

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				- \$ 155
				\$ 39,167
Medicare Payment Rate				× 80%
Medicare Paid				\$ 31,334
Total Part B Expenses			\$ 43,587	
Less Medicare Paid			- 31,334	
PATIENT LIABILITY ♦			\$ 12,253	

♦ Some Doctors did not accept Medicare's "Approved Charge" as full payment. In New York, the most a physician can charge for services covered by Medicare is 105% of the approved amount for nonparticipating physicians. For routine office visits covered by Medicare, a nonparticipating physician can charge up to 115% of the fee schedule amount.

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.

A SIDE BY SIDE Guide 2010



Agent Training Guide to ProCare Medicare Supplement Policies
Presented by



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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 these standardized plans:

A, B, C, D, F, F+, G, K, L, and N.

See the chart below for plans First United American Life Insurance Company offers; the outline of coverage shows all standardized plans. See the outline of coverage for details and exceptions.

MEDICARE PLANS / BENEFITS	A	B	C	D	F [▼]	G	K [■]	L [■]	N [●]
Basic Benefits									
Hospitalization (Part A Coinsurance)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medical Expenses (Part B Coinsurance)	100%	100%	100%	100%	100%	100%	50%	75%	Copay [●]
Blood	✓	✓	✓	✓	✓	✓	50%	75%	✓
Hospice	✓	✓	✓	✓	✓	✓	50%	75%	✓
Skilled Nursing Facility Coinsurance			✓	✓	✓	✓	50%	75%	✓
Part A Deductible		✓	✓	✓	✓	✓	50%	75%	✓
Part B Deductible			✓		✓				
Excess Doctor Charges					100%	100%			
Foreign Travel Emergency			✓	✓	✓	✓			✓
Out-of-Pocket Annual Limit [■]							\$4,620	\$2,310	

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.

- ▼ Plan F also has an option called a high deductible Plan F (F+). The high deductible plan pays the same benefits as Plan F after one has paid a calendar-year deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed the calendar-year deductible (\$2,000 in 2010). 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 Plan F.
- 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-G. Once you reach the annual limit (\$4,620 for Plan K, \$2,310 for Plan L), the plan pays 100% of the Medicare copayments, 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.
- Plan N pays 100% of Medical Expenses (Part B Coinsurance) except for a copayment of up to \$20 for an office visit and up to \$50 for an emergency room visit. The emergency room copayment is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.

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 copayments of \$275 for days 61-90, then \$550 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 \$137.50 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 \$155 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 \$86,729 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	\$ 1,100
Days 61-90 @ \$275 per day	\$ 8,250
Days 91-150 @ \$550 per day	\$ 33,000
Days 151-170, All Charges	\$ 20,000
BLOOD:	
3 Pints @ \$60 per pint	\$ 180
Part A Subtotal	\$ 62,530
SKILLED NURSING FACILITY:	
Days 21-100 @ \$137.50 per day	\$ 11,000
OTHER BENEFITS:	
At Home Recovery, 14 visits @ \$40 each	\$ 560
Part A Total	\$ 74,090
PART B *	
OUTPATIENT HOSPITAL SERVICES: ▲	
50% of Medicare Allowed Charges	\$ 381
PART B DEDUCTIBLE:	
	\$ 155
20% OF APPROVED CHARGES:	
(NOT COVERED BY MEDICARE)	\$ 7,838
EXCESS CHARGES:	
(NOT COVERED BY MEDICARE)	\$ 4,265
Part B Total	\$ 12,639
DEDUCTIBLE / OUT-OF-POCKET LIMIT	
MEDICARE UNPAID	\$ 86,729
PLAN PAYS	
PATIENT PAYS	\$ 86,729

PLAN A	PLAN B	PLAN C	PLAN D
NOT COVERED	\$ 1,100	\$ 1,100	\$ 1,100
\$ 8,250	\$ 8,250	\$ 8,250	\$ 8,250
\$ 33,000	\$ 33,000	\$ 33,000	\$ 33,000
\$ 20,000	\$ 20,000	\$ 20,000	\$ 20,000
\$ 180	\$ 180	\$ 180	\$ 180
\$ 61,430	\$ 62,530	\$ 62,530	\$ 62,530
NOT COVERED	NOT COVERED	\$ 11,000	\$ 11,000
NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
\$ 61,430	\$ 62,530	\$ 73,530	\$ 73,530
\$ 381	\$ 381	\$ 381	\$ 381
NOT COVERED	NOT COVERED	\$ 155	NOT COVERED
\$ 7,838	\$ 7,838	\$ 7,838	\$ 7,838
NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
\$ 8,219 *	\$ 8,219 *	\$ 8,374 *	\$ 8,219 *
\$ 86,729	\$ 86,729	\$ 86,729	\$ 86,729
\$ 69,649	\$ 70,749	\$ 81,904	\$ 81,749
\$ 17,080	\$ 15,980	\$ 4,825	\$ 4,980

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

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

	PLAN F	PLAN F+	PLAN G	PLAN K	PLAN L	PLAN N
PART A						
DAILY HOSPITAL CHARGES:						
	\$ 1,100	\$ 1,100	\$ 1,100	(50%) \$ 550	(75%) \$ 825	\$ 1,100
	\$ 8,250	\$ 8,250	\$ 8,250	(100%) \$ 8,250	(100%) \$ 8,250	\$ 8,250
	\$ 33,000	\$ 33,000	\$ 33,000	(100%) \$ 33,000	(100%) \$ 33,000	\$ 33,000
	\$ 20,000	\$ 20,000	\$ 20,000	(100%) \$ 20,000	(100%) \$ 20,000	\$ 20,000
BLOOD:						
	\$ 180	\$ 180	\$ 180	(50%) \$ 90	(75%) \$ 135	\$ 180
Part A Subtotal	\$ 62,530	\$ 62,530	\$ 62,530	\$ 61,890	\$ 62,210	\$ 62,530
SKILLED NURSING FACILITY:						
	\$ 11,000	\$ 11,000	\$ 11,000	(50%) \$ 5,500	(75%) \$ 8,250	\$ 11,000
OTHER BENEFITS:						
	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Part A Total	\$ 73,530	\$ 73,530	\$ 73,530	\$ 67,390	\$ 70,460	\$ 74,090
PART B *						
OUTPATIENT HOSPITAL SERVICES: ▲						
	\$ 381	\$ 381	\$ 381	(50%) \$ 191	(75%) \$ 286	\$ 381
PART B DEDUCTIBLE:						
	\$ 155	\$ 155	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
20% OF APPROVED CHARGES:						
	\$ 7,838	\$ 7,838	\$ 7,838	(50%) \$ 3,919	(75%) \$ 5,879	\$ 7,638
EXCESS CHARGES:						
	\$ 4,265	\$ 4,265	\$ 4,265	NOT COVERED	NOT COVERED	NOT COVERED
Part B Total	\$ 12,639 *	\$ 12,639 *	\$ 12,484 *	\$ 4,110 *	\$ 6,165 *	\$ 8,019 *
DEDUCTIBLE / OUT-OF-POCKET LIMIT		DEDUCTIBLE \$ 2,000		ANN LIMIT \$ 4,620	ANN LIMIT \$ 2,310	
MEDICARE UNPAID	\$ 86,729	\$ 86,729	\$ 86,729	\$ 86,729	\$ 86,729	\$ 86,729
PLAN PAYS	\$ 86,169	\$ 84,169	\$ 84,169	\$ 77,129	\$ 79,439	\$ 81,549
PATIENT PAYS	\$ 560	\$ 2,560	\$ 715	\$ 9,600	\$ 7,290	\$ 5,180

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

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