

SERFF Tracking Number: NELLI-127180425 State: Arkansas  
Filing Company: Philadelphia American Life Insurance Company State Tracking Number: 48872  
Company Tracking Number: MS.A.PAL.AR  
TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.012 Multi-Plan 2010  
Standard Plans 2010  
Product Name: MS.A.PAL.AR  
Project Name/Number: MS.A.PAL.AR/MS.A.PAL.AR

## Filing at a Glance

Company: Philadelphia American Life Insurance Company

Product Name: MS.A.PAL.AR SERFF Tr Num: NELLI-127180425 State: Arkansas  
TOI: MS08I Individual Medicare Supplement - SERFF Status: Closed-Approved- State Tr Num: 48872  
Standard Plans 2010 Closed  
Sub-TOI: MS08I.012 Multi-Plan 2010 Co Tr Num: MS.A.PAL.AR State Status: Approved-Closed  
Filing Type: Form/Rate Reviewer(s): Stephanie Fowler  
Author: Brian Hull Disposition Date: 07/06/2011  
Date Submitted: 05/25/2011 Disposition Status: Approved-Closed  
Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

## General Information

Project Name: MS.A.PAL.AR Status of Filing in Domicile: Authorized  
Project Number: MS.A.PAL.AR Date Approved in Domicile: 04/21/2010  
Requested Filing Mode: Review & Approval Domicile Status Comments:  
Explanation for Combination/Other: Market Type: Individual  
Submission Type: New Submission Individual Market Type:  
Overall Rate Impact: Filing Status Changed: 07/06/2011  
State Status Changed: 07/06/2011  
Deemer Date: Created By: Brian Hull  
Submitted By: Brian Hull Corresponding Filing Tracking Number:

Filing Description:  
RE: NEW FORMS FILING – 2010 INDIVIDUAL STANDARDIZED MEDICARE SUPPLEMENT PLANS  
PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY  
NAIC # 67784 / FEIN # 74-1952955

Form Number / Description

MS.A.PAL.AR / Plan A Medicare Supplement Policy  
MS.C.PAL.AR / Plan C Medicare Supplement Policy  
MS.D.PAL.AR / Plan D Medicare Supplement Policy  
MS.F.PAL.AR / Plan F Medicare Supplement Policy

SERFF Tracking Number: NELL-127180425 State: Arkansas  
 Filing Company: Philadelphia American Life Insurance Company State Tracking Number: 48872  
 Company Tracking Number: MS.A.PAL.AR  
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.012 Multi-Plan 2010  
 Standard Plans 2010  
 Product Name: MS.A.PAL.AR  
 Project Name/Number: MS.A.PAL.AR/MS.A.PAL.AR

MS.FX.PAL.AR / High Deductible Plan F Medicare Supplement Policy  
 MS.G.PAL.AR / Plan G Medicare Supplement Policy  
 MS.N.PAL.AR / Plan N Medicare Supplement Policy  
 MS.APP.PAL.AR / Application  
 MS.REPL.PAL / Replacement Notice  
 MS.PREEX.AMD.PAL / Pre-Existing Condition Deletion Amendment  
 MS.OOC.PAL.AR / Outline of Coverage

We are submitting the captioned forms for your consideration and approval. These forms are new and not intended to replace any existing approved forms. Other than state specific differences, if there are any, identical forms were filed in our domiciliary state of Texas on April 21, 2010. No part of this filing contains any unusual or controversial items from normal company or industry standards. The forms will be marketed by captive and independent agents.

## Company and Contact

### Filing Contact Information

Brian Hull, bhull@neweralife.com  
 200 Westlake Blvd. Ste. #1200 281-368-7278 [Phone]  
 Houston, TX 77079

### Filing Company Information

Philadelphia American Life Insurance Company CoCode: 67784 State of Domicile: Texas  
 200 Westlake Park #1200 Group Code: 520 Company Type:  
 Houston, TX 77079 Group Name: State ID Number:  
 (281) 368-7200 ext. [Phone] FEIN Number: 74-1952955

-----

## Filing Fees

Fee Required? Yes  
 Fee Amount: \$650.00  
 Retaliatory? Yes  
 Fee Explanation: AR fees: 12 forms, 1 rate  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Philadelphia American Life Insurance Company	\$650.00	05/25/2011	47987940

SERFF Tracking Number: NELI-127180425 State: Arkansas  
 Filing Company: Philadelphia American Life Insurance Company State Tracking Number: 48872  
 Company Tracking Number: MS.A.PAL.AR  
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.012 Multi-Plan 2010  
 Standard Plans 2010  
 Product Name: MS.A.PAL.AR  
 Project Name/Number: MS.A.PAL.AR/MS.A.PAL.AR

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	07/06/2011	07/06/2011

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Stephanie Fowler	06/30/2011	06/30/2011	Brian Hull	07/06/2011	07/06/2011
Pending Industry Response	Stephanie Fowler	06/24/2011	06/24/2011	Brian Hull	06/27/2011	06/27/2011

SERFF Tracking Number: NELL-127180425 State: Arkansas  
 Filing Company: Philadelphia American Life Insurance Company State Tracking Number: 48872  
 Company Tracking Number: MS.A.PAL.AR  
 TOI: MS08I Individual Medicare Supplement - Standard Plans 2010 Sub-TOI: MS08I.012 Multi-Plan 2010  
 Product Name: MS.A.PAL.AR  
 Project Name/Number: MS.A.PAL.AR/MS.A.PAL.AR

## Disposition

Disposition Date: 07/06/2011

Implementation Date:

Status: Approved-Closed

Comment: This approval is subject to the following:

- Increases will not be given more frequently than once in a twelve-month period;
- The insured shall be notified by the insurer of its intention to increase the rate for renewal not less than thirty (30) days prior to the effective date of the renewal.

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Philadelphia American Life Insurance Company	%	%	\$		\$	%	%

SERFF Tracking Number: NELL-127180425 State: Arkansas  
 Filing Company: Philadelphia American Life Insurance Company State Tracking Number: 48872  
 Company Tracking Number: MS.A.PAL.AR  
 TOI: MS081 Individual Medicare Supplement - Sub-TOI: MS081.012 Multi-Plan 2010  
 Standard Plans 2010  
 Product Name: MS.A.PAL.AR  
 Project Name/Number: MS.A.PAL.AR/MS.A.PAL.AR

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification	Approved	No
Supporting Document	Outline of Coverage	Approved	Yes
Supporting Document	redline changes example		No
Form (revised)	Policy - Plan A	Approved	Yes
Form	Policy - Plan A	Disapproved	No
Form	Policy - Plan A	Disapproved	No
Form (revised)	Policy - Plan C	Approved	Yes
Form	Policy - Plan C	Disapproved	No
Form	Policy - Plan C	Disapproved	No
Form (revised)	Policy - Plan D	Approved	Yes
Form	Policy - Plan D	Disapproved	No
Form	Policy - Plan D	Disapproved	No
Form (revised)	Policy - Plan F	Approved	Yes
Form	Policy - Plan F	Disapproved	No
Form	Policy - Plan F	Disapproved	No
Form (revised)	Policy - High Ded. Plan F	Approved	Yes
Form	Policy - High Ded. Plan F	Disapproved	No
Form	Policy - High Ded. Plan F	Disapproved	No
Form (revised)	Policy - Plan G	Approved	Yes
Form	Policy - Plan G	Disapproved	No
Form	Policy - Plan G	Disapproved	No
Form (revised)	Policy - Plan N	Approved	Yes
Form	Policy - Plan N	Disapproved	No
Form	Policy - Plan N	Disapproved	No
Form (revised)	Application	Approved	Yes
Form	Application	Disapproved	No
Form	Replacement Form	Approved	Yes
Form	Pre-Existing Condition Amendment	Approved	Yes
Form (revised)	Brochure	Approved	Yes
Form	Brochure	Disapproved	No
Form (revised)	Outline of Coverage	Approved	Yes
Form	Outline of Coverage	Disapproved	No



SERFF Tracking Number: NELI-127180425 State: Arkansas  
Filing Company: Philadelphia American Life Insurance Company State Tracking Number: 48872  
Company Tracking Number: MS.A.PAL.AR  
TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.012 Multi-Plan 2010  
Standard Plans 2010  
Product Name: MS.A.PAL.AR  
Project Name/Number: MS.A.PAL.AR/MS.A.PAL.AR

## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 06/30/2011  
Submitted Date 06/30/2011  
Respond By Date 08/01/2011

Dear Brian Hull,

This will acknowledge receipt of the captioned filing.

### Objection 1

- Policy - Plan A, MS.A.PAL.AR (Form)
- Policy - Plan C, MS.C.PAL.AR (Form)
- Policy - Plan D, MS.D.PAL.AR (Form)
- Policy - Plan F, MS.F.PAL.AR (Form)
- Policy - High Ded. Plan F, MS.FX.PAL.AR (Form)
- Policy - Plan G, MS.G.PAL.AR (Form)
- Policy - Plan N, MS.N.PAL.AR (Form)

Comment: ACA 23-79-112 (b)(8) states that "every policy shall specify...the conditions pertaining to the insurance." Since these forms include a Pre-Existing Condition provision, please include a statement to that effect on the cover of these policies.

### Objection 2

- Policy - Plan A, MS.A.PAL.AR (Form)
- Policy - Plan C, MS.C.PAL.AR (Form)
- Policy - Plan D, MS.D.PAL.AR (Form)
- Policy - Plan F, MS.F.PAL.AR (Form)
- Policy - High Ded. Plan F, MS.FX.PAL.AR (Form)
- Policy - Plan G, MS.G.PAL.AR (Form)
- Policy - Plan N, MS.N.PAL.AR (Form)

Comment: PREMIUM PAYMENT provision - Please remove the language that states that the premiums may be changed "at any time and from time to time". As was pointed out previously, this information is not correct.

### Objection 3

- Application, MS.APP.PAL.AR (Form)

Comment: R&R 27, Sec. 11 prohibits discrimination of pricing during Open Enrollment. The Tobacco Use question is an underwriting question and we ask that it be moved to the Medical Question section since it is not required to be answered during Open Enrollment.

SERFF Tracking Number: NELL-127180425 State: Arkansas  
Filing Company: Philadelphia American Life Insurance Company State Tracking Number: 48872  
Company Tracking Number: MS.A.PAL.AR  
TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.012 Multi-Plan 2010  
Standard Plans 2010  
Product Name: MS.A.PAL.AR  
Project Name/Number: MS.A.PAL.AR/MS.A.PAL.AR

#### Objection 4

- Brochure, MS.BRO.PAL.AR (Form)

Comment: INSURED BILLING - second bullet point - AR Rule 27, Sec. 6C prohibits a policy fee or any other similar charge. Please remove this language from this form and from any other forms in this filing.

#### Objection 5

- Outline of Coverage, MS.OOC.PAL.AR (Form)

Comment: As stated in a different objection, policy fees are not allowed. Please remove this language.

#### Objection 6

- Rates, [MS.A.PAL.AR, MS.C.PAL.AR, MS.D.PAL.AR, MS.F.PAL.AR, MS.FX.PAL.AR, MS.G.PAL.AR, MS.N.PAL.AR] (Rate)

Comment: As stated in a different objection, policy fees are not allowed. Please remove this language.

Please feel free to contact me if you have questions.

Sincerely,

Stephanie Fowler

SERFF Tracking Number: NELI-127180425 State: Arkansas  
 Filing Company: Philadelphia American Life Insurance Company State Tracking Number: 48872  
 Company Tracking Number: MS.A.PAL.AR  
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.012 Multi-Plan 2010  
 Standard Plans 2010  
 Product Name: MS.A.PAL.AR  
 Project Name/Number: MS.A.PAL.AR/MS.A.PAL.AR

## Response Letter

Response Letter Status Submitted to State  
 Response Letter Date 07/06/2011  
 Submitted Date 07/06/2011

Dear Stephanie Fowler,

### Comments:

Thank you for your review of our filing.

### Response 1

Comments: Added Pre-Existing Condition to first page of policy.

### Related Objection 1

Applies To:

- Policy - Plan A, MS.A.PAL.AR (Form)
- Policy - Plan C, MS.C.PAL.AR (Form)
- Policy - Plan D, MS.D.PAL.AR (Form)
- Policy - Plan F, MS.F.PAL.AR (Form)
- Policy - High Ded. Plan F, MS.FX.PAL.AR (Form)
- Policy - Plan G, MS.G.PAL.AR (Form)
- Policy - Plan N, MS.N.PAL.AR (Form)

Comment:

ACA 23-79-112 (b)(8) states that "every policy shall specify...the conditions pertaining to the insurance." Since these forms include a Pre-Existing Condition provision, please include a statement to that effect on the cover of these policies.

### Changed Items:

No Supporting Documents changed.

### Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific	Readability Score	Attach Document

SERFF Tracking Number: NELI-127180425 State: Arkansas  
 Filing Company: Philadelphia American Life Insurance Company State Tracking Number: 48872  
 Company Tracking Number: MS.A.PAL.AR  
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.012 Multi-Plan 2010  
 Standard Plans 2010

Product Name: MS.A.PAL.AR

Project Name/Number: MS.A.PAL.AR/MS.A.PAL.AR

Policy - Plan A MS.A.PAL Policy/Contract/Fraternal Initial 50.900 MS.A.PAL  
 .AR Certificate .AR.pdf

**Previous Version**

Policy - Plan A MS.A.PAL Policy/Contract/Fraternal Initial 50.900 MS.A.PAL  
 .AR Certificate .AR.pdf

Policy - Plan A MS.A.PAL Policy/Contract/Fraternal Initial 50.900 MS.A.PAL  
 .AR Certificate .AR.pdf

Policy - Plan C MS.C.PAL Policy/Contract/Fraternal Initial 51.800 MS.C.PAL  
 .AR Certificate .AR.pdf

**Previous Version**

Policy - Plan C MS.C.PAL Policy/Contract/Fraternal Initial 51.800 MS.C.PAL  
 .AR Certificate .AR.pdf

Policy - Plan C MS.C.PAL Policy/Contract/Fraternal Initial 51.800 MS.C.PAL  
 .AR Certificate .AR.pdf

Policy - Plan D MS.D.PAL Policy/Contract/Fraternal Initial 51.000 MS.D.PAL  
 .AR Certificate .AR.pdf

**Previous Version**

Policy - Plan D MS.D.PAL Policy/Contract/Fraternal Initial 51.000 MS.D.PAL  
 .AR Certificate .AR.pdf

Policy - Plan D MS.D.PAL Policy/Contract/Fraternal Initial 51.000 MS.D.PAL  
 .AR Certificate .AR.pdf

Policy - Plan F MS.F.PAL Policy/Contract/Fraternal Initial 50.700 MS.F.PAL  
 .AR Certificate .AR.pdf

**Previous Version**

Policy - Plan F MS.F.PAL Policy/Contract/Fraternal Initial 50.700 MS.F.PAL  
 .AR Certificate .AR.pdf

Policy - Plan F MS.F.PAL Policy/Contract/Fraternal Initial 50.700 MS.F.PAL  
 .AR Certificate .AR.pdf

Policy - High Ded. Plan MS.FX.PA Policy/Contract/Fraternal Initial 50.700 MS.FX.PA  
 F L.AR Certificate L.AR.pdf

**Previous Version**

Policy - High Ded. Plan MS.FX.PA Policy/Contract/Fraternal Initial 50.700 MS.FX.PA  
 F L.AR Certificate L.AR.pdf

Policy - High Ded. Plan MS.FX.PA Policy/Contract/Fraternal Initial 50.700 MS.FX.PA  
 F L.AR Certificate L.AR.pdf

SERFF Tracking Number: NELL-127180425 State: Arkansas  
 Filing Company: Philadelphia American Life Insurance Company State Tracking Number: 48872  
 Company Tracking Number: MS.A.PAL.AR  
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.012 Multi-Plan 2010  
 Standard Plans 2010

Product Name: MS.A.PAL.AR

Project Name/Number: MS.A.PAL.AR/MS.A.PAL.AR

Policy - Plan G	MS.G.PAL	Policy/Contract/Fraternal Initial	50.900	MS.G.PAL
	.AR	Certificate		.AR.pdf

**Previous Version**

Policy - Plan G	MS.G.PAL	Policy/Contract/Fraternal Initial	50.900	MS.G.PAL
	.AR	Certificate		.AR.pdf

Policy - Plan G	MS.G.PAL	Policy/Contract/Fraternal Initial	50.900	MS.G.PAL
	.AR	Certificate		.AR.pdf

Policy - Plan N	MS.N.PAL	Policy/Contract/Fraternal Initial	50.300	MS.N.PAL
	.AR	Certificate		.AR.pdf

**Previous Version**

Policy - Plan N	MS.N.PAL	Policy/Contract/Fraternal Initial	50.300	MS.N.PAL
	.AR	Certificate		.AR.pdf

Policy - Plan N	MS.N.PAL	Policy/Contract/Fraternal Initial	50.300	MS.N.PAL
	.AR	Certificate		.AR.pdf

No Rate/Rule Schedule items changed.

**Response 2**

Comments: Removed that sentence entirely since the corrected version of it is located under the "Guaranteed Renewable ..." provision.

**Related Objection 1**

Applies To:

- Policy - Plan A, MS.A.PAL.AR (Form)
- Policy - Plan C, MS.C.PAL.AR (Form)
- Policy - Plan D, MS.D.PAL.AR (Form)
- Policy - Plan F, MS.F.PAL.AR (Form)
- Policy - High Ded. Plan F, MS.FX.PAL.AR (Form)
- Policy - Plan G, MS.G.PAL.AR (Form)
- Policy - Plan N, MS.N.PAL.AR (Form)

Comment:

PREMIUM PAYMENT provision - Please remove the language that states that the premiums may be changed "at any time and from time to time". As was pointed out previously, this information is not correct.

**Changed Items:**

SERFF Tracking Number: NELI-127180425 State: Arkansas  
 Filing Company: Philadelphia American Life Insurance Company State Tracking Number: 48872  
 Company Tracking Number: MS.A.PAL.AR  
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.012 Multi-Plan 2010  
 Standard Plans 2010  
 Product Name: MS.A.PAL.AR  
 Project Name/Number: MS.A.PAL.AR/MS.A.PAL.AR

No Supporting Documents changed.

**Form Schedule Item Changes**

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Policy - Plan A	MS.A.PAL		Policy/Contract/Fraternal Certificate	Initial		50.900	MS.A.PAL .AR.pdf
<b>Previous Version</b>							
Policy - Plan A	MS.A.PAL		Policy/Contract/Fraternal Certificate	Initial		50.900	MS.A.PAL .AR.pdf
Policy - Plan A	MS.A.PAL		Policy/Contract/Fraternal Certificate	Initial		50.900	MS.A.PAL .AR.pdf
Policy - Plan C	MS.C.PAL		Policy/Contract/Fraternal Certificate	Initial		51.800	MS.C.PAL .AR.pdf
<b>Previous Version</b>							
Policy - Plan C	MS.C.PAL		Policy/Contract/Fraternal Certificate	Initial		51.800	MS.C.PAL .AR.pdf
Policy - Plan C	MS.C.PAL		Policy/Contract/Fraternal Certificate	Initial		51.800	MS.C.PAL .AR.pdf
Policy - Plan D	MS.D.PAL		Policy/Contract/Fraternal Certificate	Initial		51.000	MS.D.PAL .AR.pdf
<b>Previous Version</b>							
Policy - Plan D	MS.D.PAL		Policy/Contract/Fraternal Certificate	Initial		51.000	MS.D.PAL .AR.pdf
Policy - Plan D	MS.D.PAL		Policy/Contract/Fraternal Certificate	Initial		51.000	MS.D.PAL .AR.pdf
Policy - Plan F	MS.F.PAL		Policy/Contract/Fraternal Certificate	Initial		50.700	MS.F.PAL .AR.pdf
<b>Previous Version</b>							
Policy - Plan F	MS.F.PAL		Policy/Contract/Fraternal Certificate	Initial		50.700	MS.F.PAL .AR.pdf
Policy - Plan F	MS.F.PAL		Policy/Contract/Fraternal Certificate	Initial		50.700	MS.F.PAL .AR.pdf

SERFF Tracking Number: NELI-127180425 State: Arkansas  
 Filing Company: Philadelphia American Life Insurance Company State Tracking Number: 48872  
 Company Tracking Number: MS.A.PAL.AR  
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.012 Multi-Plan 2010  
 Standard Plans 2010  
 Product Name: MS.A.PAL.AR  
 Project Name/Number: MS.A.PAL.AR/MS.A.PAL.AR

Policy - High Ded. Plan	MS.FX.PA	Policy/Contract/Fraternal	Initial	50.700	MS.FX.PA
F	L.AR	Certificate			L.AR.pdf

**Previous Version**

Policy - High Ded. Plan	MS.FX.PA	Policy/Contract/Fraternal	Initial	50.700	MS.FX.PA
F	L.AR	Certificate			L.AR.pdf

Policy - High Ded. Plan	MS.FX.PA	Policy/Contract/Fraternal	Initial	50.700	MS.FX.PA
F	L.AR	Certificate			L.AR.pdf

Policy - Plan G	MS.G.PAL	Policy/Contract/Fraternal	Initial	50.900	MS.G.PAL
	.AR	Certificate			.AR.pdf

**Previous Version**

Policy - Plan G	MS.G.PAL	Policy/Contract/Fraternal	Initial	50.900	MS.G.PAL
	.AR	Certificate			.AR.pdf

Policy - Plan G	MS.G.PAL	Policy/Contract/Fraternal	Initial	50.900	MS.G.PAL
	.AR	Certificate			.AR.pdf

Policy - Plan N	MS.N.PAL	Policy/Contract/Fraternal	Initial	50.300	MS.N.PAL
	.AR	Certificate			.AR.pdf

**Previous Version**

Policy - Plan N	MS.N.PAL	Policy/Contract/Fraternal	Initial	50.300	MS.N.PAL
	.AR	Certificate			.AR.pdf

Policy - Plan N	MS.N.PAL	Policy/Contract/Fraternal	Initial	50.300	MS.N.PAL
	.AR	Certificate			.AR.pdf

No Rate/Rule Schedule items changed.

**Response 3**

Comments: Moved the Tobacco question to the Health Questions section.

**Related Objection 1**

Applies To:

- Application, MS.APP.PAL.AR (Form)

Comment:

R&R 27, Sec. 11 prohibits discrimination of pricing during Open Enrollment. The Tobacco Use question is an underwriting question and we ask that it be moved to the Medical Question section since it is not required to be answered during Open Enrollment.

SERFF Tracking Number: NELI-127180425 State: Arkansas  
 Filing Company: Philadelphia American Life Insurance Company State Tracking Number: 48872  
 Company Tracking Number: MS.A.PAL.AR  
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.012 Multi-Plan 2010  
 Standard Plans 2010  
 Product Name: MS.A.PAL.AR  
 Project Name/Number: MS.A.PAL.AR/MS.A.PAL.AR

**Changed Items:**

No Supporting Documents changed.

**Form Schedule Item Changes**

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Application	MS.APP.P AL.AR		Application/Enrollment Form	Initial		50.100	MS.APP.P AL.AR.pdf
<b>Previous Version</b>							
Application	MS.APP.P AL.AR		Application/Enrollment Form	Initial		50.100	MS.APP.P AL.AR.pdf

No Rate/Rule Schedule items changed.

**Response 4**

Comments: Removed Policy Fee sentence.

**Related Objection 1**

Applies To:

- Brochure, MS.BRO.PAL.AR (Form)

Comment:

INSURED BILLING - second bullet point - AR Rule 27, Sec. 6C prohibits a policy fee or any other similar charge. Please remove this language from this form and from any other forms in this filing.

**Changed Items:**

No Supporting Documents changed.

**Form Schedule Item Changes**

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Brochure	MS.BRO.		Advertising	Initial		52.000	MS.BRO.

SERFF Tracking Number: NELI-127180425 State: Arkansas  
 Filing Company: Philadelphia American Life Insurance Company State Tracking Number: 48872  
 Company Tracking Number: MS.A.PAL.AR  
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.012 Multi-Plan 2010  
 Standard Plans 2010  
 Product Name: MS.A.PAL.AR  
 Project Name/Number: MS.A.PAL.AR/MS.A.PAL.AR  
 PAL.AR

PAL.AR.p  
df

**Previous Version**

Brochure	MS.BRO. PAL.AR	Advertising	Initial	52.000	MS.BRO. PAL.AR.p df
----------	-------------------	-------------	---------	--------	---------------------------

No Rate/Rule Schedule items changed.

**Response 5**

Comments: Removed the Policy Fees from the Outline.

**Related Objection 1**

Applies To:

- Outline of Coverage, MS.OOC.PAL.AR (Form)

Comment:

As stated in a different objection, policy fees are not allowed. Please remove this language.

**Changed Items:**

No Supporting Documents changed.

**Form Schedule Item Changes**

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Outline of Coverage	MS.OOC. PAL.AR		Outline of Coverage	Initial		50.900	MS.OOC. PAL.AR.p df

**Previous Version**

Outline of Coverage	MS.OOC. PAL.AR		Outline of Coverage	Initial		50.900	MS.OOC. PAL.AR.p df
---------------------	-------------------	--	---------------------	---------	--	--------	---------------------------

No Rate/Rule Schedule items changed.

SERFF Tracking Number: NELL-127180425 State: Arkansas  
 Filing Company: Philadelphia American Life Insurance Company State Tracking Number: 48872  
 Company Tracking Number: MS.A.PAL.AR  
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.012 Multi-Plan 2010  
 Standard Plans 2010  
 Product Name: MS.A.PAL.AR  
 Project Name/Number: MS.A.PAL.AR/MS.A.PAL.AR

**Response 6**

Comments: Removed Policy Fees from the Rates.

**Related Objection 1**

Applies To:

- Rates, [MS.A.PAL.AR, MS.C.PAL.AR, MS.D.PAL.AR, MS.F.PAL.AR, MS.FX.PAL.AR, MS.G.PAL.AR, MS.N.PAL.AR] (Rate)

Comment:

As stated in a different objection, policy fees are not allowed. Please remove this language.

**Changed Items:**

No Supporting Documents changed.

No Form Schedule items changed.

**Rate/Rule Schedule Item Changes**

Document Name:	Affected Form Numbers:	Rate Action:	Rate Action Information:	Attach Document:
Rates	MS.A.PAL.AR,MS.C.PAL.A R,MS.D.PAL.AR,MS.F.PAL. AR,MS.FX.PAL.AR,MS.G.P AL.AR,MS.N.PAL.AR	New	Previous State Filing Number	0

**Previous Version**

Rates	MS.A.PAL.AR, MS.C.PAL.AR, MS.D.PAL.AR, MS.F.PAL.AR, MS.FX.PAL.AR, MS.G.PAL.AR, MS.N.PAL.AR	New	Previous State Filing Number	0
-------	--	-----	------------------------------	---

Thanks

Sincerely,

*SERFF Tracking Number:* NELL-127180425 *State:* Arkansas  
*Filing Company:* Philadelphia American Life Insurance Company *State Tracking Number:* 48872  
*Company Tracking Number:* MS.A.PAL.AR  
*TOI:* MS08I Individual Medicare Supplement - *Sub-TOI:* MS08I.012 Multi-Plan 2010  
Standard Plans 2010  
*Product Name:* MS.A.PAL.AR  
*Project Name/Number:* MS.A.PAL.AR/MS.A.PAL.AR

**Brian Hull**

SERFF Tracking Number: NELL-127180425 State: Arkansas  
Filing Company: Philadelphia American Life Insurance Company State Tracking Number: 48872  
Company Tracking Number: MS.A.PAL.AR  
TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.012 Multi-Plan 2010  
Standard Plans 2010  
Product Name: MS.A.PAL.AR  
Project Name/Number: MS.A.PAL.AR/MS.A.PAL.AR

## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 06/24/2011  
Submitted Date 06/24/2011  
Respond By Date 07/25/2011

Dear Brian Hull,

This will acknowledge receipt of the captioned filing.

### Objection 1

- Policy - Plan A, MS.A.PAL.AR (Form)
- Policy - Plan C, MS.C.PAL.AR (Form)
- Policy - Plan D, MS.D.PAL.AR (Form)
- Policy - Plan F, MS.F.PAL.AR (Form)
- Policy - High Ded. Plan F, MS.FX.PAL.AR (Form)
- Policy - Plan G, MS.G.PAL.AR (Form)
- Policy - Plan N, MS.N.PAL.AR (Form)

Comment: The premiums may not be raised after the the first renewal date. Rates may only be increased once in a 12 month period.

Please feel free to contact me if you have questions.

Sincerely,

Stephanie Fowler

SERFF Tracking Number: NELI-127180425 State: Arkansas  
 Filing Company: Philadelphia American Life Insurance Company State Tracking Number: 48872  
 Company Tracking Number: MS.A.PAL.AR  
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.012 Multi-Plan 2010  
 Standard Plans 2010  
 Product Name: MS.A.PAL.AR  
 Project Name/Number: MS.A.PAL.AR/MS.A.PAL.AR

## Response Letter

Response Letter Status Submitted to State  
 Response Letter Date 06/27/2011  
 Submitted Date 06/27/2011

Dear Stephanie Fowler,

### Comments:

Thank you for your review of our filing.

### Response 1

Comments: We have corrected the rate change language in all plans. Please see the "redline changes example" for your convenience.

### Related Objection 1

Applies To:

- Policy - Plan A, MS.A.PAL.AR (Form)
- Policy - Plan C, MS.C.PAL.AR (Form)
- Policy - Plan D, MS.D.PAL.AR (Form)
- Policy - Plan F, MS.F.PAL.AR (Form)
- Policy - High Ded. Plan F, MS.FX.PAL.AR (Form)
- Policy - Plan G, MS.G.PAL.AR (Form)
- Policy - Plan N, MS.N.PAL.AR (Form)

Comment:

The premiums may not be raised after the the first renewal date. Rates may only be increased once in a 12 month period.

### Changed Items:

#### Supporting Document Schedule Item Changes

Satisfied -Name: redline changes example

Comment:

#### Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific	Readability Score	Attach Document
-----------	-------------	--------------	-----------	--------	-----------------	-------------------	-----------------

SERFF Tracking Number: NELI-127180425 State: Arkansas  
 Filing Company: Philadelphia American Life Insurance Company State Tracking Number: 48872  
 Company Tracking Number: MS.A.PAL.AR  
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.012 Multi-Plan 2010  
 Standard Plans 2010  
 Product Name: MS.A.PAL.AR  
 Project Name/Number: MS.A.PAL.AR/MS.A.PAL.AR

Data

Policy - Plan A	MS.A.PAL .AR	Policy/Contract/Fraternal Certificate	Initial	50.900	MS.A.PAL .AR.pdf
<b>Previous Version</b>					
Policy - Plan A	MS.A.PAL .AR	Policy/Contract/Fraternal Certificate	Initial	50.900	MS.A.PAL .AR.pdf
Policy - Plan C	MS.C.PAL .AR	Policy/Contract/Fraternal Certificate	Initial	51.800	MS.C.PAL .AR.pdf
<b>Previous Version</b>					
Policy - Plan C	MS.C.PAL .AR	Policy/Contract/Fraternal Certificate	Initial	51.800	MS.C.PAL .AR.pdf
Policy - Plan D	MS.D.PAL .AR	Policy/Contract/Fraternal Certificate	Initial	51.000	MS.D.PAL .AR.pdf
<b>Previous Version</b>					
Policy - Plan D	MS.D.PAL .AR	Policy/Contract/Fraternal Certificate	Initial	51.000	MS.D.PAL .AR.pdf
Policy - Plan F	MS.F.PAL .AR	Policy/Contract/Fraternal Certificate	Initial	50.700	MS.F.PAL .AR.pdf
<b>Previous Version</b>					
Policy - Plan F	MS.F.PAL .AR	Policy/Contract/Fraternal Certificate	Initial	50.700	MS.F.PAL .AR.pdf
Policy - High Ded. Plan F	MS.FX.PA L.AR	Policy/Contract/Fraternal Certificate	Initial	50.700	MS.FX.PA L.AR.pdf
<b>Previous Version</b>					
Policy - High Ded. Plan F	MS.FX.PA L.AR	Policy/Contract/Fraternal Certificate	Initial	50.700	MS.FX.PA L.AR.pdf
Policy - Plan G	MS.G.PAL .AR	Policy/Contract/Fraternal Certificate	Initial	50.900	MS.G.PAL .AR.pdf
<b>Previous Version</b>					
Policy - Plan G	MS.G.PAL .AR	Policy/Contract/Fraternal Certificate	Initial	50.900	MS.G.PAL .AR.pdf
Policy - Plan N	MS.N.PAL .AR	Policy/Contract/Fraternal Certificate	Initial	50.300	MS.N.PAL .AR.pdf
<b>Previous Version</b>					
Policy - Plan N	MS.N.PAL	Policy/Contract/Fraternal	Initial	50.300	MS.N.PAL

SERFF Tracking Number: NELL-127180425 State: Arkansas  
Filing Company: Philadelphia American Life Insurance Company State Tracking Number: 48872  
Company Tracking Number: MS.A.PAL.AR  
TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.012 Multi-Plan 2010  
Standard Plans 2010  
Product Name: MS.A.PAL.AR  
Project Name/Number: MS.A.PAL.AR/MS.A.PAL.AR  
.AR Certificate .AR.pdf

No Rate/Rule Schedule items changed.

Thanks!

Sincerely,  
Brian Hull

SERFF Tracking Number: NELI-127180425 State: Arkansas  
 Filing Company: Philadelphia American Life Insurance Company State Tracking Number: 48872  
 Company Tracking Number: MS.A.PAL.AR  
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.012 Multi-Plan 2010  
 Standard Plans 2010  
 Product Name: MS.A.PAL.AR  
 Project Name/Number: MS.A.PAL.AR/MS.A.PAL.AR

## Form Schedule

### Lead Form Number: MS.A.PAL.AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 07/06/2011	MS.A.PAL. AR	Policy/Cont ract/Fratern al Certificate	Policy - Plan A	Initial		50.900	MS.A.PAL.AR .pdf
Approved 07/06/2011	MS.C.PAL. AR	Policy/Cont ract/Fratern al Certificate	Policy - Plan C	Initial		51.800	MS.C.PAL.AR .pdf
Approved 07/06/2011	MS.D.PAL. AR	Policy/Cont ract/Fratern al Certificate	Policy - Plan D	Initial		51.000	MS.D.PAL.AR .pdf
Approved 07/06/2011	MS.F.PAL. AR	Policy/Cont ract/Fratern al Certificate	Policy - Plan F	Initial		50.700	MS.F.PAL.AR .pdf
Approved 07/06/2011	MS.FX.PAL. .AR	Policy/Cont ract/Fratern al Certificate	Policy - High Ded. Plan F	Initial		50.700	MS.FX.PAL.A R.pdf
Approved 07/06/2011	MS.G.PAL. AR	Policy/Cont ract/Fratern al Certificate	Policy - Plan G	Initial		50.900	MS.G.PAL.A R.pdf
Approved 07/06/2011	MS.N.PAL. AR	Policy/Cont ract/Fratern al Certificate	Policy - Plan N	Initial		50.300	MS.N.PAL.AR .pdf
Approved 07/06/2011	MS.APP.P AL.AR	Application/ Enrollment	Application	Initial		50.100	MS.APP.PAL. AR.pdf

<i>SERFF Tracking Number:</i>	<i>NELI-127180425</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Philadelphia American Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>48872</i>
<i>Company Tracking Number:</i>	<i>MS.A.PAL.AR</i>		
<i>TOI:</i>	<i>MS08I Individual Medicare Supplement -</i>	<i>Sub-TOI:</i>	<i>MS08I.012 Multi-Plan 2010</i>
	<i>Standard Plans 2010</i>		
<i>Product Name:</i>	<i>MS.A.PAL.AR</i>		
<i>Project Name/Number:</i>	<i>MS.A.PAL.AR/MS.A.PAL.AR</i>		
	<i>Form</i>		
Approved MS.REPL. 07/06/2011 PAL	Application/ Replacement Form Enrollment Form	Initial	52.800 MS.REPL.PA L.pdf
Approved MS.PREEX 07/06/2011 .AMD.PAL	Policy/Cont Pre-Existing ract/Fratern Condition al Amendment Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	53.000 MS.PREEX.A MD.PAL.pdf
Approved MS.BRO.P 07/06/2011 AL.AR	Advertising Brochure	Initial	52.000 MS.BRO.PAL .AR.pdf
Approved MS.OOC.P 07/06/2011 AL.AR	Outline of Coverage Coverage	Initial	50.900 MS.OOC.PAL .AR.pdf

Philadelphia American Life Insurance Company

(A stock company, herein called the Company)

PO Box 4884

Houston, TX 77210-4884

MEDICARE SUPPLEMENT POLICY  
STANDARD PLAN A

**INSURING CLAUSE**

The Company insures the applicant, first named in the Schedule of Benefits, hereinafter called the Insured, against loss due to Hospital confinement and for other specified expense resulting from accidental bodily Injury or Sickness, subject to all provisions, limitations and exclusions, and will pay the benefits provided herein. This Policy is issued in consideration of the application and payment of the initial premium. A copy of the application is attached to this Policy and made a part of it.

**GUARANTEED RENEWABLE FOR LIFE, COMPANY CANNOT CANCEL POLICY  
COMPANY MAY CHANGE PREMIUM RATES BY CLASS AND AS MEDICARE BENEFITS  
CHANGE AS PROVIDED IN THE GUARANTEED RENEWABLE PROVISION**

**GUARANTEED RENEWABLE**

You have the right to continue this Policy in force for life by the timely payment in full of each renewal premium. While this Policy is in force, we will not add any restrictive riders or endorsements. We may not cancel or nonrenew this Policy solely on the ground of your health status or for any reason other than nonpayment of premium or material misrepresentation.

We reserve the right to revise the table of premium rates on a class basis. We can only change your premiums if a change is made for all policies bearing this form number in the state where you reside. Before a change in rates can become effective, we must give you at least 30 days written notice. We will deliver the notice to you, or mail it to your last address shown in our records.

**NOTICE OF 30 DAY RIGHT TO EXAMINE THE POLICY**

If you are not satisfied with this Policy for any reason, the Policy may be returned to us within the first 30 days after you receive it, for a full refund of all premium paid. If the Policy is returned, it shall be void from the Effective Date. To return the Policy, simply mail or deliver it to us at our mailing address: P.O. Box 4884, Houston, TX 77210-4884.

**PLEASE READ YOUR POLICY CAREFULLY**

This Policy may not cover all of the costs associated with medical care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all Policy limitations.

**This policy contains a Pre-Existing Condition provision.**

**CAUTION: Policy benefits are limited to those approved by Medicare for payment.**

**NOTICE TO BUYER: This policy may not cover all of your medical expenses.**

**Please verify the accuracy and completeness of the medical history information on the application.  
Erroneous or incomplete application data could jeopardize Your claim.**

In Witness Whereof. PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY has issued this Policy at its Home Office in Houston, Texas and the Effective Date is as specified in the Schedule of Benefits.



SECRETARY



PRESIDENT

NON-PARTICIPATING

TABLE OF CONTENTS

Insuring Clause .....1  
Guaranteed Renewable .....1  
Notice of 30 Day Right to Examine the Policy .....1  
Table of Contents .....2  
Schedule of Benefits .....3  
Definitions.....4  
Core Benefits.....6  
Additional Benefits.....6  
Exclusions and Limitations .....7  
Pre-Existing Condition Limitations .....7  
Changes in Medicare .....7  
Extension of Benefits.....7  
Suspension of Coverage for Medicaid .....7  
Guaranteed Renewal Including Right To Change Premium.....8  
General Provisions .....9

**SCHEDULE OF BENEFITS**

Insured	[John Doe]			[0000100000]	Policy Number
Issue Age	[65]	[male]	[ntu]	[June 01, 2011]	Effective Date

ANNUAL	SEMIANNUAL	QUARTERLY	MONTHLY	MONTHLY BANK DRAFT
				[\$82.70]

**DESCRIPTION OF COVERAGE**

**BENEFIT AMOUNT**

**MEDICARE PART A - HOSPITAL SERVICES**

**HOSPITALIZATION**

First 60 days	\$0
61 <sup>st</sup> TO 90 <sup>th</sup> day	[\$283] a day
91 <sup>st</sup> TO 150 <sup>th</sup> day	[\$566] a day
151 <sup>st</sup> thru 515 <sup>th</sup> day	100% of Medicare part A eligible expenses

**BLOOD**

Reasonable cost for the first 3 pints, unless already paid for under Medicare Part B

**HOSPICE CARE**

Up to \$5 copay for prescription drugs / Part A coinsurance for in patient respite care

**MEDICARE PART B – MEDICAL SERVICES**

**MEDICAL EXPENSE**

Physician's services, inpatient and outpatient medical and surgical services and supplied physical and speech therapy diagnostic test, durable medical equipment	20% coinsurance
--	-----------------

**BLOOD**

Reasonable cost for the first 3 pints, unless already paid for under Medicare Part A

## DEFINITIONS

---

Wherever used in this Policy:

**BENEFIT PERIOD** means, while this Policy is in force, a period of time that: (i) begins on the first day You receive Medicare covered services as an inpatient in a Hospital; and, (ii) ends after You are out of the Hospital and have not received skilled care in any facility for 60 days in a row. Benefit Periods cannot overlap. A new Benefit Period will not begin during an existing one. A new Benefit Period starts when inpatient Hospital services are again required. The number of Benefit Periods is unlimited.

**CONTINUOUS PERIOD OF CREDITABLE COVERAGE** means the period during which an individual was covered by creditable coverage, if, during the period of the coverage, the individual had no breaks in coverage greater than 63 days.

**CREDITABLE COVERAGE** means coverage under: (i) a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.); (ii) a group health benefit plan provided by a health insurance carrier or an HMO; (iii) an individual health insurance policy or evidence of coverage; (iv) Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. Section 1395c et seq.); (v) Title XIX of the Social Security Act (42 U.S.C. Section 1396 et seq.), other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1396s); (vi) Chapter 55 of Title 10, United States Code (10 U.S.C. Section 1071 et seq.); (vii) a medical care program of the Indian Health Service or of a tribal organization; (viii) a state or political subdivision health benefits risk pool; (ix) a health plan offered under Chapter 89 of Title 5, United States Code (5 U.S.C. Section 8901 et seq.); (x) any plan established or maintained by a state, county or other political subdivision of a state that provides health insurance coverage to individuals who are enrolled in the plan; (xi) a health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. Section 2504(e)); (xii) health insurance coverage provided under a contract with an issuer that has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder without the issuer's consent) that is within 12 months of the date the contract becomes effective; (xiii) Short-term limited duration insurance.

Creditable coverage does not include: (i) accident-only, disability income insurance, or a combination of accident-only and disability income insurance; (ii) coverage issued as a supplement to liability insurance; (iii) liability insurance, including general liability insurance and automobile liability insurance; (iv) workers' compensation or similar insurance; (v) automobile medical payment insurance; (vi) credit only insurance; (vii) coverage for onsite medical clinics; (viii) other coverage that is similar to the coverage described in this subparagraph under which benefits for medical care are secondary or incidental to other insurance benefits and specified in federal regulations; (ix) if offered separately, coverage that provides limited scope dental or vision benefits; (x) if offered separately, long-term care coverage or benefits, nursing home care coverage or benefits, home health care coverage or benefits, community based care coverage or benefits, or any combination of those coverages or benefits; (xi) if offered separately, coverage for other limited benefits specified by federal regulations; (xii) if offered as independent, non-coordinated benefits, coverage for specified disease or illness; (xiii) if offered as independent, non-coordinated benefits, for hospital indemnity or other fixed indemnity insurance; or (xiv) Medicare supplemental health insurance as defined under Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 U.S.C. Section 1071 et seq.), and similar supplemental coverage provided under a group plan, but only if such insurance or coverages are provided under a separate policy, certificate, or contract of insurance.

**EMERGENCY CARE** means care needed immediately because of an Injury or a Sickness of sudden and unexpected onset.

**HOSPITAL** means an institution licensed and operated pursuant to law, primarily and continuously engaged in providing, for compensation from its patients, either on its premises or in facilities available to the Hospital on a contractual prearranged basis, medical, diagnostic, and major surgical facilities under the supervision of the staff of one or more duly licensed Physician's and provides twenty-four hours a day nursing service by or under the supervision of a Graduate Registered Nurse. The term "Hospital" does not include any institution or portion thereof which is used principally as a facility for the aged, rest, nursing, convalescence, care of mental or nervous disorders, or any military, veteran's hospital, or soldier's home or any hospital contracted for or operated by the federal government or any agency thereof for the treatment of members or ex-members of the armed forces except for services rendered on an emergency basis where a legal liability exists for charges made for such services. Notwithstanding the above, a Hospital shall include a facility which is accredited by the Joint Commission on Accreditation of Hospitals and which offers medical, therapeutic, and psychiatric care for the treatment of alcoholism.

**INJURY** means accidental bodily Injury sustained by the Insured which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force. It does not include injuries for which benefits are provided under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

**MEDICARE** means Title I, Part I of Public Law 89-97, as Enacted by the 89th Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof.

**MEDICARE ELIGIBLE EXPENSES** are health care expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

**PHYSICIAN** means a person other than a family member of the Insured who is a practitioner of the healing arts and licensed by the State to treat the Injury or Sickness for which claim is made.

**PRE-EXISTING CONDITION** means a condition for which medical advice or treatment was recommended by a Physician or received from a Physician within a six month period preceding the Effective Date of the coverage of the Insured.

**SICKNESS** means illness or disease of the Insured which first manifests itself after the Effective Date of insurance and while the insurance is in force. Sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law are excluded.

**YOU, YOUR, AND YOURS** refers to the Insured named on the Schedule of Benefits page.

**WE, US, AND OUR** refers to Philadelphia American Life Insurance Company.

## **CORE BENEFITS**

---

### **PART A - HOSPITAL EXPENSE BENEFITS**

Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

Upon exhaustion of the Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Part A Medicare Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

Hospice Care: Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

### **PART B - MEDICAL EXPENSE BENEFITS**

Coverage for the coinsurance amount, or in the case of Hospital outpatient department services paid under a prospective payment system, the co-payment amount, of Medicare Eligible Expenses under Part B regardless of Hospital confinement, subject to the Medicare Part B deductible.

## **EXCLUSIONS AND LIMITATIONS**

---

This Policy does not provide a benefit for any expense incurred unless the respective services are determined by Medicare to be a Medicare Eligible Expense. However, those expenses Medicare does not pay because Your Medicare benefits have been exhausted are covered.

## **PRE-EXISTING CONDITION LIMITATIONS**

---

Pre-Existing Conditions as defined are not covered during the first six months after the Effective Date of coverage. No Pre-Existing Condition exclusion shall be applicable if the individual, as of the date of application of this Policy, has had a Continuous Period of Creditable Coverage of at least six months. The six month Pre-Existing Condition exclusion period shall be reduced by the aggregate of the period of Creditable Coverage applicable to the individual as of the enrollment date of Medicare Part B benefits. If you are an Eligible Person for Guaranteed Issue, the waiting period for Pre-Existing Conditions is waived.

## **CHANGES IN MEDICARE**

---

Benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and co-payment percentage factors. Premiums may be modified to correspond with such changes.

## **EXTENSION OF BENEFITS**

---

If this Policy terminates, Your benefits for Continuous Total Disability which started while the Policy was in force will not be affected. In this case benefits continue under the condition that you remain continuously disabled, and only for the duration of the policy Benefit Period or until payment of the maximum benefit has been made. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

For the purpose of this section "Continuous Total Disability" means the Insured's complete inability to engage in any occupation for pay or profit, or if not employed, to engage in the normal activities of a person of the same age. The Insured must also require the regular care of a Physician.

## **SUSPENSION OF COVERAGE FOR MEDICAID**

---

This Policy shall be suspended at the request of the Insured for the period (not to exceed 24 months) in which the Insured has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the Insured notifies the Company of such Policy within 90 days after the date the individual becomes entitled to the assistance. Upon receipt of timely notice, the Company shall return to the Insured the portion of the premium attributable to the period of Medicaid eligibility, subject to adjustment for paid claims.

If such suspension occurs and if Insured loses entitlement to such medical assistance, this Policy shall be automatically reinstated (effective as of the date of termination of such entitlement) as of the termination of such entitlement if the Insured provides notice of loss of such entitlement within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement.

The Policy shall provide that benefits and premiums under the Policy shall be suspended, at the request of the Insured, if the Insured is entitled to benefits under section 226 (b) of the Social Security Act and is covered under a group health plan (as defined in section 1862 (b) (1) (A) (v) of the Social Security Act). If suspension occurs and if the Insured loses coverage under the group health plan, the Policy shall be automatically reinstated (effective as of the date of loss of coverage) if the Insured provides notice of loss of coverage within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of entitlement. Reinstatement of such coverages shall not provide for any waiting period with respect to treatment of preexisting conditions; shall provide for coverage which is substantially equivalent to coverage in effect before the date of such suspension and shall provide for classification of premiums on terms at least as favorable to the Insured as the premium classification terms that would have been applied to the Insured had the coverage not been suspended.

## **GUARANTEED RENEWAL INCLUDING RIGHT TO CHANGE PREMIUM**

---

This Policy may be renewed at the option of the Insured for consecutive terms of the same duration as the term specified in the Schedule of Benefits by the payment prior to the expiration of the Grace Period, of the premium rates in effect at the time of such renewal.

The Company reserves the right to change in no less than 12 month intervals its table of premium applicable on a class basis to premiums for all policies on the same form as this Policy issued to persons residing in the state of residence of the Insured. In case of any change, the new table of premium rates will apply to premiums thereafter becoming due under this Policy. The Company shall notify the Insured in writing at his last known address of such change at least 30 days before the due date at which time such change is to become effective. No rate adjustment may be made on an individual basis.

The Company shall not use or change premium rates for Your Medicare Supplement Policy unless the rates which shall be on a level premium basis, rating schedule and supporting documentation have been filed with and approved by the Commissioner/Director in accordance with the filing requirements and procedures.

Benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any change in the applicable Medicare deductible amount and co-payment percentage factors. Premiums may be changed to correspond with such changes.

## GENERAL PROVISIONS

---

**ENTIRE CONTRACT; CHANGES:** This Policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. A change in this Policy is not valid until the change is approved by an executive officer of the Company and unless the approval is endorsed on or attached to the Policy. An agent does not have authority to change this Policy or to waive any of its provisions.

**OWNERSHIP; CONTROL OF POLICY:** This contract is made with the Insured who has signed the application and every transaction relating to this Policy shall be between the Company and such Insured.

**TIME LIMIT ON CERTAIN DEFENSES:** After 2 years from the Effective Date of this Policy, no misstatements, except for fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for loss incurred after the expiration of such 2 year period.

**PREMIUM PAYMENT:** This Policy is issued in consideration of the application and the payment in advance of the first premium for the initial term. This Policy shall take effect at 12 o'clock noon, Standard Time of the place where the Insured resides, and shall remain in effect until the same hour on the date on which the initial term expires. The Effective Date of this Policy and the first premium are shown in the Schedule of Benefits. At the option of the Insured, this Policy may be continued in force in accordance with and subject to its terms for successive periods by the payment of renewal premiums for the term of 1 month, 3 months, 6 months or 12 months, at the Company's applicable table of rates in effect on the respective due dates of such renewal premiums. All premiums, including the first premium, shall be due and payable at the Home Office of the Company.

**GRACE PERIOD:** A grace period of 31 days will be granted for the payment of each premium due after the first premium. During the grace period, the Policy continues in force.

**REINSTATEMENT:** If a renewal premium is not paid before the expiration of the period granted for the Insured to make the payment, a subsequent acceptance of the premium by the Company to accept the premium, without requiring in connection with the acceptance an application for reinstatement, reinstates the Policy. However, if the Company requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated on approval of the application by the Company or, if the application is not approved, on the 45th day after the date of the conditional receipt unless the Company before that date has notified the Insured in writing of the Company's disapproval of the application. The reinstated Policy covers only loss resulting from an accidental Injury sustained after the date of reinstatement and loss due to Sickness that begins after the date of reinstatement. In all other respects the Insured and Company have the same rights under the reinstated Policy as they had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed in the Policy or attached to the Policy in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days before the date of reinstatement.

**NOTICE OF CLAIM:** A written notice of claim must be given to the Company before the 21st day after the date of the occurrence or beginning of any loss covered by the Policy, or as soon after that date as is reasonably possible. A notice given by or on behalf of the Insured or the beneficiary to the Insurer at its Home Office in Houston, Texas or to any authorized agent of the Company, with information sufficient to identify the Insured, constitutes notice to the Company.

**CLAIM FORMS:** The Company, on receipt of a notice of claim, will provide to the claimant the forms usually provided by the Company for filing proof of loss. If the forms are not provided before the 16th day after the date of the notice, the claimant shall be considered to have complied with the requirements of this Policy as to proof of loss on submitting, within the time fixed in the Policy for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which the claim is made.

**PROOF OF LOSS:** A written proof of loss must be provided to the Company at the Company's designated office before the 91st day after the date of the loss. Failure to provide the proof within the required time does not invalidate or reduce any claim if it was not reasonably possible to give proof within the required time. In that case, the proof must be provided as soon as reasonably possible but not later than one year after the time proof is otherwise required, except in the event of a legal incapacity.

**TIME OF PAYMENT OF CLAIMS:** Amounts payable under this Policy for any loss other than benefits for loss of time will be paid immediately upon receipt of due written proof of such loss.

**PAYMENT OF CLAIMS:** All indemnities will be payable to the Insured. If any indemnity of this Policy shall be payable to the estate of the Insured, or to an Insured or beneficiary who is a minor or otherwise not competent to give a valid release, the Company may pay such indemnity, up to an amount not exceeding \$1,000 to any relative by blood or connection by marriage to the Insured or beneficiary who is deemed by the Company to be equitably entitled thereto. Any payment made by the Company in good faith pursuant to this provision shall fully discharge the Company to the extent of such payment. Subject to any written direction of the Insured in the application or otherwise all or a portion of any indemnities provided by this Policy on account of Hospital, nursing, medical or surgical services may, at the Company's option and unless the Insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the Hospital or person rendering such services; but it is not required that the services be rendered by a particular Hospital or person.

**PHYSICAL EXAMINATIONS AND AUTOPSY:** The Company at its own expense has the right and opportunity to conduct a physical examination of the Insured when and as often as the Company reasonably requires while a claim under the Policy is pending and, in case of death, to require that an autopsy be conducted if not forbidden by law.

**ASSIGNMENT:** No assignment of interest under this Policy shall be binding upon the Company unless and until the original or duplicate is filed at the Home Office of the Company, which does not assume any responsibility for the validity thereof.

**LEGAL ACTIONS:** An action at law or in equity may not be brought to recover on this Policy before the 61st day after the date written proof of loss has been provided in accordance with the requirements of this Policy. An action at law or in equity may not be brought after the expiration of three years after the time written proof of loss is required to be provided.

**CHANGE OF BENEFICIARY:** Unless the Insured makes an irrevocable designation of beneficiary, the right to change a beneficiary is reserved for the Insured, and the consent of the beneficiary or beneficiaries is not required for the surrender or assignment of this Policy, for any change of beneficiary or beneficiaries, or for any other changes in this Policy.

**UNEARNED PREMIUMS:** The unearned premiums paid for any period beyond the end of the Policy month, if any, in which Your death occurred or Your request of coverage cancellation, will be returned to the beneficiary of Your estate. The unearned premiums, if any, will be paid in a lump sum on a date no later than thirty (30) days after proof of Your death has been furnished or receipt of cancellation request has been made to the Company.

**CANCELLATION BY THE INSURED; NON-CANCELLATION BY THE INSURER:** The Insured may cancel this Policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid. The earned premium shall be computed on a pro-rata basis. Cancellation shall be without prejudice to any claim originated prior to the effective date of cancellation. The insurer may not cancel this Policy. This provision nullifies any other provision, contained in this Policy or in any endorsement hereon or in any rider attached hereto, which provides for cancellation of this Policy by the insurer or by the Insured.

**CONFORMITY WITH STATE STATUTES:** Any provision of this Policy that, on its Effective Date, conflicts with the statutes of the state in which the Insured resides on the Effective Date is by this clause effectively amended to conform to the minimum requirements of that state's statutes.

Philadelphia American Life Insurance Company

(A stock company, herein called the Company)

PO Box 4884

Houston, TX 77210-4884

MEDICARE SUPPLEMENT POLICY  
STANDARD PLAN C

**INSURING CLAUSE**

The Company insures the applicant, first named in the Schedule of Benefits, hereinafter called the Insured, against loss due to Hospital confinement and for other specified expense resulting from accidental bodily Injury or Sickness, subject to all provisions, limitations and exclusions, and will pay the benefits provided herein. This Policy is issued in consideration of the application and payment of the initial premium. A copy of the application is attached to this Policy and made a part of it.

**GUARANTEED RENEWABLE FOR LIFE, COMPANY CANNOT CANCEL POLICY  
COMPANY MAY CHANGE PREMIUM RATES BY CLASS AND AS MEDICARE BENEFITS  
CHANGE AS PROVIDED IN THE GUARANTEED RENEWABLE PROVISION**

**GUARANTEED RENEWABLE**

You have the right to continue this Policy in force for life by the timely payment in full of each renewal premium. While this Policy is in force, we will not add any restrictive riders or endorsements. We may not cancel or nonrenew this Policy solely on the ground of your health status or for any reason other than nonpayment of premium or material misrepresentation.

We reserve the right to revise the table of premium rates on a class basis. We can only change your premiums if a change is made for all policies bearing this form number in the state where you reside. Before a change in rates can become effective, we must give you at least 30 days written notice. We will deliver the notice to you, or mail it to your last address shown in our records.

**NOTICE OF 30 DAY RIGHT TO EXAMINE THE POLICY**

If you are not satisfied with this Policy for any reason, the Policy may be returned to us within the first 30 days after you receive it, for a full refund of all premium paid. If the Policy is returned, it shall be void from the Effective Date. To return the Policy, simply mail or deliver it to us at our mailing address: P.O. Box 4884, Houston, TX 77210-4884.

**PLEASE READ YOUR POLICY CAREFULLY**

This Policy may not cover all of the costs associated with medical care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all Policy limitations.

**This policy contains a Pre-Existing Condition provision.**

**CAUTION: Policy benefits are limited to those approved by Medicare for payment.**

**NOTICE TO BUYER: This policy may not cover all of your medical expenses.**

**Please verify the accuracy and completeness of the medical history information on the application.  
Erroneous or incomplete application data could jeopardize Your claim.**

In Witness Whereof. PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY has issued this Policy at its Home Office in Houston, Texas and the Effective Date is as specified in the Schedule of Benefits.



SECRETARY



PRESIDENT

NON-PARTICIPATING

TABLE OF CONTENTS

Insuring Clause .....1

Guaranteed Renewable .....1

Notice of 30 Day Right to Examine the Policy .....1

Table of Contents .....2

Schedule of Benefits .....3

Definitions.....4

Core Benefits.....6

Additional Benefits.....6

Exclusions and Limitations .....7

Pre-Existing Condition Limitations .....7

Changes in Medicare .....7

Extension of Benefits.....7

Suspension of Coverage for Medicaid .....7

Guaranteed Renewal Including Right To Change Premium.....8

General Provisions .....9

**SCHEDULE OF BENEFITS**

Insured	[John Doe]			[0000100000]	Policy Number
Issue Age	[65]	[male]	[ntu]	[June 01, 2011]	Effective Date

ANNUAL	SEMIANNUAL	QUARTERLY	MONTHLY	MONTHLY BANK DRAFT
				[\$103.37]

**DESCRIPTION OF COVERAGE**

**BENEFIT AMOUNT**

**MEDICARE PART A - HOSPITAL SERVICES**

**HOSPITALIZATION**

First 60 days	\$[1,132] Part A Deductible
61 <sup>st</sup> TO 90 <sup>th</sup> day	\$[283] a day
91 <sup>st</sup> TO 150 <sup>th</sup> day	\$[566] a day
151 <sup>st</sup> thru 515 <sup>th</sup> day	100% of Medicare part A eligible expenses

**SKILLED NURSING FACILITY CARE**

First 20 days	\$[0]
21 <sup>st</sup> TO 100 <sup>th</sup> day	\$[141.50] a day
101 <sup>st</sup> day and after	\$[0] a day

**BLOOD**

Reasonable cost for the first 3 pints, unless already paid for under Medicare Part B

**HOSPICE CARE**

Up to \$5 copay for prescription drugs / Part A coinsurance for in patient respite care

**MEDICARE PART B – MEDICAL SERVICES**

**MEDICAL EXPENSE**

Physician's services, inpatient and outpatient medical and surgical services and supplied physical and speech therapy diagnostic test, durable medical equipment	20% coinsurance
--	-----------------

**BLOOD**

Reasonable cost for the first 3 pints, unless already paid for under Medicare Part A

**MEDICARE PART B DEDUCTIBLE**

Coverage for all the Medicare Part B deductible amount per Calendar Year regardless of hospital confinement

**FOREIGN TRAVEL EMERGENCY CARE**

Medically necessary emergency care services beginning during the first 60 days of each trip	80% of Medicare eligible expense subject to a deductible of \$250 for each Insured – up to a lifetime maximum of \$50,000 for each Insured
---	--

## DEFINITIONS

---

Wherever used in this Policy:

**BENEFIT PERIOD** means, while this Policy is in force, a period of time that: (i) begins on the first day You receive Medicare covered services as an inpatient in a Hospital; and, (ii) ends after You are out of the Hospital and have not received skilled care in any facility for 60 days in a row. Benefit Periods cannot overlap. A new Benefit Period will not begin during an existing one. A new Benefit Period starts when inpatient Hospital services are again required. The number of Benefit Periods is unlimited.

**CONTINUOUS PERIOD OF CREDITABLE COVERAGE** means the period during which an individual was covered by creditable coverage, if, during the period of the coverage, the individual had no breaks in coverage greater than 63 days.

**CREDITABLE COVERAGE** means coverage under: (i) a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.); (ii) a group health benefit plan provided by a health insurance carrier or an HMO; (iii) an individual health insurance policy or evidence of coverage; (iv) Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. Section 1395c et seq.); (v) Title XIX of the Social Security Act (42 U.S.C. Section 1396 et seq.), other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1396s); (vi) Chapter 55 of Title 10, United States Code (10 U.S.C. Section 1071 et seq.); (vii) a medical care program of the Indian Health Service or of a tribal organization; (viii) a state or political subdivision health benefits risk pool; (ix) a health plan offered under Chapter 89 of Title 5, United States Code (5 U.S.C. Section 8901 et seq.); (x) any plan established or maintained by a state, county or other political subdivision of a state that provides health insurance coverage to individuals who are enrolled in the plan; (xi) a health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. Section 2504(e)); (xii) health insurance coverage provided under a contract with an issuer that has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder without the issuer's consent) that is within 12 months of the date the contract becomes effective; (xiii) Short-term limited duration insurance.

Creditable coverage does not include: (i) accident-only, disability income insurance, or a combination of accident-only and disability income insurance; (ii) coverage issued as a supplement to liability insurance; (iii) liability insurance, including general liability insurance and automobile liability insurance; (iv) workers' compensation or similar insurance; (v) automobile medical payment insurance; (vi) credit only insurance; (vii) coverage for onsite medical clinics; (viii) other coverage that is similar to the coverage described in this subparagraph under which benefits for medical care are secondary or incidental to other insurance benefits and specified in federal regulations; (ix) if offered separately, coverage that provides limited scope dental or vision benefits; (x) if offered separately, long-term care coverage or benefits, nursing home care coverage or benefits, home health care coverage or benefits, community based care coverage or benefits, or any combination of those coverages or benefits; (xi) if offered separately, coverage for other limited benefits specified by federal regulations; (xii) if offered as independent, non-coordinated benefits, coverage for specified disease or illness; (xiii) if offered as independent, non-coordinated benefits, for hospital indemnity or other fixed indemnity insurance; or (xiv) Medicare supplemental health insurance as defined under Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 U.S.C. Section 1071 et seq.), and similar supplemental coverage provided under a group plan, but only if such insurance or coverages are provided under a separate policy, certificate, or contract of insurance.

**EMERGENCY CARE** means care needed immediately because of an Injury or a Sickness of sudden and unexpected onset.

**HOSPITAL** means an institution licensed and operated pursuant to law, primarily and continuously engaged in providing, for compensation from its patients, either on its premises or in facilities available to the Hospital on a contractual prearranged basis, medical, diagnostic, and major surgical facilities under the supervision of the staff of one or more duly licensed Physician's and provides twenty-four hours a day nursing service by or under the supervision of a Graduate Registered Nurse. The term "Hospital" does not include any institution or portion thereof which is used principally as a facility for the aged, rest, nursing, convalescence, care of mental or nervous disorders, or any military, veteran's hospital, or soldier's home or any hospital contracted for or operated by the federal government or any agency thereof for the treatment of members or ex-members of the armed forces except for services rendered on an emergency basis where a legal liability exists for charges made for such services. Notwithstanding the above, a Hospital shall include a facility which is accredited by the Joint Commission on Accreditation of Hospitals and which offers medical, therapeutic, and psychiatric care for the treatment of alcoholism.

**INJURY** means accidental bodily Injury sustained by the Insured which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force. It does not include injuries for which benefits are provided under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

**MEDICARE** means Title I, Part I of Public Law 89-97, as Enacted by the 89th Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof.

**MEDICARE ELIGIBLE EXPENSES** are health care expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

**PHYSICIAN** means a person other than a family member of the Insured who is a practitioner of the healing arts and licensed by the State to treat the Injury or Sickness for which claim is made.

**PRE-EXISTING CONDITION** means a condition for which medical advice or treatment was recommended by a Physician or received from a Physician within a six month period preceding the Effective Date of the coverage of the Insured.

**SICKNESS** means illness or disease of the Insured which first manifests itself after the Effective Date of insurance and while the insurance is in force. Sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law are excluded.

**YOU, YOUR, AND YOURS** refers to the Insured named on the Schedule of Benefits page.

**WE, US, AND OUR** refers to Philadelphia American Life Insurance Company.

## **CORE BENEFITS**

---

### **PART A - HOSPITAL EXPENSE BENEFITS**

Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Part A Medicare Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

Hospice Care: Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

### **PART B - MEDICAL EXPENSE BENEFITS**

Coverage for the coinsurance amount, or in the case of Hospital outpatient department services paid under a prospective payment system, the co-payment amount, of Medicare Eligible Expenses under Part B regardless of Hospital confinement, subject to the Medicare Part B deductible.

## **ADDITIONAL BENEFITS**

---

Medicare Part A Deductible: Coverage for one hundred percent (100%) of the Medicare Part A inpatient hospital deductible amount per benefit period.

Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare part A.

Medicare Part B Deductible: Coverage for one hundred percent (100%) of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of \$250, and a lifetime maximum benefit of \$50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

## **EXCLUSIONS AND LIMITATIONS**

---

This Policy does not provide a benefit for any expense incurred unless the respective services are determined by Medicare to be a Medicare Eligible Expense. However, those expenses Medicare does not pay because Your Medicare benefits have been exhausted are covered.

## **PRE-EXISTING CONDITION LIMITATIONS**

---

Pre-Existing Conditions as defined are not covered during the first six months after the Effective Date of coverage. No Pre-Existing Condition exclusion shall be applicable if the individual, as of the date of application of this Policy, has had a Continuous Period of Creditable Coverage of at least six months. The six month Pre-Existing Condition exclusion period shall be reduced by the aggregate of the period of Creditable Coverage applicable to the individual as of the enrollment date of Medicare Part B benefits. If you are an Eligible Person for Guaranteed Issue, the waiting period for Pre-Existing Conditions is waived.

## **CHANGES IN MEDICARE**

---

Benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and co-payment percentage factors. Premiums may be modified to correspond with such changes.

## **EXTENSION OF BENEFITS**

---

If this Policy terminates, Your benefits for Continuous Total Disability which started while the Policy was in force will not be affected. In this case benefits continue under the condition that you remain continuously disabled, and only for the duration of the policy Benefit Period or until payment of the maximum benefit has been made. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

For the purpose of this section "Continuous Total Disability" means the Insured's complete inability to engage in any occupation for pay or profit, or if not employed, to engage in the normal activities of a person of the same age. The Insured must also require the regular care of a Physician.

## **SUSPENSION OF COVERAGE FOR MEDICAID**

---

This Policy shall be suspended at the request of the Insured for the period (not to exceed 24 months) in which the Insured has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the Insured notifies the Company of such Policy within 90 days after the date the individual becomes entitled to the assistance. Upon receipt of timely notice, the Company shall return to the Insured the portion of the premium attributable to the period of Medicaid eligibility, subject to adjustment for paid claims.

If such suspension occurs and if Insured loses entitlement to such medical assistance, this Policy shall be automatically reinstated (effective as of the date of termination of such entitlement) as of the termination of such entitlement if the Insured provides notice of loss of such entitlement within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement.

The Policy shall provide that benefits and premiums under the Policy shall be suspended, at the request of the Insured, if the Insured is entitled to benefits under section 226 (b) of the Social Security Act and is covered under a group health plan (as defined in section 1862 (b) (1) (A) (v) of the Social Security Act). If suspension occurs and if the Insured loses coverage under the group health plan, the Policy shall be automatically reinstated (effective as of the date of loss of coverage) if the Insured provides notice of loss of coverage within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of entitlement. Reinstatement of such coverages shall not provide for any waiting period with respect to treatment of preexisting conditions; shall provide for coverage which is substantially equivalent to coverage in effect before the date of such suspension and shall provide for classification of premiums on terms at least as favorable to the Insured as the premium classification terms that would have been applied to the Insured had the coverage not been suspended.

## **GUARANTEED RENEWAL INCLUDING RIGHT TO CHANGE PREMIUM**

---

This Policy may be renewed at the option of the Insured for consecutive terms of the same duration as the term specified in the Schedule of Benefits by the payment prior to the expiration of the Grace Period, of the premium rates in effect at the time of such renewal.

The Company reserves the right to change in no less than 12 month intervals its table of premium applicable on a class basis to premiums for all policies on the same form as this Policy issued to persons residing in the state of residence of the Insured. In case of any change, the new table of premium rates will apply to premiums thereafter becoming due under this Policy. The Company shall notify the Insured in writing at his last known address of such change at least 30 days before the due date at which time such change is to become effective. No rate adjustment may be made on an individual basis.

The Company shall not use or change premium rates for Your Medicare Supplement Policy unless the rates which shall be on a level premium basis, rating schedule and supporting documentation have been filed with and approved by the Commissioner/Director in accordance with the filing requirements and procedures.

Benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any change in the applicable Medicare deductible amount and co-payment percentage factors. Premiums may be changed to correspond with such changes.

## GENERAL PROVISIONS

---

**ENTIRE CONTRACT; CHANGES:** This Policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. A change in this Policy is not valid until the change is approved by an executive officer of the Company and unless the approval is endorsed on or attached to the Policy. An agent does not have authority to change this Policy or to waive any of its provisions.

**OWNERSHIP; CONTROL OF POLICY:** This contract is made with the Insured who has signed the application and every transaction relating to this Policy shall be between the Company and such Insured.

**TIME LIMIT ON CERTAIN DEFENSES:** After 2 years from the Effective Date of this Policy, no misstatements, except for fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for loss incurred after the expiration of such 2 year period.

**PREMIUM PAYMENT:** This Policy is issued in consideration of the application and the payment in advance of the first premium for the initial term. This Policy shall take effect at 12 o'clock noon, Standard Time of the place where the Insured resides, and shall remain in effect until the same hour on the date on which the initial term expires. The Effective Date of this Policy and the first premium are shown in the Schedule of Benefits. At the option of the Insured, this Policy may be continued in force in accordance with and subject to its terms for successive periods by the payment of renewal premiums for the term of 1 month, 3 months, 6 months or 12 months, at the Company's applicable table of rates in effect on the respective due dates of such renewal premiums. All premiums, including the first premium, shall be due and payable at the Home Office of the Company.

**GRACE PERIOD:** A grace period of 31 days will be granted for the payment of each premium due after the first premium. During the grace period, the Policy continues in force.

**REINSTATEMENT:** If a renewal premium is not paid before the expiration of the period granted for the Insured to make the payment, a subsequent acceptance of the premium by the Company to accept the premium, without requiring in connection with the acceptance an application for reinstatement, reinstates the Policy. However, if the Company requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated on approval of the application by the Company or, if the application is not approved, on the 45th day after the date of the conditional receipt unless the Company before that date has notified the Insured in writing of the Company's disapproval of the application. The reinstated Policy covers only loss resulting from an accidental Injury sustained after the date of reinstatement and loss due to Sickness that begins after the date of reinstatement. In all other respects the Insured and Company have the same rights under the reinstated Policy as they had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed in the Policy or attached to the Policy in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days before the date of reinstatement.

**NOTICE OF CLAIM:** A written notice of claim must be given to the Company before the 21st day after the date of the occurrence or beginning of any loss covered by the Policy, or as soon after that date as is reasonably possible. A notice given by or on behalf of the Insured or the beneficiary to the Insurer at its Home Office in Houston, Texas or to any authorized agent of the Company, with information sufficient to identify the Insured, constitutes notice to the Company.

**CLAIM FORMS:** The Company, on receipt of a notice of claim, will provide to the claimant the forms usually provided by the Company for filing proof of loss. If the forms are not provided before the 16th day after the date of the notice, the claimant shall be considered to have complied with the requirements of this Policy as to proof of loss on submitting, within the time fixed in the Policy for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which the claim is made.

**PROOF OF LOSS:** A written proof of loss must be provided to the Company at the Company's designated office before the 91st day after the date of the loss. Failure to provide the proof within the required time does not invalidate or reduce any claim if it was not reasonably possible to give proof within the required time. In that case, the proof must be provided as soon as reasonably possible but not later than one year after the time proof is otherwise required, except in the event of a legal incapacity.

**TIME OF PAYMENT OF CLAIMS:** Amounts payable under this Policy for any loss other than benefits for loss of time will be paid immediately upon receipt of due written proof of such loss.

**PAYMENT OF CLAIMS:** All indemnities will be payable to the Insured. If any indemnity of this Policy shall be payable to the estate of the Insured, or to an Insured or beneficiary who is a minor or otherwise not competent to give a valid release, the Company may pay such indemnity, up to an amount not exceeding \$1,000 to any relative by blood or connection by marriage to the Insured or beneficiary who is deemed by the Company to be equitably entitled thereto. Any payment made by the Company in good faith pursuant to this provision shall fully discharge the Company to the extent of such payment. Subject to any written direction of the Insured in the application or otherwise all or a portion of any indemnities provided by this Policy on account of Hospital, nursing, medical or surgical services may, at the Company's option and unless the Insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the Hospital or person rendering such services; but it is not required that the services be rendered by a particular Hospital or person.

**PHYSICAL EXAMINATIONS AND AUTOPSY:** The Company at its own expense has the right and opportunity to conduct a physical examination of the Insured when and as often as the Company reasonably requires while a claim under the Policy is pending and, in case of death, to require that an autopsy be conducted if not forbidden by law.

**ASSIGNMENT:** No assignment of interest under this Policy shall be binding upon the Company unless and until the original or duplicate is filed at the Home Office of the Company, which does not assume any responsibility for the validity thereof.

**LEGAL ACTIONS:** An action at law or in equity may not be brought to recover on this Policy before the 61st day after the date written proof of loss has been provided in accordance with the requirements of this Policy. An action at law or in equity may not be brought after the expiration of three years after the time written proof of loss is required to be provided.

**CHANGE OF BENEFICIARY:** Unless the Insured makes an irrevocable designation of beneficiary, the right to change a beneficiary is reserved for the Insured, and the consent of the beneficiary or beneficiaries is not required for the surrender or assignment of this Policy, for any change of beneficiary or beneficiaries, or for any other changes in this Policy.

**UNEARNED PREMIUMS:** The unearned premiums paid for any period beyond the end of the Policy month, if any, in which Your death occurred or Your request of coverage cancellation, will be returned to the beneficiary of Your estate. The unearned premiums, if any, will be paid in a lump sum on a date no later than thirty (30) days after proof of Your death has been furnished or receipt of cancellation request has been made to the Company.

**CANCELLATION BY THE INSURED; NON-CANCELLATION BY THE INSURER:** The Insured may cancel this Policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid. The earned premium shall be computed on a pro-rata basis. Cancellation shall be without prejudice to any claim originated prior to the effective date of cancellation. The insurer may not cancel this Policy. This provision nullifies any other provision, contained in this Policy or in any endorsement hereon or in any rider attached hereto, which provides for cancellation of this Policy by the insurer or by the Insured.

**CONFORMITY WITH STATE STATUTES:** Any provision of this Policy that, on its Effective Date, conflicts with the statutes of the state in which the Insured resides on the Effective Date is by this clause effectively amended to conform to the minimum requirements of that state's statutes.

Philadelphia American Life Insurance Company

(A stock company, herein called the Company)

PO Box 4884

Houston, TX 77210-4884

MEDICARE SUPPLEMENT POLICY  
STANDARD PLAN D

**INSURING CLAUSE**

The Company insures the applicant, first named in the Schedule of Benefits, hereinafter called the Insured, against loss due to Hospital confinement and for other specified expense resulting from accidental bodily Injury or Sickness, subject to all provisions, limitations and exclusions, and will pay the benefits provided herein. This Policy is issued in consideration of the application and payment of the initial premium. A copy of the application is attached to this Policy and made a part of it.

**GUARANTEED RENEWABLE FOR LIFE, COMPANY CANNOT CANCEL POLICY  
COMPANY MAY CHANGE PREMIUM RATES BY CLASS AND AS MEDICARE BENEFITS  
CHANGE AS PROVIDED IN THE GUARANTEED RENEWABLE PROVISION**

**GUARANTEED RENEWABLE**

You have the right to continue this Policy in force for life by the timely payment in full of each renewal premium. While this Policy is in force, we will not add any restrictive riders or endorsements. We may not cancel or nonrenew this Policy solely on the ground of your health status or for any reason other than nonpayment of premium or material misrepresentation.

We reserve the right to revise the table of premium rates on a class basis. We can only change your premiums if a change is made for all policies bearing this form number in the state where you reside. Before a change in rates can become effective, we must give you at least 30 days written notice. We will deliver the notice to you, or mail it to your last address shown in our records.

**NOTICE OF 30 DAY RIGHT TO EXAMINE THE POLICY**

If you are not satisfied with this Policy for any reason, the Policy may be returned to us within the first 30 days after you receive it, for a full refund of all premium paid. If the Policy is returned, it shall be void from the Effective Date. To return the Policy, simply mail or deliver it to us at our mailing address: P.O. Box 4884, Houston, TX 77210-4884.

**PLEASE READ YOUR POLICY CAREFULLY**

This Policy may not cover all of the costs associated with medical care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all Policy limitations.

**This policy contains a Pre-Existing Condition provision.**

**CAUTION: Policy benefits are limited to those approved by Medicare for payment.**

**NOTICE TO BUYER: This policy may not cover all of your medical expenses.**

**Please verify the accuracy and completeness of the medical history information on the application.  
Erroneous or incomplete application data could jeopardize Your claim.**

In Witness Whereof. PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY has issued this Policy at its Home Office in Houston, Texas and the Effective Date is as specified in the Schedule of Benefits.



SECRETARY



PRESIDENT

NON-PARTICIPATING

TABLE OF CONTENTS

Insuring Clause .....1  
Guaranteed Renewable .....1  
Notice of 30 Day Right to Examine the Policy .....1  
Table of Contents .....2  
Schedule of Benefits .....3  
Definitions.....4  
Core Benefits.....6  
Additional Benefits.....6  
Exclusions and Limitations .....7  
Pre-Existing Condition Limitations .....7  
Changes in Medicare .....7  
Extension of Benefits.....7  
Suspension of Coverage for Medicaid .....7  
Guaranteed Renewal Including Right To Change Premium.....8  
General Provisions .....9

**SCHEDULE OF BENEFITS**

Insured	[John Doe]			[0000100000]	Policy Number
Issue Age	[65]	[male]	[ntu]	[June 01, 2011]	Effective Date

ANNUAL	SEMIANNUAL	QUARTERLY	MONTHLY	MONTHLY BANK DRAFT
				[\$110.00]

**DESCRIPTION OF COVERAGE**

**BENEFIT AMOUNT**

**MEDICARE PART A - HOSPITAL SERVICES**

**HOSPITALIZATION**

First 60 days	\$[1,132] Part A Deductible
61 <sup>st</sup> TO 90 <sup>th</sup> day	\$[283] a day
91 <sup>st</sup> TO 150 <sup>th</sup> day	\$[566] a day
151 <sup>st</sup> thru 515 <sup>th</sup> day	100% of Medicare part A eligible expenses

**SKILLED NURSING FACILITY CARE**

First 20 days	\$[0]
21 <sup>st</sup> TO 100 <sup>th</sup> day	\$[141.50] a day
101 <sup>st</sup> day and after	\$[0] a day

**BLOOD**

Reasonable cost for the first 3 pints, unless already paid for under Medicare Part B

**HOSPICE CARE**

Up to \$5 copay for prescription drugs / Part A coinsurance for in patient respite care

**MEDICARE PART B – MEDICAL SERVICES**

**MEDICAL EXPENSE**

Physician's services, inpatient and outpatient medical and surgical services and supplied physical and speech therapy diagnostic test, durable medical equipment	20% coinsurance
--	-----------------

**BLOOD**

Reasonable cost for the first 3 pints, unless already paid for under Medicare Part A

**FOREIGN TRAVEL EMERGENCY CARE**

Medically necessary emergency care services beginning during the first 60 days of each trip	80% of Medicare eligible expense subject to a deductible of \$250 for each Insured – up to a lifetime maximum of \$50,000 for each Insured
---	--

## DEFINITIONS

---

Wherever used in this Policy:

**BENEFIT PERIOD** means, while this Policy is in force, a period of time that: (i) begins on the first day You receive Medicare covered services as an inpatient in a Hospital; and, (ii) ends after You are out of the Hospital and have not received skilled care in any facility for 60 days in a row. Benefit Periods cannot overlap. A new Benefit Period will not begin during an existing one. A new Benefit Period starts when inpatient Hospital services are again required. The number of Benefit Periods is unlimited.

**CONTINUOUS PERIOD OF CREDITABLE COVERAGE** means the period during which an individual was covered by creditable coverage, if, during the period of the coverage, the individual had no breaks in coverage greater than 63 days.

**CREDITABLE COVERAGE** means coverage under: (i) a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.); (ii) a group health benefit plan provided by a health insurance carrier or an HMO; (iii) an individual health insurance policy or evidence of coverage; (iv) Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. Section 1395c et seq.); (v) Title XIX of the Social Security Act (42 U.S.C. Section 1396 et seq.), other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1396s); (vi) Chapter 55 of Title 10, United States Code (10 U.S.C. Section 1071 et seq.); (vii) a medical care program of the Indian Health Service or of a tribal organization; (viii) a state or political subdivision health benefits risk pool; (ix) a health plan offered under Chapter 89 of Title 5, United States Code (5 U.S.C. Section 8901 et seq.); (x) any plan established or maintained by a state, county or other political subdivision of a state that provides health insurance coverage to individuals who are enrolled in the plan; (xi) a health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. Section 2504(e)); (xii) health insurance coverage provided under a contract with an issuer that has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder without the issuer's consent) that is within 12 months of the date the contract becomes effective; (xiii) Short-term limited duration insurance.

Creditable coverage does not include: (i) accident-only, disability income insurance, or a combination of accident-only and disability income insurance; (ii) coverage issued as a supplement to liability insurance; (iii) liability insurance, including general liability insurance and automobile liability insurance; (iv) workers' compensation or similar insurance; (v) automobile medical payment insurance; (vi) credit only insurance; (vii) coverage for onsite medical clinics; (viii) other coverage that is similar to the coverage described in this subparagraph under which benefits for medical care are secondary or incidental to other insurance benefits and specified in federal regulations; (ix) if offered separately, coverage that provides limited scope dental or vision benefits; (x) if offered separately, long-term care coverage or benefits, nursing home care coverage or benefits, home health care coverage or benefits, community based care coverage or benefits, or any combination of those coverages or benefits; (xi) if offered separately, coverage for other limited benefits specified by federal regulations; (xii) if offered as independent, non-coordinated benefits, coverage for specified disease or illness; (xiii) if offered as independent, non-coordinated benefits, for hospital indemnity or other fixed indemnity insurance; or (xiv) Medicare supplemental health insurance as defined under Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 U.S.C. Section 1071 et seq.), and similar supplemental coverage provided under a group plan, but only if such insurance or coverages are provided under a separate policy, certificate, or contract of insurance.

**EMERGENCY CARE** means care needed immediately because of an Injury or a Sickness of sudden and unexpected onset.

**HOSPITAL** means an institution licensed and operated pursuant to law, primarily and continuously engaged in providing, for compensation from its patients, either on its premises or in facilities available to the Hospital on a contractual prearranged basis, medical, diagnostic, and major surgical facilities under the supervision of the staff of one or more duly licensed Physician's and provides twenty-four hours a day nursing service by or under the supervision of a Graduate Registered Nurse. The term "Hospital" does not include any institution or portion thereof which is used principally as a facility for the aged, rest, nursing, convalescence, care of mental or nervous disorders, or any military, veteran's hospital, or soldier's home or any hospital contracted for or operated by the federal government or any agency thereof for the treatment of members or ex-members of the armed forces except for services rendered on an emergency basis where a legal liability exists for charges made for such services. Notwithstanding the above, a Hospital shall include a facility which is accredited by the Joint Commission on Accreditation of Hospitals and which offers medical, therapeutic, and psychiatric care for the treatment of alcoholism.

**INJURY** means accidental bodily Injury sustained by the Insured which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force. It does not include injuries for which benefits are provided under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

**MEDICARE** means Title I, Part I of Public Law 89-97, as Enacted by the 89th Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof.

**MEDICARE ELIGIBLE EXPENSES** are health care expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

**PHYSICIAN** means a person other than a family member of the Insured who is a practitioner of the healing arts and licensed by the State to treat the Injury or Sickness for which claim is made.

**PRE-EXISTING CONDITION** means a condition for which medical advice or treatment was recommended by a Physician or received from a Physician within a six month period preceding the Effective Date of the coverage of the Insured.

**SICKNESS** means illness or disease of the Insured which first manifests itself after the Effective Date of insurance and while the insurance is in force. Sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law are excluded.

**YOU, YOUR, AND YOURS** refers to the Insured named on the Schedule of Benefits page.

**WE, US, AND OUR** refers to Philadelphia American Life Insurance Company.

## **CORE BENEFITS**

---

### **PART A - HOSPITAL EXPENSE BENEFITS**

Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

Upon exhaustion of the Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Part A Medicare Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

Hospice Care: Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

### **PART B - MEDICAL EXPENSE BENEFITS**

Coverage for the coinsurance amount, or in the case of Hospital outpatient department services paid under a prospective payment system, the co-payment amount, of Medicare Eligible Expenses under Part B regardless of Hospital confinement, subject to the Medicare Part B deductible.

## **ADDITIONAL BENEFITS**

---

Medicare Part A Deductible: Coverage for one hundred percent (100%) of the Medicare Part A inpatient hospital deductible amount per benefit period.

Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare part A.

Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of \$250, and a lifetime maximum benefit of \$50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

## **EXCLUSIONS AND LIMITATIONS**

---

This Policy does not provide a benefit for any expense incurred unless the respective services are determined by Medicare to be a Medicare Eligible Expense. However, those expenses Medicare does not pay because Your Medicare benefits have been exhausted are covered.

## **PRE-EXISTING CONDITION LIMITATIONS**

---

Pre-Existing Conditions as defined are not covered during the first six months after the Effective Date of coverage. No Pre-Existing Condition exclusion shall be applicable if the individual, as of the date of application of this Policy, has had a Continuous Period of Creditable Coverage of at least six months. The six month Pre-Existing Condition exclusion period shall be reduced by the aggregate of the period of Creditable Coverage applicable to the individual as of the enrollment date of Medicare Part B benefits. If you are an Eligible Person for Guaranteed Issue, the waiting period for Pre-Existing Conditions is waived.

## **CHANGES IN MEDICARE**

---

Benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and co-payment percentage factors. Premiums may be modified to correspond with such changes.

## **EXTENSION OF BENEFITS**

---

If this Policy terminates, Your benefits for Continuous Total Disability which started while the Policy was in force will not be affected. In this case benefits continue under the condition that you remain continuously disabled, and only for the duration of the policy Benefit Period or until payment of the maximum benefit has been made. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

For the purpose of this section "Continuous Total Disability" means the Insured's complete inability to engage in any occupation for pay or profit, or if not employed, to engage in the normal activities of a person of the same age. The Insured must also require the regular care of a Physician.

## **SUSPENSION OF COVERAGE FOR MEDICAID**

---

This Policy shall be suspended at the request of the Insured for the period (not to exceed 24 months) in which the Insured has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the Insured notifies the Company of such Policy within 90 days after the date the individual becomes entitled to the assistance. Upon receipt of timely notice, the Company shall return to the Insured the portion of the premium attributable to the period of Medicaid eligibility, subject to adjustment for paid claims.

If such suspension occurs and if Insured loses entitlement to such medical assistance, this Policy shall be automatically reinstated (effective as of the date of termination of such entitlement) as of the termination of such entitlement if the Insured provides notice of loss of such entitlement within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement.

The Policy shall provide that benefits and premiums under the Policy shall be suspended, at the request of the Insured, if the Insured is entitled to benefits under section 226 (b) of the Social Security Act and is covered under a group health plan (as defined in section 1862 (b) (1) (A) (v) of the Social Security Act). If suspension occurs and if the Insured loses coverage under the group health plan, the Policy shall be automatically reinstated (effective as of the date of loss of coverage) if the Insured provides notice of loss of coverage within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of entitlement. Reinstatement of such coverages shall not provide for any waiting period with respect to treatment of preexisting conditions; shall provide for coverage which is substantially equivalent to coverage in effect before the date of such suspension and shall provide for classification of premiums on terms at least as favorable to the Insured as the premium classification terms that would have been applied to the Insured had the coverage not been suspended.

## **GUARANTEED RENEWAL INCLUDING RIGHT TO CHANGE PREMIUM**

---

This Policy may be renewed at the option of the Insured for consecutive terms of the same duration as the term specified in the Schedule of Benefits by the payment prior to the expiration of the Grace Period, of the premium rates in effect at the time of such renewal.

The Company reserves the right to change in no less than 12 month intervals its table of premium applicable on a class basis to premiums for all policies on the same form as this Policy issued to persons residing in the state of residence of the Insured. In case of any change, the new table of premium rates will apply to premiums thereafter becoming due under this Policy. The Company shall notify the Insured in writing at his last known address of such change at least 30 days before the due date at which time such change is to become effective. No rate adjustment may be made on an individual basis.

The Company shall not use or change premium rates for Your Medicare Supplement Policy unless the rates which shall be on a level premium basis, rating schedule and supporting documentation have been filed with and approved by the Commissioner/Director in accordance with the filing requirements and procedures.

Benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any change in the applicable Medicare deductible amount and co-payment percentage factors. Premiums may be changed to correspond with such changes.

## GENERAL PROVISIONS

---

**ENTIRE CONTRACT; CHANGES:** This Policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. A change in this Policy is not valid until the change is approved by an executive officer of the Company and unless the approval is endorsed on or attached to the Policy. An agent does not have authority to change this Policy or to waive any of its provisions.

**OWNERSHIP; CONTROL OF POLICY:** This contract is made with the Insured who has signed the application and every transaction relating to this Policy shall be between the Company and such Insured.

**TIME LIMIT ON CERTAIN DEFENSES:** After 2 years from the Effective Date of this Policy, no misstatements, except for fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for loss incurred after the expiration of such 2 year period.

**PREMIUM PAYMENT:** This Policy is issued in consideration of the application and the payment in advance of the first premium for the initial term. This Policy shall take effect at 12 o'clock noon, Standard Time of the place where the Insured resides, and shall remain in effect until the same hour on the date on which the initial term expires. The Effective Date of this Policy and the first premium are shown in the Schedule of Benefits. At the option of the Insured, this Policy may be continued in force in accordance with and subject to its terms for successive periods by the payment of renewal premiums for the term of 1 month, 3 months, 6 months or 12 months, at the Company's applicable table of rates in effect on the respective due dates of such renewal premiums. All premiums, including the first premium, shall be due and payable at the Home Office of the Company.

**GRACE PERIOD:** A grace period of 31 days will be granted for the payment of each premium due after the first premium. During the grace period, the Policy continues in force.

**REINSTATEMENT:** If a renewal premium is not paid before the expiration of the period granted for the Insured to make the payment, a subsequent acceptance of the premium by the Company to accept the premium, without requiring in connection with the acceptance an application for reinstatement, reinstates the Policy. However, if the Company requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated on approval of the application by the Company or, if the application is not approved, on the 45th day after the date of the conditional receipt unless the Company before that date has notified the Insured in writing of the Company's disapproval of the application. The reinstated Policy covers only loss resulting from an accidental Injury sustained after the date of reinstatement and loss due to Sickness that begins after the date of reinstatement. In all other respects the Insured and Company have the same rights under the reinstated Policy as they had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed in the Policy or attached to the Policy in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days before the date of reinstatement.

**NOTICE OF CLAIM:** A written notice of claim must be given to the Company before the 21st day after the date of the occurrence or beginning of any loss covered by the Policy, or as soon after that date as is reasonably possible. A notice given by or on behalf of the Insured or the beneficiary to the Insurer at its Home Office in Houston, Texas or to any authorized agent of the Company, with information sufficient to identify the Insured, constitutes notice to the Company.

**CLAIM FORMS:** The Company, on receipt of a notice of claim, will provide to the claimant the forms usually provided by the Company for filing proof of loss. If the forms are not provided before the 16th day after the date of the notice, the claimant shall be considered to have complied with the requirements of this Policy as to proof of loss on submitting, within the time fixed in the Policy for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which the claim is made.

**PROOF OF LOSS:** A written proof of loss must be provided to the Company at the Company's designated office before the 91st day after the date of the loss. Failure to provide the proof within the required time does not invalidate or reduce any claim if it was not reasonably possible to give proof within the required time. In that case, the proof must be provided as soon as reasonably possible but not later than one year after the time proof is otherwise required, except in the event of a legal incapacity.

**TIME OF PAYMENT OF CLAIMS:** Amounts payable under this Policy for any loss other than benefits for loss of time will be paid immediately upon receipt of due written proof of such loss.

**PAYMENT OF CLAIMS:** All indemnities will be payable to the Insured. If any indemnity of this Policy shall be payable to the estate of the Insured, or to an Insured or beneficiary who is a minor or otherwise not competent to give a valid release, the Company may pay such indemnity, up to an amount not exceeding \$1,000 to any relative by blood or connection by marriage to the Insured or beneficiary who is deemed by the Company to be equitably entitled thereto. Any payment made by the Company in good faith pursuant to this provision shall fully discharge the Company to the extent of such payment. Subject to any written direction of the Insured in the application or otherwise all or a portion of any indemnities provided by this Policy on account of Hospital, nursing, medical or surgical services may, at the Company's option and unless the Insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the Hospital or person rendering such services; but it is not required that the services be rendered by a particular Hospital or person.

**PHYSICAL EXAMINATIONS AND AUTOPSY:** The Company at its own expense has the right and opportunity to conduct a physical examination of the Insured when and as often as the Company reasonably requires while a claim under the Policy is pending and, in case of death, to require that an autopsy be conducted if not forbidden by law.

**ASSIGNMENT:** No assignment of interest under this Policy shall be binding upon the Company unless and until the original or duplicate is filed at the Home Office of the Company, which does not assume any responsibility for the validity thereof.

**LEGAL ACTIONS:** An action at law or in equity may not be brought to recover on this Policy before the 61st day after the date written proof of loss has been provided in accordance with the requirements of this Policy. An action at law or in equity may not be brought after the expiration of three years after the time written proof of loss is required to be provided.

**CHANGE OF BENEFICIARY:** Unless the Insured makes an irrevocable designation of beneficiary, the right to change a beneficiary is reserved for the Insured, and the consent of the beneficiary or beneficiaries is not required for the surrender or assignment of this Policy, for any change of beneficiary or beneficiaries, or for any other changes in this Policy.

**UNEARNED PREMIUMS:** The unearned premiums paid for any period beyond the end of the Policy month, if any, in which Your death occurred or Your request of coverage cancellation, will be returned to the beneficiary of Your estate. The unearned premiums, if any, will be paid in a lump sum on a date no later than thirty (30) days after proof of Your death has been furnished or receipt of cancellation request has been made to the Company.

**CANCELLATION BY THE INSURED; NON-CANCELLATION BY THE INSURER:** The Insured may cancel this Policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid. The earned premium shall be computed on a pro-rata basis. Cancellation shall be without prejudice to any claim originated prior to the effective date of cancellation. The insurer may not cancel this Policy. This provision nullifies any other provision, contained in this Policy or in any endorsement hereon or in any rider attached hereto, which provides for cancellation of this Policy by the insurer or by the Insured.

**CONFORMITY WITH STATE STATUTES:** Any provision of this Policy that, on its Effective Date, conflicts with the statutes of the state in which the Insured resides on the Effective Date is by this clause effectively amended to conform to the minimum requirements of that state's statutes.

Philadelphia American Life Insurance Company

(A stock company, herein called the Company)

PO Box 4884

Houston, TX 77210-4884

MEDICARE SUPPLEMENT POLICY  
STANDARD PLAN F

**INSURING CLAUSE**

The Company insures the applicant, first named in the Schedule of Benefits, hereinafter called the Insured, against loss due to Hospital confinement and for other specified expense resulting from accidental bodily Injury or Sickness, subject to all provisions, limitations and exclusions, and will pay the benefits provided herein. This Policy is issued in consideration of the application and payment of the initial premium. A copy of the application is attached to this Policy and made a part of it.

**GUARANTEED RENEWABLE FOR LIFE, COMPANY CANNOT CANCEL POLICY  
COMPANY MAY CHANGE PREMIUM RATES BY CLASS AND AS MEDICARE BENEFITS  
CHANGE AS PROVIDED IN THE GUARANTEED RENEWABLE PROVISION**

**GUARANTEED RENEWABLE**

You have the right to continue this Policy in force for life by the timely payment in full of each renewal premium. While this Policy is in force, we will not add any restrictive riders or endorsements. We may not cancel or nonrenew this Policy solely on the ground of your health status or for any reason other than nonpayment of premium or material misrepresentation.

We reserve the right to revise the table of premium rates on a class basis. We can only change your premiums if a change is made for all policies bearing this form number in the state where you reside. Before a change in rates can become effective, we must give you at least 30 days written notice. We will deliver the notice to you, or mail it to your last address shown in our records.

**NOTICE OF 30 DAY RIGHT TO EXAMINE THE POLICY**

If you are not satisfied with this Policy for any reason, the Policy may be returned to us within the first 30 days after you receive it, for a full refund of all premium paid. If the Policy is returned, it shall be void from the Effective Date. To return the Policy, simply mail or deliver it to us at our mailing address: P.O. Box 4884, Houston, TX 77210-4884.

**PLEASE READ YOUR POLICY CAREFULLY**

This Policy may not cover all of the costs associated with medical care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all Policy limitations.

**This policy contains a Pre-Existing Condition provision.**

**CAUTION: Policy benefits are limited to those approved by Medicare for payment.**

**NOTICE TO BUYER: This policy may not cover all of your medical expenses.**

**Please verify the accuracy and completeness of the medical history information on the application.  
Erroneous or incomplete application data could jeopardize Your claim.**

In Witness Whereof. PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY has issued this Policy at its Home Office in Houston, Texas and the Effective Date is as specified in the Schedule of Benefits.



SECRETARY



PRESIDENT

NON-PARTICIPATING

TABLE OF CONTENTS

Insuring Clause .....1

Guaranteed Renewable .....1

Notice of 30 Day Right to Examine the Policy .....1

Table of Contents .....2

Schedule of Benefits .....3

Definitions.....4

Core Benefits.....6

Additional Benefits.....6

Exclusions and Limitations .....7

Pre-Existing Condition Limitations .....7

Changes in Medicare .....7

Extension of Benefits.....7

Suspension of Coverage for Medicaid .....7

Guaranteed Renewal Including Right To Change Premium.....8

General Provisions .....9

**SCHEDULE OF BENEFITS**

Insured [John Doe]	[0000100000]	Policy Number
Issue Age [65]	[male]	[ntu]
	[June 01, 2011]	Effective Date

ANNUAL	SEMIANNUAL	QUARTERLY	MONTHLY	MONTHLY BANK DRAFT
				[\$119.86]

**DESCRIPTION OF COVERAGE**

**BENEFIT AMOUNT**

**MEDICARE PART A - HOSPITAL SERVICES**

HOSPITALIZATION

First 60 days	\$[1,132] Part A Deductible
61 <sup>st</sup> TO 90 <sup>th</sup> day	\$[283] a day
91 <sup>st</sup> TO 150 <sup>th</sup> day	\$[566] a day
151 <sup>st</sup> thru 515 <sup>th</sup> day	100% of Medicare part A eligible expenses

SKILLED NURSING FACILITY CARE

First 20 days	\$[0]
21 <sup>st</sup> TO 100 <sup>th</sup> day	\$[141.50] a day
101 <sup>st</sup> day and after	\$[0] a day

BLOOD

Reasonable cost for the first 3 pints, unless already paid for under Medicare Part B

HOSPICE CARE

Up to \$5 copay for prescription drugs / Part A coinsurance for in patient respite care

**MEDICARE PART B – MEDICAL SERVICES**

MEDICAL EXPENSE

Physician's services, inpatient and outpatient medical and surgical services and supplied physical and speech therapy diagnostic test, durable medical equipment	20% coinsurance
--	-----------------

BLOOD

Reasonable cost for the first 3 pints, unless already paid for under Medicare Part A

MEDICARE PART B DEDUCTIBLE

Coverage for all the Medicare Part B deductible amount per Calendar Year regardless of hospital confinement

MEDICARE PART B EXCESS

100% of the difference between the actual Medicare Part B charge as billed and the Medicare approved Part B charge, not to exceed any charge limitation established by the Medicare program or state law

FOREIGN TRAVEL EMERGENCY CARE

Medically necessary emergency care services beginning during the first 60 days of each trip	80% of Medicare eligible expense subject to a deductible of \$250 for each Insured – up to a lifetime maximum of \$50,000 for each Insured
---	--

## DEFINITIONS

---

Wherever used in this Policy:

**BENEFIT PERIOD** means, while this Policy is in force, a period of time that: (i) begins on the first day You receive Medicare covered services as an inpatient in a Hospital; and, (ii) ends after You are out of the Hospital and have not received skilled care in any facility for 60 days in a row. Benefit Periods cannot overlap. A new Benefit Period will not begin during an existing one. A new Benefit Period starts when inpatient Hospital services are again required. The number of Benefit Periods is unlimited.

**CONTINUOUS PERIOD OF CREDITABLE COVERAGE** means the period during which an individual was covered by creditable coverage, if, during the period of the coverage, the individual had no breaks in coverage greater than 63 days.

**CREDITABLE COVERAGE** means coverage under: (i) a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.); (ii) a group health benefit plan provided by a health insurance carrier or an HMO; (iii) an individual health insurance policy or evidence of coverage; (iv) Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. Section 1395c et seq.); (v) Title XIX of the Social Security Act (42 U.S.C. Section 1396 et seq.), other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1396s); (vi) Chapter 55 of Title 10, United States Code (10 U.S.C. Section 1071 et seq.); (vii) a medical care program of the Indian Health Service or of a tribal organization; (viii) a state or political subdivision health benefits risk pool; (ix) a health plan offered under Chapter 89 of Title 5, United States Code (5 U.S.C. Section 8901 et seq.); (x) any plan established or maintained by a state, county or other political subdivision of a state that provides health insurance coverage to individuals who are enrolled in the plan; (xi) a health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. Section 2504(e)); (xii) health insurance coverage provided under a contract with an issuer that has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder without the issuer's consent) that is within 12 months of the date the contract becomes effective; (xiii) Short-term limited duration insurance.

Creditable coverage does not include: (i) accident-only, disability income insurance, or a combination of accident-only and disability income insurance; (ii) coverage issued as a supplement to liability insurance; (iii) liability insurance, including general liability insurance and automobile liability insurance; (iv) workers' compensation or similar insurance; (v) automobile medical payment insurance; (vi) credit only insurance; (vii) coverage for onsite medical clinics; (viii) other coverage that is similar to the coverage described in this subparagraph under which benefits for medical care are secondary or incidental to other insurance benefits and specified in federal regulations; (ix) if offered separately, coverage that provides limited scope dental or vision benefits; (x) if offered separately, long-term care coverage or benefits, nursing home care coverage or benefits, home health care coverage or benefits, community based care coverage or benefits, or any combination of those coverages or benefits; (xi) if offered separately, coverage for other limited benefits specified by federal regulations; (xii) if offered as independent, non-coordinated benefits, coverage for specified disease or illness; (xiii) if offered as independent, non-coordinated benefits, for hospital indemnity or other fixed indemnity insurance; or (xiv) Medicare supplemental health insurance as defined under Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 U.S.C. Section 1071 et seq.), and similar supplemental coverage provided under a group plan, but only if such insurance or coverages are provided under a separate policy, certificate, or contract of insurance.

**EMERGENCY CARE** means care needed immediately because of an Injury or a Sickness of sudden and unexpected onset.

**HOSPITAL** means an institution licensed and operated pursuant to law, primarily and continuously engaged in providing, for compensation from its patients, either on its premises or in facilities available to the Hospital on a contractual prearranged basis, medical, diagnostic, and major surgical facilities under the supervision of the staff of one or more duly licensed Physician's and provides twenty-four hours a day nursing service by or under the supervision of a Graduate Registered Nurse. The term "Hospital" does not include any institution or portion thereof which is used principally as a facility for the aged, rest, nursing, convalescence, care of mental or nervous disorders, or any military, veteran's hospital, or soldier's home or any hospital contracted for or operated by the federal government or any agency thereof for the treatment of members or ex-members of the armed forces except for services rendered on an emergency basis where a legal liability exists for charges made for such services. Notwithstanding the above, a Hospital shall include a facility which is accredited

by the Joint Commission on Accreditation of Hospitals and which offers medical, therapeutic, and psychiatric care for the treatment of alcoholism.

**INJURY** means accidental bodily Injury sustained by the Insured which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force. It does not include injuries for which benefits are provided under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

**MEDICARE** means Title I, Part I of Public Law 89-97, as Enacted by the 89th Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof.

**MEDICARE ELIGIBLE EXPENSES** are health care expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

**PHYSICIAN** means a person other than a family member of the Insured who is a practitioner of the healing arts and licensed by the State to treat the Injury or Sickness for which claim is made.

**PRE-EXISTING CONDITION** means a condition for which medical advice or treatment was recommended by a Physician or received from a Physician within a six month period preceding the Effective Date of the coverage of the Insured.

**SICKNESS** means illness or disease of the Insured which first manifests itself after the Effective Date of insurance and while the insurance is in force. Sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law are excluded.

**YOU, YOUR, AND YOURS** refers to the Insured named on the Schedule of Benefits page.

**WE, US, AND OUR** refers to Philadelphia American Life Insurance Company.

## **CORE BENEFITS**

---

### **PART A - HOSPITAL EXPENSE BENEFITS**

Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

Upon exhaustion of the Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Part A Medicare Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

Hospice Care: Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

### **PART B - MEDICAL EXPENSE BENEFITS**

Coverage for the coinsurance amount, or in the case of Hospital outpatient department services paid under a prospective payment system, the co-payment amount, of Medicare Eligible Expenses under Part B regardless of Hospital confinement, subject to the Medicare Part B deductible.

## **ADDITIONAL BENEFITS**

---

Medicare Part A Deductible: Coverage for one hundred percent (100%) of the Medicare Part A inpatient hospital deductible amount per benefit period.

Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.

Medicare Part B Deductible: Coverage for one hundred percent (100%) of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

One Hundred Percent (100%) of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of \$250, and a lifetime maximum benefit of fifty thousand dollars \$50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

## **EXCLUSIONS AND LIMITATIONS**

---

This Policy does not provide a benefit for any expense incurred unless the respective services are determined by Medicare to be a Medicare Eligible Expense. However, those expenses Medicare does not pay because Your Medicare benefits have been exhausted are covered.

## **PRE-EXISTING CONDITION LIMITATIONS**

---

Pre-Existing Conditions as defined are not covered during the first six months after the Effective Date of coverage. No Pre-Existing Condition exclusion shall be applicable if the individual, as of the date of application of this Policy, has had a Continuous Period of Creditable Coverage of at least six months. The six month Pre-Existing Condition exclusion period shall be reduced by the aggregate of the period of Creditable Coverage applicable to the individual as of the enrollment date of Medicare Part B benefits. If you are an Eligible Person for Guaranteed Issue, the waiting period for Pre-Existing Conditions is waived.

## **CHANGES IN MEDICARE**

---

Benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and co-payment percentage factors. Premiums may be modified to correspond with such changes.

## **EXTENSION OF BENEFITS**

---

If this Policy terminates, Your benefits for Continuous Total Disability which started while the Policy was in force will not be affected. In this case benefits continue under the condition that you remain continuously disabled, and only for the duration of the policy Benefit Period or until payment of the maximum benefit has been made. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

For the purpose of this section "Continuous Total Disability" means the Insured's complete inability to engage in any occupation for pay or profit, or if not employed, to engage in the normal activities of a person of the same age. The Insured must also require the regular care of a Physician.

## **SUSPENSION OF COVERAGE FOR MEDICAID**

---

This Policy shall be suspended at the request of the Insured for the period (not to exceed 24 months) in which the Insured has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the Insured notifies the Company of such Policy within 90 days after the date the individual becomes entitled to the assistance. Upon receipt of timely notice, the Company shall return to the Insured the portion of the premium attributable to the period of Medicaid eligibility, subject to adjustment for paid claims.

If such suspension occurs and if Insured loses entitlement to such medical assistance, this Policy shall be automatically reinstated (effective as of the date of termination of such entitlement) as of the termination of such entitlement if the Insured provides notice of loss of such entitlement within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement.

The Policy shall provide that benefits and premiums under the Policy shall be suspended, at the request of the Insured, if the Insured is entitled to benefits under section 226 (b) of the Social Security Act and is covered under a group health plan (as defined in section 1862 (b) (1) (A) (v) of the Social Security Act). If suspension occurs and if the Insured loses coverage under the group health plan, the Policy shall be automatically reinstated (effective as of the date of loss of coverage) if the Insured provides notice of loss of coverage within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of entitlement. Reinstatement of such coverages shall not provide for any waiting period with respect to treatment of preexisting conditions; shall provide for coverage which is substantially equivalent to coverage in effect before the date of such suspension and shall provide for classification of premiums on terms at least as favorable to the Insured as the premium classification terms that would have been applied to the Insured had the coverage not been suspended.

## **GUARANTEED RENEWAL INCLUDING RIGHT TO CHANGE PREMIUM**

---

This Policy may be renewed at the option of the Insured for consecutive terms of the same duration as the term specified in the Schedule of Benefits by the payment prior to the expiration of the Grace Period, of the premium rates in effect at the time of such renewal.

The Company reserves the right to change in no less than 12 month intervals its table of premium applicable on a class basis to premiums for all policies on the same form as this Policy issued to persons residing in the state of residence of the Insured. In case of any change, the new table of premium rates will apply to premiums thereafter becoming due under this Policy. The Company shall notify the Insured in writing at his last known address of such change at least 30 days before the due date at which time such change is to become effective. No rate adjustment may be made on an individual basis.

The Company shall not use or change premium rates for Your Medicare Supplement Policy unless the rates which shall be on a level premium basis, rating schedule and supporting documentation have been filed with and approved by the Commissioner/Director in accordance with the filing requirements and procedures.

Benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any change in the applicable Medicare deductible amount and co-payment percentage factors. Premiums may be changed to correspond with such changes.

## GENERAL PROVISIONS

---

**ENTIRE CONTRACT; CHANGES:** This Policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. A change in this Policy is not valid until the change is approved by an executive officer of the Company and unless the approval is endorsed on or attached to the Policy. An agent does not have authority to change this Policy or to waive any of its provisions.

**OWNERSHIP; CONTROL OF POLICY:** This contract is made with the Insured who has signed the application and every transaction relating to this Policy shall be between the Company and such Insured.

**TIME LIMIT ON CERTAIN DEFENSES:** After 2 years from the Effective Date of this Policy, no misstatements, except for fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for loss incurred after the expiration of such 2 year period.

**PREMIUM PAYMENT:** This Policy is issued in consideration of the application and the payment in advance of the first premium for the initial term. This Policy shall take effect at 12 o'clock noon, Standard Time of the place where the Insured resides, and shall remain in effect until the same hour on the date on which the initial term expires. The Effective Date of this Policy and the first premium are shown in the Schedule of Benefits. At the option of the Insured, this Policy may be continued in force in accordance with and subject to its terms for successive periods by the payment of renewal premiums for the term of 1 month, 3 months, 6 months or 12 months, at the Company's applicable table of rates in effect on the respective due dates of such renewal premiums. All premiums, including the first premium, shall be due and payable at the Home Office of the Company.

**GRACE PERIOD:** A grace period of 31 days will be granted for the payment of each premium due after the first premium. During the grace period, the Policy continues in force.

**REINSTATEMENT:** If a renewal premium is not paid before the expiration of the period granted for the Insured to make the payment, a subsequent acceptance of the premium by the Company to accept the premium, without requiring in connection with the acceptance an application for reinstatement, reinstates the Policy. However, if the Company requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated on approval of the application by the Company or, if the application is not approved, on the 45th day after the date of the conditional receipt unless the Company before that date has notified the Insured in writing of the Company's disapproval of the application. The reinstated Policy covers only loss resulting from an accidental Injury sustained after the date of reinstatement and loss due to Sickness that begins after the date of reinstatement. In all other respects the Insured and Company have the same rights under the reinstated Policy as they had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed in the Policy or attached to the Policy in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days before the date of reinstatement.

**NOTICE OF CLAIM:** A written notice of claim must be given to the Company before the 21st day after the date of the occurrence or beginning of any loss covered by the Policy, or as soon after that date as is reasonably possible. A notice given by or on behalf of the Insured or the beneficiary to the Insurer at its Home Office in Houston, Texas or to any authorized agent of the Company, with information sufficient to identify the Insured, constitutes notice to the Company.

**CLAIM FORMS:** The Company, on receipt of a notice of claim, will provide to the claimant the forms usually provided by the Company for filing proof of loss. If the forms are not provided before the 16th day after the date of the notice, the claimant shall be considered to have complied with the requirements of this Policy as to proof of loss on submitting, within the time fixed in the Policy for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which the claim is made.

**PROOF OF LOSS:** A written proof of loss must be provided to the Company at the Company's designated office before the 91st day after the date of the loss. Failure to provide the proof within the required time does not invalidate or reduce any claim if it was not reasonably possible to give proof within the required time. In that case, the proof must be provided as soon as reasonably possible but not later than one year after the time proof is otherwise required, except in the event of a legal incapacity.

**TIME OF PAYMENT OF CLAIMS:** Amounts payable under this Policy for any loss other than benefits for loss of time will be paid immediately upon receipt of due written proof of such loss.

**PAYMENT OF CLAIMS:** All indemnities will be payable to the Insured. If any indemnity of this Policy shall be payable to the estate of the Insured, or to an Insured or beneficiary who is a minor or otherwise not competent to give a valid release, the Company may pay such indemnity, up to an amount not exceeding \$1,000 to any relative by blood or connection by marriage to the Insured or beneficiary who is deemed by the Company to be equitably entitled thereto. Any payment made by the Company in good faith pursuant to this provision shall fully discharge the Company to the extent of such payment. Subject to any written direction of the Insured in the application or otherwise all or a portion of any indemnities provided by this Policy on account of Hospital, nursing, medical or surgical services may, at the Company's option and unless the Insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the Hospital or person rendering such services; but it is not required that the services be rendered by a particular Hospital or person.

**PHYSICAL EXAMINATIONS AND AUTOPSY:** The Company at its own expense has the right and opportunity to conduct a physical examination of the Insured when and as often as the Company reasonably requires while a claim under the Policy is pending and, in case of death, to require that an autopsy be conducted if not forbidden by law.

**ASSIGNMENT:** No assignment of interest under this Policy shall be binding upon the Company unless and until the original or duplicate is filed at the Home Office of the Company, which does not assume any responsibility for the validity thereof.

**LEGAL ACTIONS:** An action at law or in equity may not be brought to recover on this Policy before the 61st day after the date written proof of loss has been provided in accordance with the requirements of this Policy. An action at law or in equity may not be brought after the expiration of three years after the time written proof of loss is required to be provided.

**CHANGE OF BENEFICIARY:** Unless the Insured makes an irrevocable designation of beneficiary, the right to change a beneficiary is reserved for the Insured, and the consent of the beneficiary or beneficiaries is not required for the surrender or assignment of this Policy, for any change of beneficiary or beneficiaries, or for any other changes in this Policy.

**UNEARNED PREMIUMS:** The unearned premiums paid for any period beyond the end of the Policy month, if any, in which Your death occurred or Your request of coverage cancellation, will be returned to the beneficiary of Your estate. The unearned premiums, if any, will be paid in a lump sum on a date no later than thirty (30) days after proof of Your death has been furnished or receipt of cancellation request has been made to the Company.

**CANCELLATION BY THE INSURED; NON-CANCELLATION BY THE INSURER:** The Insured may cancel this Policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid. The earned premium shall be computed on a pro-rata basis. Cancellation shall be without prejudice to any claim originated prior to the effective date of cancellation. The insurer may not cancel this Policy. This provision nullifies any other provision, contained in this Policy or in any endorsement hereon or in any rider attached hereto, which provides for cancellation of this Policy by the insurer or by the Insured.

**CONFORMITY WITH STATE STATUTES:** Any provision of this Policy that, on its Effective Date, conflicts with the statutes of the state in which the Insured resides on the Effective Date is by this clause effectively amended to conform to the minimum requirements of that state's statutes.

Philadelphia American Life Insurance Company

(A stock company, herein called the Company)

PO Box 4884

Houston, TX 77210-4884

MEDICARE SUPPLEMENT POLICY  
STANDARD PLAN F (High Deductible)

**INSURING CLAUSE**

The Company insures the applicant, first named in the Schedule of Benefits, hereinafter called the Insured, against loss due to Hospital confinement and for other specified expense resulting from accidental bodily Injury or Sickness, subject to all provisions, limitations and exclusions, and will pay the benefits provided herein. This Policy is issued in consideration of the application and payment of the initial premium. A copy of the application is attached to this Policy and made a part of it.

**GUARANTEED RENEWABLE FOR LIFE, COMPANY CANNOT CANCEL POLICY  
COMPANY MAY CHANGE PREMIUM RATES BY CLASS AND AS MEDICARE BENEFITS  
CHANGE AS PROVIDED IN THE GUARANTEED RENEWABLE PROVISION**

**GUARANTEED RENEWABLE**

You have the right to continue this Policy in force for life by the timely payment in full of each renewal premium. While this Policy is in force, we will not add any restrictive riders or endorsements. We may not cancel or nonrenew this Policy solely on the ground of your health status or for any reason other than nonpayment of premium or material misrepresentation.

We reserve the right to revise the table of premium rates on a class basis. We can only change your premiums if a change is made for all policies bearing this form number in the state where you reside. Before a change in rates can become effective, we must give you at least 30 days written notice. We will deliver the notice to you, or mail it to your last address shown in our records.

**NOTICE OF 30 DAY RIGHT TO EXAMINE THE POLICY**

If you are not satisfied with this Policy for any reason, the Policy may be returned to us within the first 30 days after you receive it, for a full refund of all premium paid. If the Policy is returned, it shall be void from the Effective Date. To return the Policy, simply mail or deliver it to us at our mailing address: P.O. Box 4884, Houston, TX 77210-4884.

**PLEASE READ YOUR POLICY CAREFULLY**

This Policy may not cover all of the costs associated with medical care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all Policy limitations.

**This policy contains a Pre-Existing Condition provision.**

**CAUTION: Policy benefits are limited to those approved by Medicare for payment.**

**NOTICE TO BUYER: This policy may not cover all of your medical expenses.**

**Please verify the accuracy and completeness of the medical history information on the application.  
Erroneous or incomplete application data could jeopardize Your claim.**

In Witness Whereof. PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY has issued this Policy at its Home Office in Houston, Texas and the Effective Date is as specified in the Schedule of Benefits.



SECRETARY



PRESIDENT

NON-PARTICIPATING

TABLE OF CONTENTS

Insuring Clause .....1  
Guaranteed Renewable .....1  
Notice of 30 Day Right to Examine the Policy .....1  
Table of Contents .....2  
Schedule of Benefits .....3  
Definitions.....4  
Core Benefits.....6  
Additional Benefits.....6  
Exclusions and Limitations .....7  
Pre-Existing Condition Limitations .....7  
Changes in Medicare .....7  
Extension of Benefits.....7  
Suspension of Coverage for Medicaid .....7  
Guaranteed Renewal Including Right To Change Premium.....8  
General Provisions .....9

**SCHEDULE OF BENEFITS**

Insured	[John Doe]			[0000100000]	Policy Number
Issue Age	[65]	[male]	[ntu]	[June 01, 2011]	Effective Date

ANNUAL	SEMIANNUAL	QUARTERLY	MONTHLY	MONTHLY BANK DRAFT
				[\$53.93]

**DESCRIPTION OF COVERAGE**

**BENEFIT AMOUNT**

**MEDICARE PART A - HOSPITAL SERVICES**

**HOSPITALIZATION**

First 60 days	\$[1,132] Part A Deductible
61 <sup>st</sup> TO 90 <sup>th</sup> day	\$[283] a day
91 <sup>st</sup> TO 150 <sup>th</sup> day	\$[566] a day
151 <sup>st</sup> thru 515 <sup>th</sup> day	100% of Medicare part A eligible expenses

**SKILLED NURSING FACILITY CARE**

First 20 days	\$[0]
21 <sup>st</sup> TO 100 <sup>th</sup> day	\$[141.50] a day
101 <sup>st</sup> day and after	\$[0] a day

**BLOOD**

Reasonable cost for the first 3 pints, unless already paid for under Medicare Part B

**HOSPICE CARE**

Up to \$5 copay for prescription drugs / Part A coinsurance for in patient respite care

**MEDICARE PART B – MEDICAL SERVICES**

**MEDICAL EXPENSE**

Physician's services, inpatient and outpatient medical and surgical services and supplied physical and speech therapy diagnostic test, durable medical equipment	20% coinsurance
--	-----------------

**BLOOD**

Reasonable cost for the first 3 pints, unless already paid for under Medicare Part A

**MEDICARE PART B DEDUCTIBLE**

Coverage for all the Medicare Part B deductible amount per Calendar Year regardless of hospital confinement

**MEDICARE PART B EXCESS**

100% of the difference between the actual Medicare Part B charge as billed and the Medicare approved Part B charge, not to exceed any charge limitation established by the Medicare program or state law

**FOREIGN TRAVEL EMERGENCY CARE**

Medically necessary emergency care services beginning during the first 60 days of each trip	80% of Medicare eligible expense subject to a deductible of \$250 for each Insured – up to a lifetime maximum of \$50,000 for each Insured
---	--

**CALENDAR YEAR DEDUCTIBLE**

\$[2,000]

## DEFINITIONS

---

Wherever used in this Policy:

**BENEFIT PERIOD** means, while this Policy is in force, a period of time that: (i) begins on the first day You receive Medicare covered services as an inpatient in a Hospital; and, (ii) ends after You are out of the Hospital and have not received skilled care in any facility for 60 days in a row. Benefit Periods cannot overlap. A new Benefit Period will not begin during an existing one. A new Benefit Period starts when inpatient Hospital services are again required. The number of Benefit Periods is unlimited.

**CONTINUOUS PERIOD OF CREDITABLE COVERAGE** means the period during which an individual was covered by creditable coverage, if, during the period of the coverage, the individual had no breaks in coverage greater than 63 days.

**CREDITABLE COVERAGE** means coverage under: (i) a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.); (ii) a group health benefit plan provided by a health insurance carrier or an HMO; (iii) an individual health insurance policy or evidence of coverage; (iv) Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. Section 1395c et seq.); (v) Title XIX of the Social Security Act (42 U.S.C. Section 1396 et seq.), other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1396s); (vi) Chapter 55 of Title 10, United States Code (10 U.S.C. Section 1071 et seq.); (vii) a medical care program of the Indian Health Service or of a tribal organization; (viii) a state or political subdivision health benefits risk pool; (ix) a health plan offered under Chapter 89 of Title 5, United States Code (5 U.S.C. Section 8901 et seq.); (x) any plan established or maintained by a state, county or other political subdivision of a state that provides health insurance coverage to individuals who are enrolled in the plan; (xi) a health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. Section 2504(e)); (xii) health insurance coverage provided under a contract with an issuer that has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder without the issuer's consent) that is within 12 months of the date the contract becomes effective; (xiii) Short-term limited duration insurance.

Creditable coverage does not include: (i) accident-only, disability income insurance, or a combination of accident-only and disability income insurance; (ii) coverage issued as a supplement to liability insurance; (iii) liability insurance, including general liability insurance and automobile liability insurance; (iv) workers' compensation or similar insurance; (v) automobile medical payment insurance; (vi) credit only insurance; (vii) coverage for onsite medical clinics; (viii) other coverage that is similar to the coverage described in this subparagraph under which benefits for medical care are secondary or incidental to other insurance benefits and specified in federal regulations; (ix) if offered separately, coverage that provides limited scope dental or vision benefits; (x) if offered separately, long-term care coverage or benefits, nursing home care coverage or benefits, home health care coverage or benefits, community based care coverage or benefits, or any combination of those coverages or benefits; (xi) if offered separately, coverage for other limited benefits specified by federal regulations; (xii) if offered as independent, non-coordinated benefits, coverage for specified disease or illness; (xiii) if offered as independent, non-coordinated benefits, for hospital indemnity or other fixed indemnity insurance; or (xiv) Medicare supplemental health insurance as defined under Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 U.S.C. Section 1071 et seq.), and similar supplemental coverage provided under a group plan, but only if such insurance or coverages are provided under a separate policy, certificate, or contract of insurance.

**EMERGENCY CARE** means care needed immediately because of an Injury or a Sickness of sudden and unexpected onset.

**HOSPITAL** means an institution licensed and operated pursuant to law, primarily and continuously engaged in providing, for compensation from its patients, either on its premises or in facilities available to the Hospital on a contractual prearranged basis, medical, diagnostic, and major surgical facilities under the supervision of the staff of one or more duly licensed Physician's and provides twenty-four hours a day nursing service by or under the supervision of a Graduate Registered Nurse. The term "Hospital" does not include any institution or portion thereof which is used principally as a facility for the aged, rest, nursing, convalescence, care of mental or nervous disorders, or any military, veteran's hospital, or soldier's home or any hospital contracted for or operated by the federal government or any agency thereof for the treatment of members or ex-members of the armed forces except for services rendered on an emergency basis where a legal liability exists for charges made for such services. Notwithstanding the above, a Hospital shall include a facility which is accredited by the Joint Commission on Accreditation of Hospitals and which offers medical, therapeutic, and psychiatric care for the treatment of alcoholism.

**INJURY** means accidental bodily Injury sustained by the Insured which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force. It does not include injuries for which benefits are provided under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

**MEDICARE** means Title I, Part I of Public Law 89-97, as Enacted by the 89th Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof.

**MEDICARE ELIGIBLE EXPENSES** are health care expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

**PHYSICIAN** means a person other than a family member of the Insured who is a practitioner of the healing arts and licensed by the State to treat the Injury or Sickness for which claim is made.

**PRE-EXISTING CONDITION** means a condition for which medical advice or treatment was recommended by a Physician or received from a Physician within a six month period preceding the Effective Date of the coverage of the Insured.

**SICKNESS** means illness or disease of the Insured which first manifests itself after the Effective Date of insurance and while the insurance is in force. Sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law are excluded.

**YOU, YOUR, AND YOURS** refers to the Insured named on the Schedule of Benefits page.

**WE, US, AND OUR** refers to Philadelphia American Life Insurance Company.

## **CORE BENEFITS**

---

### **PART A - HOSPITAL EXPENSE BENEFITS**

Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

Upon exhaustion of the Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Part A Medicare Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

Hospice Care: Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

### **PART B - MEDICAL EXPENSE BENEFITS**

Coverage for the coinsurance amount, or in the case of Hospital outpatient department services paid under a prospective payment system, the co-payment amount, of Medicare Eligible Expenses under Part B regardless of Hospital confinement, subject to the Medicare Part B deductible.

## **ADDITIONAL BENEFITS**

---

Medicare Part A Deductible: Coverage for one hundred percent (100%) of the Medicare Part A inpatient hospital deductible amount per benefit period.

Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.

Medicare Part B Deductible: Coverage for one hundred percent (100%) of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

One Hundred Percent (100%) of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of \$250, and a lifetime maximum benefit of fifty thousand dollars \$50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

## **EXCLUSIONS AND LIMITATIONS**

---

This Policy does not provide a benefit for any expense incurred unless the respective services are determined by Medicare to be a Medicare Eligible Expense. However, those expenses Medicare does not pay because Your Medicare benefits have been exhausted are covered.

## **PRE-EXISTING CONDITION LIMITATIONS**

---

Pre-Existing Conditions as defined are not covered during the first six months after the Effective Date of coverage. No Pre-Existing Condition exclusion shall be applicable if the individual, as of the date of application of this Policy, has had a Continuous Period of Creditable Coverage of at least six months. The six month Pre-Existing Condition exclusion period shall be reduced by the aggregate of the period of Creditable Coverage applicable to the individual as of the enrollment date of Medicare Part B benefits. If you are an Eligible Person for Guaranteed Issue, the waiting period for Pre-Existing Conditions is waived.

## **CHANGES IN MEDICARE**

---

Benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and co-payment percentage factors. Premiums may be modified to correspond with such changes.

## **EXTENSION OF BENEFITS**

---

If this Policy terminates, Your benefits for Continuous Total Disability which started while the Policy was in force will not be affected. In this case benefits continue under the condition that you remain continuously disabled, and only for the duration of the policy Benefit Period or until payment of the maximum benefit has been made. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

For the purpose of this section "Continuous Total Disability" means the Insured's complete inability to engage in any occupation for pay or profit, or if not employed, to engage in the normal activities of a person of the same age. The Insured must also require the regular care of a Physician.

## **SUSPENSION OF COVERAGE FOR MEDICAID**

---

This Policy shall be suspended at the request of the Insured for the period (not to exceed 24 months) in which the Insured has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the Insured notifies the Company of such Policy within 90 days after the date the individual becomes entitled to the assistance. Upon receipt of timely notice, the Company shall return to the Insured the portion of the premium attributable to the period of Medicaid eligibility, subject to adjustment for paid claims.

If such suspension occurs and if Insured loses entitlement to such medical assistance, this Policy shall be automatically reinstated (effective as of the date of termination of such entitlement) as of the termination of such entitlement if the Insured provides notice of loss of such entitlement within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement.

The Policy shall provide that benefits and premiums under the Policy shall be suspended, at the request of the Insured, if the Insured is entitled to benefits under section 226 (b) of the Social Security Act and is covered under a group health plan (as defined in section 1862 (b) (1) (A) (v) of the Social Security Act). If suspension occurs and if the Insured loses coverage under the group health plan, the Policy shall be automatically reinstated (effective as of the date of loss of coverage) if the Insured provides notice of loss of coverage within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of entitlement. Reinstatement of such coverages shall not provide for any waiting period with respect to treatment of preexisting conditions; shall provide for coverage which is substantially equivalent to coverage in effect before the date of such suspension and shall provide for classification of premiums on terms at least as favorable to the Insured as the premium classification terms that would have been applied to the Insured had the coverage not been suspended.

## **GUARANTEED RENEWAL INCLUDING RIGHT TO CHANGE PREMIUM**

---

This Policy may be renewed at the option of the Insured for consecutive terms of the same duration as the term specified in the Schedule of Benefits by the payment prior to the expiration of the Grace Period, of the premium rates in effect at the time of such renewal.

The Company reserves the right to change in no less than 12 month intervals its table of premium applicable on a class basis to premiums for all policies on the same form as this Policy issued to persons residing in the state of residence of the Insured. In case of any change, the new table of premium rates will apply to premiums thereafter becoming due under this Policy. The Company shall notify the Insured in writing at his last known address of such change at least 30 days before the due date at which time such change is to become effective. No rate adjustment may be made on an individual basis.

The Company shall not use or change premium rates for Your Medicare Supplement Policy unless the rates which shall be on a level premium basis, rating schedule and supporting documentation have been filed with and approved by the Commissioner/Director in accordance with the filing requirements and procedures.

Benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any change in the applicable Medicare deductible amount and co-payment percentage factors. Premiums may be changed to correspond with such changes.

## GENERAL PROVISIONS

---

**ENTIRE CONTRACT; CHANGES:** This Policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. A change in this Policy is not valid until the change is approved by an executive officer of the Company and unless the approval is endorsed on or attached to the Policy. An agent does not have authority to change this Policy or to waive any of its provisions.

**OWNERSHIP; CONTROL OF POLICY:** This contract is made with the Insured who has signed the application and every transaction relating to this Policy shall be between the Company and such Insured.

**TIME LIMIT ON CERTAIN DEFENSES:** After 2 years from the Effective Date of this Policy, no misstatements, except for fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for loss incurred after the expiration of such 2 year period.

**PREMIUM PAYMENT:** This Policy is issued in consideration of the application and the payment in advance of the first premium for the initial term. This Policy shall take effect at 12 o'clock noon, Standard Time of the place where the Insured resides, and shall remain in effect until the same hour on the date on which the initial term expires. The Effective Date of this Policy and the first premium are shown in the Schedule of Benefits. At the option of the Insured, this Policy may be continued in force in accordance with and subject to its terms for successive periods by the payment of renewal premiums for the term of 1 month, 3 months, 6 months or 12 months, at the Company's applicable table of rates in effect on the respective due dates of such renewal premiums. All premiums, including the first premium, shall be due and payable at the Home Office of the Company.

**GRACE PERIOD:** A grace period of 31 days will be granted for the payment of each premium due after the first premium. During the grace period, the Policy continues in force.

**REINSTATEMENT:** If a renewal premium is not paid before the expiration of the period granted for the Insured to make the payment, a subsequent acceptance of the premium by the Company to accept the premium, without requiring in connection with the acceptance an application for reinstatement, reinstates the Policy. However, if the Company requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated on approval of the application by the Company or, if the application is not approved, on the 45th day after the date of the conditional receipt unless the Company before that date has notified the Insured in writing of the Company's disapproval of the application. The reinstated Policy covers only loss resulting from an accidental Injury sustained after the date of reinstatement and loss due to Sickness that begins after the date of reinstatement. In all other respects the Insured and Company have the same rights under the reinstated Policy as they had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed in the Policy or attached to the Policy in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days before the date of reinstatement.

**NOTICE OF CLAIM:** A written notice of claim must be given to the Company before the 21st day after the date of the occurrence or beginning of any loss covered by the Policy, or as soon after that date as is reasonably possible. A notice given by or on behalf of the Insured or the beneficiary to the Insurer at its Home Office in Houston, Texas or to any authorized agent of the Company, with information sufficient to identify the Insured, constitutes notice to the Company.

**CLAIM FORMS:** The Company, on receipt of a notice of claim, will provide to the claimant the forms usually provided by the Company for filing proof of loss. If the forms are not provided before the 16th day after the date of the notice, the claimant shall be considered to have complied with the requirements of this Policy as to proof of loss on submitting, within the time fixed in the Policy for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which the claim is made.

**PROOF OF LOSS:** A written proof of loss must be provided to the Company at the Company's designated office before the 91st day after the date of the loss. Failure to provide the proof within the required time does not invalidate or reduce any claim if it was not reasonably possible to give proof within the required time. In that case, the proof must be provided as soon as reasonably possible but not later than one year after the time proof is otherwise required, except in the event of a legal incapacity.

**TIME OF PAYMENT OF CLAIMS:** Amounts payable under this Policy for any loss other than benefits for loss of time will be paid immediately upon receipt of due written proof of such loss.

**PAYMENT OF CLAIMS:** All indemnities will be payable to the Insured. If any indemnity of this Policy shall be payable to the estate of the Insured, or to an Insured or beneficiary who is a minor or otherwise not competent to give a valid release, the Company may pay such indemnity, up to an amount not exceeding \$1,000 to any relative by blood or connection by marriage to the Insured or beneficiary who is deemed by the Company to be equitably entitled thereto. Any payment made by the Company in good faith pursuant to this provision shall fully discharge the Company to the extent of such payment. Subject to any written direction of the Insured in the application or otherwise all or a portion of any indemnities provided by this Policy on account of Hospital, nursing, medical or surgical services may, at the Company's option and unless the Insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the Hospital or person rendering such services; but it is not required that the services be rendered by a particular Hospital or person.

**PHYSICAL EXAMINATIONS AND AUTOPSY:** The Company at its own expense has the right and opportunity to conduct a physical examination of the Insured when and as often as the Company reasonably requires while a claim under the Policy is pending and, in case of death, to require that an autopsy be conducted if not forbidden by law.

**ASSIGNMENT:** No assignment of interest under this Policy shall be binding upon the Company unless and until the original or duplicate is filed at the Home Office of the Company, which does not assume any responsibility for the validity thereof.

**LEGAL ACTIONS:** An action at law or in equity may not be brought to recover on this Policy before the 61st day after the date written proof of loss has been provided in accordance with the requirements of this Policy. An action at law or in equity may not be brought after the expiration of three years after the time written proof of loss is required to be provided.

**CHANGE OF BENEFICIARY:** Unless the Insured makes an irrevocable designation of beneficiary, the right to change a beneficiary is reserved for the Insured, and the consent of the beneficiary or beneficiaries is not required for the surrender or assignment of this Policy, for any change of beneficiary or beneficiaries, or for any other changes in this Policy.

**UNEARNED PREMIUMS:** The unearned premiums paid for any period beyond the end of the Policy month, if any, in which Your death occurred or Your request of coverage cancellation, will be returned to the beneficiary of Your estate. The unearned premiums, if any, will be paid in a lump sum on a date no later than thirty (30) days after proof of Your death has been furnished or receipt of cancellation request has been made to the Company.

**CANCELLATION BY THE INSURED; NON-CANCELLATION BY THE INSURER:** The Insured may cancel this Policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid. The earned premium shall be computed on a pro-rata basis. Cancellation shall be without prejudice to any claim originated prior to the effective date of cancellation. The insurer may not cancel this Policy. This provision nullifies any other provision, contained in this Policy or in any endorsement hereon or in any rider attached hereto, which provides for cancellation of this Policy by the insurer or by the Insured.

**CONFORMITY WITH STATE STATUTES:** Any provision of this Policy that, on its Effective Date, conflicts with the statutes of the state in which the Insured resides on the Effective Date is by this clause effectively amended to conform to the minimum requirements of that state's statutes.

Philadelphia American Life Insurance Company

(A stock company, herein called the Company)

PO Box 4884

Houston, TX 77210-4884

MEDICARE SUPPLEMENT POLICY  
STANDARD PLAN G

**INSURING CLAUSE**

The Company insures the applicant, first named in the Schedule of Benefits, hereinafter called the Insured, against loss due to Hospital confinement and for other specified expense resulting from accidental bodily Injury or Sickness, subject to all provisions, limitations and exclusions, and will pay the benefits provided herein. This Policy is issued in consideration of the application and payment of the initial premium. A copy of the application is attached to this Policy and made a part of it.

**GUARANTEED RENEWABLE FOR LIFE, COMPANY CANNOT CANCEL POLICY  
COMPANY MAY CHANGE PREMIUM RATES BY CLASS AND AS MEDICARE BENEFITS  
CHANGE AS PROVIDED IN THE GUARANTEED RENEWABLE PROVISION**

**GUARANTEED RENEWABLE**

You have the right to continue this Policy in force for life by the timely payment in full of each renewal premium. While this Policy is in force, we will not add any restrictive riders or endorsements. We may not cancel or nonrenew this Policy solely on the ground of your health status or for any reason other than nonpayment of premium or material misrepresentation.

We reserve the right to revise the table of premium rates on a class basis. We can only change your premiums if a change is made for all policies bearing this form number in the state where you reside. Before a change in rates can become effective, we must give you at least 30 days written notice. We will deliver the notice to you, or mail it to your last address shown in our records.

**NOTICE OF 30 DAY RIGHT TO EXAMINE THE POLICY**

If you are not satisfied with this Policy for any reason, the Policy may be returned to us within the first 30 days after you receive it, for a full refund of all premium paid. If the Policy is returned, it shall be void from the Effective Date. To return the Policy, simply mail or deliver it to us at our mailing address: P.O. Box 4884, Houston, TX 77210-4884.

**PLEASE READ YOUR POLICY CAREFULLY**

This Policy may not cover all of the costs associated with medical care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all Policy limitations.

**This policy contains a Pre-Existing Condition provision.**

**CAUTION: Policy benefits are limited to those approved by Medicare for payment.**

**NOTICE TO BUYER: This policy may not cover all of your medical expenses.**

**Please verify the accuracy and completeness of the medical history information on the application.  
Erroneous or incomplete application data could jeopardize Your claim.**

In Witness Whereof. PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY has issued this Policy at its Home Office in Houston, Texas and the Effective Date is as specified in the Schedule of Benefits.



SECRETARY



PRESIDENT

NON-PARTICIPATING

TABLE OF CONTENTS

Insuring Clause .....1

Guaranteed Renewable .....1

Notice of 30 Day Right to Examine the Policy .....1

Table of Contents .....2

Schedule of Benefits .....3

Definitions.....4

Core Benefits.....6

Additional Benefits.....6

Exclusions and Limitations .....7

Pre-Existing Condition Limitations .....7

Changes in Medicare .....7

Extension of Benefits.....7

Suspension of Coverage for Medicaid .....7

Guaranteed Renewal Including Right To Change Premium.....8

General Provisions .....9

**SCHEDULE OF BENEFITS**

Insured [John Doe]	[0000100000]	Policy Number
Issue Age [65]	[male]	[ntu]
	[June 01, 2011]	Effective Date

ANNUAL	SEMIANNUAL	QUARTERLY	MONTHLY	MONTHLY BANK DRAFT
				[\$101.87]

**DESCRIPTION OF COVERAGE**

**BENEFIT AMOUNT**

**MEDICARE PART A - HOSPITAL SERVICES**

**HOSPITALIZATION**

First 60 days	\$[1,132] Part A Deductible
61 <sup>st</sup> TO 90 <sup>th</sup> day	\$[283] a day
91 <sup>st</sup> TO 150 <sup>th</sup> day	\$[566] a day
151 <sup>st</sup> thru 515 <sup>th</sup> day	100% of Medicare part A eligible expenses

**SKILLED NURSING FACILITY CARE**

First 20 days	\$[0]
21 <sup>st</sup> TO 100 <sup>th</sup> day	\$[141.50] a day
101 <sup>st</sup> day and after	\$[0] a day

**BLOOD**

Reasonable cost for the first 3 pints, unless already paid for under Medicare Part B

**HOSPICE CARE**

Up to \$5 copay for prescription drugs / Part A coinsurance for in patient respite care

**MEDICARE PART B – MEDICAL SERVICES**

**MEDICAL EXPENSE**

Physician’s services, inpatient and outpatient medical and surgical services and supplied physical and speech therapy diagnostic test, durable medical equipment	20% coinsurance
--	-----------------

**BLOOD**

Reasonable cost for the first 3 pints, unless already paid for under Medicare Part A

**MEDICARE PART B EXCESS**

100% of the difference between the actual Medicare Part B charge as billed and the Medicare approved Part B charge, not to exceed any charge limitation established by the Medicare program or state law

**FOREIGN TRAVEL EMERGENCY CARE**

Medically necessary emergency care services beginning during the first 60 days of each trip	80% of Medicare eligible expense subject to a deductible of \$250 for each Insured – up to a lifetime maximum of \$50,000 for each Insured
---	--

## DEFINITIONS

---

Wherever used in this Policy:

**BENEFIT PERIOD** means, while this Policy is in force, a period of time that: (i) begins on the first day You receive Medicare covered services as an inpatient in a Hospital; and, (ii) ends after You are out of the Hospital and have not received skilled care in any facility for 60 days in a row. Benefit Periods cannot overlap. A new Benefit Period will not begin during an existing one. A new Benefit Period starts when inpatient Hospital services are again required. The number of Benefit Periods is unlimited.

**CONTINUOUS PERIOD OF CREDITABLE COVERAGE** means the period during which an individual was covered by creditable coverage, if, during the period of the coverage, the individual had no breaks in coverage greater than 63 days.

**CREDITABLE COVERAGE** means coverage under: (i) a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.); (ii) a group health benefit plan provided by a health insurance carrier or an HMO; (iii) an individual health insurance policy or evidence of coverage; (iv) Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. Section 1395c et seq.); (v) Title XIX of the Social Security Act (42 U.S.C. Section 1396 et seq.), other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1396s); (vi) Chapter 55 of Title 10, United States Code (10 U.S.C. Section 1071 et seq.); (vii) a medical care program of the Indian Health Service or of a tribal organization; (viii) a state or political subdivision health benefits risk pool; (ix) a health plan offered under Chapter 89 of Title 5, United States Code (5 U.S.C. Section 8901 et seq.); (x) any plan established or maintained by a state, county or other political subdivision of a state that provides health insurance coverage to individuals who are enrolled in the plan; (xi) a health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. Section 2504(e)); (xii) health insurance coverage provided under a contract with an issuer that has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder without the issuer's consent) that is within 12 months of the date the contract becomes effective; (xiii) Short-term limited duration insurance.

Creditable coverage does not include: (i) accident-only, disability income insurance, or a combination of accident-only and disability income insurance; (ii) coverage issued as a supplement to liability insurance; (iii) liability insurance, including general liability insurance and automobile liability insurance; (iv) workers' compensation or similar insurance; (v) automobile medical payment insurance; (vi) credit only insurance; (vii) coverage for onsite medical clinics; (viii) other coverage that is similar to the coverage described in this subparagraph under which benefits for medical care are secondary or incidental to other insurance benefits and specified in federal regulations; (ix) if offered separately, coverage that provides limited scope dental or vision benefits; (x) if offered separately, long-term care coverage or benefits, nursing home care coverage or benefits, home health care coverage or benefits, community based care coverage or benefits, or any combination of those coverages or benefits; (xi) if offered separately, coverage for other limited benefits specified by federal regulations; (xii) if offered as independent, non-coordinated benefits, coverage for specified disease or illness; (xiii) if offered as independent, non-coordinated benefits, for hospital indemnity or other fixed indemnity insurance; or (xiv) Medicare supplemental health insurance as defined under Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 U.S.C. Section 1071 et seq.), and similar supplemental coverage provided under a group plan, but only if such insurance or coverages are provided under a separate policy, certificate, or contract of insurance.

**EMERGENCY CARE** means care needed immediately because of an Injury or a Sickness of sudden and unexpected onset.

**HOSPITAL** means an institution licensed and operated pursuant to law, primarily and continuously engaged in providing, for compensation from its patients, either on its premises or in facilities available to the Hospital on a contractual prearranged basis, medical, diagnostic, and major surgical facilities under the supervision of the staff of one or more duly licensed Physician's and provides twenty-four hours a day nursing service by or under the supervision of a Graduate Registered Nurse. The term "Hospital" does not include any institution or portion thereof which is used principally as a facility for the aged, rest, nursing, convalescence, care of mental or nervous disorders, or any military, veteran's hospital, or soldier's home or any hospital contracted for or operated by the federal government or any agency thereof for the treatment of members or ex-members of the armed forces except for services rendered on an emergency basis where a legal liability exists for charges made for such services. Notwithstanding the above, a Hospital shall include a facility which is accredited by the Joint Commission on Accreditation of Hospitals and which offers medical, therapeutic, and psychiatric care for the treatment of alcoholism.

**INJURY** means accidental bodily Injury sustained by the Insured which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force. It does not include injuries for which benefits are provided under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

**MEDICARE** means Title I, Part I of Public Law 89-97, as Enacted by the 89th Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof.

**MEDICARE ELIGIBLE EXPENSES** are health care expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

**PHYSICIAN** means a person other than a family member of the Insured who is a practitioner of the healing arts and licensed by the State to treat the Injury or Sickness for which claim is made.

**PRE-EXISTING CONDITION** means a condition for which medical advice or treatment was recommended by a Physician or received from a Physician within a six month period preceding the Effective Date of the coverage of the Insured.

**SICKNESS** means illness or disease of the Insured which first manifests itself after the Effective Date of insurance and while the insurance is in force. Sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law are excluded.

**YOU, YOUR, AND YOURS** refers to the Insured named on the Schedule of Benefits page.

**WE, US, AND OUR** refers to Philadelphia American Life Insurance Company.

## **CORE BENEFITS**

---

### **PART A - HOSPITAL EXPENSE BENEFITS**

Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

Upon exhaustion of the Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Part A Medicare Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

Hospice Care: Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

### **PART B - MEDICAL EXPENSE BENEFITS**

Coverage for the coinsurance amount, or in the case of Hospital outpatient department services paid under a prospective payment system, the co-payment amount, of Medicare Eligible Expenses under Part B regardless of Hospital confinement, subject to the Medicare Part B deductible.

## **ADDITIONAL BENEFITS**

---

Medicare Part A Deductible: Coverage for one hundred percent (100%) of the Medicare Part A inpatient hospital deductible amount per benefit period.

Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.

One Hundred Percent (100%) of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of \$250, and a lifetime maximum benefit of \$50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

## **EXCLUSIONS AND LIMITATIONS**

---

This Policy does not provide a benefit for any expense incurred unless the respective services are determined by Medicare to be a Medicare Eligible Expense. However, those expenses Medicare does not pay because Your Medicare benefits have been exhausted are covered.

## **PRE-EXISTING CONDITION LIMITATIONS**

---

Pre-Existing Conditions as defined are not covered during the first six months after the Effective Date of coverage. No Pre-Existing Condition exclusion shall be applicable if the individual, as of the date of application of this Policy, has had a Continuous Period of Creditable Coverage of at least six months. The six month Pre-Existing Condition exclusion period shall be reduced by the aggregate of the period of Creditable Coverage applicable to the individual as of the enrollment date of Medicare Part B benefits. If you are an Eligible Person for Guaranteed Issue, the waiting period for Pre-Existing Conditions is waived.

## **CHANGES IN MEDICARE**

---

Benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and co-payment percentage factors. Premiums may be modified to correspond with such changes.

## **EXTENSION OF BENEFITS**

---

If this Policy terminates, Your benefits for Continuous Total Disability which started while the Policy was in force will not be affected. In this case benefits continue under the condition that you remain continuously disabled, and only for the duration of the policy Benefit Period or until payment of the maximum benefit has been made. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

For the purpose of this section "Continuous Total Disability" means the Insured's complete inability to engage in any occupation for pay or profit, or if not employed, to engage in the normal activities of a person of the same age. The Insured must also require the regular care of a Physician.

## **SUSPENSION OF COVERAGE FOR MEDICAID**

---

This Policy shall be suspended at the request of the Insured for the period (not to exceed 24 months) in which the Insured has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the Insured notifies the Company of such Policy within 90 days after the date the individual becomes entitled to the assistance. Upon receipt of timely notice, the Company shall return to the Insured the portion of the premium attributable to the period of Medicaid eligibility, subject to adjustment for paid claims.

If such suspension occurs and if Insured loses entitlement to such medical assistance, this Policy shall be automatically reinstated (effective as of the date of termination of such entitlement) as of the termination of such entitlement if the Insured provides notice of loss of such entitlement within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement.

The Policy shall provide that benefits and premiums under the Policy shall be suspended, at the request of the Insured, if the Insured is entitled to benefits under section 226 (b) of the Social Security Act and is covered under a group health plan (as defined in section 1862 (b) (1) (A) (v) of the Social Security Act). If suspension occurs and if the Insured loses coverage under the group health plan, the Policy shall be automatically reinstated (effective as of the date of loss of coverage) if the Insured provides notice of loss of coverage within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of entitlement. Reinstatement of such coverages shall not provide for any waiting period with respect to treatment of preexisting conditions; shall provide for coverage which is substantially equivalent to coverage in effect before the date of such suspension and shall provide for classification of premiums on terms at least as favorable to the Insured as the premium classification terms that would have been applied to the Insured had the coverage not been suspended.

## **GUARANTEED RENEWAL INCLUDING RIGHT TO CHANGE PREMIUM**

---

This Policy may be renewed at the option of the Insured for consecutive terms of the same duration as the term specified in the Schedule of Benefits by the payment prior to the expiration of the Grace Period, of the premium rates in effect at the time of such renewal.

The Company reserves the right to change in no less than 12 month intervals its table of premium applicable on a class basis to premiums for all policies on the same form as this Policy issued to persons residing in the state of residence of the Insured. In case of any change, the new table of premium rates will apply to premiums thereafter becoming due under this Policy. The Company shall notify the Insured in writing at his last known address of such change at least 30 days before the due date at which time such change is to become effective. No rate adjustment may be made on an individual basis.

The Company shall not use or change premium rates for Your Medicare Supplement Policy unless the rates which shall be on a level premium basis, rating schedule and supporting documentation have been filed with and approved by the Commissioner/Director in accordance with the filing requirements and procedures.

Benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any change in the applicable Medicare deductible amount and co-payment percentage factors. Premiums may be changed to correspond with such changes.

## **GENERAL PROVISIONS**

---

**ENTIRE CONTRACT; CHANGES:** This Policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. A change in this Policy is not valid until the change is approved by an executive officer of the Company and unless the approval is endorsed on or attached to the Policy. An agent does not have authority to change this Policy or to waive any of its provisions.

**OWNERSHIP; CONTROL OF POLICY:** This contract is made with the Insured who has signed the application and every transaction relating to this Policy shall be between the Company and such Insured.

**TIME LIMIT ON CERTAIN DEFENSES:** After 2 years from the Effective Date of this Policy, no misstatements, except for fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for loss incurred after the expiration of such 2 year period.

**PREMIUM PAYMENT:** This Policy is issued in consideration of the application and the payment in advance of the first premium for the initial term. This Policy shall take effect at 12 o'clock noon, Standard Time of the place where the Insured resides, and shall remain in effect until the same hour on the date on which the initial term expires. The Effective Date of this Policy and the first premium are shown in the Schedule of Benefits. At the option of the Insured, this Policy may be continued in force in accordance with and subject to its terms for successive periods by the payment of renewal premiums for the term of 1 month, 3 months, 6 months or 12 months, at the Company's applicable table of rates in effect on the respective due dates of such renewal premiums. All premiums, including the first premium, shall be due and payable at the Home Office of the Company.

**GRACE PERIOD:** A grace period of 31 days will be granted for the payment of each premium due after the first premium. During the grace period, the Policy continues in force.

**REINSTATEMENT:** If a renewal premium is not paid before the expiration of the period granted for the Insured to make the payment, a subsequent acceptance of the premium by the Company to accept the premium, without requiring in connection with the acceptance an application for reinstatement, reinstates the Policy. However, if the Company requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated on approval of the application by the Company or, if the application is not approved, on the 45th day after the date of the conditional receipt unless the Company before that date has notified the Insured in writing of the Company's disapproval of the application. The reinstated Policy covers only loss resulting from an accidental Injury sustained after the date of reinstatement and loss due to Sickness that begins after the date of reinstatement. In all other respects the Insured and Company have the same rights under the reinstated Policy as they had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed in the Policy or attached to the Policy in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days before the date of reinstatement.

**NOTICE OF CLAIM:** A written notice of claim must be given to the Company before the 21st day after the date of the occurrence or beginning of any loss covered by the Policy, or as soon after that date as is reasonably possible. A notice given by or on behalf of the Insured or the beneficiary to the Insurer at its Home Office in Houston, Texas or to any authorized agent of the Company, with information sufficient to identify the Insured, constitutes notice to the Company.

**CLAIM FORMS:** The Company, on receipt of a notice of claim, will provide to the claimant the forms usually provided by the Company for filing proof of loss. If the forms are not provided before the 16th day after the date of the notice, the claimant shall be considered to have complied with the requirements of this Policy as to proof of loss on submitting, within the time fixed in the Policy for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which the claim is made.

**PROOF OF LOSS:** A written proof of loss must be provided to the Company at the Company's designated office before the 91st day after the date of the loss. Failure to provide the proof within the required time does not invalidate or reduce any claim if it was not reasonably possible to give proof within the required time. In that case, the proof must be provided as soon as reasonably possible but not later than one year after the time proof is otherwise required, except in the event of a legal incapacity.

**TIME OF PAYMENT OF CLAIMS:** Amounts payable under this Policy for any loss other than benefits for loss of time will be paid immediately upon receipt of due written proof of such loss.

**PAYMENT OF CLAIMS:** All indemnities will be payable to the Insured. If any indemnity of this Policy shall be payable to the estate of the Insured, or to an Insured or beneficiary who is a minor or otherwise not competent to give a valid release, the Company may pay such indemnity, up to an amount not exceeding \$1,000 to any relative by blood or connection by marriage to the Insured or beneficiary who is deemed by the Company to be equitably entitled thereto. Any payment made by the Company in good faith pursuant to this provision shall fully discharge the Company to the extent of such payment. Subject to any written direction of the Insured in the application or otherwise all or a portion of any indemnities provided by this Policy on account of Hospital, nursing, medical or surgical services may, at the Company's option and unless the Insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the Hospital or person rendering such services; but it is not required that the services be rendered by a particular Hospital or person.

**PHYSICAL EXAMINATIONS AND AUTOPSY:** The Company at its own expense has the right and opportunity to conduct a physical examination of the Insured when and as often as the Company reasonably requires while a claim under the Policy is pending and, in case of death, to require that an autopsy be conducted if not forbidden by law.

**ASSIGNMENT:** No assignment of interest under this Policy shall be binding upon the Company unless and until the original or duplicate is filed at the Home Office of the Company, which does not assume any responsibility for the validity thereof.

**LEGAL ACTIONS:** An action at law or in equity may not be brought to recover on this Policy before the 61st day after the date written proof of loss has been provided in accordance with the requirements of this Policy. An action at law or in equity may not be brought after the expiration of three years after the time written proof of loss is required to be provided.

**CHANGE OF BENEFICIARY:** Unless the Insured makes an irrevocable designation of beneficiary, the right to change a beneficiary is reserved for the Insured, and the consent of the beneficiary or beneficiaries is not required for the surrender or assignment of this Policy, for any change of beneficiary or beneficiaries, or for any other changes in this Policy.

**UNEARNED PREMIUMS:** The unearned premiums paid for any period beyond the end of the Policy month, if any, in which Your death occurred or Your request of coverage cancellation, will be returned to the beneficiary of Your estate. The unearned premiums, if any, will be paid in a lump sum on a date no later than thirty (30) days after proof of Your death has been furnished or receipt of cancellation request has been made to the Company.

**CANCELLATION BY THE INSURED; NON-CANCELLATION BY THE INSURER:** The Insured may cancel this Policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid. The earned premium shall be computed on a pro-rata basis. Cancellation shall be without prejudice to any claim originated prior to the effective date of cancellation. The insurer may not cancel this Policy. This provision nullifies any other provision, contained in this Policy or in any endorsement hereon or in any rider attached hereto, which provides for cancellation of this Policy by the insurer or by the Insured.

**CONFORMITY WITH STATE STATUTES:** Any provision of this Policy that, on its Effective Date, conflicts with the statutes of the state in which the Insured resides on the Effective Date is by this clause effectively amended to conform to the minimum requirements of that state's statutes.

Philadelphia American Life Insurance Company

(A stock company, herein called the Company)

PO Box 4884

Houston, TX 77210-4884

MEDICARE SUPPLEMENT POLICY  
STANDARD PLAN N

**INSURING CLAUSE**

The Company insures the applicant, first named in the Schedule of Benefits, hereinafter called the Insured, against loss due to Hospital confinement and for other specified expense resulting from accidental bodily Injury or Sickness, subject to all provisions, limitations and exclusions, and will pay the benefits provided herein. This Policy is issued in consideration of the application and payment of the initial premium. A copy of the application is attached to this Policy and made a part of it.

**GUARANTEED RENEWABLE FOR LIFE, COMPANY CANNOT CANCEL POLICY  
COMPANY MAY CHANGE PREMIUM RATES BY CLASS AND AS MEDICARE BENEFITS  
CHANGE AS PROVIDED IN THE GUARANTEED RENEWABLE PROVISION**

**GUARANTEED RENEWABLE**

You have the right to continue this Policy in force for life by the timely payment in full of each renewal premium. While this Policy is in force, we will not add any restrictive riders or endorsements. We may not cancel or nonrenew this Policy solely on the ground of your health status or for any reason other than nonpayment of premium or material misrepresentation.

We reserve the right to revise the table of premium rates on a class basis. We can only change your premiums if a change is made for all policies bearing this form number in the state where you reside. Before a change in rates can become effective, we must give you at least 30 days written notice. We will deliver the notice to you, or mail it to your last address shown in our records.

**NOTICE OF 30 DAY RIGHT TO EXAMINE THE POLICY**

If you are not satisfied with this Policy for any reason, the Policy may be returned to us within the first 30 days after you receive it, for a full refund of all premium paid. If the Policy is returned, it shall be void from the Effective Date. To return the Policy, simply mail or deliver it to us at our mailing address: P.O. Box 4884, Houston, TX 77210-4884.

**PLEASE READ YOUR POLICY CAREFULLY**

This Policy may not cover all of the costs associated with medical care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all Policy limitations.

**This policy contains a Pre-Existing Condition provision.**

**CAUTION: Policy benefits are limited to those approved by Medicare for payment.**

**NOTICE TO BUYER: This policy may not cover all of your medical expenses.**

**Please verify the accuracy and completeness of the medical history information on the application.  
Erroneous or incomplete application data could jeopardize Your claim.**

In Witness Whereof. PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY has issued this Policy at its Home Office in Houston, Texas and the Effective Date is as specified in the Schedule of Benefits.



SECRETARY



PRESIDENT

NON-PARTICIPATING

TABLE OF CONTENTS

Insuring Clause .....1

Guaranteed Renewable .....1

Notice of 30 Day Right to Examine the Policy .....1

Table of Contents .....2

Schedule of Benefits .....3

Definitions.....4

Core Benefits.....6

Additional Benefits.....6

Exclusions and Limitations .....7

Pre-Existing Condition Limitations .....7

Changes in Medicare .....7

Extension of Benefits.....7

Suspension of Coverage for Medicaid .....7

Guaranteed Renewal Including Right To Change Premium.....8

General Provisions .....9

**SCHEDULE OF BENEFITS**

Insured [John Doe] [0000100000] Policy Number  
Issue Age [65] [male] [ntu] [June 01, 2011] Effective Date

ANNUAL SEMIANNUAL QUARTERLY MONTHLY MONTHLY BANK DRAFT  
\$[91.68]

**DESCRIPTION OF COVERAGE**

**BENEFIT AMOUNT**

**MEDICARE PART A - HOSPITAL SERVICES**

**HOSPITALIZATION**

First 60 days  
61<sup>st</sup> TO 90<sup>th</sup> day  
91<sup>st</sup> TO 150<sup>th</sup> day  
151<sup>st</sup> thru 515<sup>th</sup> day

[\$[1,132] Part A Deductible  
[\$[283] a day  
[\$[566] a day  
100% of Medicare part A eligible expenses

**SKILLED NURSING FACILITY CARE**

First 20 days  
21<sup>st</sup> TO 100<sup>th</sup> day  
101<sup>st</sup> day and after

[\$[0]  
[\$[141.50] a day  
[\$[0] a day

**BLOOD**

Reasonable cost for the first 3 pints, unless already paid for under Medicare Part B

**HOSPICE CARE**

Up to \$5 copay for prescription drugs / Part A coinsurance for in patient respite care

**MEDICARE PART B – MEDICAL SERVICES**

**MEDICAL EXPENSE**

Physician’s services, inpatient and outpatient medical and surgical services and supplied physical and speech therapy diagnostic test, durable medical equipment

20% coinsurance  
Balance of remainder of Medicare Approved Amounts:  
Up to \$20 copayment per office visit  
Up to \$50 copayment per emergency room (waived if admitted to any hospital and emergency visit is covered)

**BLOOD**

Reasonable cost for the first 3 pints, unless already paid for under Medicare Part A

**FOREIGN TRAVEL EMERGENCY CARE**

Medically necessary emergency care services beginning during the first 60 days of each trip

80% of Medicare eligible expense subject to a deductible of \$250 for each Insured – up to a lifetime maximum of \$50,000 for each Insured

## DEFINITIONS

---

Wherever used in this Policy:

**BENEFIT PERIOD** means, while this Policy is in force, a period of time that: (i) begins on the first day You receive Medicare covered services as an inpatient in a Hospital; and, (ii) ends after You are out of the Hospital and have not received skilled care in any facility for 60 days in a row. Benefit Periods cannot overlap. A new Benefit Period will not begin during an existing one. A new Benefit Period starts when inpatient Hospital services are again required. The number of Benefit Periods is unlimited.

**CONTINUOUS PERIOD OF CREDITABLE COVERAGE** means the period during which an individual was covered by creditable coverage, if, during the period of the coverage, the individual had no breaks in coverage greater than 63 days.

**CREDITABLE COVERAGE** means coverage under: (i) a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.); (ii) a group health benefit plan provided by a health insurance carrier or an HMO; (iii) an individual health insurance policy or evidence of coverage; (iv) Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. Section 1395c et seq.); (v) Title XIX of the Social Security Act (42 U.S.C. Section 1396 et seq.), other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1396s); (vi) Chapter 55 of Title 10, United States Code (10 U.S.C. Section 1071 et seq.); (vii) a medical care program of the Indian Health Service or of a tribal organization; (viii) a state or political subdivision health benefits risk pool; (ix) a health plan offered under Chapter 89 of Title 5, United States Code (5 U.S.C. Section 8901 et seq.); (x) any plan established or maintained by a state, county or other political subdivision of a state that provides health insurance coverage to individuals who are enrolled in the plan; (xi) a health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. Section 2504(e)); (xii) health insurance coverage provided under a contract with an issuer that has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder without the issuer's consent) that is within 12 months of the date the contract becomes effective; (xiii) Short-term limited duration insurance.

Creditable coverage does not include: (i) accident-only, disability income insurance, or a combination of accident-only and disability income insurance; (ii) coverage issued as a supplement to liability insurance; (iii) liability insurance, including general liability insurance and automobile liability insurance; (iv) workers' compensation or similar insurance; (v) automobile medical payment insurance; (vi) credit only insurance; (vii) coverage for onsite medical clinics; (viii) other coverage that is similar to the coverage described in this subparagraph under which benefits for medical care are secondary or incidental to other insurance benefits and specified in federal regulations; (ix) if offered separately, coverage that provides limited scope dental or vision benefits; (x) if offered separately, long-term care coverage or benefits, nursing home care coverage or benefits, home health care coverage or benefits, community based care coverage or benefits, or any combination of those coverages or benefits; (xi) if offered separately, coverage for other limited benefits specified by federal regulations; (xii) if offered as independent, non-coordinated benefits, coverage for specified disease or illness; (xiii) if offered as independent, non-coordinated benefits, for hospital indemnity or other fixed indemnity insurance; or (xiv) Medicare supplemental health insurance as defined under Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 U.S.C. Section 1071 et seq.), and similar supplemental coverage provided under a group plan, but only if such insurance or coverages are provided under a separate policy, certificate, or contract of insurance.

**EMERGENCY CARE** means care needed immediately because of an Injury or a Sickness of sudden and unexpected onset.

**HOSPITAL** means an institution licensed and operated pursuant to law, primarily and continuously engaged in providing, for compensation from its patients, either on its premises or in facilities available to the Hospital on a contractual prearranged basis, medical, diagnostic, and major surgical facilities under the supervision of the staff of one or more duly licensed Physician's and provides twenty-four hours a day nursing service by or under the supervision of a Graduate Registered Nurse. The term "Hospital" does not include any institution or portion thereof which is used principally as a facility for the aged, rest, nursing, convalescence, care of mental or nervous disorders, or any military, veteran's hospital, or soldier's home or any hospital contracted for or operated by the federal government or any agency thereof for the treatment of members or ex-members of the armed forces except for services rendered on an emergency basis where a legal liability exists for charges made for such services. Notwithstanding the above, a Hospital shall include a facility which is accredited

by the Joint Commission on Accreditation of Hospitals and which offers medical, therapeutic, and psychiatric care for the treatment of alcoholism.

**INJURY** means accidental bodily Injury sustained by the Insured which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force. It does not include injuries for which benefits are provided under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

**MEDICARE** means Title I, Part I of Public Law 89-97, as Enacted by the 89th Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof.

**MEDICARE ELIGIBLE EXPENSES** are health care expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

**PHYSICIAN** means a person other than a family member of the Insured who is a practitioner of the healing arts and licensed by the State to treat the Injury or Sickness for which claim is made.

**PRE-EXISTING CONDITION** means a condition for which medical advice or treatment was recommended by a Physician or received from a Physician within a six month period preceding the Effective Date of the coverage of the Insured.

**SICKNESS** means illness or disease of the Insured which first manifests itself after the Effective Date of insurance and while the insurance is in force. Sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law are excluded.

**YOU, YOUR, AND YOURS** refers to the Insured named on the Schedule of Benefits page.

**WE, US, AND OUR** refers to Philadelphia American Life Insurance Company.

## **CORE BENEFITS**

---

### **PART A - HOSPITAL EXPENSE BENEFITS**

Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period.

Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.

Upon exhaustion of the Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Part A Medicare Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

Hospice Care: Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

### **PART B - MEDICAL EXPENSE BENEFITS**

Coverage for the coinsurance amount, or in the case of Hospital outpatient department services paid under a prospective payment system, the co-payment amount, of Medicare Eligible Expenses under Part B regardless of Hospital confinement, subject to the Medicare Part B deductible and copayments in the following amounts;

- (a) the lesser of twenty dollars (\$20) or the Medicare Part B coinsurance or co-payment for each covered health care provider office visit (including visits to medical specialists); and
- (b) the lesser of fifty dollars (\$50) or the Medicare Part B coinsurance or co-payment for each covered emergency room visit, however, this co-payment shall be waived if the Insured is admitted to any Hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

## **ADDITIONAL BENEFITS**

---

Medicare Part A Deductible: Coverage for one hundred percent (100%) of the Medicare Part A inpatient hospital deductible amount per benefit period.

Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare part A.

Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of \$250, and a lifetime maximum benefit of \$50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

## **EXCLUSIONS AND LIMITATIONS**

---

This Policy does not provide a benefit for any expense incurred unless the respective services are determined by Medicare to be a Medicare Eligible Expense. However, those expenses Medicare does not pay because Your Medicare benefits have been exhausted are covered.

## **PRE-EXISTING CONDITION LIMITATIONS**

---

Pre-Existing Conditions as defined are not covered during the first six months after the Effective Date of coverage. No Pre-Existing Condition exclusion shall be applicable if the individual, as of the date of application of this Policy, has had a Continuous Period of Creditable Coverage of at least six months. The six month Pre-Existing Condition exclusion period shall be reduced by the aggregate of the period of Creditable Coverage applicable to the individual as of the enrollment date of Medicare Part B benefits. If you are an Eligible Person for Guaranteed Issue, the waiting period for Pre-Existing Conditions is waived.

## **CHANGES IN MEDICARE**

---

Benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and co-payment percentage factors. Premiums may be modified to correspond with such changes.

## **EXTENSION OF BENEFITS**

---

If this Policy terminates, Your benefits for Continuous Total Disability which started while the Policy was in force will not be affected. In this case benefits continue under the condition that you remain continuously disabled, and only for the duration of the policy Benefit Period or until payment of the maximum benefit has been made. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

For the purpose of this section "Continuous Total Disability" means the Insured's complete inability to engage in any occupation for pay or profit, or if not employed, to engage in the normal activities of a person of the same age. The Insured must also require the regular care of a Physician.

## **SUSPENSION OF COVERAGE FOR MEDICAID**

---

This Policy shall be suspended at the request of the Insured for the period (not to exceed 24 months) in which the Insured has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the Insured notifies the Company of such Policy within 90 days after the date the individual becomes entitled to the assistance. Upon receipt of timely notice, the Company shall return to the Insured the portion of the premium attributable to the period of Medicaid eligibility, subject to adjustment for paid claims.

If such suspension occurs and if Insured loses entitlement to such medical assistance, this Policy shall be automatically reinstated (effective as of the date of termination of such entitlement) as of the termination of such entitlement if the Insured provides notice of loss of such entitlement within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement.

The Policy shall provide that benefits and premiums under the Policy shall be suspended, at the request of the Insured, if the Insured is entitled to benefits under section 226 (b) of the Social Security Act and is covered under a group health plan (as defined in section 1862 (b) (1) (A) (v) of the Social Security Act). If suspension occurs and if the Insured loses coverage under the group health plan, the Policy shall be automatically reinstated (effective as of the date of loss of coverage) if the Insured provides notice of loss of coverage within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of entitlement. Reinstatement of such coverages shall not provide for any waiting period with respect to treatment of preexisting conditions; shall provide for coverage which is substantially equivalent to coverage in effect before the date of such suspension and shall provide for classification of premiums on terms at least as favorable to the Insured as the premium classification terms that would have been applied to the Insured had the coverage not been suspended.

## **GUARANTEED RENEWAL INCLUDING RIGHT TO CHANGE PREMIUM**

---

This Policy may be renewed at the option of the Insured for consecutive terms of the same duration as the term specified in the Schedule of Benefits by the payment prior to the expiration of the Grace Period, of the premium rates in effect at the time of such renewal.

The Company reserves the right to change in no less than 12 month intervals its table of premium applicable on a class basis to premiums for all policies on the same form as this Policy issued to persons residing in the state of residence of the Insured. In case of any change, the new table of premium rates will apply to premiums thereafter becoming due under this Policy. The Company shall notify the Insured in writing at his last known address of such change at least 30 days before the due date at which time such change is to become effective. No rate adjustment may be made on an individual basis.

The Company shall not use or change premium rates for Your Medicare Supplement Policy unless the rates which shall be on a level premium basis, rating schedule and supporting documentation have been filed with and approved by the Commissioner/Director in accordance with the filing requirements and procedures.

Benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any change in the applicable Medicare deductible amount and co-payment percentage factors. Premiums may be changed to correspond with such changes.

## **GENERAL PROVISIONS**

---

**ENTIRE CONTRACT; CHANGES:** This Policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. A change in this Policy is not valid until the change is approved by an executive officer of the Company and unless the approval is endorsed on or attached to the Policy. An agent does not have authority to change this Policy or to waive any of its provisions.

**OWNERSHIP; CONTROL OF POLICY:** This contract is made with the Insured who has signed the application and every transaction relating to this Policy shall be between the Company and such Insured.

**TIME LIMIT ON CERTAIN DEFENSES:** After 2 years from the Effective Date of this Policy, no misstatements, except for fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for loss incurred after the expiration of such 2 year period.

**PREMIUM PAYMENT:** This Policy is issued in consideration of the application and the payment in advance of the first premium for the initial term. This Policy shall take effect at 12 o'clock noon, Standard Time of the place where the Insured resides, and shall remain in effect until the same hour on the date on which the initial term expires. The Effective Date of this Policy and the first premium are shown in the Schedule of Benefits. At the option of the Insured, this Policy may be continued in force in accordance with and subject to its terms for successive periods by the payment of renewal premiums for the term of 1 month, 3 months, 6 months or 12 months, at the Company's applicable table of rates in effect on the respective due dates of such renewal premiums. All premiums, including the first premium, shall be due and payable at the Home Office of the Company.

**GRACE PERIOD:** A grace period of 31 days will be granted for the payment of each premium due after the first premium. During the grace period, the Policy continues in force.

**REINSTATEMENT:** If a renewal premium is not paid before the expiration of the period granted for the Insured to make the payment, a subsequent acceptance of the premium by the Company to accept the premium, without requiring in connection with the acceptance an application for reinstatement, reinstates the Policy. However, if the Company requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated on approval of the application by the Company or, if the application is not approved, on the 45th day after the date of the conditional receipt unless the Company before that date has notified the Insured in writing of the Company's disapproval of the application. The reinstated Policy covers only loss resulting from an accidental Injury sustained after the date of reinstatement and loss due to Sickness that begins after the date of reinstatement. In all other respects the Insured and Company have the same rights under the reinstated Policy as they had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed in the Policy or attached to the Policy in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days before the date of reinstatement.

**NOTICE OF CLAIM:** A written notice of claim must be given to the Company before the 21st day after the date of the occurrence or beginning of any loss covered by the Policy, or as soon after that date as is reasonably possible. A notice given by or on behalf of the Insured or the beneficiary to the Insurer at its Home Office in Houston, Texas or to any authorized agent of the Company, with information sufficient to identify the Insured, constitutes notice to the Company.

**CLAIM FORMS:** The Company, on receipt of a notice of claim, will provide to the claimant the forms usually provided by the Company for filing proof of loss. If the forms are not provided before the 16th day after the date of the notice, the claimant shall be considered to have complied with the requirements of this Policy as to proof of loss on submitting, within the time fixed in the Policy for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which the claim is made.

**PROOF OF LOSS:** A written proof of loss must be provided to the Company at the Company's designated office before the 91st day after the date of the loss. Failure to provide the proof within the required time does not invalidate or reduce any claim if it was not reasonably possible to give proof within the required time. In that case, the proof must be provided as soon as reasonably possible but not later than one year after the time proof is otherwise required, except in the event of a legal incapacity.

**TIME OF PAYMENT OF CLAIMS:** Amounts payable under this Policy for any loss other than benefits for loss of time will be paid immediately upon receipt of due written proof of such loss.

**PAYMENT OF CLAIMS:** All indemnities will be payable to the Insured. If any indemnity of this Policy shall be payable to the estate of the Insured, or to an Insured or beneficiary who is a minor or otherwise not competent to give a valid release, the Company may pay such indemnity, up to an amount not exceeding \$1,000 to any relative by blood or connection by marriage to the Insured or beneficiary who is deemed by the Company to be equitably entitled thereto. Any payment made by the Company in good faith pursuant to this provision shall fully discharge the Company to the extent of such payment. Subject to any written direction of the Insured in the application or otherwise all or a portion of any indemnities provided by this Policy on account of Hospital, nursing, medical or surgical services may, at the Company's option and unless the Insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the Hospital or person rendering such services; but it is not required that the services be rendered by a particular Hospital or person.

**PHYSICAL EXAMINATIONS AND AUTOPSY:** The Company at its own expense has the right and opportunity to conduct a physical examination of the Insured when and as often as the Company reasonably requires while a claim under the Policy is pending and, in case of death, to require that an autopsy be conducted if not forbidden by law.

**ASSIGNMENT:** No assignment of interest under this Policy shall be binding upon the Company unless and until the original or duplicate is filed at the Home Office of the Company, which does not assume any responsibility for the validity thereof.

**LEGAL ACTIONS:** An action at law or in equity may not be brought to recover on this Policy before the 61st day after the date written proof of loss has been provided in accordance with the requirements of this Policy. An action at law or in equity may not be brought after the expiration of three years after the time written proof of loss is required to be provided.

**CHANGE OF BENEFICIARY:** Unless the Insured makes an irrevocable designation of beneficiary, the right to change a beneficiary is reserved for the Insured, and the consent of the beneficiary or beneficiaries is not required for the surrender or assignment of this Policy, for any change of beneficiary or beneficiaries, or for any other changes in this Policy.

**UNEARNED PREMIUMS:** The unearned premiums paid for any period beyond the end of the Policy month, if any, in which Your death occurred or Your request of coverage cancellation, will be returned to the beneficiary of Your estate. The unearned premiums, if any, will be paid in a lump sum on a date no later than thirty (30) days after proof of Your death has been furnished or receipt of cancellation request has been made to the Company.

**CANCELLATION BY THE INSURED; NON-CANCELLATION BY THE INSURER:** The Insured may cancel this Policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid. The earned premium shall be computed on a pro-rata basis. Cancellation shall be without prejudice to any claim originated prior to the effective date of cancellation. The insurer may not cancel this Policy. This provision nullifies any other provision, contained in this Policy or in any endorsement hereon or in any rider attached hereto, which provides for cancellation of this Policy by the insurer or by the Insured.

**CONFORMITY WITH STATE STATUTES:** Any provision of this Policy that, on its Effective Date, conflicts with the statutes of the state in which the Insured resides on the Effective Date is by this clause effectively amended to conform to the minimum requirements of that state's statutes.

**APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE**  
For Seniors with Medicare Parts A and B



**SECTION 1 – CHOICE OF COVERAGE**

Please check the box for your choice of coverage:

- STANDARD PLAN A     STANDARD PLAN D     STANDARD PLAN HD F     STANDARD PLAN N]  
 STANDARD PLAN C     STANDARD PLAN F     STANDARD PLAN G

**SECTION 2 – APPLICATION INFORMATION**

A copy of this application will be returned to you, for your records, along with your policy, when you are enrolled.

**Please copy the information from your Medicare card here**



NAME OF BENEFICIARY (Applicant)	CLAIM NUMBER	SEX
_____	_____	_____
IS ENTITLED TO	EFFECTIVE DATE	
HOSPITAL INSURANCE (PART A)	_____	
MEDICAL INSURANCE (PART B)	_____	

Requested effective date, or end date of prior Medicare supplement, if replacing \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Name (as it appears on your Medicare card) \_\_\_\_\_

Social Security Number 

--	--	--	--	--	--	--	--	--	--

 Date of Birth \_\_\_\_\_

Home Address, Apt. No., Suite No. \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Home Telephone Number \_\_\_\_\_

Billing Address, (if different from home address) \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Care of/Attention \_\_\_\_\_

**SECTION 3 – BILLING INFORMATION**

- Annual     Semi-Annual     Quarterly     Monthly

PAC (Checking Account Deduction Only)

Please indicate a preferred draft date (excluding the 29<sup>th</sup>, 30<sup>th</sup>, 31<sup>st</sup>) \_\_\_\_\_

*Affix check here. Please make check or money order for premium payable to Philadelphia American Life Insurance Company.*

**No agency checks are accepted.**

**Applicant: Please return application to agent or to the address below:**

Philadelphia American Life Insurance Company, Underwriting Department  
P.O. Box 4884  
Houston, Texas 77210-4884



If you had coverage from any Medicare Plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. START \_\_\_/\_\_\_/\_\_\_ END \_\_\_/\_\_\_/\_\_\_

If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?  Yes  No

Was this your first time in this type of Medicare plan?  Yes  No

Did you drop a Medicare supplement policy to enroll in this Medicare plan?  Yes  No

Do you have another Medicare supplement policy in force?  Yes  No

If so, with what company, and what plan do you have? \_\_\_\_\_

If so, do you intend to replace your current Medicare supplement policy with this policy?  Yes  No

Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)  Yes  No

If so, with what company and what kind of policy? \_\_\_\_\_

If so, what are your dates of coverage under the other policy? START \_\_\_/\_\_\_/\_\_\_ END \_\_\_/\_\_\_/\_\_\_ (If you are still covered under the other policy, leave "END" blank.)

## SECTION 7 – CONDITIONS OF APPLICATION

Please read the following carefully.

1. I agree to submit the premium required for the plan requested with this application. Such premium will be returned to me if my application is rejected or if I decide to cancel the policy within the first thirty (30) days. If my application is accepted, the amount paid will be applied to the premium.
2. Philadelphia American will not reject my application if it is submitted during the six-month period beginning in the first month after I first enrolled in Medicare Part B or when I am an Eligible Person for Guaranteed Issue. If my application is not received during the open enrollment period, Philadelphia American has the right to reject my application. If Philadelphia American rejects my application, I will be notified in writing and the premium submitted with this application will be refunded. I understand and agree that if Philadelphia American rejects my application, under no circumstances will any Philadelphia American benefits be payable. **Cashing of my check by Philadelphia American does not constitute approval of my application.**
3. If my application is accepted, this application will become part of the agreement between Philadelphia American and myself.
4. The selling agent has no authority to promise me coverage or to modify Philadelphia American underwriting policy or terms of any Philadelphia American coverage.
5. I alone am responsible for reading and accurately completing this application. I have left nothing out regarding my past or present health. I understand that I am not eligible for any benefits if any information requested on this application, **even information about my Medicare coverage**, is false, incomplete or omitted and that Philadelphia American may void all coverage from the original effective date of the policy for intentional material misstatements or omissions.

## SECTION 8 – AUTHORIZATION AND AGREEMENTS

### Notice to Applicant

1. You do not need more than one Medicare supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
4. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
5. If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
6. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

### **Authorization To Obtain or Release Medical Information – You Are Entitled To A Copy of This Signed Authorization for Your Files If Requested. (Read all five paragraphs and sign below)**

- I hereby authorize the U.S. Department of Health and Human Services (including the Health Care Financing Administration and any contractors or agents, including Medicare intermediaries), any physician, health care practitioner, hospital, clinic, or other medical or medically related facility to furnish an agent, designee, or representative of Philadelphia American any and all records pertaining to claims payments or rejections, medical history, services rendered, or treatment given to anyone enrolled hereunder or added hereafter for purposes of review, investigation, or evaluation of an application or a claim.
- I also authorize Philadelphia American, or its agents, designees or representatives to disclose to a hospital or health care service plan, self-insurer, or insurer any such medical information obtained if such a disclosure is necessary to allow the processing of any claim.
- This authorization shall become effective immediately and shall remain in effect as long as is necessary to enable Philadelphia American to process claims. A photocopy shall be valid.
- I understand and agree to the Replacement Notification, the Disclosure Statement (only for Medicare SELECT applicants), the Conditions of Application and the Authorization. I acknowledge receipt of the "Guide to Health Insurance for People with Medicare," and "Outline of Medicare Supplement Coverage and Premium Information" as required. I understand that receipt of money with this application does not create Philadelphia American coverage. Coverage will come into effect only if this application is approved by Philadelphia American.
- I, the applicant, acknowledge that I have read and understand this Application in its entirety and realize that any false statement or intentional material misrepresentation in the Application may result in loss of coverage under the policy.

**Warning: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits**

X

Applicant's Signature

Date of Signature

## MEDICARE SUPPLEMENT PLAN REPLACEMENT WORKSHEET

Agents please complete if replacing other existing Medicare coverage

### Insured

Name	SS#
Proposed Plan	

### Old Plan

Company Name	
Expiration Date	Contract No.

### Benefit Comparison

	Old Plan	Philadelphia American Plan
Part A Deductible		
Part A Coinsurance		
Additional Hospital Days		
Skilled Nursing Facility Coinsurance		
Hospice		
Part B Deductible		
20% Part B Coinsurance		
50% Part B Coinsurance (Nervous and Mental)		
Part B Excess Charges at 100%		
Prescription Drugs		
Emergency Travel Benefits Outside the U.S.		
At-Home Recovery (pre June 1, 2010 Standardized plans)		
Preventive Medical Care (pre June 1, 2010 Standardized plans)		
10% or Greater Premium Savings		

Does this plan have benefits clearly and substantially better than those of the old plans? _____ If yes, explain below:
Agent Signature _____ Agent No. _____ Date _____

### OPTIONAL MONTHLY CHECKING ACCOUNT DEDUCTION AUTHORIZATION FOR SENIORS

As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and payable to the order of Philadelphia American Life Insurance Company provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debt shall be the same as if it were a check drawn on you and signed personally by me. I authorize Philadelphia American to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Philadelphia American premiums. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such debt. I further agree that if any such debt be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no obligation whatsoever even though such dishonor results in forfeiture of insurance.

**Please attach a blank check marked "VOID".**

Insured	Social Security Number
	Bank Name
<b>X</b> _____ Date	<b>X</b> _____ Date

Authorized Signature(s) (as it/they appear in the financial institution's records; all authorized persons must sign)

---

**PRIORITY PROCESSING**

COMPLETE THIS FORM TO ENROLL IN THE  
OPTIONAL MONTHLY CHECKING ACCOUNT  
DEDUCTION  
AUTHORIZATION FOR SENIORS.

**INCLUDE A BLANK CHECK MARKED "VOID".**

**A DEPOSIT SLIP IS NOT ACCEPTABLE.**

**PHILADELPHIA AMERICAN LIFE  
INSURANCE COMPANY**

**SENIOR SERVICES  
TOLL-FREE NUMBER**



Monday – Friday  
8:00 a.m. to 5:00 p.m.

(877) 368-4691

**FOR AGENT ONLY**

Please list any other health insurance policies or coverages you have sold to the applicant which are still in force, and any other health insurance policies or coverages you have sold to the applicant in the past five years which are no longer in force. Please submit with the application, as required:

Date	Name of Policy	Name and Address of Insurance Company
From: Mo./Yr. _____	_____	Name: _____
To: Mo./Yr. _____	_____	Address: _____
	_____	City/State: _____

(Attach additional sheets if necessary)

I have read and understand the application. I additionally certify that I have given the "Guide to Health Insurance for People with Medicare," and an outline of coverage and a disclosure statement for the policy applied for, and that the applicant has both Parts A and B of Medicare. The applied for policy will not duplicate any health insurance coverage. I have requested and received documentation that indicates that the applied for policy will not duplicate any coverage. I have verified the information in the Replacement Notification Section.

**SIGNED AT**

Agent's Signature \_\_\_\_\_ Date of Signature \_\_\_\_\_ (City and State) \_\_\_\_\_

Print Agent's Name \_\_\_\_\_ Agent No. \_\_\_\_\_

Street Address \_\_\_\_\_ Telephone No. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

E-mail Address: \_\_\_\_\_ *For split commissions, please add name and agent no.*

Premium Amount \$ \_\_\_\_\_ Agent Name \_\_\_\_\_

Send Policy To:  Agent  Insured Agent No. \_\_\_\_\_

**SENIOR SERVICES TOLL-FREE NUMBER**

Monday - Friday: 8:00 a.m. to 5:00 p.m. (Central Standard Time)

(877) 368-4691

**PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY**

---

**PREMIUM RECEIPT**

Date \_\_\_\_\_ Amount \_\_\_\_\_

Name \_\_\_\_\_

Social Security Number \_\_\_\_\_

Account \_\_\_\_\_ Check Number \_\_\_\_\_

Policy Description \_\_\_\_\_

Received by \_\_\_\_\_

This is a receipt for cash received only. This receipt does not guarantee insurance coverage.

## ELIGIBLE PERSONS FOR GUARANTEED ISSUE

**ELIGIBLE PERSON** means an individual who:

Is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual; or the individual is or the individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates or ceases to provide all health benefits to the individual because the individual leaves the plan.

Is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under section 1894 of the Social Security Act, and there are circumstances similar to the following that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in Medicare Advantage plan:

- (a) The certification of the organization or plan has been terminated; or
- (b) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;
- (c) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856), or the plan is terminated for all individuals within a residence area;
- (d) The individual demonstrates, in accordance with guidelines established by the Secretary, that:
  - (i) The organization offering the plan substantially violated a material provision of the organization's contract under U.S.C. Title 42, Chapter 7, Subchapter XVIII, Part D in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or
  - (ii) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or
- (e) The individual meets such other exceptional conditions as the Secretary may provide.

Is enrolled with an entity listed in subparagraphs (i) -- (iv) of this paragraph and enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under Section 12B(2).

- (i) An eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost);
- (ii) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;
- (iii) An organization under an agreement under Section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or
- (iv) An organization under a Medicare Select policy.

Is enrolled under a Medicare Supplement policy and the enrollment ceases because:

- (a) Of the insolvency of the issuer or bankruptcy of the non-issuer organization;
- (b) Of other involuntary termination of coverage or enrollment under the policy; or
- (c) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

Is enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, any eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under section 1894 of the Social Security Act, or Medicare Select policy; and the subsequent enrollment is terminated by the enrollee during any period within the first 12 months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e) of the Social Security Act); or

Upon first becoming enrolled in Medicare Part B for benefits at age 65 or older, enrolls in Medicare Advantage plan under Part C of Medicare, or in a PACE program under section 1894 of the Social Security Act, and disenrolls from the plan or program no later than 12 months after the effective date of enrollment.

Is enrolled in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare part D along with the application for a Medicare Supplement plan of A, B, C, F (including F with high deductible), K or L that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage.



P.O. Box 4884  
Houston, Texas 77210-4884

**NOTICE TO APPLICANT REGARDING  
REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR  
MEDICARE ADVANTAGE**

**Philadelphia American Life Insurance Company  
P.O. Box 4884  
Houston, Texas 77210-4884**

**Save This Notice! IT May Be Important To You In The Future!**

According to your application or information you have furnished, you intend to terminate existing Medicare supplement or Medicare Advantage coverage and replace it with a policy to be issued by Philadelphia American Life Insurance Company. Your new policy will provide 30 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy or Medicare Advantage coverage only if, after due consideration and acceptance by the replacing issuer, you find that purchase of this Medicare supplement coverage is a wise decision. You should evaluate the need for other accident and sickness coverage you have that may duplicate the benefits provided under this policy.

**STATEMENT TO APPLICANT BY AGENT**

I have reviewed your current medical or health coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s):

(Check one):

- Additional benefits,
- Same benefits but lower premiums,
- Fewer benefits and lower premiums,
- My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment. \_\_\_\_\_
- Other, (please specify) \_\_\_\_\_ .

- (1) **Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.**
- (2) **State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will reduce any time periods applicable to pre-existing conditions, waiting periods, elimination periods or probationary periods in the new policy to the extent such time was spent under the original policy.**
- (3) **If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the issuer to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, read and review it carefully to be certain that all information has been properly recorded.**
- (4) **Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.**

\_\_\_\_\_  
Signature of Agent

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Print Agent Name

\_\_\_\_\_  
Print Applicant Name

\_\_\_\_\_  
Print Agent Address

\_\_\_\_\_  
Date

WHITE COPY: To be sent to Home Office with Completed Application. Yellow: Given to Applicant



---

200 Westlake Park Blvd., P. O. Box 4884, Houston, Texas 77210

### **Amendment**

Your contract is amended by deleting Pre-Existing Condition Limitations in its entirety.

This amendment is attached to and made a part of your contract.

This amendment is subject to all provisions, exclusions and limitations of the contract not inconsistent herewith. In all other respects, your coverage remains the same.

**Philadelphia American Life Insurance Company**

*Bill S. Chen*  
President



## The Insurance Plans of Choice for Medicare Supplemental Coverage

### Philadelphia American Life Insurance Company

P.O. Box 4884  
Houston, TX 77210-4884

#### POLICY FORM NUMBERS:

MS.A.PAL.AR, MS.C.PAL.AR, MS.D.PAL.AR, MS.F.PAL.AR,  
MS.FX.PAL.AR, MS.G.PAL.AR, MS.N.PAL.AR

*Standard Plan A*  
*Standard Plan C*  
*Standard Plan D*  
*Standard Plan F*  
*Standard Plan High Deductible F*  
*Standard Plan G*  
*Standard Plan N*

**ARKANSAS**

## MEDICARE AND PHILADELPHIA AMERICAN – BOTH SIDES OF THE STORY

When it comes to Medicare, it's important that you know both sides of the story, the advantages and disadvantages of relying only on Medicare to provide for your health care needs.

Before Medicare pays for any of the medical services you want or need, you must first pay the Medicare deductibles. There are health care costs that Medicare either does not cover in full or does not pay at all. This can result in significant out-of-pocket expenses for you.

PHILADELPHIA AMERICAN's Medicare Supplement Insurance Plans help pay the bills that Medicare doesn't and provide you with protection from the ever-increasing gaps in Medicare. Plus, you receive the following benefits:

- Affordable Medicare supplement plans.
- Your right to use the doctor of your choice. You may see any doctor accepting Medicare patients.
- Guaranteed Renewable.
- No annual maximums for Medicare-covered services.
- Accurate and speedy claim payments usually made in less than a week.
- Toll-free dedicated customer service phone number:

**1-877-368-4691**

### FREEDOM TO CHOOSE

You've earned the right to choose your own doctor or hospital, and we respect that right. Our plans allow you to use any Medicare-participating physician and any Medicare-approved hospital in the state.

### PROTECTION AGAINST EXCESS CHARGES

Under Part B of Medicare, you may have out-of-pocket costs if your physician or medical supplier does not accept assignment of your Medicare claim and charges more than Medicare's approved amount. The difference to be paid is called the 'excess charge.' With some plans, your doctor's charges for Medicare's covered services are paid in full, including the Medicare Part B deductible.

### GUARANTEED ISSUE

Acceptance of your application is guaranteed if you are 65 or older and apply within six (6) months of your initial enrollment in Part B of Medicare. You must already be enrolled in both Parts A and B of Medicare to apply for these plans.

Acceptance for this coverage is also guaranteed if you are transferring from certain Philadelphia American Non-Medicare supplement plans. There is no waiting period for preexisting conditions.

### INSURED BILLING

Home Office **MUST** receive your application no later than 5 working days **PRIOR** to your requested effective date.

You should submit premium with your application. The amount of the premium submitted depends on the payment mode you have selected. After your policy is issued, PHILADELPHIA AMERICAN will bill you according to the payment mode you have selected.



PHILADELPHIA AMERICAN reserves the right to reject your application. If your application is rejected, you will be notified in writing and any premium submitted will be refunded.

With the PHILADELPHIA AMERICAN monthly Checking Account Deduction Program, you can have your monthly PHILADELPHIA AMERICAN dues withdrawn directly from your checking account on or about the sixth (6th) day of each month. When you receive your bank statement, your PHILADELPHIA AMERICAN monthly checking account deduction will be included. To find out more about this convenient service, contact your PHILADELPHIA AMERICAN Authorized Agent, or call us toll-free at:

**1-877-368-4691**

Summary Billing offers you the convenience of consolidating your billing with any other PHILADELPHIA AMERICAN senior plan member, such as a spouse or relative.

This means that we can combine separate billings onto a single statement, even if you and the other person(s) are enrolled in different PHILADELPHIA AMERICAN senior plans.

The result is less paper work for you because one statement, one check and one envelope does the job. Summary Billing is also available if you choose the Monthly Checking Account Deduction Program.

### **GUARANTEED RENEWABLE**

PHILADELPHIA AMERICAN Medicare supplements are guaranteed renewable.

After the first modal premium payment, the term of this coverage is for the modal duration. As mentioned before, the first modal premium must be submitted with the application.

You have the option to pay premium on monthly, bimonthly or quarterly basis.

It renews automatically, subject to the right of PHILADELPHIA AMERICAN to change rates on a class basis.

We will not cancel your coverage, except for the reasons listed below:

- If we discover any concealment of material facts upon enrollment
- If you do not pay your premiums, your coverage will end automatically without notice from us
- You cease to be covered under both Parts A and B of Medicare
- You enroll in a Medicare Coordinated Care Plan (also sometimes referred to as Medicare-at-Risk Plans) or special Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs) that seniors eligible for Medicare may be able to join.



## MEDICARE CHANGES

PHILADELPHIA AMERICAN will send an annual notice to you 30 days prior to the effective date of Medicare changes, which will describe these changes and the changes in your Medicare supplement coverage.

## QUESTIONS

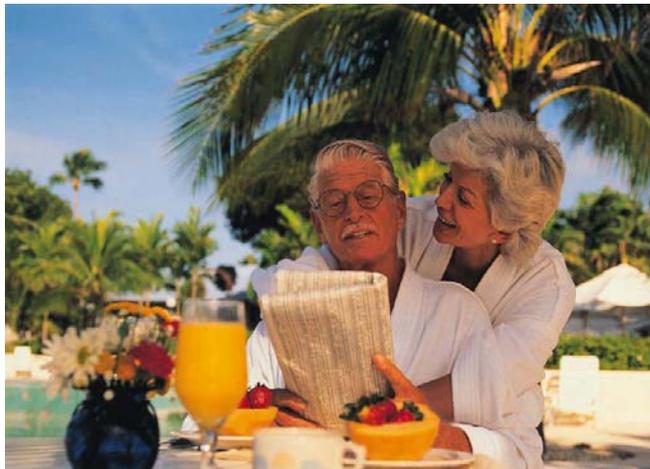
After you receive your policy, please feel free to contact your PHILADELPHIA AMERICAN Authorized Agent, or call us toll-free at:

**1-877-368-4691**

You can write to us at PHILADELPHIA AMERICAN LIFE

**P.O. Box 4884  
Houston, TX 77210-4884**

Please review the enclosed Outline of Coverage for complete information regarding the benefits, conditions, limitations, exclusions and cost of coverage.



**PHILADELPHIA  
AMERICAN**  
LIFE INSURANCE COMPANY®

### **PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY**

P.O. Box 4884

HOUSTON, TX 77210-4884

TOLL-FREE: 1-877-368-4691

PHILADELPHIA AMERICAN is not affiliated with Social Security, Medicare, or any other governmental agency. Medical coverage is provided by PHILADELPHIAAMERICAN LIFE INSURANCE COMPANY.

# PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY

P.O. Box 4884, Houston, Texas 77210-4884

## BENEFIT CHART OF MEDICARE SUPPLEMENT PLANS SOLD ON OR AFTER [JANUARY 1, 2011]

This chart shows the benefits included in each of the Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state.

### BASIC BENEFITS

- **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, co-payments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or co-payments.
- **Blood** - First three pints of blood each year.
- **Hospice** - Part A coinsurance.

### *SHADED PLANS ARE AVAILABLE IN YOUR STATE*

A	B	C	D	F	F*	G	K	L	M	N
Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance*		Basic, including 100% Part B co-insurance	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 co-insurance	Basic, including 100% Part B co-insurance, except up to \$20 co-payment for office visit, and up to \$50 co-payment for ER
		Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance		Skilled Nursing Facility Co-insurance	50% Skilled Nursing Facility Co-insurance	75% Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance
	Part A Ded.	Part A Ded.	Part A Ded.	Part A Ded.		Part A Ded.	50% Part A Ded.	75% Part A Ded.	50% Part A Ded.	Part A Ded.
		Part B Ded.		Part B Ded.						
				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
*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 \$[2,000] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed \$[2,000]. 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.							Out-of-pocket limit \$[4,620]; paid at 100% after limit reached.	Out-of-pocket limit \$[2,310]; paid at 100% after limit reached.		

**PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY**  
 Medicare Supplement Premium  
**Arkansas**  
 June 1, 2011

		<b>Age 65 and above</b>	
		<b>Area 1</b>	<b>Area 2</b>
<b>Plan A</b>	NTU	97.20	108.00
	TU	108.00	120.00
<b>Plan C</b>	NTU	130.82	145.35
	TU	145.35	161.50
<b>Plan D</b>	NTU	121.50	135.00
	TU	135.00	150.00
<b>Plan F</b>	NTU	132.35	147.06
	TU	147.06	163.40
<b>Plan F (High deductible)</b>	NTU	32.40	36.00
	TU	36.00	40.00
<b>Plan G</b>	NTU	113.40	126.00
	TU	126.00	140.00
<b>Plan N</b>	NTU	97.20	108.00
	TU	108.00	120.00

**Area 1** all zip codes except: 720-723, 755

**Area 2** zip codes: 720-723, 755

**Modal Factors:** Monthly Bank Draft = 1.0,  
 Bi-Monthly = 2.0, Quarterly = 3.0

<b>NTU:</b> Non-Tobacco User
<b>TU:</b> Tobacco User

## **PREMIUM INFORMATION**

We, Philadelphia American Life Insurance Company, can only raise your premium if we raise the premium for all policies like yours in this state. 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 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 P.O. Box 4884, Houston Texas 77210-4884. If you send the policy back to us within 30 days after you receive it, we'll 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 Philadelphia American Life Insurance Company nor its agents are connected to Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult Medicare and You 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 60 days in a row.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION *</b> 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 \$[1,132]  All but \$[283] a day  All but \$[566] a day  \$0  \$0	\$0  \$[283] a day  \$[566] a day  100% of Medicare eligible expenses \$0	\$[1,132] (Part A deductible) \$0  \$0  \$0**  All Costs
<b>SKILLED NURSING FACILITY CARE *</b> 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 \$[141.50] a day  \$0	\$0 \$0  \$0	\$0 Up to \$[141.50] a day All Costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment / coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment / coinsurance	\$0

(continued)

\*\* 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 \$[162] 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
<b>MEDICAL EXPENSES -</b> 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 \$[162] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0  Generally 80%	\$0  Generally 20%	\$[162] (Part B deductible) \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All Costs
<b>BLOOD</b> First 3 pints Next \$[162] of Medicare Approved Amount*  Remainder of Medicare Approved Amounts	\$0 \$0  Generally 80%	All Costs \$0  Generally 20%	\$0 \$[162] (Part B deductible) \$0
<b>CLINICAL LABORATORY SERVICES</b> BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies - Durable medical equipment: First \$[162] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0  Generally 80%	\$0 \$0  Generally 20%	\$0 \$[162] (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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION *</b> 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 \$[1,132]  All but \$[283] a day  All but \$[566] a day  \$0  \$0	\$[1,132] (Part A deductible) \$[283] a day \$[566] a day  100% of Medicare eligible expenses \$0	\$0  \$0  \$0  \$0 **  All Costs
<b>SKILLED NURSING FACILITY CARE *</b> 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 \$[141.50] a day  \$0	\$0 Up to \$[141.50] a day \$0	\$0 \$0  All Costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment / coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment / coinsurance	\$0

(continued)

\*\* 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 \$[162] 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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES -</b> 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 \$[162] of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	\$0  Generally 80%	\$[162] (Part B deductible) Generally 20%	\$0  \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amount)	\$0	\$0	All Costs
<b>BLOOD</b> First 3 pints Next \$[162] of Medicare Approved Amount*  Remainder of Medicare Approved Amounts	\$0 \$0  Generally 80%	All Costs \$[162] (Part B deductible) Generally 20%	\$0 \$0  \$0
<b>CLINICAL LABORATORY SERVICES</b> BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies - Durable medical equipment: First \$[162] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0  Generally 80%	\$0 \$[162] (Part B deductible) Generally 20%	\$0 \$0  \$0

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

<b>FOREIGN TRAVEL - NOT COVERED BY                      MEDICARE</b> 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 \$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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION *</b> 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 \$[1,132]  All but \$[283] a day  All but \$[566] a day  \$0  \$0	\$[1,132] (Part A deductible) \$[283] a day \$[566] a day  100% of Medicare eligible expenses \$0	\$0  \$0  \$0  \$0 **  All Costs
<b>SKILLED NURSING FACILITY CARE *</b> 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 \$[141.50] a day  \$0	\$0 Up to \$[141.50] a day \$0	\$0 \$0  All Costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment / coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment / coinsurance	\$0

(continued)

\*\* 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 \$[162] 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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES -</b> 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 \$[162] of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	\$0  Generally 80%	\$0  Generally 20%	\$[162] (Part B deductible) \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amount)	\$0	\$0	All Costs
<b>BLOOD</b> First 3 pints Next \$[162] of Medicare Approved Amount*  Remainder of Medicare Approved Amounts	\$0 \$0  Generally 80%	All Costs \$0  Generally 20%	\$0 \$[162] (Part B deductible) \$0
<b>CLINICAL LABORATORY SERVICES</b> BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies - Durable medical equipment: First \$[162] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0  Generally 80%	\$0 \$0  Generally 20%	\$0 \$[162] (Part B deductible) \$0

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

<b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b> 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 \$50,000 lifetime maximum
--	------------	--	---

**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 60 days in a row.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION *</b> 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 \$[1,132]  All but \$[283] a day  All but \$[566] a day  \$0  \$0	\$[1,132] (Part A deductible) \$[283] a day  \$[566] a day  100% of Medicare eligible expenses \$0	\$0  \$0  \$0  \$0 **  All Costs
<b>SKILLED NURSING FACILITY CARE *</b> 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 \$[141.50] a day  \$0	\$0 Up to \$[141.50] a day \$0	\$0 \$0  All Costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment / coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment / coinsurance	\$0

(continued)

\*\* 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 \$[162] 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
<b>MEDICAL EXPENSES -</b> 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 \$[162] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0  Generally 80%	\$[162] (Part B deductible) Generally 20%	\$0  \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amount)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$[162] of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	\$0 \$0  Generally 80%	All Costs \$[162] (Part B deductible) Generally 20%	\$0 \$0  \$0
<b>CLINICAL LABORATORY SERVICES</b> BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies - Durable medical equipment: First \$[162] of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	100% \$0  Generally 80%	\$0 \$[162] (Part B deductible) Generally 20%	\$0 \$0  \$0

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL - NOT COVERED BY                      MEDICARE</b> 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 \$50,000 lifetime maximum

**HIGH DEDUCTIBLE 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 60 days in a row.
- \*\* This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$[2,000] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are \$[2,000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$[2,000] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$[2,000] DEDUCTIBLE,** YOU PAY
<p><b>HOSPITALIZATION *</b> 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"> <li>- While using 60 lifetime reserve days</li> <li>- Once lifetime reserve days are used:                             <ul style="list-style-type: none"> <li>- Additional 365 days</li> </ul> </li> <li>- Beyond the Additional 365 days</li> </ul>	<p>All but \$[1,132]</p> <p>All but \$[283] a day</p> <p>All but \$[566] a day</p> <p>\$0</p> <p>\$0</p>	<p>\$[1,132] (Part A deductible)</p> <p>\$[283] a day</p> <p>\$[566] 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><b>SKILLED NURSING FACILITY CARE *</b> 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 \$[141.50] a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$[141.50] a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All Costs</p>
<p><b>BLOOD</b> First 3 pints</p> <p>Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p><b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.</p>	<p>All but very limited co-payment / coinsurance for outpatient drugs and inpatient respite care</p>	<p>Medicare co-payment / coinsurance</p>	<p>\$0</p>

(continued)

\*\*\* 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.

**HIGH DEDUCTIBLE PLAN F (continued)**

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

- \* Once you have been billed \$[162] 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.
- \*\* This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$[2,000] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are \$[2,000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$[2,000] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$[2,000] DEDUCTIBLE,** YOU PAY
<b>MEDICAL EXPENSES -</b> 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 \$[162] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$[162] (Part B deductible) Generally 20%	\$0 \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amount)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$[162] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 Generally 80%	All Costs \$[162] (Part B deductible) Generally 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES</b> BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$[2,000] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$[2,000] DEDUCTIBLE,** YOU PAY
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies - Durable medical equipment: First \$[162] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 Generally 80%	\$0 \$[162] (Part B deductible) Generally 20%	\$0 \$0 \$0

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>AFTER YOU PAY \$[2,000] DEDUCTIBLE,** PLAN PAYS</b>	<b>IN ADDITION TO \$[2,000] DEDUCTIBLE,** YOU PAY</b>
<p><b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b>                      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>

**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 60 days in a row.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION *</b> 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 \$[1,132]  All but \$[283] a day  All but \$[566] a day  \$0  \$0	\$[1,132] (Part A deductible) \$[283] a day  \$[566] a day  100% of Medicare eligible expenses \$0	\$0  \$0  \$0  \$0 **  All Costs
<b>SKILLED NURSING FACILITY CARE *</b> 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 \$[141.50] a day  \$0	\$0 Up to \$[141.50] a day \$0	\$0 \$0  All Costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment / coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment / coinsurance	\$0

(continued)

\*\* 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 \$[162] 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
<b>MEDICAL EXPENSES -</b> 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 \$[162] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0  Generally 80%	\$0  Generally 20%	\$[162] (Part B deductible) \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amount)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$[162] of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	\$0 \$0  Generally 80%	All Costs \$0  Generally 20%	\$0 \$[162] (Part B deductible) \$0
<b>CLINICAL LABORATORY SERVICES</b> BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies - Durable medical equipment: First \$[162] of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	100% \$0  Generally 80%	\$0 \$0  Generally 20%	\$0 \$[162] (Part B deductible) \$0

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b> 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 \$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 60 days in a row.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION *</b> 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 \$[1,132]  All but \$[283] a day  All but \$[566] a day  \$0  \$0	\$[1,132] (Part A deductible) \$[283] a day  \$[566] a day  100% of Medicare Eligible Expenses \$0	\$0  \$0  \$0  \$0 **  All Costs
<b>SKILLED NURSING FACILITY CARE *</b> 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 \$[141.50] a day  \$0	\$0 Up to \$[141.50] a day \$0	\$0 \$0  All Costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment / coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment / coinsurance	\$0

(continued)

\*\* 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 \$[162] 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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES -</b> 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 \$[162] 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 co- payment 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.	\$[162] (Part B deductible) Up to \$20 per office visit and up to \$50 per emergency room visit. The co- payment 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.
<b>Part B Excess Charges</b> (Above Medicare Approved Amount)	\$0	\$0	All Costs
<b>BLOOD</b> First 3 pints Next \$[162] of Medicare Approved Amount*  Remainder of Medicare Approved Amounts	\$0 \$0  Generally 80%	All Costs \$0  Generally 20%	\$0 \$[162] (Part B deductible) \$0
<b>CLINICAL LABORATORY SERVICES</b> BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies - Durable medical equipment: First \$[162] of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	100% \$0  Generally 80%	\$0 \$0  Generally 20%	\$0 \$[162] (Part B deductible) \$0

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p><b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b>                      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>

SERFF Tracking Number: NELL-127180425 State: Arkansas  
 Filing Company: Philadelphia American Life Insurance Company State Tracking Number: 48872  
 Company Tracking Number: MS.A.PAL.AR  
 TOI: MS08I Individual Medicare Supplement - Standard Plans 2010 Sub-TOI: MS08I.012 Multi-Plan 2010  
 Product Name: MS.A.PAL.AR  
 Project Name/Number: MS.A.PAL.AR/MS.A.PAL.AR

**Rate Information**

Rate data applies to filing.

**Filing Method:**

**Rate Change Type:**

Neutral

**Overall Percentage of Last Rate Revision:**

%

**Effective Date of Last Rate Revision:**

**Filing Method of Last Filing:**

**Company Rate Information**

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Philadelphia American Life Insurance Company	%	%				%	%

SERFF Tracking Number: NELI-127180425 State: Arkansas  
 Filing Company: Philadelphia American Life Insurance Company State Tracking Number: 48872  
 Company Tracking Number: MS.A.PAL.AR  
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.012 Multi-Plan 2010  
 Standard Plans 2010  
 Product Name: MS.A.PAL.AR  
 Project Name/Number: MS.A.PAL.AR/MS.A.PAL.AR

## Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved 07/06/2011	Rates	MS.A.PAL.AR, MS.C.PAL.AR, MS.D.PAL.AR, MS.F.PAL.AR, MS.FX.PAL.AR, MS.G.PAL.AR, MS.N.PAL.AR	New		Rates.AR.pdf

**PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY**  
 Medicare Supplement Premium  
**Arkansas**  
 June 1, 2011

		<b>Age 65 and above</b>	
		<b>Area 1</b>	<b>Area 2</b>
<b>Plan A</b>	NTU	97.20	108.00
	TU	108.00	120.00
<b>Plan C</b>	NTU	130.82	145.35
	TU	145.35	161.50
<b>Plan D</b>	NTU	121.50	135.00
	TU	135.00	150.00
<b>Plan F</b>	NTU	132.35	147.06
	TU	147.06	163.40
<b>Plan F (High deductible)</b>	NTU	32.40	36.00
	TU	36.00	40.00
<b>Plan G</b>	NTU	113.40	126.00
	TU	126.00	140.00
<b>Plan N</b>	NTU	97.20	108.00
	TU	108.00	120.00

**Area 1** all zip codes except: 720-723, 755

**Area 2** zip codes: 720-723, 755

**Modal Factors:** Monthly Bank Draft = 1.0,  
 Bi-Monthly = 2.0, Quarterly = 3.0

<b>NTU:</b> Non-Tobacco User
<b>TU:</b> Tobacco User

SERFF Tracking Number: NELI-127180425 State: Arkansas  
 Filing Company: Philadelphia American Life Insurance Company State Tracking Number: 48872  
 Company Tracking Number: MS.A.PAL.AR  
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.012 Multi-Plan 2010  
 Standard Plans 2010  
 Product Name: MS.A.PAL.AR  
 Project Name/Number: MS.A.PAL.AR/MS.A.PAL.AR

## Supporting Document Schedules

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Flesch Certification	Approved	07/06/2011
<b>Comments:</b>			
<b>Attachment:</b>			
Certification.pdf			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	Application	Approved	07/06/2011
<b>Bypass Reason:</b>	Application is uploaded under Form Schedule.		
<b>Comments:</b>			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Health - Actuarial Justification	Approved	07/06/2011
<b>Comments:</b>			
<b>Attachment:</b>			
Actuarial Memorandum.AR.pdf			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	Outline of Coverage	Approved	07/06/2011
<b>Bypass Reason:</b>	Outline of Coverage is uploaded under Form Schedule.		
<b>Comments:</b>			

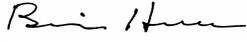
		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	redline changes example		
<b>Comments:</b>			
<b>Attachment:</b>			

*SERFF Tracking Number:* NELL-127180425 *State:* Arkansas  
*Filing Company:* Philadelphia American Life Insurance Company *State Tracking Number:* 48872  
*Company Tracking Number:* MS.A.PAL.AR  
*TOI:* MS08I Individual Medicare Supplement - *Sub-TOI:* MS08I.012 Multi-Plan 2010  
Standard Plans 2010  
*Product Name:* MS.A.PAL.AR  
*Project Name/Number:* MS.A.PAL.AR/MS.A.PAL.AR  
redline example.MS.A.PAL.AR.pdf

CERTIFICATION

I, Brian Hull, hereby certify that Philadelphia American Life Insurance Company complies with the following:

Rule and Regulation 19 Unfair Sex Discrimination  
Rule and Regulation 49 Guaranty Association Notice  
ACA 23-80-206 Flesch Readability  
ACA 23-79-138 Consumer Information Notice



---

Brian Hull, AIRC  
Assistant Vice President  
Philadelphia American Life Insurance Company

SERFF Tracking Number: NELI-127180425 State: Arkansas  
 Filing Company: Philadelphia American Life Insurance Company State Tracking Number: 48872  
 Company Tracking Number: MS.A.PALAR  
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.012 Multi-Plan 2010  
 Standard Plans 2010  
 Product Name: MS.A.PALAR  
 Project Name/Number: MS.A.PALAR/MS.A.PALAR

## Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
05/24/2011	Rate and Rule	Rates	07/06/2011	Rates.AR.pdf (Superceded)