$185.39	79	\$217.15	\$285.57	\$248.70	\$205.99				
80	\$197.87	\$264.73	\$230.54	\$190.96	80	\$219.86	\$294.15	\$256.16	\$212.18				
81	\$199.84	\$272.67	\$237.46	\$196.68	81	\$222.05	\$302.97	\$263.84	\$218.53				
82	\$201.35	\$280.84	\$244.59	\$202.59	82	\$223.72	\$312.05	\$271.77	\$225.10				
83	\$202.36	\$289.27	\$251.93	\$208.66	83	\$224.85	\$321.41	\$279.92	\$231.85				
84	\$202.86	\$297.95	\$259.48	\$214.93	84	\$225.40	\$331.06	\$288.31	\$238.81				
85+	\$203.38	\$306.90	\$267.26	\$221.37	85+	\$225.98	\$341.00	\$296.96	\$245.97				

See Premium Information regarding eligibility for the Household Discount (10%).

To calculate other modal premiums, first apply Household Discount, if eligible, and then for monthly premiums add \$5.00 to the A.B.W. premium, or for other modes, multiply the A.B.W. premium by the following factors: Annual-12, Semiannual-6, Quarterly-3.

Automatic Bank Withdrawal Rates
ZIP Code: 930 – 932, 934, 936 – 941, 943 – 949, 954, 959 – 961

Non-Tobacco – Attained Age Premiums							Tobacco – Attained Age Premiums						
Age	Plan A	Plan F	Plan G	Plan N	Age	Plan A	Plan F	Plan G	Plan N				
0-64	\$185.70	\$280.21	\$244.03	\$202.12	0-64	\$206.33	\$311.35	\$271.14	\$224.58				
65-68	\$132.45	\$165.50	\$144.13	\$119.37	65-68	\$147.17	\$183.89	\$160.14	\$132.63				
69	\$137.75	\$172.12	\$149.89	\$124.14	69	\$153.06	\$191.24	\$166.54	\$137.93				
70	\$142.91	\$178.57	\$155.50	\$128.79	70	\$158.79	\$198.41	\$172.78	\$143.10				
71	\$147.91	\$184.81	\$160.96	\$133.30	71	\$164.35	\$205.35	\$178.84	\$148.11				
72	\$152.72	\$190.82	\$166.18	\$137.63	72	\$169.69	\$212.02	\$184.64	\$152.92				
73	\$157.29	\$196.53	\$171.17	\$141.76	73	\$174.77	\$218.37	\$190.19	\$157.51				
74	\$161.62	\$202.43	\$176.31	\$146.02	74	\$179.58	\$224.92	\$195.90	\$162.25				
75	\$165.67	\$208.49	\$181.59	\$150.40	75	\$184.08	\$231.66	\$201.77	\$167.11				
76	\$169.39	\$214.75	\$187.04	\$154.92	76	\$188.21	\$238.61	\$207.82	\$172.13				
77	\$172.77	\$221.19	\$192.64	\$159.55	77	\$191.97	\$245.77	\$214.04	\$177.28				
78	\$175.80	\$227.83	\$198.42	\$164.35	78	\$195.33	\$253.14	\$220.47	\$182.61				
79	\$178.44	\$234.67	\$204.36	\$169.27	79	\$198.27	\$260.74	\$227.07	\$188.08				
80	\$180.67	\$241.71	\$210.50	\$174.36	80	\$200.74	\$268.57	\$233.89	\$193.73				
81	\$182.47	\$248.96	\$216.81	\$179.58	81	\$202.74	\$276.62	\$240.90	\$199.53				
82	\$183.84	\$256.43	\$223.33	\$184.98	82	\$204.27	\$284.92	\$248.14	\$205.53				
83	\$184.77	\$264.11	\$230.02	\$190.52	83	\$205.30	\$293.46	\$255.58	\$211.69				
84	\$185.22	\$272.04	\$236.92	\$196.24	84	\$205.80	\$302.27	\$263.24	\$218.04				
85+	\$185.70	\$280.21	\$244.03	\$202.12	85+	\$206.33	\$311.35	\$271.14	\$224.58				

See Premium Information regarding eligibility for the Household Discount (10%).

To calculate other modal premiums, first apply Household Discount, if eligible, and then for monthly premiums add \$5.00 to the A.B.W. premium, or for other modes, multiply the A.B.W. premium by the following factors: Annual-12, Semiannual-6, Quarterly-3.

**Automatic Bank Withdrawal Rates
ZIP Code: 942, 955 – 958**

Non-Tobacco – Attained Age Premiums							Tobacco – Attained Age Premiums						
Age	Plan A	Plan F	Plan G	Plan N	Age	Plan A	Plan F	Plan G	Plan N				
0-64	\$168.01	\$253.52	\$220.79	\$182.88	0-64	\$186.68	\$281.69	\$245.32	\$203.20				
65-68	\$119.83	\$149.73	\$130.39	\$107.99	65-68	\$133.15	\$166.37	\$144.88	\$119.99				
69	\$124.63	\$155.72	\$135.61	\$112.31	69	\$138.48	\$173.02	\$150.68	\$124.79				
70	\$129.30	\$161.56	\$140.69	\$116.53	70	\$143.67	\$179.51	\$156.32	\$129.48				
71	\$133.82	\$167.21	\$145.62	\$120.61	71	\$148.69	\$185.79	\$161.80	\$134.01				
72	\$138.18	\$172.64	\$150.35	\$124.52	72	\$153.53	\$191.82	\$167.06	\$138.36				
73	\$142.32	\$177.81	\$154.86	\$128.26	73	\$158.13	\$197.57	\$172.07	\$142.51				
74	\$146.23	\$183.15	\$159.52	\$132.11	74	\$162.48	\$203.50	\$177.24	\$146.79				
75	\$149.89	\$188.64	\$164.29	\$136.07	75	\$166.54	\$209.60	\$182.55	\$151.19				
76	\$153.26	\$194.30	\$169.22	\$140.16	76	\$170.29	\$215.89	\$188.02	\$155.73				
77	\$156.32	\$200.13	\$174.29	\$144.36	77	\$173.69	\$222.37	\$193.66	\$160.40				
78	\$159.06	\$206.14	\$179.52	\$148.69	78	\$176.73	\$229.04	\$199.47	\$165.21				
79	\$161.45	\$212.31	\$184.90	\$153.14	79	\$179.39	\$235.90	\$205.45	\$170.16				
80	\$163.46	\$218.69	\$190.45	\$157.75	80	\$181.62	\$242.99	\$211.61	\$175.28				
81	\$165.10	\$225.25	\$196.16	\$162.48	81	\$183.44	\$250.28	\$217.96	\$180.53				
82	\$166.33	\$232.00	\$202.05	\$167.35	82	\$184.81	\$257.78	\$224.50	\$185.95				
83	\$167.17	\$238.97	\$208.12	\$172.38	83	\$185.74	\$265.52	\$231.24	\$191.53				
84	\$167.58	\$246.14	\$214.35	\$177.55	84	\$186.20	\$273.49	\$238.17	\$197.28				
85+	\$168.01	\$253.52	\$220.79	\$182.88	85+	\$186.68	\$281.69	\$245.32	\$203.20				

See Premium Information regarding eligibility for the Household Discount (10%).

To calculate other modal premiums, first apply Household Discount, if eligible, and then for monthly premiums add \$5.00 to the A.B.W. premium, or for other modes, multiply the A.B.W. premium by the following factors: Annual-12, Semiannual-6, Quarterly-3.

**Automatic Bank Withdrawal Rates
ZIP Code: 950 – 953**

Non-Tobacco – Attained Age Premiums							Tobacco – Attained Age Premiums						
Age	Plan A	Plan F	Plan G	Plan N	Age	Plan A	Plan F	Plan G	Plan N				
0-64	\$176.85	\$266.87	\$232.41	\$192.50	0-64	\$196.50	\$296.52	\$258.23	\$213.89				
65-68	\$126.14	\$157.62	\$137.26	\$113.68	65-68	\$140.16	\$175.13	\$152.51	\$126.31				
69	\$131.19	\$163.92	\$142.75	\$118.22	69	\$145.77	\$182.13	\$158.61	\$131.36				
70	\$136.11	\$170.06	\$148.09	\$122.66	70	\$151.23	\$188.96	\$164.55	\$136.29				
71	\$140.87	\$176.01	\$153.29	\$126.95	71	\$156.52	\$195.57	\$170.32	\$141.06				
72	\$145.45	\$181.73	\$158.26	\$131.08	72	\$161.61	\$201.92	\$175.85	\$145.64				
73	\$149.80	\$187.17	\$163.02	\$135.01	73	\$166.45	\$207.97	\$181.13	\$150.01				
74	\$153.93	\$192.79	\$167.91	\$139.07	74	\$171.03	\$214.21	\$186.57	\$154.52				
75	\$157.78	\$198.57	\$172.94	\$143.23	75	\$175.31	\$220.63	\$192.16	\$159.15				
76	\$161.32	\$204.52	\$178.13	\$147.54	76	\$179.25	\$227.25	\$197.92	\$163.93				
77	\$164.55	\$210.66	\$183.46	\$151.96	77	\$182.83	\$234.07	\$203.85	\$168.84				
78	\$167.43	\$216.98	\$188.97	\$156.52	78	\$186.03	\$241.09	\$209.97	\$173.91				
79	\$169.95	\$223.49	\$194.63	\$161.21	79	\$188.83	\$248.32	\$216.26	\$179.12				
80	\$172.06	\$230.20	\$200.47	\$166.05	80	\$191.18	\$255.78	\$222.75	\$184.50				
81	\$173.78	\$237.10	\$206.49	\$171.03	81	\$193.09	\$263.45	\$229.43	\$190.03				
82	\$175.09	\$244.21	\$212.69	\$176.17	82	\$194.54	\$271.35	\$236.32	\$195.74				
83	\$175.97	\$251.54	\$219.07	\$181.45	83	\$195.52	\$279.49	\$243.41	\$201.61				
84	\$176.40	\$259.09	\$225.63	\$186.89	84	\$196.00	\$287.88	\$250.70	\$207.66				
85+	\$176.85	\$266.87	\$232.41	\$192.50	85+	\$196.50	\$296.52	\$258.23	\$213.89				

See Premium Information regarding eligibility for the Household Discount (10%).

To calculate other modal premiums, first apply Household Discount, if eligible, and then for monthly premiums add \$5.00 to the A.B.W. premium, or for other modes, multiply the A.B.W. premium by the following factors: Annual-12, Semiannual-6, Quarterly-3.

PREMIUM INFORMATION

We, Physicians Life Insurance Company, can only raise your premium if we raise the premium for all policies like yours in California. Your Renewal Premium will increase due to age on or after your birthday. In addition, it may also increase to cover changes in Medicare benefits and inflation.

HOUSEHOLD DISCOUNT

If you either reside in a household with your spouse, or with another person (but no more than three) that is age 60 or older and has continuously resided with you for the last 12 months, we will provide you a 10% household discount off your Medicare Supplement premium. The discount is applied to the Automatic Bank Withdrawal premium, prior to any modal premium adjustments.

If you do not qualify for the household discount when your policy is first issued, you may qualify at a later date if the above qualifications are met and we receive a completed Household Discount Questionnaire that reflects an attestation to the resident information.

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 PHYSICIANS LIFE INSURANCE COMPANY, 2600 DODGE STREET, OMAHA, NE 68131. 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 Physicians Life 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.

For additional information concerning policy benefits, contact the Health Insurance Counseling and Advocacy Program (HICAP) or your agent. Call the HICAP toll-free number, 1-800-434-0222, for a referral to your local HICAP office.

LIMITATIONS AND EXCLUSIONS

We will not pay for:

- a) confinement that begins or expenses incurred while your policy is not in force, or
- b) services of the type not covered by Medicare, unless specifically provided by 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.

**PHYSICIANS LIFE INSURANCE COMPANY
MEDICARE SUPPLEMENT
OUTLINE OF COVERAGE**

L-030 Series

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			\$1,556 (Part A Deductible)
First 60 days	All but \$1,556	\$0	\$0
61st thru 90th day	All but \$389 a day	\$389 a day	\$0
91st day and after			
- While using 60 lifetime reserve days	All but \$778 a day	\$778 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 \$194.50 a day	\$0	Up to \$194.50 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 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 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 \$233 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 \$233 of Medicare Approved Amounts*	\$0	\$0	\$233 (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 \$233 of Medicare Approved Amounts*	\$0	\$0	\$233 (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 \$233 of Medicare Approved Amounts*	\$0	\$0	\$233 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

PLAN F

PHYSICIANS LIFE INSURANCE COMPANY MEDICARE SUPPLEMENT OUTLINE OF COVERAGE

L-30 Series

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 \$1,556	\$1,556 (Part A Deductible)	\$0
61st thru 90th day	All but \$389 a day	\$389 a day	\$0
91st day and after - While using 60 lifetime reserve days	All but \$778 a day	\$778 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 \$194.50 a day	Up to \$194.50 a day	\$0
101st day and after	\$0	\$0	All Costs
BLOOD First 3 pints Additional Amounts	\$0 100%	3 pints \$0	\$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 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 \$233 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 \$233 of Medicare Approved Amounts*	\$0	\$233 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charge (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints	\$0	All Costs	\$0
Next \$233 of Medicare Approved Amounts*	\$0	\$233 (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 -Durable medical equipment First \$233 of Medicare Approved Amounts*	100%	\$0	\$0
Remainder of Medicare Approved Amounts	80%	\$233 (Part B Deductible) 20%	\$0 \$0

PLAN F

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 U.S.A. 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

PLAN G

**PHYSICIANS LIFE INSURANCE COMPANY
MEDICARE SUPPLEMENT
OUTLINE OF COVERAGE**

L-030 Series

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 \$1,556	\$1,556 (Part A Deductible)	\$0
61st thru 90th day	All but \$389 a day	\$389 a day	\$0
91st day and after			
- While using 60 lifetime reserve days	All but \$778 a day	\$778 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 \$194.50 a day	Up to \$194.50 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 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 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 \$233 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	\$0	\$0	\$233 (Part B Deductible)
First \$233 of Medicare Approved Amounts*	Generally 80%	Generally 20%	\$0
Remainder of Medicare Approved Amounts	\$0	100%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)			
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$233 of Medicare Approved Amounts*	\$0	\$0	\$233 (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 \$233 of Medicare Approved Amounts*	\$0	\$0	\$233 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

PLAN G

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 U.S.A. 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

**PHYSICIANS LIFE INSURANCE COMPANY
MEDICARE SUPPLEMENT
OUTLINE OF COVERAGE**

L-030 Series

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 \$1,556	\$1,556 (Part A Deductible)	\$0
61st thru 90th day	All but \$389 a day	\$389 a day	\$0
91st day and after	All but \$778 a day	\$778 a day	\$0
- While using 60 lifetime reserve days			
Once lifetime reserve days are used:		100% of Medicare Eligible Expenses	\$0**
- Additional 365 days	\$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 \$194.50 a day	Up to \$194.50 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 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 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 \$233 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 \$233 of Medicare Approved Amounts*	\$0	\$0	\$233 (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 \$233 of Medicare Approved Amounts*	\$0	\$0	\$233 (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 \$233 of Medicare Approved Amounts*	\$0	\$0	\$233 (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 U.S.A.			
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

Medicare Supplement Height/Weight Chart

Male Build Chart			
Height	Weight		
	Decline if Under Minimum	Normal	Decline if Over Maximum
4' 10"	100	100 – 174	222
4' 11"	101	101 – 175	225
5' 0"	102	102 – 178	229
5' 1"	104	104 – 181	236
5' 2"	106	106 – 185	241
5' 3"	109	109 – 190	247
5' 4"	112	112 – 195	254
5' 5"	115	115 – 201	262
5' 6"	119	119 – 207	270
5' 7"	122	122 – 214	278
5' 8"	126	126 – 220	286
5' 9"	130	130 – 226	293
5' 10"	134	134 – 231	300
5' 11"	138	138 – 236	307
6' 0"	142	142 – 242	315
6' 1"	147	147 – 248	323
6' 2"	152	152 – 254	332
6' 3"	157	157 – 261	342
6' 4"	162	162 – 268	352
6' 5"	167	167 – 275	362
6' 6"	172	172 – 282	372
6' 7"	177	177 – 289	382
6' 8"	182	182 – 296	392
6' 9"	187	187 – 304	402
6' 10"	192	192 – 311	413
6' 11"	197	197 – 319	424
7' 0"	202	202 – 327	435

Female Build Chart			
Height	Weight		
	Decline if Under Minimum	Normal	Decline if Over Maximum
4' 10"	90	90 – 148	193
4' 11"	91	91 – 151	200
5' 0"	92	92 – 154	200
5' 1"	94	94 – 157	204
5' 2"	97	97 – 160	207
5' 3"	99	99 - 163	211
5' 4"	102	102 – 166	215
5' 5"	105	105 – 170	220
5' 6"	108	108 – 173	224
5' 7"	112	112 – 177	230
5' 8"	113	113 – 182	236
5' 9"	118	118 - 188	244
5' 10"	122	122 - 194	254
5' 11"	125	125 – 201	262
6' 0"	129	129 – 208	271
6' 1"	132	132 – 215	280
6' 2"	136	136 – 221	288
6' 3"	139	139 – 228	297
6' 4"	143	143 - 234	305
6' 5"	146	146 – 240	312
6' 6"	150	150 – 244	317
6' 7"	154	154 – 250	325

