Explanation of Part B Expenses

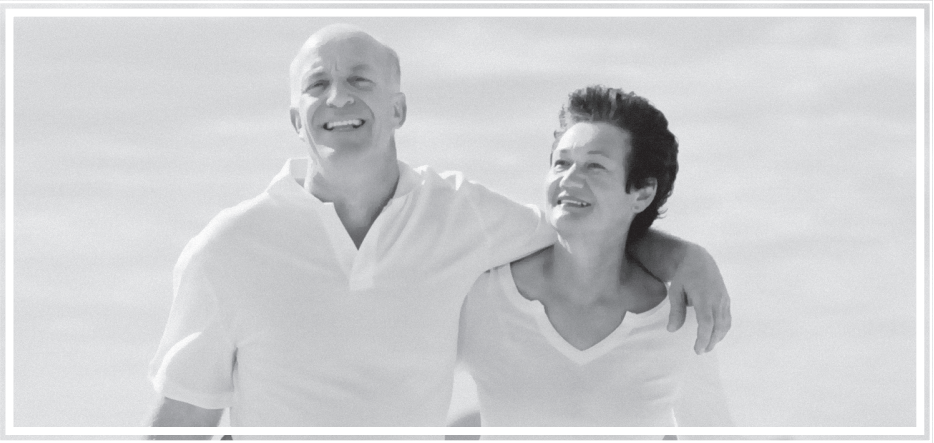
An explanation of Part B Calculations: (Excluding Outpatient Hospital Services)	CHARGE PER OCCURRENCE		TOTAL CHARGE	
	PATIENT INCURRED	MEDICARE APPROVED	PATIENT INCURRED	MEDICARE APPROVED
10 Doctor Office Visits	$ 110	$ 100	$ 1,100	$ 1,000
Specialist #1	157	137	157	137
Specialist #2	314	273	314	273
Surgeon's 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
			$ 43,837	$ 39,592
Less Part B Deductible				- $183
				$ 39,409
Medicare Payment Rate				× 80%
Medicare Paid				$ 31,527
Total Part B Expenses				$ 43,837
Less Medicare Paid				- 31,527
PATIENT LIABILITY ◆				**$ 12,310**

◆ Some Doctors did not accept Medicare's 'Approved Charge' as full payment. The most a non-participating physician can charge for most services covered by Medicare is 115% of the physician 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 2018



CHRISTIANCARE360

"LET US REBUILD THE CITY WALLS" - NEHEMIAH

ChristianCare360.com

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.

We offer 10 of the 11 standardized plans:

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

See the chart below for plans we offer; 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%	100% ●
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■							$5,240	$2,620	

Plan availability may vary by state.

▼ 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 deductible. Benefits from high deductible Plan F begin after out-of-pocket expenses exceed the calendar-year deductible *($2,240 in 2018)*. Out-of-pocket expenses for this deductible are expenses that are ordinarily 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. Out-of-pocket expenses do not include premium.

■ Plans K and L provide for different out-of-pocket cost-sharing *(50% for Plan K, 25% for Plan L)*. Once you reach the annual limit *($5,240 for Plan K, $2,620 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 may be increased each year for inflation. This limit does not include premium.

● 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 $335 for days 61-90, then $670 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 (SNF) for 100 days. Medicare paid for the first 20 days of confinement; for days 21 through 100, the patient paid $167.50 a day.

PART B eligible expenses for medical services included 10 visits to the doctor (each visit cost at least $100) 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 $183 Medicare Part B deductible which is subtracted from the total "Approved Charges." For outpatient hospital charges, our patient's co-payment liability was established by Medicare's national co-payment 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 co-payment.

After Medicare Parts A and B — but without any supplemental insurance — our patient owed $97,861 for this illness. This example, coupled with this side-by-side guide, demonstrates how United American Medicare Supplement ProCare policies can make a dramatic difference for our patient's life savings.

PATIENT LIABILITY		PLAN A	PLAN B	PLAN C	PLAN D
PART A					
DAILY HOSPITAL CHARGES:					
Days 1-60, Part A Deductible	$1,340	Not Covered	$1,340	$1,340	$1,340
Days 61-90 @ $335 per day	$10,050	$10,050	$10,050	$10,050	$10,050
Days 91-150 @ $670 per day	$40,200	$40,200	$40,200	$40,200	$40,200
Days 151-170, All Charges	$20,000	$20,000	$20,000	$20,000	$20,000
BLOOD:					
3 Pints @ $60 per pint	$180	$180	$180	$180	$180
Part A Subtotal	**$71,770**	**$70,430**	**$71,770**	**$71,770**	**$71,770**
SKILLED NURSING FACILITY:					
Days 21-100 @ $167.50 per day	$13,400	Not Covered	Not Covered	$13,400	$13,400
Part A Total	**$85,170**	**$70,430**	**$71,770**	**$85,170**	**$85,170**
PART B					
OUTPATIENT HOSPITAL SERVICES: ▲					
	$381	$381	$381	$381	$381
PART B DEDUCTIBLE:					
	$183	NOT COVERED	NOT COVERED	$183	NOT COVERED
20% OF APPROVED CHARGES:					
(NOT COVERED BY MEDICARE)	$7,882	$7,882	$7,882	$7,882	$7,882
EXCESS CHARGES: ▲▲					
(NOT COVERED BY MEDICARE)	$4,245	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Part B Total	**$12,691**	**$8,263**	**$8,263**	**$8,446**	**$8,263**
DEDUCTIBLE / OUT-OF-POCKET LIMIT					
MEDICARE UNPAID	***$97,861***	***$97,861***	***$97,861***	***$97,861***	***$97,861***
PLAN PAYS		***$78,693***	***$80,033***	***$93,616***	***$93,433***
PATIENT PAYS	***$97,861***	***$19,168***	***$17,828***	***$4,245***	***$4,428***

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

▲▲ The most a non-participating physician can charge for most services covered by Medicare is 115% of the physician fee schedule amount.

	PLAN F	PLAN HDF	PLAN G	PLAN K	PLAN L	PLAN N
PART A						
DAILY HOSPITAL CHARGES:						
	$1,340	$1,340	$1,340	$670	$1,005	$1,340
	$10,050	$10,050	$10,050	$10,050	$10,050	$10,050
	$40,200	$40,200	$40,200	$40,200	$40,200	$40,200
	$20,000	$20,000	$20,000	$20,000	$20,000	$20,000
BLOOD:						
	$180	$180	$180	$90	$135	$180
Part A Subtotal	**$71,770**	**$71,770**	**$71,770**	**$71,010**	**$71,390**	**$71,770**
SKILLED NURSING FACILITY:						
	$13,400	$13,400	$13,400	$6,700	$10,050	$13,400
Part A Total	**$85,170**	**$85,170**	**$85,170**	**$77,710**	**$81,440**	**$85,170**
PART B						
OUTPATIENT HOSPITAL SERVICES: ▲						
	$381	$381	$381	(50%) $191	(75%) $286	$381
PART B DEDUCTIBLE:						
	$183	$183	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
20% OF APPROVED CHARGES:						
	$7,882	$7,882	$7,882	(50%) $3,941	(75%) $5,912	$7,682
EXCESS CHARGES: ▲▲						
	$4,245	$4,245	$4,245	NOT COVERED	NOT COVERED	NOT COVERED
Part B Total	**$12,691**	**$12,691**	**$12,508**	**$4,132**	**$6,198**	**$8,063**
DEDUCTIBLE / OUT-OF-POCKET LIMIT		***DEDUCTIBLE $2,240***		***ANNUAL LIMIT $5,240***	***ANNUAL LIMIT $2,620***	
MEDICARE UNPAID	***$97,861***	***$97,861***	***$97,861***	***$97,861***	***$97,861***	***$97,861***
PLAN PAYS	***$97,861***	***$95,621***	***$97,678***	***$88,193***	***$90,813***	***$93,233***
PATIENT PAYS	***0***	***$2,240***	***$183***	***$9,668***	***$7,048***	***$4,628***

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

▲▲ The most a non-participating physician can charge for most services covered by Medicare is 115% of the physician fee schedule amount.