



OUTLINE OF MEDICARE SUPPLEMENT COVERAGE - COVER PAGE: 1 of 2

- Benefit Plan(s) PLAN A - POLICY FORM H-0016A.NE.PA
 PLAN B - POLICY FORM H-0017B.NE.PA
 PLAN C - POLICY FORM H-0020C.NE.PA
 PLAN D - POLICY FORM H-0022D.NE.PA

NEW ERA LIFE INSURANCE COMPANY

200 Westlake Park Blvd., Suite 1200 ♦ Houston, TX 77079 1-(800) 552-7879

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A & B". Some plans may not be available in your state. **See Outlines of Coverage sections for details about ALL plans**

BASIC BENEFITS for Plans A-J:

- Hospitalization: ----- Part A co-insurance plus coverage for 365 additional days after Medicare benefits end.
 Medical Expenses:----- Part B co-insurance (Generally, 20% of Medicare-approved expenses), or, in the case of hospital outpatient department services paid under a prospective payment system, applicable copayments.
 Blood:----- First three pints of blood each year.

A	B	C	D	E	F	F*	G	H	I	J	J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits		Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	
		Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance		Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	
		Part B Deductible			Part B Deductible					Part B Deductible	
					Part B Excess (100%)		Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)	
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	
			At-Home Recovery				At-Home Recovery		At-Home Recovery	At-Home Recovery	
				Preventive Care						Preventive Care	

*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 or offer the same benefits as Plans F and J after one has paid a calendar year \$[1,900] deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses are \$[1,900]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.



OUTLINE OF MEDICARE SUPPLEMENT COVERAGE - COVER PAGE: 2 of 2

- | | | | | |
|-----------------|--------|---|---------------------------|--------------------------|
| Benefit Plan(s) | PLAN A | - | POLICY FORM H-0016A.NE.PA | <input type="checkbox"/> |
| | PLAN B | - | POLICY FORM H-0017B.NE.PA | <input type="checkbox"/> |
| | PLAN C | - | POLICY FORM H-0020C.NE.PA | <input type="checkbox"/> |
| | PLAN D | - | POLICY FORM H-0022D.NE.PA | <input type="checkbox"/> |

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Basic Benefits for Plans K and L include similar services as plans A-J, but cost-sharing for the basic benefits is at different levels.

J	K**	L**
Basic Benefits	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 50% Hospice cost-sharing 50% of Medicare-eligible expenses for the first three pints of blood 50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 75% Hospice cost-sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services
Skilled Nursing Facility Co-Insurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care		
	[\$4000] Out of Pocket Annual Limit***	[\$2000] Out of Pocket Annual Limit***

**Plans K and L provide for different cost-sharing for items and services than Plans A-J.

Once you reach the annual limit, 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 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 increase each year for inflation.

See Outlines of Coverage for details and exceptions

PREMIUM INFORMATION

We, New Era Life Insurance Company, can only raise your premium if we raise the premium for all policies like yours in this State. You will have automatic renewal premium increases on the policy anniversary date based on your age as of that date. Additionally, we reserve the right to revise the table of premium rates.

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 New Era Life Insurance Company, P.O. Box 4884, Houston, TX 77210-4884. If you send the policy back within 30 days after you receive it, we will treat the policy as if it had never been issued and return all 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 **New Era 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 "The Medicare Handbook" for more details.

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.



NEW ERA LIFE INSURANCE COMPANY
ATTAINED AGE MONTHLY PREMIUM PER INDIVIDUAL - EFFECTIVE 6/1/07
STANDARD MEDICARE SUPPLEMENT PLAN A - PENNSYLVANIA

PLAN A

POLICY FORM H-0016A

ATT.	AREA C			
	AGE	MNTU	MTU	FNTU
<66	65.11	72.35	60.23	66.92
66	65.11	72.35	60.23	66.92
67	67.23	74.69	62.19	69.10
68	69.41	77.13	64.21	71.34
69	71.67	79.63	66.29	73.66
70	74.00	82.22	68.46	76.06
71	76.41	84.89	70.68	78.52
72	78.89	87.65	72.97	81.07
73	81.45	90.50	75.33	83.71
74	84.09	93.44	77.79	86.43
75	86.83	96.47	80.32	89.25
76	89.65	99.61	82.93	92.15
77	92.57	102.85	85.62	95.13
78	95.57	106.19	88.40	98.22
79	98.68	109.64	91.28	101.42
80	101.89	113.20	94.25	104.72
81	105.20	116.89	97.30	108.12
82	108.62	120.69	100.47	111.63
83	112.15	124.61	103.74	115.27
84	115.79	128.66	107.11	119.01
85	119.56	132.84	110.59	122.88
86	123.44	137.16	114.19	126.87
87	127.45	141.62	117.90	131.00
88	131.60	146.22	121.73	135.25
89	135.87	150.97	125.69	139.65
90+	140.29	155.88	129.77	144.19

AREA D			
MNTU	MTU	FNTU	FTU
76.60	85.11	70.86	78.73
76.60	85.11	70.86	78.73
79.09	87.88	73.16	81.29
81.66	90.74	75.54	83.93
84.32	93.68	77.99	86.66
87.06	96.73	80.53	89.48
89.89	99.87	83.14	92.38
92.81	103.12	85.85	95.38
95.82	106.47	88.63	98.48
98.94	109.93	91.52	101.68
102.15	113.50	94.49	104.99
105.47	117.19	97.56	108.40
108.90	121.00	100.74	111.92
112.44	124.93	104.00	115.56
116.09	128.99	107.38	119.31
119.87	133.18	110.88	123.20
123.76	137.51	114.48	127.20
127.78	141.98	118.20	131.34
131.94	146.60	122.04	135.61
136.23	151.36	126.01	140.01
140.66	156.29	130.11	144.57
145.23	161.36	134.34	149.26
149.95	166.61	138.70	154.12
154.82	172.02	143.21	159.13
159.85	177.61	147.86	164.30
165.05	183.39	152.67	169.63

AREA E			
MNTU	MTU	FNTU	FTU
82.73	91.92	76.53	85.02
82.73	91.92	76.53	85.02
85.42	94.91	79.01	87.79
88.19	97.99	81.58	90.65
91.06	101.17	84.23	93.59
94.03	104.47	86.97	96.64
97.07	107.86	89.79	99.77
100.23	111.36	92.71	103.02
103.49	114.98	95.73	106.36
106.85	118.72	98.84	109.81
110.32	122.58	102.05	113.39
113.91	126.56	105.36	117.07
117.61	130.68	108.79	120.88
121.43	134.92	112.32	124.80
125.38	139.31	115.98	128.86
129.46	143.84	119.75	133.06
133.66	148.51	123.64	137.38
138.01	153.34	127.65	141.84
142.49	158.32	131.81	146.45
147.12	163.47	136.09	151.21
151.91	168.79	140.52	156.13
156.85	174.27	145.09	161.20
161.94	179.94	149.80	166.44
167.21	185.79	154.67	171.86
172.64	191.82	159.69	177.44
178.25	198.06	164.88	183.20

AREA F			
MNTU	MTU	FNTU	FTU
95.37	105.96	88.21	98.01
95.37	105.96	88.21	98.01
98.47	109.41	91.08	101.20
101.67	112.97	94.04	104.50
104.97	116.64	97.10	107.88
108.39	120.43	100.26	111.40
111.91	124.34	103.51	115.02
115.54	128.38	106.88	118.75
119.29	132.55	110.35	122.61
123.18	136.86	113.94	126.59
127.18	141.31	117.64	130.72
131.31	145.90	121.46	134.96
135.58	150.64	125.42	139.35
139.98	155.54	129.48	143.87
144.53	160.60	133.70	148.55
149.23	165.81	138.05	153.38
154.09	171.20	142.52	158.37
159.09	176.77	147.16	163.51
164.26	182.51	151.94	168.83
169.60	188.45	156.88	174.31
175.11	194.57	161.98	179.99
180.81	200.90	167.25	185.83
186.68	207.43	172.68	191.87
192.75	214.17	178.30	198.11
199.02	221.13	184.09	204.55
205.48	228.32	190.07	211.19

NO OPEN ENROLLEES OR GUARANTEED ISSUE ENROLLEES WILL BE CHARGED TOBACCO USER RATES
 THE PREMIUM RATE WILL BE AUTOMATICALLY INCREASED EVERY YEAR BASED ON THE INSURED'S ATTAINED AGE.

ZIP CODES	
AREA C	153-188, 195-196
AREA D	150-152, 189, 193-194
AREA E	190
AREA F	191

MNTU:	MALE NON-TOBACCO
MTU:	MALE TOBACCO
FNTU:	FEMALE NON-TOBACCO
FTU:	FEMALE TOBACCO

MODAL FACTOR	
MONTHLY BANK DRAFT	1.0
BI-MONTHLY	2.0
QUARTERLY	3.0
SEMI-ANNUAL	6.0
ANNUAL	12.0

RATE.NE.PA.6.07

ADD ONE TIME NON-REFUNDABLE \$10 APPLICATION FEE



NEW ERA LIFE INSURANCE COMPANY
ATTAINED AGE MONTHLY PREMIUM PER INDIVIDUAL - EFFECTIVE 6/1/07
STANDARD MEDICARE SUPPLEMENT PLAN B - PENNSYLVANIA

PLAN B

POLICY FORM H-0017B

ATT.	AREA C			
AGE	MNTU	MTU	FNTU	FTU
<66	85.32	94.80	78.92	87.69
66	85.32	94.80	78.92	87.69
67	88.09	97.87	81.48	90.54
68	90.96	101.06	84.14	93.48
69	93.91	104.34	86.87	96.51
70	96.96	107.74	89.70	99.66
71	100.12	111.23	92.61	102.89
72	103.37	114.85	95.61	106.23
73	106.73	118.59	98.71	109.69
74	110.19	122.44	101.93	113.25
75	113.78	126.41	105.24	116.94
76	117.47	130.52	108.66	120.74
77	121.30	134.76	112.20	124.66
78	125.23	139.15	115.84	128.70
79	129.30	143.67	119.60	132.89
80	133.51	148.34	123.50	137.22
81	137.85	153.16	127.50	141.67
82	142.33	158.14	131.65	146.28
83	146.95	163.28	135.93	151.04
84	151.73	168.59	140.35	155.94
85	156.66	174.07	144.92	161.02
86	161.75	179.73	149.63	166.25
87	167.01	185.57	154.49	171.65
88	172.44	191.60	159.51	177.23
89	178.04	197.83	164.69	182.99
90+	183.83	204.26	170.04	188.94

AREA D			
MNTU	MTU	FNTU	FTU
100.38	111.53	92.85	103.16
100.38	111.53	92.85	103.16
103.64	115.15	95.86	106.52
107.00	118.90	98.98	109.98
110.48	122.76	102.20	113.55
114.08	126.75	105.53	117.24
117.78	130.87	108.95	121.05
121.61	135.12	112.49	124.98
125.56	139.51	116.14	129.05
129.64	144.04	119.92	133.24
133.85	148.73	123.82	137.57
138.20	153.56	127.84	142.05
142.70	158.55	132.00	146.66
147.33	163.70	136.28	151.42
152.12	169.02	140.71	156.34
157.07	174.52	145.29	161.43
162.17	180.19	150.01	166.68
167.44	186.05	154.88	172.10
172.88	192.09	159.92	177.69
178.50	198.34	165.12	183.46
184.31	204.79	170.49	189.43
190.30	211.44	176.03	195.58
196.48	218.32	181.75	201.94
202.87	225.41	187.66	208.51
209.46	232.74	193.75	215.29
216.27	240.30	200.04	222.28

AREA E			
MNTU	MTU	FNTU	FTU
108.41	120.45	100.28	111.41
108.41	120.45	100.28	111.41
111.92	124.36	103.53	115.03
115.56	128.40	106.90	118.78
119.32	132.57	110.37	122.63
123.21	136.89	113.97	126.63
127.20	141.34	117.66	130.74
131.34	145.92	121.48	134.99
135.60	150.67	125.43	139.37
140.01	155.56	129.52	143.89
144.56	160.63	133.72	148.58
149.26	165.84	138.06	153.41
154.12	171.24	142.56	158.39
159.12	176.80	147.18	163.53
164.29	182.54	151.97	168.85
169.63	188.48	156.91	174.35
175.14	194.60	162.01	180.01
180.83	200.93	167.27	185.86
186.71	207.46	172.71	191.91
192.78	214.21	178.33	198.14
199.05	221.17	184.13	204.59
205.52	228.35	190.11	211.23
212.20	235.79	196.29	218.10
219.10	243.45	202.67	225.19
226.22	251.35	209.25	232.51
233.57	259.53	216.05	240.05

AREA F			
MNTU	MTU	FNTU	FTU
124.97	138.85	115.59	128.43
124.97	138.85	115.59	128.43
129.03	143.36	119.35	132.61
133.22	148.03	123.23	136.93
137.55	152.83	127.24	141.37
142.03	157.81	131.38	145.97
146.64	162.93	135.64	150.71
151.40	168.23	140.05	155.61
156.32	173.69	144.59	160.66
161.40	179.33	149.30	165.88
166.65	185.16	154.15	171.28
172.06	191.18	159.16	176.85
177.66	197.39	164.34	182.59
183.42	203.81	169.67	188.52
189.39	210.44	175.19	194.65
195.55	217.27	180.89	200.98
201.91	224.33	186.75	207.52
208.46	231.63	192.83	214.26
215.24	239.15	199.10	221.22
222.23	246.94	205.57	228.41
229.46	254.96	212.26	235.85
236.93	263.25	219.16	243.50
244.62	271.80	226.27	251.42
252.57	280.64	233.63	259.60
260.78	289.75	241.22	268.03
269.26	299.17	249.06	276.73

NO OPEN ENROLLEES OR GUARANTEED ISSUE ENROLLEES WILL BE CHARGED TOBACCO USER RATES
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ZIP CODES	
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AREA D	150-152, 189, 193-194
AREA E	190
AREA F	191

MNTU:	MALE NON-TOBACCO
MTU:	MALE TOBACCO
FNTU:	FEMALE NON-TOBACCO
FTU:	FEMALE TOBACCO

MODAL FACTOR	
MONTHLY BANK DRAFT	1.0
BI-MONTHLY	2.0
QUARTERLY	3.0
SEMI-ANNUAL	6.0
ANNUAL	12.0

RATE.NE.PA.6.07

ADD ONE TIME NON-REFUNDABLE \$10 APPLICATION FEE



NEW ERA LIFE INSURANCE COMPANY
ATTAINED AGE MONTHLY PREMIUM PER INDIVIDUAL - EFFECTIVE 6/1/07
STANDARD MEDICARE SUPPLEMENT PLAN C - PENNSYLVANIA

PLAN C

POLICY FORM H-0020C

ATT. AGE	AREA C			
	MNTU	MTU	FNTU	FTU
<66	89.81	99.79	83.08	92.30
66	89.81	99.79	83.08	92.30
67	92.73	103.03	85.77	95.31
68	95.74	106.38	88.56	98.40
69	98.85	109.83	91.44	101.59
70	102.07	113.41	94.42	104.91
71	105.39	117.09	97.48	108.31
72	108.81	120.89	100.65	111.82
73	112.35	124.83	103.91	115.46
74	115.99	128.88	107.30	119.21
75	119.77	133.07	110.78	123.10
76	123.66	137.39	114.38	127.10
77	127.68	141.86	118.10	131.22
78	131.82	146.47	121.94	135.48
79	136.11	151.23	125.90	139.89
80	140.54	156.14	130.00	144.44
81	145.10	161.22	134.21	149.13
82	149.82	166.47	138.58	153.98
83	154.68	171.87	143.09	158.99
84	159.72	177.46	147.74	164.15
85	164.91	183.23	152.54	169.49
86	170.26	189.19	157.50	175.00
87	175.80	195.34	162.62	180.69
88	181.52	201.68	167.90	186.56
89	187.41	208.24	173.36	192.62
90+	193.51	215.01	178.99	198.88

AREA D			
MNTU	MTU	FNTU	FTU
105.66	117.40	97.73	108.59
105.66	117.40	97.73	108.59
109.09	121.21	100.91	112.12
112.63	125.15	104.19	115.77
116.30	129.22	107.57	119.53
120.08	133.42	111.08	123.41
123.98	137.76	114.68	127.42
128.01	142.23	118.41	131.56
132.17	146.85	122.25	135.84
136.46	151.62	126.23	140.25
140.90	156.55	130.33	144.82
145.48	161.64	134.57	149.52
150.21	166.90	138.95	154.38
155.08	172.32	143.45	159.39
160.12	177.92	148.12	164.57
165.33	183.70	152.93	169.93
170.71	189.67	157.90	175.45
176.25	195.84	163.04	181.15
181.98	202.20	168.34	187.04
187.90	208.78	173.81	193.11
194.01	215.57	179.46	199.40
200.31	222.57	185.29	205.88
206.82	229.81	191.31	212.57
213.55	237.28	197.53	219.48
220.49	244.99	203.95	226.62
227.65	252.95	210.57	233.97

AREA E			
MNTU	MTU	FNTU	FTU
114.11	126.79	105.56	117.28
114.11	126.79	105.56	117.28
117.81	130.91	108.98	121.09
121.65	135.16	112.52	125.03
125.60	139.55	116.18	129.09
129.69	144.10	119.96	133.29
133.90	148.78	123.85	137.62
138.25	153.60	127.88	142.09
142.74	158.60	132.04	146.70
147.38	163.75	136.33	151.47
152.17	169.08	140.76	156.40
157.11	174.57	145.33	161.48
162.23	180.25	150.06	166.73
167.49	186.10	154.93	172.14
172.93	192.15	159.97	177.74
178.56	198.40	165.17	183.53
184.36	204.84	170.53	189.49
190.35	211.50	176.08	195.64
196.54	218.38	181.80	202.01
202.93	225.48	187.71	208.56
209.53	232.81	193.82	215.35
216.34	240.37	200.12	222.35
223.37	248.19	206.62	229.57
230.63	256.26	213.34	237.04
238.12	264.58	220.26	244.74
245.86	273.19	227.42	252.69

AREA F			
MNTU	MTU	FNTU	FTU
131.54	146.15	121.67	135.19
131.54	146.15	121.67	135.19
135.82	150.91	125.63	139.59
140.23	155.82	129.71	144.14
144.79	160.88	133.93	148.81
149.50	166.11	138.30	153.65
154.36	171.51	142.78	158.65
159.37	177.08	147.42	163.80
164.54	182.83	152.20	169.12
169.90	188.77	157.16	174.61
175.42	194.91	162.26	180.30
181.12	201.24	167.54	186.16
187.01	207.78	172.99	192.20
193.08	214.53	178.60	198.44
199.36	221.51	184.41	204.89
205.84	228.71	190.41	211.56
212.54	236.14	196.58	218.44
219.44	243.82	202.98	225.54
226.57	251.74	209.58	232.87
233.93	259.93	216.39	240.43
241.54	268.38	223.43	248.26
249.39	277.10	230.69	256.31
257.50	286.11	238.18	264.65
265.87	295.41	245.93	273.26
274.51	305.00	253.91	282.13
283.43	314.92	262.16	291.30

NO OPEN ENROLLEES OR GUARANTEED ISSUE ENROLLEES WILL BE CHARGED TOBACCO USER RATES
 THE PREMIUM RATE WILL BE AUTOMATICALLY INCREASED EVERY YEAR BASED ON THE INSURED'S ATTAINED AGE.

ZIP CODES	
AREA C	153-188, 195-196
AREA D	150-152, 189, 193-194
AREA E	190
AREA F	191

MNTU:	MALE NON-TOBACCO
MTU:	MALE TOBACCO
FNTU:	FEMALE NON-TOBACCO
FTU:	FEMALE TOBACCO

MODAL FACTOR	
MONTHLY BANK DRAFT	1.0
BI-MONTHLY	2.0
QUARTERLY	3.0
SEMI-ANNUAL	6.0
ANNUAL	12.0

RATE.NE.PA.6.07

ADD ONE TIME NON-REFUNDABLE \$10 APPLICATION FEE



NEW ERA LIFE INSURANCE COMPANY
ATTAINED AGE MONTHLY PREMIUM PER INDIVIDUAL - EFFECTIVE 6/1/07
STANDARD MEDICARE SUPPLEMENT PLAN D - PENNSYLVANIA

PLAN D

POLICY FORM H-0022D

ATT. AGE	AREA C			
	MNTU	MTU	FNTU	FTU
<66	87.83	97.59	81.25	90.27
66	87.83	97.59	81.25	90.27
67	90.69	100.76	83.89	93.21
68	93.64	104.04	86.61	96.24
69	96.67	107.42	89.43	99.36
70	99.82	110.91	92.35	102.60
71	103.07	114.51	95.34	105.93
72	106.42	118.23	98.43	109.36
73	109.87	122.08	101.62	112.92
74	113.44	126.05	104.93	116.59
75	117.13	130.14	108.35	120.39
76	120.93	134.37	111.87	124.30
77	124.87	138.74	115.50	128.33
78	128.92	143.25	119.25	132.50
79	133.11	147.91	123.13	136.81
80	137.44	152.71	127.14	141.26
81	141.91	157.67	131.26	145.85
82	146.52	162.80	135.53	150.59
83	151.28	168.09	139.94	155.49
84	156.20	173.56	144.48	160.54
85	161.28	179.20	149.19	165.76
86	166.52	185.03	154.04	171.15
87	171.93	191.04	159.04	176.71
88	177.52	197.24	164.21	182.45
89	183.29	203.66	169.55	188.38
90+	189.25	210.28	175.05	194.51

AREA D			
MNTU	MTU	FNTU	FTU
103.33	114.81	95.58	106.20
103.33	114.81	95.58	106.20
106.69	118.54	98.69	109.66
110.16	122.40	101.90	113.22
113.74	126.37	105.21	116.90
117.44	130.49	108.64	120.70
121.25	134.72	112.16	124.62
125.19	139.10	115.80	128.67
129.26	143.62	119.56	132.85
133.46	148.29	123.45	137.16
137.80	153.11	127.47	141.63
142.27	158.08	131.60	146.23
146.90	163.22	135.89	150.98
151.67	168.53	140.29	155.88
156.60	174.00	144.86	160.95
161.69	179.66	149.57	166.19
166.95	185.50	154.43	171.59
172.37	191.53	159.45	177.17
177.98	197.75	164.63	182.93
183.76	204.18	169.98	188.87
189.74	210.82	175.51	195.01
195.91	217.67	181.22	201.35
202.27	224.75	187.10	207.89
208.85	232.05	193.19	214.65
215.64	239.60	199.46	221.63
222.64	247.38	205.94	228.83

AREA E			
MNTU	MTU	FNTU	FTU
111.60	124.00	103.23	114.69
111.60	124.00	103.23	114.69
115.22	128.03	106.58	118.42
118.97	132.19	110.05	122.28
122.84	136.48	113.62	126.25
126.84	140.93	117.32	130.36
130.95	145.50	121.13	134.59
135.21	150.22	125.06	138.96
139.60	155.11	129.13	143.48
144.14	160.15	133.33	148.13
148.82	165.36	137.66	152.96
153.65	170.73	142.13	157.93
158.66	176.29	146.76	163.06
163.81	182.01	151.52	168.35
169.13	187.92	156.45	173.83
174.63	194.03	161.53	179.49
180.31	200.34	166.78	185.32
186.16	206.85	172.20	191.34
192.21	213.57	177.80	197.56
198.46	220.52	183.58	203.97
204.92	227.69	189.56	210.61
211.58	235.08	195.71	217.45
218.46	242.73	202.07	224.52
225.56	250.62	208.64	231.83
232.88	258.76	215.42	239.36
240.45	267.18	222.41	247.13

AREA F			
MNTU	MTU	FNTU	FTU
128.65	142.94	119.00	132.21
128.65	142.94	119.00	132.21
132.83	147.59	122.86	136.52
137.14	152.39	126.86	140.96
141.60	157.34	130.99	145.53
146.21	162.46	135.25	150.27
150.96	167.73	139.64	155.15
155.86	173.18	144.18	160.19
160.92	178.80	148.85	165.40
166.16	184.62	153.70	170.76
171.56	190.62	158.69	176.33
177.13	196.82	163.85	182.06
182.90	203.21	169.18	187.97
188.83	209.81	174.67	194.08
194.97	216.64	180.35	200.38
201.31	223.68	186.22	206.90
207.86	230.94	192.26	213.63
214.61	238.46	198.52	220.57
221.58	246.20	204.97	227.74
228.78	254.21	211.62	235.14
236.22	262.47	218.51	242.80
243.91	271.00	225.61	250.67
251.83	279.81	232.94	258.82
260.02	288.91	240.51	267.25
268.47	298.29	248.33	275.93
277.19	307.99	256.40	284.89

NO OPEN ENROLLEES OR GUARANTEED ISSUE ENROLLEES WILL BE CHARGED TOBACCO USER RATES
 THE PREMIUM RATE WILL BE AUTOMATICALLY INCREASED EVERY YEAR BASED ON THE INSURED'S ATTAINED AGE.

ZIP CODES	
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FTU:	FEMALE TOBACCO

MODAL FACTOR	
MONTHLY BANK DRAFT	1.0
BI-MONTHLY	2.0
QUARTERLY	3.0
SEMI-ANNUAL	6.0
ANNUAL	12.0

RATE.NE.PA.6.07

ADD ONE TIME NON-REFUNDABLE \$10 APPLICATION FEE

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 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>HOSPITALIZATION * Semi-private room and board, general nursing and miscellaneous services and supplies.</p> <p>First 60 days</p> <p>61st thru 90th day.....</p> <p>91st day and after:</p> <ul style="list-style-type: none"> - While using 60 lifetime reserve days - Once lifetime reserve days are used: <ul style="list-style-type: none"> - Additional 365 days..... - Beyond the Additional 365 days .. 	<p>All but \$[1,024]</p> <p>All but \$[256] a day</p> <p>All but \$[512] a day</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>\$[256] a day</p> <p>\$[512] a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$[1,024] (Part A Deductible)</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All Costs</p>
<p>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.</p> <p>First 20 days</p> <p>21st thru 100th day.....</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$[128] a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$[128] a day</p> <p>All Costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p>HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited co-insurance for outpatient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance</p>

**** 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 (CONTINUED)

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

* Once you have been billed \$[135] 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 \$[135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$[135] (Part B Deductible) \$0
Part B Excess Charges (Above Medicare Approved Amount)	\$0	\$0	All Costs
BLOOD First 3 pints Next \$[135] of Medicare Approved Amount* Remainder of Medicare Approved Amounts ..	\$0 \$0 Generally 80%	All Costs \$0 Generally 20%	\$0 \$[135] (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES - BLOOD 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 \$[135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 Generally 80%	\$0 \$0 Generally 20%	\$0 \$[135] (Part B Deductible) \$0

PLAN B

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 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>HOSPITALIZATION * Semi-private room and board, general nursing and miscellaneous services and supplies.</p> <p>First 60 days</p> <p>61st thru 90th day.....</p> <p>91st day and after: While using 60 lifetime reserve days</p> <p>Once lifetime reserve days are used: - Additional 365 days</p> <p>- Beyond the Additional 365 days ..</p>	<p>All but \$[1,024]</p> <p>All but \$[256] a day</p> <p>All but \$[512] a day</p> <p>\$0</p> <p>\$0</p>	<p>\$[1,024] (Part A Deductible)</p> <p>\$[256] a day</p> <p>\$[512] a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All Costs</p>
<p>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.</p> <p>First 20 days</p> <p>21st thru 100th day.....</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$[128] a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$[128] a day</p> <p>All Costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p>HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited co-insurance for outpatient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance</p>

** **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 B (CONTINUED)
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed \$[135] 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 \$[135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$[135] (Part B Deductible) \$0
Part B Excess Charges (Above Medicare Approved Amount)	\$0	\$0	All Costs
BLOOD First 3 pints Next \$[135] of Medicare Approved Amount* Remainder of Medicare Approved Amounts	\$0 \$0 Generally 80%	All Costs \$0 Generally 20%	\$0 \$[135] (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES - BLOOD 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 \$[135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 Generally 80%	\$0 \$0 Generally 20%	\$0 \$[135] (Part B Deductible) \$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 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION * Semi-private room and board, general nursing and miscellaneous services and supplies. First 60 days 61st thru 90th day..... 91st day and after: - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days..... - Beyond the Additional 365 days ..	All but \$[1,024] All but \$[256] a day All but \$[512] a day \$0 \$0	\$[1,024] (Part A Deductible) \$[256] a day \$[512] a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$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 21st thru 100th day..... 101st day and after	All approved amounts All but \$[128] a day \$0	\$0 Up to \$[128] a day \$0	\$0 \$0 All Costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited co-insurance for outpatient drugs and inpatient respite care	\$0	Balance

** **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 (CONTINUED)

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

* Once you have been billed \$[135] 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 \$[135] of Medicare Approved Amounts*	\$0	\$[135] (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amount)	\$0	\$0	All Costs
BLOOD First 3 pints	\$0	All Costs	\$0
Next \$[135] of Medicare Approved Amount*	\$0	\$[135] (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
CLINICAL LABORATORY SERVICES - BLOOD 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 \$[135] of Medicare Approved Amounts*	\$0	\$[135] (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over \$50,000 lifetime maximum

PLAN D

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 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>HOSPITALIZATION * Semi-private room and board, general nursing and miscellaneous services and supplies.</p> <p>First 60 days</p> <p>61st thru 90th day.....</p> <p>91st day and after:</p> <ul style="list-style-type: none"> - While using 60 lifetime reserve days - Once lifetime reserve days are used: <ul style="list-style-type: none"> - Additional 365 days..... - Beyond the Additional 365 days .. 	<p>All but \$[1,024]</p> <p>All but \$[256] a day</p> <p>All but \$[512] a day</p> <p>\$0</p> <p>\$0</p>	<p>\$[1,024] (Part A Deductible)</p> <p>\$[256] a day</p> <p>\$[512] a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All Costs</p>
<p>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.</p> <p>First 20 days</p> <p>21st thru 100th day.....</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$[128] a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$[128] a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All Costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p>HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited co-insurance for outpatient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance</p>

**** 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 D (CONTINUED)

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

* Once you have been billed \$[135] 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 \$[135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$0 Generally 20%	 \$[135] (Part B Deductible) \$0
Part B Excess Charges (Above Medicare Approved Amount)	\$0	\$0	All costs
BLOOD First 3 pints Next \$[135] of Medicare Approved Amount* Remainder of Medicare Approved Amounts	 \$0 \$0 Generally 80%	 All Costs \$0 Generally 20%	 \$0 \$[135] (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN D (CONTINUED)

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment: First \$[135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts</p>	<p>100% \$0 Generally 80%</p>	<p>\$0 \$0 Generally 20%</p>	<p>\$0 \$[135] (Part B Deductible) \$0</p>
<p>AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE Home-care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home-Care Treatment Plan - Benefit for each visit - Number of visits covered (must be received within 8 weeks of last Medicare-approved visit) - Calendar year maximum</p>	<p>\$0 \$0 \$0</p>	<p>Actual charges to \$40 a visit Up to the number of Medicare-approved visits, not to exceed 7 each week \$1,600</p>	<p>Balance Balance Balance</p>

OTHER BENEFITS - NOT COVERED BY MEDICARE

<p>FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges</p>	<p>\$0 \$0</p>	<p>\$0 80% to a lifetime maximum benefit of \$50,000</p>	<p>\$250 20% and amounts over \$50,000 lifetime maximum</p>
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