

Explanation of Part B Expenses

An explanation of Part B Calculations:	CHARGE PER OCCURRENCE		TOTAL CHARGE	
	PATIENT INCURRED	MEDICARE APPROVED	PATIENT INCURRED	MEDICARE APPROVED
10 Doctor Office Visits	\$ 85	\$ 73	\$ 850	\$ 730
Specialist #1	157	137	157	137
Specialist #2	314	273	314	273
Surgeon's Fee	27,650	25,220	27,650	25,220
Asst. Surgeon's Fee	6,495	5,913	6,495	5,913
Anesthesiologist's Fee	3,871	3,369	3,871	3,369
40 Doctor's Visits - Hospital	90	78	3,600	3,120
10 Doctor's Visits - SNF	65	56	+ 650	+ 560
			\$ 43,587	\$ 39,322
Less Part B Deductible				- \$ 135
				\$ 39,187
Medicare Payment Rate				× 80%
Medicare Paid				\$ 31,350
Total Part B Expenses			\$ 43,587	
Less Medicare Paid			- 31,350	
PATIENT LIABILITY ♦			\$ 12,237	

♦ Some Doctors did not accept Medicare's "Approved Charge" as full payment. New York limits the amount you can be charged for most non-hospital Part B services to 105% of the Medicare approved amount. The limit for doctor's office visits is 115%. If your New York provider does not accept Medicare assignment, he can charge you no more than the allowed percentage approved less Medicare paid for the services provided.

About this Hypothetical Example

The cost figures shown for Parts A and B in our example represent a long term confinement in a hospital, outpatient hospital services, skilled nursing facility, and at-home services that, although uncommon, help to illustrate the financial impact such an illness could have upon a patient. This case allows you to compare the benefits of each of our Medicare Supplement policies for each possible expense.

ASIDE BY SIDE

Guide

2009



Agent Training Guide to ProCare Medicare Supplement Policies
Presented by



Choosing a Medicare Supplement Plan

Medicare Supplement insurance policies are the same by law. Depending on the plan selected, coverages pay various Medicare deductibles, coinsurances, and other medical expenses not covered by Medicare. However, insurers' rates and services vary, which makes it very important for Seniors to shop carefully to get the best value for their dollars.

First United American Life Insurance Company offers 9 of the 14 standardized plans: A, B, C, D, F, HDF+, G, K, and L.

PLANS / BENEFITS	A	B	C	D	E [●]	F [▼]	G	H	I	J ^{▼●}	K ^{■●}	L ^{■●}
Part A - Basic Benefits	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	100%	100%
Part B - Basic Benefits	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	50%	75%
Part B Preventive Services [●]											100%	100%
Skilled Nursing Facility Coinsurance			✓	✓	✓	✓	✓	✓	✓	✓	50%	75%
Part A Deductible		✓	✓	✓	✓	✓	✓	✓	✓	✓	50%	75%
Part B Deductible			✓			✓				✓		
Excess Doctor Charges						100%	80%		100%	100%		
Foreign Travel Emergency			✓	✓	✓	✓	✓	✓	✓	✓		
At-Home Recovery				✓			✓		✓	✓		
Preventive Care [●]					✓					✓		
Out-of-Pocket Annual Limit [■]											\$4,620	\$2,310

The Medicare Supplement Plans offered by First United American are in maroon.

- Preventive Care benefits included with Plans E, J, and high deductible Plan J are for preventive care not covered by Medicare. This benefit is not the same as the Part B Preventive Services included only with Part B - Basic Benefits for Plans K and L.
- ▼ Plans F and J also have an option called a high deductible Plan F and a high deductible Plan J. These high deductible plans pay the same benefits as Plans F and J after one has paid a calendar-year deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses exceed the calendar-year deductible (\$2,000 in 2009). 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 separate foreign travel emergency deductible in Plans F and J.
- Plans K and L provide for different out-of-pocket cost-sharing (50% for Plan K, 25% for Plan L) for items and services than Plans A-J. Once you reach the annual limit (\$4,620 for Plan K, \$2,310 for Plan L), the plan pays 100% of the Medicare co-payments, coinsurance, and deductibles for the rest of the calendar-year. The out-of-pocket annual limit does NOT include the charges from your provider that exceed Medicare-approved amounts, called "excess charges". You will be responsible for paying excess charges. The out-of-pocket annual limit will be increased each year for inflation. See Outline of Coverage for details and exceptions.

The policies described herein meet the minimum standards for Medicare Supplement insurance as defined by the New York State Insurance Department. The expected benefit ratio for the policies is 65%. This ratio is the portion of the future premiums which the Company expects to return as benefits, when averaged over all people with these policies. UNDERWRITING INFORMATION ABOUT THESE POLICIES – For each of the Medicare Supplement policies shown in this brochure.

- 1 The policy effective date is the date the application is accepted in the home office or a later date that is requested. Policies submitted with a monthly premium will be effective the date the Company issues the policy.
- 2 The pre-existing waiting period is 60 days — waiting period waived if replacing an existing health policy. *
- 3 The applicant must be insured by no other Medicare Supplements unless the coverage is being replaced.

* Pre-existing conditions — a condition must have been treated, had treatment recommended, or had medical advice given within six months prior to the effective date of the policy.

NOW, LET'S
COMPARE...

A Hypothetical Example

PART A of this hypothetical situation involves a patient who was confined in a hospital for 170 days. (These days need not be consecutive; as long as the patient was never out of the hospital 60 days in a row, Medicare treats this as a single, long confinement.) After the 60th day, the patient paid daily co-payments of \$267 for days 61-90, then \$534 for days 91-150. He also paid extra charges for blood. Note, too, that Medicare Part A coverage completely ended after the 150th day in the hospital.

Next, our hypothetical patient entered a skilled nursing facility for 100 days. Medicare paid for the first 20 days of confinement; for days 21 through 100, the patient paid \$133.50 a day.

Upon dismissal from the skilled nursing facility, the patient received 14 Medicare approved home health care visits to complete recovery. The patient also received 14 non-Medicare-covered at-home recovery visits for assistance with activities of daily living.

PART B eligible expenses for medical services included 10 visits to the doctor plus specialists' fees and outpatient hospital services; the surgeon's and assistant surgeon's fees; the anesthesiologist's fee; 40 doctor visits while in the hospital and another 10 doctor visits while in the skilled nursing facility.

For each of these expenses (except outpatient hospital charges), Medicare recognized only its "Approved Charge," and then paid only 80% of that "Approved Charge." Our patient was responsible for the other 20%, as well as Part B Excess Expense. Additionally, he paid the \$135 Medicare Part B deductible, which is subtracted from the total "Approved Charges." For outpatient hospital charges, our patient's coinsurance liability was established by Medicare's National Coinsurance rate for the type of service provided. Medicare's allowable total reimbursement to the hospital was less than the billed amount. Medicare pays the allowed reimbursement less the patient's coinsurance. On average, the Medicare payment is 50% of the total payment. Your coinsurance is the remaining 50%.

After Medicare Parts A and B – but without any supplemental insurance – our patient owed \$85,157 for this illness. This example, coupled with this side-by-side guide, demonstrates how First United American Medicare Supplement ProCare policies can make a dramatic difference for our patient's life savings.

PATIENT LIABILITY	
PART A	
DAILY HOSPITAL CHARGES:	
Days 1-60, Part A Deductible	\$ 1,068
Days 61-90 @ \$267 per day	\$ 8,010
Days 91-150 @ \$534 per day	\$ 32,040
Days 151-170, All Charges	\$ 20,000
BLOOD:	
3 Pints @ \$60 per pint	\$ 180
Part A Subtotal	\$ 61,298
SKILLED NURSING FACILITY:	
Days 21-100 @ \$133.50 per day	\$ 10,680
OTHER BENEFITS:	
At Home Recovery, 14 visits @ \$40 each	\$ 560
Part A Total	\$ 72,538
PART B *	
OUTPATIENT HOSPITAL SERVICES: ^	
50% of Medicare Allowed Charges	\$ 381
PART B DEDUCTIBLE:	
	\$ 135
20% OF APPROVED CHARGES:	
(NOT COVERED BY MEDICARE)	\$ 7,838
EXCESS CHARGES:	
(NOT COVERED BY MEDICARE)	\$ 4,265
Part B Total	\$ 12,619
DEDUCTIBLE / OUT-OF-POCKET LIMIT	
MEDICARE UNPAID	\$ 85,157
PLAN PAYS	
PATIENT PAYS	\$ 85,157

PLAN A	PLAN B	PLAN C
PART A PAID		
DAILY HOSPITAL CHARGES:		
NOT COVERED	\$ 1,068	\$ 1,068
\$ 8,010	\$ 8,010	\$ 8,010
\$ 32,040	\$ 32,040	\$ 32,040
\$ 20,000	\$ 20,000	\$ 20,000
BLOOD:		
\$ 180	\$ 180	\$ 180
\$ 60,230	\$ 61,298	\$ 61,298
SKILLED NURSING FACILITY:		
NOT COVERED	NOT COVERED	\$ 10,680
OTHER BENEFITS:		
NOT COVERED	NOT COVERED	NOT COVERED
\$ 60,230	\$ 61,298	\$ 71,978
PART B* PAID		
OUTPATIENT HOSPITAL SERVICES: ^		
\$ 381	\$ 381	\$ 381
PART B DEDUCTIBLE:		
NOT COVERED	NOT COVERED	\$ 135
20% OF APPROVED CHARGES:		
\$ 7,838	\$ 7,838	\$ 7,838
EXCESS CHARGES:		
NOT COVERED	NOT COVERED	NOT COVERED
\$ 8,219 *	\$ 8,219 *	\$ 8,354 *
MEDICARE UNPAID		
\$ 85,157	\$ 85,157	\$ 85,157
PLAN A PAYS	PLAN B PAYS	PLAN C PAYS
\$ 68,449	\$ 69,517	\$ 80,332
PATIENT PAYS	PATIENT PAYS	PATIENT PAYS
\$ 16,708	\$ 15,640	\$ 4,825

* NOTE: An explanation of the Part B expenses is presented on the back page.

PLAN D	PLAN F	PLAN HDF
PART A PAID		
DAILY HOSPITAL CHARGES:		
\$ 1,068	\$ 1,068	\$ 1,068
\$ 8,010	\$ 8,010	\$ 8,010
\$ 32,040	\$ 32,040	\$ 32,040
\$ 20,000	\$ 20,000	\$ 20,000
BLOOD:		
\$ 180	\$ 180	\$ 180
\$ 61,298	\$ 61,298	\$ 61,298
SKILLED NURSING FACILITY:		
\$ 10,680	\$ 10,680	\$ 10,680
OTHER BENEFITS:		
\$ 560	NOT COVERED	NOT COVERED
\$ 72,538	\$ 71,978	\$ 71,978
PART B* PAID		
OUTPATIENT HOSPITAL SERVICES:▲		
\$ 381	\$ 381	\$ 381
PART B DEDUCTIBLE:		
NOT COVERED	\$ 135	\$ 135
20% OF APPROVED CHARGES:		
\$ 7,838	\$ 7,838	\$ 7,838
EXCESS CHARGES:		
NOT COVERED	\$ 4,265	\$ 4,265
\$ 8,219 *	\$ 12,619 *	\$ 12,619 *
		ANNUAL DEDUCTIBLE \$ 2,000
MEDICARE UNPAID \$ 85,157	MEDICARE UNPAID \$ 85,157	MEDICARE UNPAID \$ 85,157
PLAN D PAYS \$ 80,757	PLAN F PAYS \$ 84,597	PLAN HDF PAYS \$ 82,597
PATIENT PAYS \$ 4,400	PATIENT PAYS \$ 560	PATIENT PAYS \$ 2,560

PLAN G	PLAN K	PLAN L
PART A PAID		
DAILY HOSPITAL CHARGES:		
\$ 1,068	(50%) \$ 534	(75%) \$ 801
\$ 8,010	(100%) \$ 8,010	(100%) \$ 8,010
\$ 32,040	(100%) \$ 32,040	(100%) \$ 32,040
\$ 20,000	(100%) \$ 20,000	(100%) \$ 20,000
BLOOD:		
\$ 180	(50%) \$ 90	(75%) \$ 135
\$ 61,298	\$ 60,674	\$ 60,986
SKILLED NURSING FACILITY:		
\$ 10,680	(50%) \$ 5,340	(75%) \$ 8,010
OTHER BENEFITS:		
\$ 560	NOT COVERED	NOT COVERED
\$ 72,538	\$ 66,014	\$ 68,996
PART B* PAID		
OUTPATIENT HOSPITAL SERVICES:▲		
\$ 381	(50%) \$ 191	(75%) \$ 286
PART B DEDUCTIBLE:		
NOT COVERED	NOT COVERED	NOT COVERED
20% OF APPROVED CHARGES:		
\$ 7,838	(50%) \$ 3,919	(75%) \$ 5,879
EXCESS CHARGES:		
\$ 3,412	NOT COVERED	NOT COVERED
\$ 11,631 *	\$ 4,110 *	\$ 6,165 *
	ANNUAL LIMIT \$ 4,620	ANNUAL LIMIT \$ 2,310
MEDICARE UNPAID \$ 85,157	MEDICARE UNPAID \$ 85,157	MEDICARE UNPAID \$ 85,157
PLAN G PAYS \$ 84,169	PLAN K PAYS \$ 75,577	PLAN L PAYS \$ 77,887
PATIENT PAYS \$ 988	PATIENT PAYS \$ 9,580	PATIENT PAYS \$ 7,270

▲ **NOTE:** The coinsurance owed for outpatient hospital services is established by Medicare based on the type of services provided.