INDIVIDUAL ASSURANCE COMPANY, LIFE, HEALTH & ACCIDENT

Outline Of Medicare Supplement Plans Sold for Effective Date on or After June 1, 2010

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A". Some plans may not be available in your state.

Basic Benefits:

Hospitalization - Part A coinsurance plus coverage for 365 additional days after Medicare benefits end;

Medical Expenses - Part B coinsurance (generally 20% of Medicare-approved expenses) or co-payments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of the part B coinsurance or copayments;

Blood - First three pints of blood each year;

Hospice - Part A coinsurance.

A❖	B	C	D	F❖ F*	G❖	K	L	M	N❖
Basic Including 100% Part B coinsurance	Basic Including 100% Part B coinsurance	Basic Including 100% Part B coinsurance	Basic Including 100% Part B coinsurance	Basic Including 100% Part B coinsurance	Basic Including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic Including 100% Part B coinsurance, except up to $20 co-payment for office visits and up to $50 co-payment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible					
				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
						Out-of-Pocket limit $5120; paid at 100% after limit reached	Out-of-Pocket limit $2560; paid at 100% after limit reached		

❖Plans currently available for sale.

*Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2200 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2200. 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.

Premiums - Monthly Bank Draft
Female
Zip Codes: 970-972
A one-time $25 policy fee applies to each application

Age	Non-Tobacco A	Non-Tobacco F	Non-Tobacco G	Non-Tobacco N	Tobacco A	Tobacco F	Tobacco G	Tobacco N
0-64	127.34	150.17	122.68	97.40	146.45	172.70	141.09	112.01
65	127.34	150.17	122.68	97.40	146.45	172.70	141.09	112.01
66	127.34	150.17	122.68	97.40	146.45	172.70	141.09	112.01
67	127.34	150.17	122.68	97.40	146.45	172.70	141.09	112.01
68	132.77	156.14	128.12	101.63	152.68	179.56	147.34	116.88
69	138.09	162.26	133.70	105.88	158.81	186.59	153.75	121.76
70	143.25	167.94	138.88	109.88	164.73	193.14	159.71	126.36
71	147.53	173.44	143.89	113.90	169.66	199.46	165.48	130.98
72	151.82	178.94	148.90	117.92	174.59	205.78	171.24	135.61
73	156.10	184.43	153.91	121.94	179.52	212.10	177.00	140.23
74	160.39	189.93	158.92	125.96	184.44	218.42	182.76	144.85
75	164.81	195.59	164.07	130.09	189.53	224.93	188.68	149.60
76	168.37	201.16	169.03	134.24	193.63	231.33	194.38	154.38
77	171.98	206.81	174.05	138.46	197.78	237.83	200.16	159.23
78	175.79	212.71	179.30	142.86	202.16	244.61	206.20	164.28
79	179.65	218.70	184.63	147.32	206.60	251.51	212.32	169.42
80	183.72	224.97	190.20	151.98	211.27	258.72	218.73	174.78
81	187.15	231.28	195.80	156.88	215.22	265.97	225.17	180.41
82	190.78	237.89	201.66	161.99	219.40	273.57	231.91	186.29
83	194.48	244.61	207.63	167.20	223.65	281.30	238.77	192.28
84	198.23	251.45	213.70	172.50	227.96	289.17	245.75	198.37
85	202.04	258.42	219.87	177.89	232.34	297.18	252.85	204.57
86	205.92	265.40	226.00	183.21	236.81	305.21	259.90	210.69
87	209.88	272.53	232.27	188.65	241.36	313.41	267.11	216.95
88	213.91	279.82	238.67	194.21	246.00	321.79	274.47	223.35
89	217.83	287.03	245.01	199.74	250.51	330.08	281.76	229.70
90	221.64	294.14	251.27	205.21	254.89	338.27	288.96	235.99
91	224.27	299.96	256.39	209.79	257.90	344.96	294.85	241.26
92	226.92	305.87	261.59	214.44	260.95	351.75	300.83	246.61
93	229.22	311.35	266.43	218.81	263.60	358.06	306.40	251.63
94	231.55	316.91	271.34	223.24	266.28	364.45	312.04	256.73
95	233.90	322.55	276.32	227.74	268.99	370.93	317.77	261.90
96	237.80	327.93	280.92	231.53	273.47	377.12	323.06	266.26
97	241.76	333.39	285.61	235.39	278.03	383.40	328.45	270.70
98	245.79	338.95	290.37	239.31	282.66	389.79	333.92	275.21
99	249.89	344.60	295.21	243.30	287.37	396.29	339.49	279.80

Modal Factors: Annual = MBD x 12; SA = MBD x 6; Q = MBD x 3

Premiums - Monthly Bank Draft
Male
Zip Codes: 970-972
A one-time $25 policy fee applies to each application

	Non-Tobacco				Tobacco			
Age	A	F	G	N	A	F	G	N
0-64	146.45	172.70	141.09	112.01	168.41	198.60	162.25	128.81
65	146.45	172.70	141.09	112.01	168.41	198.60	162.25	128.81
66	146.45	172.70	141.09	112.01	168.41	198.60	162.25	128.81
67	146.45	172.70	141.09	112.01	168.41	198.60	162.25	128.81
68	152.68	179.56	147.34	116.88	175.58	206.50	169.44	134.41
69	158.81	186.59	153.75	121.76	182.63	214.58	176.81	140.02
70	164.73	193.14	159.71	126.36	189.44	222.11	183.67	145.32
71	169.66	199.46	165.48	130.98	195.11	229.38	190.30	150.63
72	174.59	205.78	171.24	135.61	200.78	236.65	196.92	155.95
73	179.52	212.10	177.00	140.23	206.44	243.91	203.55	161.26
74	184.44	218.42	182.76	144.85	212.11	251.18	210.17	166.58
75	189.53	224.93	188.68	149.60	217.96	258.67	216.98	172.04
76	193.63	231.33	194.38	154.38	222.67	266.03	223.54	177.54
77	197.78	237.83	200.16	159.23	227.45	273.50	230.19	183.11
78	202.16	244.61	206.20	164.28	232.48	281.31	237.13	188.93
79	206.60	251.51	212.32	169.42	237.59	289.23	244.17	194.83
80	211.27	258.72	218.73	174.78	242.96	297.53	251.54	201.00
81	215.22	265.97	225.17	180.41	247.50	305.87	258.95	207.47
82	219.40	273.57	231.91	186.29	252.31	314.61	266.70	214.23
83	223.65	281.30	238.77	192.28	257.20	323.50	274.59	221.12
84	227.96	289.17	245.75	198.37	262.16	332.55	282.61	228.13
85	232.34	297.18	252.85	204.57	267.20	341.75	290.78	235.26
86	236.81	305.21	259.90	210.69	272.34	350.99	298.89	242.30
87	241.36	313.41	267.11	216.95	277.57	360.42	307.17	249.49
88	246.00	321.79	274.47	223.35	282.90	370.06	315.64	256.85
89	250.51	330.08	281.76	229.70	288.09	379.60	324.02	264.15
90	254.89	338.27	288.96	235.99	293.12	389.01	332.30	271.39
91	257.90	344.96	294.85	241.26	296.59	396.70	339.07	277.44
92	260.95	351.75	300.83	246.61	300.10	404.51	345.95	283.60
93	263.60	358.06	306.40	251.63	303.15	411.77	352.36	289.38
94	266.28	364.45	312.04	256.73	306.22	419.12	358.85	295.24
95	268.99	370.93	317.77	261.90	309.33	426.58	365.43	301.18
96	273.47	377.12	323.06	266.26	314.49	433.68	371.52	306.20
97	278.03	383.40	328.45	270.70	319.73	440.91	377.71	311.30
98	282.66	389.79	333.92	275.21	325.06	448.26	384.01	316.49
99	287.37	396.29	339.49	279.80	330.48	455.73	390.41	321.77

Modal Factors: Annual = MBD x 12; SA = MBD x 6; Q = MBD x 3

Premiums - Monthly Bank Draft
Female
Zip Codes: 973-979
A one-time $25 policy fee applies to each application

Age	Non-Tobacco A	Non-Tobacco F	Non-Tobacco G	Non-Tobacco N	Tobacco A	Tobacco F	Tobacco G	Tobacco N
0-64	118.56	139.82	114.22	90.68	136.35	160.79	131.36	104.28
65	118.56	139.82	114.22	90.68	136.35	160.79	131.36	104.28
66	118.56	139.82	114.22	90.68	136.35	160.79	131.36	104.28
67	118.56	139.82	114.22	90.68	136.35	160.79	131.36	104.28
68	123.61	145.37	119.29	94.62	142.15	167.18	137.18	108.82
69	128.57	151.07	124.48	98.58	147.85	173.73	143.15	113.36
70	133.37	156.36	129.30	102.30	153.37	179.82	148.70	117.65
71	137.36	161.48	133.97	106.04	157.96	185.70	154.06	121.95
72	141.35	166.60	138.63	109.79	162.55	191.59	159.43	126.25
73	145.34	171.71	143.30	113.53	167.14	197.47	164.79	130.56
74	149.32	176.83	147.96	117.27	171.72	203.36	170.16	134.86
75	153.44	182.10	152.75	121.11	176.46	209.42	175.67	139.28
76	156.76	187.28	157.37	124.98	180.27	215.38	180.97	143.73
77	160.12	192.54	162.05	128.91	184.14	221.42	186.36	148.25
78	163.67	198.04	166.94	133.00	188.21	227.74	191.98	152.96
79	167.26	203.62	171.90	137.16	192.35	234.16	197.68	157.74
80	171.05	209.46	177.08	141.50	196.70	240.87	203.64	162.72
81	174.24	215.33	182.30	146.06	200.38	247.63	209.64	167.97
82	177.63	221.48	187.75	150.82	204.27	254.70	215.92	173.44
83	181.07	227.74	193.31	155.67	208.23	261.90	222.30	179.02
84	184.56	234.11	198.96	160.60	212.24	269.23	228.80	184.69
85	188.11	240.59	204.71	165.62	216.32	276.68	235.42	190.47
86	191.72	247.09	210.42	170.58	220.48	284.16	241.98	196.16
87	195.41	253.74	216.25	175.64	224.72	291.80	248.68	201.99
88	199.16	260.52	222.21	180.82	229.03	299.60	255.54	207.94
89	202.81	267.23	228.11	185.96	233.23	307.32	262.33	213.86
90	206.36	273.86	233.94	191.06	237.31	314.94	269.03	219.71
91	208.80	279.27	238.71	195.32	240.12	321.17	274.51	224.62
92	211.27	284.77	243.55	199.65	242.96	327.49	280.08	229.60
93	213.41	289.88	248.06	203.72	245.43	333.36	285.27	234.28
94	215.58	295.06	252.63	207.85	247.92	339.32	290.52	239.02
95	217.77	300.31	257.26	212.03	250.44	345.35	295.85	243.84
96	221.40	305.31	261.55	215.56	254.61	351.11	300.78	247.90
97	225.09	310.40	265.91	219.16	258.85	356.96	305.80	252.03
98	228.84	315.57	270.34	222.81	263.17	362.91	310.89	256.23
99	232.66	320.83	274.85	226.52	267.55	368.96	316.07	260.50

Modal Factors: Annual = MBD x 12; SA = MBD x 6; Q = MBD x 3

Premiums - Monthly Bank Draft
Male
Zip Codes: 973-979
A one-time $25 policy fee applies to each application

	Non-Tobacco				Tobacco			
Age	A	F	G	N	A	F	G	N
0-64	136.35	160.79	131.36	104.28	156.80	184.91	151.06	119.92
65	136.35	160.79	131.36	104.28	156.80	184.91	151.06	119.92
66	136.35	160.79	131.36	104.28	156.80	184.91	151.06	119.92
67	136.35	160.79	131.36	104.28	156.80	184.91	151.06	119.92
68	142.15	167.18	137.18	108.82	163.47	192.26	157.76	125.14
69	147.85	173.73	143.15	113.36	170.03	199.79	164.62	130.37
70	153.37	179.82	148.70	117.65	176.38	206.79	171.00	135.29
71	157.96	185.70	154.06	121.95	181.65	213.56	177.17	140.24
72	162.55	191.59	159.43	126.25	186.93	220.33	183.34	145.19
73	167.14	197.47	164.79	130.56	192.21	227.09	189.51	150.14
74	171.72	203.36	170.16	134.86	197.48	233.86	195.68	155.09
75	176.46	209.42	175.67	139.28	202.93	240.83	202.02	160.17
76	180.27	215.38	180.97	143.73	207.31	247.68	208.12	165.29
77	184.14	221.42	186.36	148.25	211.76	254.64	214.31	170.48
78	188.21	227.74	191.98	152.96	216.45	261.90	220.77	175.90
79	192.35	234.16	197.68	157.74	221.20	269.28	227.33	181.40
80	196.70	240.87	203.64	162.72	226.21	277.01	234.19	187.13
81	200.38	247.63	209.64	167.97	230.43	284.77	241.09	193.16
82	204.27	254.70	215.92	173.44	234.91	292.91	248.30	199.46
83	208.23	261.90	222.30	179.02	239.46	301.19	255.65	205.87
84	212.24	269.23	228.80	184.69	244.08	309.61	263.12	212.39
85	216.32	276.68	235.42	190.47	248.77	318.18	270.73	219.04
86	220.48	284.16	241.98	196.16	253.55	326.78	278.28	225.59
87	224.72	291.80	248.68	201.99	258.43	335.57	285.99	232.29
88	229.03	299.60	255.54	207.94	263.39	344.54	293.87	239.13
89	233.23	307.32	262.33	213.86	268.22	353.42	301.67	245.93
90	237.31	314.94	269.03	219.71	272.91	362.18	309.39	252.67
91	240.12	321.17	274.51	224.62	276.14	369.34	315.69	258.31
92	242.96	327.49	280.08	229.60	279.40	376.61	322.09	264.04
93	245.43	333.36	285.27	234.28	282.24	383.37	328.06	269.42
94	247.92	339.32	290.52	239.02	285.11	390.22	334.10	274.88
95	250.44	345.35	295.85	243.84	288.00	397.16	340.23	280.41
96	254.61	351.11	300.78	247.90	292.80	403.78	345.90	285.08
97	258.85	356.96	305.80	252.03	297.68	410.50	351.67	289.84
98	263.17	362.91	310.89	256.23	302.64	417.35	357.53	294.67
99	267.55	368.96	316.07	260.50	307.69	424.30	363.49	299.58

Modal Factors: Annual = MBD x 12; SA = MBD x 6; Q = MBD x 3

PREMIUM INFORMATION
We, Individual Assurance Company, Life, Health & Accident, can only raise your premium if we raise the premium for all policies like yours in this State. We will not change the premiums for this policy during your first year of coverage. Thereafter your premium will increase each year based on your age at that time. No rate adjustment may be made on an individual basis. Also, your renewal premiums may change on a renewal date following the Effective Date of any change in the deductible and/or coinsurance amounts which you are required to pay under Medicare. Any such premium change will be based on the actuarial computations that we then use to determine the renewal premium.

DISCLOSURES
Use this outline to compare benefits and premiums among policies, certificates and contracts.

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 us at: PO Box 3270, Salt Lake City, Utah 84110-3270. 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 Individual Assurance Company, Life, Health & Accident 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.

PLAN A
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1316	$0	$1316 (Part A deductible)
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but $658 a day	$658 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 $164.50 a day	$0	Up to $164.50 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 (continued)
MEDICARE (Part B) - MEDICAL SERVICES -PER CALENDAR YEAR

*** Once you have been billed $183 of Medicare-Approved amounts for covered services (which are noted with a double 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 TREATMENT, such as Physician's services, inpatient and out-patient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $183 of Medicare Approved Amounts**	$0	$0	$183 (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 $183 of Medicare Approved Amounts**	$0	$0	$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

Part A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
-Medically necessary skilled care services and medical supplies	100%	$0	$0
-Durable medical equipment			
First $183 of Medicare Approved Amounts**	$0	$0	$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN F
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1316	$1316 (Part A deductible)	$0
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but $658 a day	$658 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 $164.50 a day	Up to $164.50 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 F (continued)
MEDICARE (Part B) - MEDICAL SERVICES -PER CALENDAR YEAR

*** Once you have been billed $183 of Medicare-Approved amounts for covered services (which are noted with a double 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 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 $183 of Medicare Approved Amounts**	$0	$183 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $183 of Medicare Approved Amounts**	$0	$183 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
Part A & B			
HOME HEALTH CARE - MEDICARE APPROVED SERVICES			
-Medically necessary skilled care services and medical supplies	100%	$0	$0
-Durable medical equipment			
First $183 of Medicare Approved Amounts**	$0	$183 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	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 the $50,000 lifetime maximum

PLAN G
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1316	$1316 (Part A deductible)	$0
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but $658 a day	$658 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 $164.50 a day	Up to $164.50 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 (continued)
MEDICARE (Part B) - MEDICAL SERVICES -PER CALENDAR YEAR

*** Once you have been billed $183 of Medicare-Approved amounts for covered services (which are noted with a double 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 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 $183 of Medicare Approved Amounts**	$0	$0	$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $183 of Medicare Approved Amounts**	$0	$0	$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
Part A & B			
HOME HEALTH CARE - MEDICARE APPROVED SERVICES			
-Medically necessary skilled care services and medical supplies	100%	$0	$0
-Durable medical equipment			
First $183 of Medicare Approved Amounts**	$0	$0	$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	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 the $50,000 lifetime maximum

PLAN N

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1316	$1316 (Part A deductible)	$0
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but $658 a day	$658 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 $164.50 a day	Up to $164.50 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 (continued)
MEDICARE (Part B) - MEDICAL SERVICES -PER CALENDAR YEAR

*** Once you have been billed $183 of Medicare-Approved amounts for covered services (which are noted with a double 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 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 $183 of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	$0 Generally 80%	$0 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	$183 (Part B Deductible) 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 Next $183 of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	 $0 $0 80%	 All costs $0 20%	 $0 $183 (Part B Deductible) $0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
Part A & B			
HOME HEALTH CARE - MEDICARE APPROVED SERVICES -Medically necessary skilled care services and medical supplies -Durable medical equipment First $183 of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 $183 (Part B Deductible) $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 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

Premium Calculation

Medicare Supplement Plan _____

	Steps	**Example** – *Information displayed is for illustrational purposes only*	**Enrollee**
#1	**Enrollee Age** **Enrollee Zip Code**	65 12345	
#2	**Premium** Premium shown in Outline of Coverage	$150.00	
#3	**Household Premium Discount** If the applicant lives with his or her spouse, or partner in a civil union, or has continuously lived with at least one but no more than 3 other adults for at least a year, multiply premium by .93	$150.00 x .93 = $139.50	
#4	**Payment Options** Modal Premiums – To determine other pay schedules, multiply the monthly premium by: Annual = MBD x 12 Semi-Annual = MBD x 6 Quarterly= MBD x 3		

Receipt

Please Note: All premium checks must be made payable to Individual Assurance Company. ***Do not make checks payable to the insurance agent or leave the payee line blank.***

Received from _____

the sum of $_____ for _____ months premium, with this application. If for any reason the application is not approved and the policy is not issued, this premium is to be refunded. No liability is created or assumed by the Company, except for refund of this premium, until the policy applied for has been issued.

Date Receipt and Outline of Coverage was prepared _____, 20 _____

by _____

Agent's Signature

Individual Assurance Company, PO Box 3270, Salt Lake City, UT 84110-3270