RATE SHEET
NATIONAL JEWISH HEALTH

BASE PLAN		***OPTIONS***	
Facility Monthly Benefit	**$1,000**	**Home Care Level**	**TOTAL**
Home Monthly Benefit	**$500**	**Inflation Protection**	**SIMPLE CAPPED**
Facility Benefit Duration	**3 YEARS**		
Home Benefit	**50%**		
Lifetime Maximum	**$36,000**		
Elimination Period	**90 DAYS**		
Home Care Level	**PROFESSIONAL**		

This rate sheet shows the cost per $1,000 of coverage

Calculate your Premium:

_____ X _____ ÷ $1,000 = _____

Your Rate for plan chosen | Facility Monthly Benefit Amount | Your Premium

Monthly Rates

INSURANCE AGE	PLAN 1 BASE PLAN	PLAN 2 BASE PLAN WITH TOTAL HOME CARE OPTION	PLAN 3 BASE PLAN WITH SIMPLE INFLAT OPTION	PLAN 4 BASE PLAN WITH TOTAL HOME CARE SIMPLE INFLAT OPTION
18-30	2.60	3.90	3.50	5.50
31	2.60	3.90	3.60	5.50
32	2.60	4.00	3.70	5.70
33	2.70	4.10	3.80	5.80
34	2.70	4.20	4.00	6.20
35	2.80	4.30	4.10	6.30
36	2.90	4.40	4.40	6.60
37	3.00	4.60	4.50	6.80
38	3.20	4.80	4.80	7.20
39	3.30	5.00	5.10	7.60
40	3.40	5.20	5.20	7.80
41	3.60	5.40	5.50	8.20
42	3.80	5.70	5.80	8.70
43	3.90	5.90	6.10	9.10
44	4.10	6.20	6.40	9.50
45	4.40	6.50	6.80	10.00
46	4.50	6.80	7.10	10.60
47	4.70	7.10	7.50	11.10
48	5.00	7.60	8.00	11.90
49	5.20	8.00	8.30	12.50
50	5.50	8.50	8.80	13.30
51	5.90	9.10	9.30	14.10
52	6.20	9.60	9.90	14.90
53	6.60	10.20	10.50	15.80
54	6.90	10.70	11.00	16.70
55	7.40	11.50	11.70	17.50
56	7.90	12.20	12.30	18.50
57	8.50	13.10	13.20	19.80
58	9.10	13.90	14.20	21.10
59	9.70	15.00	15.30	22.60

RATE SHEET
NATIONAL JEWISH HEALTH

BASE PLAN		***OPTIONS***	
Facility Monthly Benefit	**$1,000**	**Home Care Level**	**TOTAL**
Home Monthly Benefit	**$500**	**Inflation Protection**	**SIMPLE CAPPED**
Facility Benefit Duration	**3 YEARS**		
Home Benefit	**50%**		
Lifetime Maximum	**$36,000**		
Elimination Period	**90 DAYS**		
Home Care Level	**PROFESSIONAL**		

This rate sheet shows the cost per $1,000 of coverage

Calculate your Premium:

_____ X _____ ÷ $1,000 = _____

Your Rate for plan chosen | Facility Monthly Benefit Amount | Your Premium

Monthly Rates

INSURANCE AGE	PLAN 1 BASE PLAN	PLAN 2 BASE PLAN WITH TOTAL HOME CARE OPTION	PLAN 3 BASE PLAN WITH SIMPLE INFLAT OPTION	PLAN 4 BASE PLAN WITH TOTAL HOME CARE SIMPLE INFLAT OPTION
60	10.50	16.10	16.30	24.10
61	11.50	17.30	17.70	25.90
62	12.70	19.00	19.40	28.10
63	13.80	20.50	21.00	30.20
64	15.20	22.40	23.00	32.70
65	17.40	25.00	26.10	36.40
66	19.20	27.20	28.60	39.20
67	21.40	29.80	31.50	42.70
68	23.70	32.40	34.40	46.00
69	26.30	35.40	38.00	50.00
70	29.10	38.70	41.50	53.90
71	32.30	42.40	45.60	58.70
72	35.80	46.40	50.20	63.90
73	39.80	50.90	54.90	69.10
74	44.00	55.70	60.30	75.10
75	53.00	66.40	71.70	88.50
76	58.20	72.20	78.30	95.70
77	63.90	78.50	84.70	102.70
78	70.10	85.40	92.20	110.90
79	76.90	92.90	99.60	118.90
80	84.50	101.10	108.70	128.60

RATE SHEET
NATIONAL JEWISH HEALTH

BASE PLAN		***OPTIONS***	
Facility Monthly Benefit	**$1,000**	**Home Care Level**	**TOTAL**
Home Monthly Benefit	**$500**	**Inflation Protection**	**SIMPLE CAPPED**
Facility Benefit Duration	**5 YEARS**		
Home Benefit	**50%**		
Lifetime Maximum	**$60,000**		
Elimination Period	**90 DAYS**		
Home Care Level	**PROFESSIONAL**		

This rate sheet shows the cost per $1,000 of coverage

Calculate your Premium:

_____ X _____ ÷ $1,000 = _____

Your Rate for plan chosen | Facility Monthly Benefit Amount | Your Premium

Monthly Rates

INSURANCE AGE	PLAN 1 BASE PLAN	PLAN 2 BASE PLAN WITH TOTAL HOME CARE OPTION	PLAN 3 BASE PLAN WITH SIMPLE INFLAT OPTION	PLAN 4 BASE PLAN WITH TOTAL HOME CARE SIMPLE INFLAT OPTION
18-30	3.20	4.90	4.50	6.90
31	3.30	5.10	4.60	7.10
32	3.30	5.10	4.70	7.30
33	3.40	5.30	5.00	7.60
34	3.40	5.30	5.10	7.80
35	3.60	5.60	5.30	8.10
36	3.70	5.70	5.50	8.50
37	3.90	5.90	5.80	8.90
38	4.00	6.20	6.00	9.20
39	4.20	6.40	6.30	9.50
40	4.40	6.70	6.70	10.10
41	4.50	6.90	6.90	10.50
42	4.70	7.10	7.30	11.00
43	5.00	7.50	7.70	11.60
44	5.20	7.90	8.10	12.10
45	5.50	8.20	8.60	12.80
46	5.70	8.70	9.00	13.50
47	6.00	9.20	9.50	14.30
48	6.30	9.70	9.90	15.10
49	6.60	10.30	10.50	16.00
50	7.00	10.90	11.10	16.90
51	7.40	11.50	11.70	17.90
52	7.70	12.20	12.30	18.90
53	8.20	13.00	13.00	20.10
54	8.70	13.80	13.90	21.40
55	9.20	14.60	14.50	22.20
56	9.90	15.70	15.50	23.80
57	10.50	16.70	16.50	25.30
58	11.30	17.90	17.70	27.00
59	12.20	19.20	18.90	28.80

RATE SHEET
NATIONAL JEWISH HEALTH

BASE PLAN		***OPTIONS***	
Facility Monthly Benefit	**$1,000**	**Home Care Level**	**TOTAL**
Home Monthly Benefit	**$500**	**Inflation Protection**	**SIMPLE CAPPED**
Facility Benefit Duration	**5 YEARS**		
Home Benefit	**50%**		
Lifetime Maximum	**$60,000**		
Elimination Period	**90 DAYS**		
Home Care Level	**PROFESSIONAL**		

This rate sheet shows the cost per $1,000 of coverage

Calculate your Premium:

_____ X _____ ÷ $1,000 = _____

Your Rate for plan chosen | Facility Monthly Benefit Amount | Your Premium

Monthly Rates

INSURANCE AGE	PLAN 1 BASE PLAN	PLAN 2 BASE PLAN WITH TOTAL HOME CARE OPTION	PLAN 3 BASE PLAN WITH SIMPLE INFLAT OPTION	PLAN 4 BASE PLAN WITH TOTAL HOME CARE SIMPLE INFLAT OPTION
60	13.10	20.50	20.30	30.70
61	14.30	22.30	22.10	33.20
62	15.70	24.40	24.10	36.00
63	17.10	26.50	25.90	38.70
64	18.80	28.70	28.40	41.90
65	21.40	32.20	32.10	46.70
66	23.70	35.10	35.20	50.50
67	26.30	38.40	38.70	54.80
68	29.20	42.00	42.40	59.40
69	32.20	45.70	46.50	64.20
70	35.60	50.00	50.90	69.60
71	39.60	54.80	55.70	75.50
72	43.80	60.00	61.40	82.20
73	48.60	65.80	67.00	88.90
74	53.60	72.00	73.40	96.60
75	64.50	85.80	87.10	113.70
76	71.00	93.50	95.10	123.10
77	77.80	101.70	102.90	132.30
78	85.30	110.60	112.00	142.80
79	93.50	120.30	121.00	153.40
80	102.60	130.90	131.70	165.60

RATE SHEET
NATIONAL JEWISH HEALTH

BASE PLAN		***OPTIONS***	
Facility Monthly Benefit	**$1,000**	**Home Care Level**	**TOTAL**
Home Monthly Benefit	**$500**	**Inflation Protection**	**SIMPLE CAPPED**
Facility Benefit Duration	**UNLIMITED**		
Home Benefit	**50%**		
Lifetime Maximum	**UNLIMITED**		
Elimination Period	**90 DAYS**		
Home Care Level	**PROFESSIONAL**		

This rate sheet shows the cost per $1,000 of coverage

Calculate your Premium:

_____ (Your Rate for plan chosen) X _____ (Facility Monthly Benefit Amount) ÷ $1,000 = _____ (Your Premium)

Monthly Rates

	PLAN 1	PLAN 2	PLAN 3	PLAN 4
INSURANCE AGE	BASE PLAN	BASE PLAN WITH TOTAL HOME CARE OPTION	BASE PLAN WITH SIMPLE INFLAT OPTION	BASE PLAN WITH TOTAL HOME CARE SIMPLE INFLAT OPTION
18-30	4.60	7.50	6.40	10.40
31	4.60	7.50	6.60	10.60
32	4.80	7.70	6.90	11.10
33	4.90	7.90	7.00	11.30
34	5.00	8.00	7.30	11.70
35	5.10	8.30	7.60	12.20
36	5.30	8.50	7.90	12.60
37	5.50	8.80	8.30	13.20
38	5.70	9.10	8.60	13.70
39	5.90	9.50	9.10	14.30
40	6.20	9.90	9.40	14.90
41	6.50	10.30	9.90	15.70
42	6.70	10.70	10.30	16.30
43	7.00	11.20	11.00	17.20
44	7.40	11.70	11.50	18.10
45	7.70	12.30	12.10	19.00
46	8.10	13.00	12.80	20.10
47	8.50	13.70	13.40	21.30
48	8.90	14.50	14.10	22.50
49	9.30	15.30	14.70	23.70
50	9.90	16.30	15.50	25.00
51	10.40	17.20	16.40	26.60
52	10.90	18.20	17.20	28.10
53	11.60	19.40	18.20	29.80
54	12.20	20.60	19.20	31.60
55	12.80	21.70	20.00	32.90
56	13.70	23.30	21.20	35.00
57	14.60	24.90	22.70	37.40
58	15.50	26.70	24.20	39.80
59	16.60	28.60	25.70	42.60

RATE SHEET
NATIONAL JEWISH HEALTH

BASE PLAN		***OPTIONS***	
Facility Monthly Benefit	**$1,000**	**Home Care Level**	**TOTAL**
Home Monthly Benefit	**$500**	**Inflation Protection**	**SIMPLE CAPPED**
Facility Benefit Duration	**UNLIMITED**		
Home Benefit	**50%**		
Lifetime Maximum	**UNLIMITED**		
Elimination Period	**90 DAYS**		
Home Care Level	**PROFESSIONAL**		

This rate sheet shows the cost per $1,000 of coverage

Calculate your Premium:

_____ X _____ ÷ $1,000 = _____

Your Rate for plan chosen | Facility Monthly Benefit Amount | Your Premium

Monthly Rates

INSURANCE AGE	PLAN 1 BASE PLAN	PLAN 2 BASE PLAN WITH TOTAL HOME CARE OPTION	PLAN 3 BASE PLAN WITH SIMPLE INFLAT OPTION	PLAN 4 BASE PLAN WITH TOTAL HOME CARE SIMPLE INFLAT OPTION
60	17.80	30.60	27.40	45.30
61	19.50	33.40	29.70	49.00
62	21.20	36.30	32.20	53.10
63	23.20	39.60	34.80	57.30
64	25.20	43.00	37.80	61.90
65	28.50	48.00	42.50	68.90
66	31.60	52.50	46.60	74.50
67	35.00	57.30	51.30	81.20
68	38.70	62.60	55.90	87.40
69	42.70	68.20	61.30	94.70
70	47.10	74.40	66.90	102.40
71	52.30	81.60	73.30	111.40
72	57.70	89.10	80.30	120.80
73	63.60	97.20	87.40	130.10
74	70.00	105.90	95.50	140.80
75	84.10	126.10	113.10	165.70
76	92.30	137.20	123.40	179.00
77	101.20	149.10	133.30	192.30
78	110.60	162.00	144.80	207.40
79	121.10	175.90	156.20	222.50
80	132.50	190.90	169.60	239.60