NATIONAL HEALTH INSURANCE COMPANY

Outline of Medicare Supplement Plans A, F, High Deductible F, G, N

This chart shows the benefit included in each of the standard Medicare supplement plans. Some plans may not be available. Only applicants' first eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.
Note: A ✓ means 100% of the benefit is paid.

	Plans Available to All Applicants								Medicare first eligible before 2020 only	
Benefits	**A**	**B**	**D**	**G[1]**	**K**	**L**	**M**	**N**	**C**	**F[1]**
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or Copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply[3]	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2021[2]					6220[2]	3110[2]				

[1] Plans F and G also have a high deductible option which require first paying a plan deductible of $2370 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

[2] Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

[3] Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to $20 for some office visits and up to a $50 co-payment for emergency room visits that do not result in an inpatient admission.

NATIONAL HEALTH INSURANCE COMPANY
Medicare Supplement Policy
2010 Standardized Plan A
Attained Age Premium Rates
Rates Effective Upon Approval

	Preferred				Standard			
Attained	Female		Male		Female		Male	
Age	Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly
0-64	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	1,348.89	112.41	1,524.51	127.04	1,617.56	134.80	1,827.58	152.30
66	1,348.89	112.41	1,524.51	127.04	1,617.56	134.80	1,827.58	152.30
67	1,386.66	115.56	1,567.19	130.60	1,662.86	138.57	1,878.75	156.56
68	1,405.09	117.09	1,588.03	132.34	1,684.96	140.41	1,903.72	158.64
69	1,449.07	120.76	1,637.11	136.43	1,737.03	144.75	1,962.23	163.52
70	1,494.24	124.52	1,688.52	140.71	1,791.58	149.30	2,024.39	168.70
71	1,539.41	128.28	1,739.94	145.00	1,846.14	153.85	2,085.33	173.78
72	1,585.77	132.15	1,791.35	149.28	1,900.69	158.39	2,147.48	178.96
73	1,633.33	136.11	1,845.11	153.76	1,957.73	163.14	2,212.07	184.34
74	1,682.06	140.17	1,900.03	158.34	2,016.00	168.00	2,277.89	189.82
75	1,731.99	144.33	1,957.29	163.11	2,076.75	173.06	2,346.14	195.51
76	1,784.30	148.69	2,015.71	167.98	2,138.74	178.23	2,416.83	201.40
77	1,837.79	153.15	2,076.48	173.04	2,203.22	183.60	2,489.95	207.50
78	1,892.47	157.71	2,138.41	178.20	2,268.93	189.08	2,563.08	213.59
79	1,949.53	162.46	2,202.68	183.56	2,337.12	194.76	2,641.09	220.09
80	2,007.78	167.32	2,268.11	189.01	2,406.56	200.55	2,719.09	226.59
81	2,068.40	172.37	2,337.05	194.75	2,479.71	206.64	2,801.96	233.50
82	2,130.22	177.52	2,407.17	200.60	2,554.09	212.84	2,886.06	240.51
83	2,192.03	182.67	2,477.28	206.44	2,628.49	219.04	2,970.16	247.51
84	2,253.84	187.82	2,546.23	212.19	2,701.64	225.14	3,053.03	254.42
85	2,314.47	192.87	2,615.17	217.93	2,774.79	231.23	3,134.68	261.22
86	2,375.10	197.93	2,684.11	223.68	2,847.94	237.33	3,217.57	268.13
87	2,434.54	202.88	2,750.72	229.23	2,918.61	243.22	3,298.01	274.83
88	2,495.15	207.93	2,819.66	234.97	2,991.77	249.31	3,380.88	281.74
89	2,556.98	213.08	2,888.60	240.72	3,064.92	255.41	3,462.53	288.54
90	2,621.17	218.43	2,961.05	246.75	3,141.78	261.82	3,550.29	295.86
91	2,686.55	223.88	3,035.84	252.99	3,221.13	268.43	3,639.26	303.27
92	2,754.31	229.53	3,111.79	259.32	3,301.72	275.14	3,730.67	310.89
93	2,823.25	235.27	3,190.08	265.84	3,384.80	282.07	3,824.51	318.71
94	2,893.38	241.12	3,269.54	272.46	3,469.11	289.09	3,919.58	326.63
95	2,965.89	247.16	3,351.34	279.28	3,555.90	296.33	4,018.31	334.86
96	3,039.60	253.30	3,434.30	286.19	3,643.92	303.66	4,117.02	343.09
97	3,115.68	259.64	3,520.77	293.40	3,735.67	311.31	4,220.62	351.72
98	3,194.14	266.18	3,609.59	300.80	3,829.91	319.16	4,327.87	360.66
99+	3,273.78	272.82	3,699.56	308.30	3,925.38	327.12	4,435.13	369.59

Rate Calculator

Monthly Rate

A - Monthly Rate (use table above)
B - Area Factor (see area factors below)
C - Input Household Discount (1.0 if not applicable, 0.93 if discount applies)
D - Calculate Monthly Rate (rounded to the nearest penny) D=A*B*C

Quarterly, Semi-Annual, or Annual Rate

E - Input Modal Factor (Quarterly - multiply by 3, Semi-Annual - multiply by 6, Annual - multiply by 12)
F - Calculate Final Modal Billing Rate (rounded to the nearest penny) F=D*E

Household Discount: 7%
There is no modal loading.
The rates above do not include a one time $25 policy fee.

Area Factors:

Nebraska Zip Codes	Factor
Area 1: see rate area sheet for zip codes	1.05
Area 2: see rate area sheet for zip codes	0.93

NATIONAL HEALTH INSURANCE COMPANY
Medicare Supplement Policy
2010 Standardized Plan F
Attained Age Premium Rates
Rates Effective Upon Approval

	Preferred				Standard			
Attained	Female		Male		Female		Male	
Age	Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly
0-64	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	1,748.86	145.74	1,975.89	164.66	2,096.49	174.71	2,368.89	197.41
66	1,748.86	145.74	1,975.89	164.66	2,096.49	174.71	2,368.89	197.41
67	1,797.83	149.82	2,031.22	169.27	2,155.19	179.60	2,435.22	202.94
68	1,821.73	151.81	2,058.22	171.52	2,183.85	181.99	2,467.60	205.63
69	1,877.78	156.48	2,121.36	176.78	2,250.84	187.57	2,543.03	211.92
70	1,936.17	161.35	2,187.93	182.33	2,321.49	193.46	2,623.24	218.60
71	1,994.55	166.21	2,253.37	187.78	2,390.91	199.24	2,701.06	225.09
72	2,054.11	171.18	2,321.09	193.42	2,462.77	205.23	2,782.48	231.87
73	2,116.00	176.33	2,391.12	199.26	2,537.06	211.42	2,866.29	238.86
74	2,179.06	181.59	2,462.29	205.19	2,612.58	217.72	2,952.50	246.04
75	2,244.46	187.04	2,535.76	211.31	2,690.53	224.21	3,039.90	253.33
76	2,312.19	192.68	2,612.67	217.72	2,772.13	231.01	3,132.09	261.01
77	2,381.09	198.42	2,690.73	224.23	2,854.96	237.91	3,225.47	268.79
78	2,452.32	204.36	2,771.08	230.92	2,940.22	245.02	3,322.45	276.87
79	2,525.89	210.49	2,853.73	237.81	3,027.91	252.33	3,420.63	285.05
80	2,601.80	216.82	2,939.82	244.99	3,119.26	259.94	3,524.80	293.73
81	2,680.04	223.34	3,028.21	252.35	3,213.05	267.75	3,630.16	302.51
82	2,760.62	230.05	3,118.90	259.91	3,309.27	275.77	3,739.11	311.59
83	2,841.19	236.77	3,210.73	267.56	3,406.70	283.89	3,849.26	320.77
84	2,920.60	243.38	3,300.27	275.02	3,501.71	291.81	3,957.02	329.75
85	3,000.00	250.00	3,389.81	282.48	3,596.71	299.73	4,063.57	338.63
86	3,078.24	256.52	3,478.20	289.85	3,690.50	307.54	4,170.13	347.51
87	3,155.32	262.94	3,565.44	297.12	3,783.07	315.26	4,274.30	356.19
88	3,234.73	269.56	3,654.98	304.58	3,878.07	323.17	4,382.05	365.17
89	3,315.30	276.28	3,745.66	312.14	3,974.29	331.19	4,491.00	374.25
90	3,398.22	283.19	3,839.79	319.98	4,074.16	339.51	4,603.54	383.63
91	3,483.47	290.29	3,936.22	328.02	4,176.48	348.04	4,718.49	393.21
92	3,571.05	297.59	4,034.94	336.25	4,281.23	356.77	4,837.02	403.09
93	3,659.80	304.98	4,134.81	344.57	4,387.18	365.60	4,956.75	413.06
94	3,750.88	312.57	4,238.12	353.18	4,496.80	374.73	5,081.26	423.44
95	3,844.31	320.36	4,343.73	361.98	4,608.86	384.07	5,206.97	433.91
96	3,940.06	328.34	4,451.64	370.97	4,723.35	393.61	5,336.28	444.69
97	4,038.15	336.51	4,562.98	380.25	4,841.50	403.46	5,470.37	455.86
98	4,138.59	344.88	4,676.63	389.72	4,962.07	413.51	5,606.86	467.24
99+	4,242.51	353.54	4,793.71	399.48	5,086.32	423.86	5,746.94	478.91

Rate Calculator

Monthly Rate

A - Monthly Rate (use table above)
B - Area Factor (see area factors below)
C - Input Household Discount (1.0 if not applicable, 0.93 if discount applies)
D - Calculate Monthly Rate (rounded to the nearest penny) D=A*B*C

Quarterly, Semi-Annual, or Annual Rate

E - Input Modal Factor (Quarterly - multiply by 3, Semi-Annual - multiply by 6, Annual - multiply by 12)
F - Calculate Final Modal Billing Rate (rounded to the nearest penny) F=D*E

Household Discount: 7%
There is no modal loading.
The rates above do not include a one time $25 policy fee.

Area Factors:

Nebraska Zip Codes	Factor
Area 1: see rate area sheet for zip codes	1.05
Area 2: see rate area sheet for zip codes	0.93

NATIONAL HEALTH INSURANCE COMPANY
Medicare Supplement Policy
2010 Standardized Plan High F
Attained Age Premium Rates
Rates Effective Upon Approval

	Preferred				Standard			
Attained	Female		Male		Female		Male	
Age	Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly
0-64	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	537.13	44.76	606.55	50.55	643.57	53.63	727.07	60.59
66	537.13	44.76	606.55	50.55	643.57	53.63	727.07	60.59
67	552.17	46.01	623.53	51.96	661.59	55.13	747.43	62.29
68	559.51	46.63	631.82	52.65	670.38	55.87	757.36	63.11
69	576.85	48.07	652.27	54.36	692.08	57.67	782.26	65.19
70	594.19	49.52	671.59	55.97	712.58	59.38	804.77	67.06
71	611.53	50.96	690.91	57.58	733.08	61.09	828.48	69.04
72	630.03	52.50	711.37	59.28	754.79	62.90	853.36	71.11
73	648.53	54.04	732.95	61.08	777.69	64.81	878.26	73.19
74	668.18	55.68	754.55	62.88	800.61	66.72	904.33	75.36
75	687.83	57.32	777.27	64.77	824.71	68.73	931.59	77.63
76	708.63	59.05	801.14	66.76	850.03	70.84	960.04	80.00
77	729.45	60.79	823.86	68.66	874.15	72.85	987.29	82.27
78	751.41	62.62	848.86	70.74	900.67	75.06	1,018.11	84.84
79	774.54	64.55	875.01	72.92	928.41	77.37	1,048.93	87.41
80	797.65	66.47	901.14	75.10	956.14	79.68	1,079.74	89.98
81	821.93	68.49	928.41	77.37	985.08	82.09	1,112.94	92.75
82	846.20	70.52	955.69	79.64	1,014.02	84.50	1,146.12	95.51
83	870.48	72.54	984.10	82.01	1,044.16	87.01	1,179.30	98.28
84	894.75	74.56	1,011.37	84.28	1,073.09	89.42	1,212.49	101.04
85	919.03	76.59	1,038.64	86.55	1,102.03	91.84	1,245.67	103.81
86	943.32	78.61	1,065.91	88.83	1,130.97	94.25	1,277.67	106.47
87	966.43	80.54	1,092.05	91.00	1,158.70	96.56	1,309.68	109.14
88	990.71	82.56	1,119.32	93.28	1,187.64	98.97	1,341.68	111.81
89	1,014.98	84.58	1,146.59	95.55	1,216.58	101.38	1,374.87	114.57
90	1,040.42	86.70	1,175.00	97.92	1,246.73	103.89	1,409.24	117.44
91	1,067.00	88.92	1,205.68	100.47	1,279.28	106.61	1,445.98	120.50
92	1,093.59	91.13	1,235.23	102.94	1,310.62	109.22	1,480.35	123.36
93	1,121.34	93.45	1,267.04	105.59	1,344.39	112.03	1,519.47	126.62
94	1,149.08	95.76	1,298.87	108.24	1,378.15	114.85	1,557.40	129.78
95	1,177.99	98.17	1,330.68	110.89	1,411.91	117.66	1,595.32	132.94
96	1,206.88	100.57	1,363.64	113.64	1,446.87	120.57	1,634.43	136.20
97	1,236.94	103.08	1,397.73	116.48	1,483.04	123.59	1,675.92	139.66
98	1,268.16	105.68	1,432.96	119.41	1,520.43	126.70	1,717.40	143.12
99+	1,299.37	108.28	1,468.19	122.35	1,557.80	129.82	1,760.07	146.67

Rate Calculator

Monthly Rate

A - Monthly Rate (use table above)
B - Area Factor (see area factors below)
C - Input Household Discount (1.0 if not applicable, 0.93 if discount applies)
D - Calculate Monthly Rate (rounded to the nearest penny) D=A*B*C

Quarterly, Semi-Annual, or Annual Rate

E - Input Modal Factor (Quarterly - multiply by 3, Semi-Annual - multiply by 6, Annual - multiply by 12)
F - Calculate Final Modal Billing Rate (rounded to the nearest penny) F=D*E

Household Discount: 7%
There is no modal loading.
The rates above do not include a one time $25 policy fee.

Area Factors:

Nebraska Zip Codes	Factor
Area 1: see rate area sheet for zip codes	1.05
Area 2: see rate area sheet for zip codes	0.93

NATIONAL HEALTH INSURANCE COMPANY
Medicare Supplement Policy
2010 Standardized Plan G
Attained Age Premium Rates
Rates Effective Upon Approval

	Preferred				Standard			
Attained	Female		Male		Female		Male	
Age	Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly
0-64	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	1,407.08	117.26	1,589.57	132.46	1,686.59	140.55	1,905.97	158.83
66	1,407.08	117.26	1,589.57	132.46	1,686.59	140.55	1,905.97	158.83
67	1,446.48	120.54	1,634.08	136.17	1,733.82	144.49	1,959.34	163.28
68	1,465.71	122.14	1,655.81	137.98	1,756.87	146.41	1,985.39	165.45
69	1,510.89	125.91	1,707.21	142.27	1,811.42	150.95	2,046.32	170.53
70	1,557.24	129.77	1,759.81	146.65	1,867.21	155.60	2,109.70	175.81
71	1,603.60	133.63	1,812.39	151.03	1,923.01	160.25	2,173.07	181.09
72	1,651.16	137.60	1,866.14	155.51	1,980.05	165.00	2,237.67	186.47
73	1,701.08	141.76	1,922.23	160.19	2,039.56	169.96	2,304.70	192.06
74	1,752.20	146.02	1,979.48	164.96	2,100.31	175.03	2,372.95	197.75
75	1,804.50	150.38	2,039.08	169.92	2,163.54	180.30	2,444.87	203.74
76	1,859.18	154.93	2,101.02	175.09	2,229.25	185.77	2,519.21	209.93
77	1,915.05	159.59	2,164.11	180.34	2,296.20	191.35	2,594.78	216.23
78	1,972.12	164.34	2,228.38	185.70	2,364.40	197.03	2,671.55	222.63
79	2,031.55	169.30	2,294.99	191.25	2,435.07	202.92	2,750.77	229.23
80	2,092.17	174.35	2,363.93	196.99	2,508.22	209.02	2,833.65	236.14
81	2,155.18	179.60	2,435.21	202.93	2,583.85	215.32	2,918.97	243.25
82	2,219.37	184.95	2,507.66	208.97	2,660.72	221.73	3,006.71	250.56
83	2,283.57	190.30	2,580.11	215.01	2,737.60	228.13	3,093.25	257.77
84	2,347.75	195.65	2,652.56	221.05	2,814.46	234.54	3,179.78	264.98
85	2,410.76	200.90	2,723.84	226.99	2,890.09	240.84	3,265.09	272.09
86	2,473.77	206.15	2,795.12	232.93	2,965.72	247.14	3,350.41	279.20
87	2,535.58	211.30	2,865.23	238.77	3,040.12	253.34	3,434.51	286.21
88	2,598.58	216.55	2,936.51	244.71	3,115.75	259.65	3,521.04	293.42
89	2,663.95	222.00	3,010.13	250.84	3,193.86	266.16	3,608.79	300.73
90	2,730.53	227.54	3,084.92	257.08	3,273.21	272.77	3,697.76	308.15
91	2,798.29	233.19	3,162.04	263.50	3,355.04	279.59	3,790.38	315.87
92	2,868.42	239.04	3,241.50	270.13	3,439.35	286.61	3,886.67	323.89
93	2,939.74	244.98	3,322.13	276.84	3,524.90	293.74	3,982.95	331.91
94	3,013.45	251.12	3,405.09	283.76	3,612.93	301.08	4,081.68	340.14
95	3,088.34	257.36	3,489.23	290.77	3,702.20	308.52	4,182.83	348.57
96	3,165.60	263.80	3,576.86	298.07	3,795.19	316.27	4,287.65	357.30
97	3,245.25	270.44	3,666.84	305.57	3,890.65	324.22	4,396.12	366.34
98	3,326.09	277.17	3,757.99	313.17	3,987.37	332.28	4,505.81	375.48
99+	3,409.30	284.11	3,852.64	321.05	4,087.80	340.65	4,619.15	384.93

Rate Calculator

Monthly Rate

A - Monthly Rate (use table above)

B - Area Factor (see area factors below)

C - Input Household Discount (1.0 if not applicable, 0.93 if discount applies)

D - Calculate Monthly Rate (rounded to the nearest penny) D=A*B*C

Quarterly, Semi-Annual, or Annual Rate

E - Input Modal Factor (Quarterly - multiply by 3, Semi-Annual - multiply by 6, Annual - multiply by 12)

F - Calculate Final Modal Billing Rate (rounded to the nearest penny) F=D*E

Household Discount: 7%
There is no modal loading.
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Area Factors:

Nebraska Zip Codes	Factor
Area 1: see rate area sheet for zip codes	1.05
Area 2: see rate area sheet for zip codes	0.93

NATIONAL HEALTH INSURANCE COMPANY
Medicare Supplement Policy
2010 Standardized Plan N
Attained Age Premium Rates
Rates Effective Upon Approval

	Preferred				Standard			
Attained	Female		Male		Female		Male	
Age	Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly
0-64	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	1,063.65	88.64	1,201.39	100.12	1,274.73	106.23	1,440.75	120.06
66	1,063.65	88.64	1,201.39	100.12	1,274.73	106.23	1,440.75	120.06
67	1,093.43	91.12	1,235.03	102.92	1,310.42	109.20	1,481.09	123.42
68	1,107.97	92.33	1,251.45	104.29	1,327.84	110.65	1,500.78	125.07
69	1,142.05	95.17	1,290.20	107.52	1,368.95	114.08	1,546.65	128.89
70	1,177.21	98.10	1,330.00	110.83	1,411.18	117.60	1,594.71	132.89
71	1,212.37	101.03	1,369.79	114.15	1,453.39	121.12	1,641.68	136.81
72	1,248.59	104.05	1,410.63	117.55	1,496.74	124.73	1,690.83	140.90
73	1,285.88	107.16	1,452.53	121.04	1,541.18	128.43	1,741.08	145.09
74	1,324.23	110.35	1,496.51	124.71	1,587.85	132.32	1,794.60	149.55
75	1,363.65	113.64	1,540.49	128.37	1,634.52	136.21	1,847.03	153.92
76	1,404.13	117.01	1,586.57	132.21	1,683.41	140.28	1,901.64	158.47
77	1,446.74	120.56	1,634.74	136.23	1,734.52	144.54	1,959.54	163.30
78	1,490.43	124.20	1,683.96	140.33	1,786.75	148.90	2,018.52	168.21
79	1,535.17	127.93	1,734.22	144.52	1,840.08	153.34	2,078.59	173.22
80	1,580.98	131.75	1,786.59	148.88	1,895.64	157.97	2,141.94	178.50
81	1,628.93	135.74	1,840.00	153.33	1,952.31	162.69	2,206.39	183.87
82	1,677.93	139.83	1,895.50	157.96	2,011.20	167.60	2,271.93	189.33
83	1,726.93	143.91	1,951.01	162.58	2,070.09	172.51	2,338.56	194.88
84	1,774.87	147.91	2,005.46	167.12	2,127.87	177.32	2,404.09	200.34
85	1,822.82	151.90	2,059.93	171.66	2,185.65	182.14	2,469.63	205.80
86	1,869.69	155.81	2,112.28	176.02	2,241.21	186.77	2,531.89	210.99
87	1,916.57	159.71	2,165.69	180.47	2,297.88	191.49	2,596.33	216.36
88	1,964.51	163.71	2,220.15	185.01	2,355.66	196.31	2,661.87	221.82
89	2,013.52	167.79	2,274.60	189.55	2,413.44	201.12	2,727.40	227.28
90	2,063.58	171.97	2,331.15	194.26	2,473.44	206.12	2,795.12	232.93
91	2,114.72	176.23	2,389.80	199.15	2,535.67	211.31	2,865.02	238.75
92	2,167.99	180.67	2,449.49	204.12	2,599.01	216.58	2,937.11	244.76
93	2,222.32	185.19	2,511.29	209.27	2,664.57	222.05	3,010.30	250.86
94	2,277.72	189.81	2,573.07	214.42	2,730.13	227.51	3,084.58	257.05
95	2,334.18	194.52	2,636.95	219.75	2,797.90	233.16	3,161.03	263.42
96	2,392.78	199.40	2,703.98	225.33	2,869.01	239.08	3,241.86	270.16
97	2,452.44	204.37	2,771.00	230.92	2,940.13	245.01	3,321.59	276.80
98	2,514.23	209.52	2,841.16	236.76	3,014.58	251.22	3,405.70	283.81
99+	2,577.09	214.76	2,911.33	242.61	3,089.03	257.42	3,489.80	290.82

Rate Calculator

Monthly Rate

A - Monthly Rate (use table above)
B - Area Factor (see area factors below)
C - Input Household Discount (1.0 if not applicable, 0.93 if discount applies)
D - Calculate Monthly Rate (rounded to the nearest penny) D=A*B*C

Quarterly, Semi-Annual, or Annual Rate

E - Input Modal Factor (Quarterly - multiply by 3, Semi-Annual - multiply by 6, Annual - multiply by 12)
F - Calculate Final Modal Billing Rate (rounded to the nearest penny) F=D*E

Household Discount: 7%
There is no modal loading.
The rates above do not include a one time $25 policy fee.

Area Factors:

Nebraska Zip Codes	Factor
Area 1: see rate area sheet for zip codes	1.05
Area 2: see rate area sheet for zip codes	0.93

Rate Areas by Zip Code

Area 1:	68004	68014	68020	68038	68039	68045	68047	68055
68061	68303	68305	68309	68310	68313	68314	68315	68316
68318	68319	68320	68321	68322	68323	68325	68326	68327
68329	68330	68332	68335	68337	68338	68340	68341	68342
68343	68345	68346	68348	68350	68351	68352	68354	68355
68357	68359	68361	68362	68364	68365	68367	68370	68371
68375	68376	68377	68378	68379	68380	68381	68382	68401
68406	68410	68414	68415	68416	68420	68421	68422	68424
68429	68431	68433	68434	68436	68437	68439	68440	68441
68442	68444	68445	68447	68448	68450	68452	68453	68456
68457	68458	68460	68464	68465	68466	68467	68620	68622
68623	68626	68627	68628	68633	68635	68636	68637	68638
68652	68654	68655	68660	68665	68666	68669	68711	68713
68714	68716	68717	68719	68720	68722	68724	68725	68726
68728	68729	68734	68735	68742	68745	68746	68749	68751
68753	68755	68756	68758	68759	68760	68761	68763	68764
68766	68769	68773	68777	68778	68780	68783	68784	68786
68787	68788	68789	68791	68813	68814	68815	68817	68821
68822	68823	68825	68828	68833	68834	68835	68837	68838
68842	68843	68846	68850	68853	68856	68859	68860	68862
68874	68875	68878	68879	68881	68882	68920	68922	68926
68927	68928	68929	68936	68937	68939	68942	68943	68946
68948	68952	68958	68960	68961	68964	68966	68967	68969
68970	68971	68972	68974	68976	68977	68978	68979	68981
69001	69020	69021	69022	69023	69024	69026	69027	69028
69029	69030	69032	69033	69034	69036	69037	69038	69039
69040	69041	69042	69043	69044	69045	69046	69120	69121
69122	69125	69127	69128	69129	69130	69131	69133	69134
69135	69138	69140	69141	69142	69144	69145	69146	69147
69148	69149	69150	69153	69154	69155	69156	69157	69160
69162	69168	69171	69190	69201	69210	69214	69217	69218
69220	69221	69301	69331	69333	69335	69336	69337	69339
69340	69343	69346	69347	69348	69350	69351	69354	69360
69365	69366	69367						

Area 2: All Other Zip Codes

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

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

READ YOUR POLICY VERY CAREFULLY
This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY
If you find that you are not satisfied with your policy, you may return it to us at: PO Box 1070, Winston-Salem, NC 27102-1070. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued, and return all of your payments.

POLICY REPLACEMENT
If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE
This policy may not fully cover all of your medical costs. Neither National Health Insurance Company nor its agents are connected with Medicare. This Outline of Coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "The Medicare Handbook" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT
When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1484	$0	$1484 (Part A deductible)
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after -While using 60 lifetime reserve days	All but $742 a day	$742 a day	$0
Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare eligible expenses	$0***
-Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $185.50 a day	$0	Up to $185.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	$0

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

PLAN A (continued)
MEDICARE (Part B) - MEDICAL SERVICES -PER CALENDAR YEAR

*** Once you have been billed $203 of Medicare-Approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT TREATMENT**,** such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $203 of Medicare Approved Amounts **	$0	$0	$203 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $203 of Medicare Approved Amounts**	$0	$0	$203 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES -			
TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
Part A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment First $203 of Medicare Approved Amounts**	$0	$0	$203 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

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

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

This high deductible plans pays the same benefits as Plan F after one has paid a calendar year $2,370 deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $2,370. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductible for Part A and B but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1484	$1484 (Part A deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after -While using 60 lifetime reserve days	All but $742 a day	$742 a day	$0
Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare eligible expenses	$0***
-Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $185.50 a day	Up to $185.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	$0

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

PLAN F and HIGH DEDUCTIBLE F (continued)
MEDICARE (Part B) - MEDICAL SERVICES -PER CALENDAR YEAR

*** Once you have been billed $203 of Medicare-Approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $203 of Medicare Approved Amounts **	$0	$203 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $203 of Medicare Approved Amounts**	$0	$203 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES -			
TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
Part A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $203 of Medicare Approved Amounts**	$0	$203 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
Other Benefits - Not Covered by Medicare			
FOREIGN TRAVEL - NOT COVERED BY MEDICARE**,** Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

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

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

*** This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $2370 deductible. Benefits from the high deductible plan G will not begin until out-of-pocket expenses are $2370. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1484	$1484 (Part A deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after -While using 60 lifetime reserve days	All but $742 a day	$742 a day	$0
Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare eligible expenses	$0***
-Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $185.50 a day	Up to $185.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	$0

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

PLAN G (continued)
MEDICARE (Part B) - MEDICAL SERVICES -PER CALENDAR YEAR

*** Once you have been billed $203 of Medicare-Approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.*

*** This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $2370 deductible. Benefits from the high deductible plan G will not begin until out-of-pocket expenses are $2370. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $203 of Medicare Approved Amounts **	$0	$0	$203 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $203 of Medicare Approved Amounts**	$0	$0	$203 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
Part A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $203 of Medicare Approved Amounts**	$0	$0	$203 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Other Benefits - Not Covered by Medicare			
FOREIGN TRAVEL- NOT COVERED BY MEDICARE, Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1484	$1484 (Part A deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after -While using 60 lifetime reserve days	All but $742 a day	$742 a day	$0
Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare eligible expenses	$0***
-Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $185.50 a day	Up to $185.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	$0

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

PLAN N (continued)
MEDICARE (Part B) - MEDICAL SERVICES -PER CALENDAR YEAR

*** Once you have been billed $203 of Medicare-Approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $203 of Medicare Approved Amounts **	$0	$0	$203 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $203 of Medicare Approved Amounts**	$0	$0	$203 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
Part A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment	100%	$0	$0
First $203 of Medicare Approved Amounts**	$0	$0	$203 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Other Benefits - Not Covered by Medicare			
FOREIGN TRAVEL- NOT COVERED BY MEDICARE, Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum