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RATE SHEET
MISSION ST. JOSEPH'S HEALTH SYSTEM

Base Plan		*Options*	
Facility Monthly Benefit	**$1,000**	Home Care Level	**Total**
Home Monthly Benefit	**$500**	Inflation Protection	**Compound Uncapped**
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 = _____
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 Compound Inflation Option	Plan 4 Base Plan With Total Home Care Compound Inflation Option
18-30	6.10	9.40	68.90	96.70
31	6.10	9.40	69.90	97.80
32	6.10	9.50	70.80	98.90
33	6.40	9.80	71.50	99.70
34	6.50	10.00	72.50	100.80
35	6.80	10.30	73.40	101.90
36	6.90	10.50	74.50	103.20
37	7.10	10.80	75.70	104.70
38	7.50	11.40	76.80	106.00
39	7.90	12.00	78.00	107.50
40	8.20	12.40	79.10	108.80
41	8.70	12.90	80.20	110.10
42	8.90	13.40	81.40	111.60
43	9.30	14.00	82.50	112.90
44	9.70	14.60	83.70	114.50
45	10.50	15.50	84.80	115.80
46	10.80	16.20	85.60	117.30
47	11.30	17.00	86.50	118.80
48	12.00	18.20	87.20	120.30
49	12.40	19.10	88.00	121.70
50	13.10	20.10	88.80	123.30
51	14.00	21.50	89.70	124.80
52	14.90	22.90	90.50	126.30
53	15.70	24.30	91.30	127.80
54	16.50	25.50	92.20	129.30
55	17.80	27.40	92.90	130.80
56	18.80	29.00	97.80	136.90
57	20.20	31.10	102.80	143.10
58	21.60	33.20	107.80	149.30
59	23.30	35.70	113.00	155.80

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Calculate your Premium:

_____ X _____ ÷ $1,000 = _____
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 Compound Inflation Option	Plan 4 Base Plan With Total Home Care Compound Inflation Option
60	25.10	38.20	118.00	162.10
61	27.40	41.40	123.20	168.60
62	30.20	45.20	128.50	175.20
63	33.00	49.00	133.70	181.80
64	36.30	53.20	139.20	188.60
65	41.30	59.50	144.00	194.60
66	45.70	64.70	155.60	207.60
67	51.00	70.90	169.80	224.10
68	56.30	77.10	183.00	238.80
69	62.50	84.30	198.90	256.60
70	69.30	92.10	214.00	273.80
71	76.90	100.90	234.20	296.20
72	85.40	110.50	254.80	319.10
73	94.80	121.30	276.10	343.50
74	104.70	132.60	299.30	369.30
75	126.40	158.30	353.70	432.60
76	138.60	172.00	383.90	465.40
77	152.20	187.00	412.90	496.70
78	166.90	203.30	447.10	533.30
79	183.30	221.20	480.50	569.70
80	201.40	240.80	520.70	612.70
81	221.90	262.80	565.50	660.20
82	246.20	289.40	618.80	718.00
83	271.90	317.90	673.40	778.20
84	299.70	348.40	730.30	840.50

RATE SHEET
MISSION ST. JOSEPH'S HEALTH SYSTEM

Base Plan		*Options*	
Facility Monthly Benefit	**$1,000**	Home Care Level	**Total**
Home Monthly Benefit	**$500**	Inflation Protection	**Compound Uncapped**
Facility Benefit Duration	**6 Years**		
Home Benefit	**50%**		
Lifetime Maximum	**$72,000**		
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 = _____
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 Compound Inflation Option	Plan 4 Base Plan With Total Home Care Compound Inflation Option
18-30	7.90	12.40	90.70	128.90
31	8.20	12.70	92.10	130.60
32	8.30	13.00	93.50	132.40
33	8.60	13.30	94.80	134.10
34	8.70	13.60	96.20	135.80
35	9.20	14.10	97.60	137.50
36	9.30	14.40	99.00	139.40
37	9.70	14.90	100.50	141.20
38	10.10	15.60	101.80	143.00
39	10.50	16.10	103.20	144.80
40	11.00	16.80	104.70	146.70
41	11.30	17.40	106.20	148.60
42	12.00	18.30	107.60	150.40
43	12.50	19.10	108.90	152.10
44	13.10	19.90	110.30	153.90
45	13.90	21.10	111.80	155.80
46	14.60	22.20	112.70	157.80
47	15.20	23.30	113.90	159.90
48	16.20	24.90	114.80	161.90
49	16.60	26.00	115.80	164.00
50	17.60	27.60	116.90	166.10
51	18.50	29.20	117.90	168.10
52	19.60	31.00	118.90	170.00
53	20.70	32.90	119.90	172.10
54	22.00	35.00	120.90	174.20
55	23.50	37.40	122.00	176.20
56	24.90	39.70	128.00	184.70
57	26.50	42.40	134.20	193.20
58	28.50	45.50	140.50	202.00
59	30.60	48.80	146.80	210.80

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Base Plan		*Options*	
Facility Monthly Benefit	**$1,000**	Home Care Level	**Total**
Home Monthly Benefit	**$500**	Inflation Protection	**Compound Uncapped**
Facility Benefit Duration	**6 Years**		
Home Benefit	**50%**		
Lifetime Maximum	**$72,000**		
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 = _____
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 Compound Inflation Option	Plan 4 Base Plan With Total Home Care Compound Inflation Option
60	32.70	52.20	153.10	219.60
61	35.90	56.90	159.80	228.90
62	39.30	62.00	166.20	237.80
63	43.10	67.40	172.90	247.10
64	47.30	73.50	179.50	256.30
65	53.50	81.90	185.60	264.80
66	59.30	89.50	200.50	283.50
67	65.80	97.90	218.40	305.90
68	72.80	106.80	235.10	326.10
69	80.40	116.50	254.10	349.90
70	89.00	127.40	273.50	374.10
71	98.80	139.80	299.10	405.40
72	109.40	153.00	325.00	436.70
73	120.80	167.60	350.90	469.40
74	133.70	183.50	380.40	505.10
75	160.60	218.90	448.80	592.40
76	176.50	238.20	486.40	637.20
77	193.60	259.30	523.20	681.10
78	212.30	282.00	565.50	730.90
79	232.60	306.80	607.90	782.40
80	255.00	333.70	657.30	840.90
81	280.40	364.10	712.10	905.70
82	310.40	400.60	777.60	984.90
83	342.20	439.80	845.40	1067.40
84	376.30	481.70	915.60	1153.40

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RATE SHEET
MISSION ST. JOSEPH'S HEALTH SYSTEM

Base Plan		*Options*	
Facility Monthly Benefit	**$1,000**	Home Care Level	**Total**
Home Monthly Benefit	**$500**	Inflation Protection	**Compound Uncapped**
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 = _____
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 Compound Inflation Option	Plan 4 Base Plan With Total Home Care Compound Inflation Option
18-30	11.00	17.80	123.20	181.10
31	11.00	17.90	124.40	182.90
32	11.50	18.50	125.70	184.70
33	11.60	18.80	126.90	186.30
34	11.90	19.20	128.20	188.10
35	12.10	19.60	129.50	189.90
36	12.60	20.20	131.20	192.20
37	13.10	21.10	132.90	194.60
38	13.60	21.70	134.70	197.00
39	14.10	22.50	136.50	199.30
40	14.60	23.50	138.20	201.70
41	15.50	24.60	139.90	204.10
42	16.00	25.50	141.70	206.40
43	16.70	26.60	143.50	208.80
44	17.50	27.90	145.20	211.20
45	18.40	29.30	146.90	213.50
46	19.40	31.00	147.90	216.20
47	20.20	32.50	149.10	219.10
48	21.40	34.60	150.10	221.80
49	22.20	36.40	151.10	224.40
50	23.50	38.70	152.30	227.30
51	24.60	40.80	153.30	230.00
52	26.10	43.40	154.30	232.70
53	27.60	46.30	155.30	235.30
54	29.00	49.00	156.50	238.20
55	30.50	51.70	157.50	240.90
56	32.50	55.40	164.60	252.40
57	34.70	59.30	172.00	264.20
58	37.00	63.50	179.40	276.30
59	39.60	68.10	187.00	288.60

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Facility Benefit Duration	**Unlimited**		
Home Benefit	**50%**		
Lifetime Maximum	**Unlimited**		
Elimination Period	**90 Days**		
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Monthly Rates

Insurance Age	Plan 1 Base Plan	Plan 2 Base Plan With Total Home Care Option	Plan 3 Base Plan With Compound Inflation Option	Plan 4 Base Plan With Total Home Care Compound Inflation Option
60	42.40	73.00	194.50	300.50
61	46.30	79.50	202.10	312.90
62	50.50	86.50	209.80	325.40
63	55.20	94.20	217.70	338.10
64	60.00	102.30	225.70	351.00
65	68.00	114.40	232.80	362.40
66	75.30	125.00	252.80	389.50
67	83.20	136.40	273.40	418.60
68	92.10	149.00	294.70	446.80
69	101.70	162.40	318.50	479.70
70	112.30	177.30	343.40	513.60
71	124.50	194.20	374.00	554.90
72	137.50	212.20	405.70	596.90
73	151.40	231.50	437.60	641.10
74	166.70	252.30	472.70	687.00
75	200.20	300.30	556.70	803.60
76	219.90	326.70	603.10	864.60
77	240.90	355.10	649.10	924.20
78	263.60	385.80	699.60	989.30
79	288.40	418.90	750.80	1057.70
80	315.70	454.80	810.70	1135.00
81	346.10	494.40	877.30	1220.40
82	382.30	542.30	954.90	1322.00
83	420.30	593.20	1035.00	1428.20
84	460.50	646.40	1117.40	1536.60