PREMIUM INFORMATION
Sterling Life Insurance Company

Sterling Life Insurance Company may raise Your premium if it raises the premium for all policies in Your class. Premiums are community rated and based on the mode of the premium payment selected. **Premium in the chart below is subject to change.**

Rating Area I:

- **Supplement Counties:** Anoka, Benton, Carlton, Carver, Chisago, Clay, Dakota, Dodge, Hennepin, Houston, Isanti, Olmsted, Polk, Ramsey, Scott, Sherburne, Stearns, St. Louis, Wabasha, Washington and Wright.

Rating Area II:

- **Supplement Counties:** Aitkin, Becker, Beltrami, Big Stone, Blue Earth, Brown, Cass, Chippewa, Clearwater, Cook, Cottonwood, Crow Wing, Douglas, Faribault, Fillmore, Freeborn, Goodhue, Grant, Hubbard, Itasca, Jackson, Kanabec, Kandiyohi, Kittson, Koochiching, Lac qui Parle, Lake, Lake of the Woods, Le Sueur, Lincoln, Lyon, Mahnomen, Marshall, Martin, McLeod, Meeker, Mille Lacs, Morrison, Mower, Murray, Nicollet, Nobles, Norman, Otter Tail, Pennington, Pine, Pipestone, Pope, Red Lake, Redwood, Renville, Rice, Rock, Roseau, Sibley, Steele, Stevens, Swift, Todd, Traverse, Wadena, Waseca, Watonwan, Wilkin, Winona and Yellow Medicine.

PREMIUM INFORMATION
Sterling Life Insurance Company
Rating Area I

(03/01/13)

Annual Premium		Basic	PAC Monthly Premium	
Non-Tobacco	Tobacco	Community	Non-Tobacco	Tobacco
1,776.62	2,064.72	Under 65	151.90	176.53
1,776.62	2,064.72	65 and Above	151.90	176.53

(03/01/13)

Annual Premium		Basic Riders	PAC Monthly Premium	
Part A Deductible			Part A Deductible	
Non-Tobacco	Tobacco	Community	Non-Tobacco	Tobacco
393.00	456.74	Under 65	33.60	39.05
393.00	456.74	65 and Above	33.60	39.05

(03/01/13)

Annual Premium			Basic Riders	PAC Monthly Premium		
Part B Deductible	Preventative Care	Part B Excess	Community	Part B Deductible	Preventative Care	Part B Excess
143.97	61.54	23.05	Under 65	12.31	5.26	1.97
143.97	61.54	23.05	65 and Above	12.31	5.26	1.97

(03/01/13)

Annual Premium		Extended Basic	PAC Monthly Premium	
Non-Tobacco	Tobacco	Community	Non-Tobacco	Tobacco
2,567.62	2,983.98	Under 65	219.53	255.13
2,567.62	2,983.98	65 and Above	219.53	255.13

Annual premium conversion formulas: Semi-Annual X .5203, Quarterly X .2646, Monthly X .0900
All premiums are rounded to the nearest penny.

PREMIUM INFORMATION
Sterling Life Insurance Company
Rating Area II

(03/01/13)

Annual Premium		Basic	PAC Monthly Premium	
Non-Tobacco	Tobacco	Community	Non-Tobacco	Tobacco
1,529.09	1,777.06	Under 65	130.74	151.94
1,529.09	1,777.06	65 and Above	130.74	151.94

(03/01/13)

Annual Premium		Basic Riders	PAC Monthly Premium	
Part A Deductible			Part A Deductible	
Non-Tobacco	Tobacco	Community	Non-Tobacco	Tobacco
393.00	456.74	Under 65	33.60	39.05
393.00	456.74	65 and Above	33.60	39.05

(03/01/13)

Annual Premium			Basic Riders	PAC Monthly Premium		
Part B Deductible	Preventative Care	Part B Excess	Community	Part B Deductible	Preventative Care	Part B Excess
143.97	61.54	23.05	Under 65	12.31	5.26	1.97
143.97	61.54	23.05	65 and Above	12.31	5.26	1.97

(03/01/13)

Annual Premium		Extended Basic	PAC Monthly Premium	
Non-Tobacco	Tobacco	Community	Non-Tobacco	Tobacco
2,262.23	2,629.07	Under 65	193.42	224.79
2,262.23	2,629.07	65 and Above	193.42	224.79

Annual premium conversion formulas: Semi-Annual X .5203, Quarterly X .2646, Monthly X .0900
All premiums are rounded to the nearest penny.

Part A
Hospital Insurance

2011 Original Medicare
Covers: Costs associated with stays in a hospital or Skilled Nursing Facility

When you are hospitalized for	Medicare Pays	You Pay
Days 1-60	Most hospitalization costs after the required Medicare deductible.	**$1,132** Deductible
Days 61-90	All eligible expenses, after you pay a per-day copayment.	**$283** per-day copayment, as much as **$8,490**
Days 91-150	All eligible expenses, after you pay a per-day copayment. (These are Lifetime Reserve Days which may never be used again.)	**$566** per-day copayment, as much as **$33,960**
Each day beyond 150 days	Nothing	You pay all costs
Blood	After first three pints of blood, 100% of Medicare approved amount.	First three pints of blood
Skilled Nursing Facility When you are hospitalized for at least 3 days and enter a Medicare-approved Skilled Nursing Facility within 30 days after hospital discharge and are receiving skilled nursing care.	All eligible expenses for the first 20 days; then all eligible expenses for days 21-100, after you pay a per-day copayment. Nothing after day 100.	**$0** for the first 20 days; **$141.50** per-day copayment for days 21-100, as much as: **$11,320** per benefit period All costs per day after 100
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness	All expenses related to a Medicare-approved Hospice program with limited copayment/ coinsurance.	No more than $5 for each prescription drug for pain relief and symptom control; 5% of Medicare-approved amount for inpatient respite care.

Part B
Medical Insurance

2011 Original Medicare
Covers: Physician services, outpatient care, tests and supplies

On expenses incurred for	Medicare Pays	You Pay
Annual Deductible	**$0**	**$162** per year
Medical Expenses Physician's services for inpatient and outpatient medical/surgical services; physical/speech therapy, diagnostic tests	Generally 80% of approved amount	20% of Medicare-approved amount
Clinical Laboratory Service Blood tests, urinalysis	Generally 100% of approved amount	Nothing for Medicare-approved services
Outpatient Hospital Treatment Hospital services for the diagnosis or treatment of an illness or injury	Medicare payment to hospital, based on outpatient procedure payment rates	Copayment based on outpatient procedure payment rates
Blood	After first three pints of blood, 80% of approved amount	First three pints plus 20% of Medicare-approved amount for additional pints
Covered under Parts A & B		
Home Health Care Part-time or intermittent skilled care, home health aide services, durable medical supplies and other services	100% of approved amount; 80% of approved amount for durable medical equipment	Nothing for Medicare-approved services; 20% of Medicare-approved amount for durable medical equipment

The amounts listed are for the 2011 calendar year and may change every year.

PREMIUM INFORMATION
Sterling Life Insurance Company

Sterling Life Insurance Company may raise Your premium if it raises the premium for all policies in Your class. Premiums are community rated and based on the mode of the premium payment selected. **Premium in the chart below is subject to change.**

Annual Premiums applicable to Rate Area I:

- **Supplement Only Counties:** Anoka, Benton, Carlton, Carver, Chisago, Clay, Dakota, Dodge, Hennepin, Houston, Isanti, Olmsted, Polk, Ramsey, Scott, Sherburne, Stearns, St. Louis, Wabasha, Washington and Wright.

Annual Premiums applicable to Rate Area II:

- **Supplement Only Counties:** Aitkin, Becker, Beltrami, Big Stone, Blue Earth, Brown, Cass, Chippewa, Clearwater, Cook, Cottonwood, Crow Wing, Douglas, Faribault, Fillmore, Freeborn, Goodhue, Grant, Hubbard, Itasca, Jackson, Kanabec, Kandiyohi, Kittson, Koochiching, Lac qui Parle, Lake, Lake of the Woods, Le Sueur, Lincoln, Lyon, Mahnomen, Marshall, Martin, McLeod, Meeker, Mille Lacs, Morrison, Mower, Murray, Nicollet, Nobles, Norman, Otter Tail, Pennington, Pine, Pipestone, Pope, Red Lake, Redwood, Renville, Rice, Rock, Roseau, Sibley, Steele, Stevens, Swift, Todd, Traverse, Wadena, Waseca, Watonwan, Wilkin, Winona and Yellow Medicine Counties.

PREMIUM INFORMATION
Sterling Life Insurance Company
Rating Area 1

(11/29/11)

Annual Premium		Basic	PAC Monthly Premium	
Non-Tobacco	Tobacco	Community	Non-Tobacco	Tobacco
1,616.58	1,878.73	Under 65	138.22	160.63
1,616.58	1,878.73	65 and Above	138.22	160.63

(11/29/11)

Annual Premium		Basic Riders	PAC Monthly Premium	
Part A Deductible			Part A Deductible	
Non-Tobacco	Tobacco	Community	Non-Tobacco	Tobacco
357.60	415.60	Under 65	30.57	35.53
357.60	415.60	65 and Above	30.57	35.53

(11/29/11)

Annual Premium			Basic Riders	PAC Monthly Premium		
Part B Deductible	Preventative Care	Part B Excess	Community	Part B Deductible	Preventative Care	Part B Excess
131.00	56.00	20.97	Under 65	11.20	4.79	1.79
131.00	56.00	20.97	65 and Above	11.20	4.79	1.79

(11/29/11)

Annual Premium		Extended Basic	PAC Monthly Premium	
Non-Tobacco	Tobacco	Community	Non-Tobacco	Tobacco
2,336.32	2,715.18	Under 65	199.76	232.15
2,336.32	2,715.18	65 and Above	199.76	232.15

Annual premium conversion formulas: Semi-Annual X .5203, Quarterly X .2646, Monthly X .0900
All premiums are rounded to the nearest penny.

PREMIUM INFORMATION
Sterling Life Insurance Company
Rating Area 2

(11/29/11)

Annual Premium		Basic	PAC Monthly Premium	
Non-Tobacco	Tobacco	Community	Non-Tobacco	Tobacco
1,391.35	1,616.98	Under 65	118.96	138.25
1,391.35	1,616.98	65 and Above	118.96	138.25

(11/29/11)

Annual Premium		Basic Riders	PAC Monthly Premium	
Part A Deductible			Part A Deductible	
Non-Tobacco	Tobacco	Community	Non-Tobacco	Tobacco
357.60	415.60	Under 65	30.57	35.53
357.60	415.60	65 and Above	30.57	35.53

(11/29/11)

Annual Premium			Basic Riders	PAC Monthly Premium		
Part B Deductible	Preventative Care	Part B Excess	Community	Part B Deductible	Preventative Care	Part B Excess
131.00	56.00	20.97	Under 65	11.20	4.79	1.79
131.00	56.00	20.97	65 and Above	11.20	4.79	1.79

(11/29/11)

Annual Premium		Extended Basic	PAC Monthly Premium	
Non-Tobacco	Tobacco	Community	Non-Tobacco	Tobacco
2,058.44	2,392.24	Under 65	176.00	204.54
2,058.44	2,392.24	65 and Above	176.00	204.54

Annual premium conversion formulas: Semi-Annual X .5203, Quarterly X .2646, Monthly X .0900
All premiums are rounded to the nearest penny.

PREMIUM INFORMATION
Sterling Life Insurance Company

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Annual Premiums applicable to Rate Area II:

- **Supplement Only Counties:** Aitkin, Becker, Beltrami, Big Stone, Blue Earth, Brown, Cass, Chippewa, Clearwater, Cook, Cottonwood, Crow Wing, Douglas, Faribault, Fillmore, Freeborn, Goodhue, Grant, Hubbard, Itasca, Jackson, Kanabec, Kandiyohi, Kittson, Koochiching, Lac qui Parle, Lake, Lake of the Woods, Le Sueur, Lincoln, Lyon, Mahnomen, Marshall, Martin, McLeod, Meeker, Mille Lacs, Morrison, Mower, Murray, Nicollet, Nobles, Norman, Otter Tail, Pennington, Pine, Pipestone, Pope, Red Lake, Redwood, Renville, Rice, Rock, Roseau, Sibley, Steele, Stevens, Swift, Todd, Traverse, Wadena, Waseca, Watonwan, Wilkin, Winona and Yellow Medicine Counties.

PREMIUM INFORMATION
Sterling Life Insurance Company
Rating Area 1

(11/29/11)

Annual Premium		Basic	PAC Monthly Premium	
Non-Tobacco	Tobacco	Community	Non-Tobacco	Tobacco
1,616.58	1,878.73	Under 65	138.22	160.63
1,616.58	1,878.73	65 and Above	138.22	160.63

(11/29/11)

Annual Premium		Basic Riders	PAC Monthly Premium	
Part A Deductible			Part A Deductible	
Non-Tobacco	Tobacco	Community	Non-Tobacco	Tobacco
357.60	415.60	Under 65	30.57	35.53
357.60	415.60	65 and Above	30.57	35.53

(11/29/11)

Annual Premium			Basic Riders	PAC Monthly Premium		
Part B Deductible	Preventative Care	Part B Excess	Community	Part B Deductible	Preventative Care	Part B Excess
131.00	56.00	20.97	Under 65	11.20	4.79	1.79
131.00	56.00	20.97	65 and Above	11.20	4.79	1.79

(11/29/11)

Annual Premium		Extended Basic	PAC Monthly Premium	
Non-Tobacco	Tobacco	Community	Non-Tobacco	Tobacco
2,336.32	2,715.18	Under 65	199.76	232.15
2,336.32	2,715.18	65 and Above	199.76	232.15

Annual premium conversion formulas: Semi-Annual X .5203, Quarterly X .2646, Monthly X .0900
All premiums are rounded to the nearest penny.

PREMIUM INFORMATION
Sterling Life Insurance Company
Rating Area 2

(11/29/11)

Annual Premium		Basic	PAC Monthly Premium	
Non-Tobacco	Tobacco	Community	Non-Tobacco	Tobacco
1,391.35	1,616.98	Under 65	118.96	138.25
1,391.35	1,616.98	65 and Above	118.96	138.25

(11/29/11)

Annual Premium		Basic Riders	PAC Monthly Premium	
Part A Deductible			Part A Deductible	
Non-Tobacco	Tobacco	Community	Non-Tobacco	Tobacco
357.60	415.60	Under 65	30.57	35.53
357.60	415.60	65 and Above	30.57	35.53

(11/29/11)

Annual Premium			Basic Riders	PAC Monthly Premium		
Part B Deductible	Preventative Care	Part B Excess	Community	Part B Deductible	Preventative Care	Part B Excess
131.00	56.00	20.97	Under 65	11.20	4.79	1.79
131.00	56.00	20.97	65 and Above	11.20	4.79	1.79

(11/29/11)

Annual Premium		Extended Basic	PAC Monthly Premium	
Non-Tobacco	Tobacco	Community	Non-Tobacco	Tobacco
2,058.44	2,392.24	Under 65	176.00	204.54
2,058.44	2,392.24	65 and Above	176.00	204.54

Annual premium conversion formulas: Semi-Annual X .5203, Quarterly X .2646, Monthly X .0900
All premiums are rounded to the nearest penny.

STERLING LIFE INSURANCE COMPANY

Medicare Supplement Administrative Offices/Customer Service P.O. Box 5348, Bellingham, WA 98227-5348

OUTLINE OF BASIC AND EXTENDED BASIC MEDICARE SUPPLEMENT COVERAGE - COVER PAGE 1 of 2

The Insurance Commissioner for the State of Minnesota has established two categories of Medicare Supplement insurance and minimum standards for each, with the extended basic Medicare Supplement being the most comprehensive and the basic Medicare Supplement being the least comprehensive.

Basic Medicare Supplement Coverage:

Hospitalization	Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Skilled Nursing	Skilled Nursing Facility coinsurance
Medical Expenses	Part B coinsurance (generally 20% of Medicare-approved expenses), or copayments for hospital outpatient services.
Travel Outside United States/Foreign Travel Emergency* Services not covered by Medicare	Coverage for health care received outside the United States as a result of a medical emergency.
Blood: (Part A&B)	First three pints of blood each year.
Hospice	Part A cost sharing
Home Health Care	Coverage for cost sharing for Medicare Part A or B home health care services and medical supplies subject to the Medicare Part B deductible amount.

Additional Benefits*:	• Alcoholism, Chemical Dependency or Drug Addiction Treatment • Outpatient Facility Services • Ventilator Dependent Communication Services • Reconstructive Surgery • Lyme Disease Treatment • Scalp Hair Prostheses • Diabetes • Immunizations • Cancer Screening • Ovarian Cancer Screening • Prostate Cancer Screening • Phenylketonuria Formula • Temporomandibular Joint Disorder and Craniomandibular Disorder

* **To the extent not paid by Medicare or otherwise under this policy, we will pay benefits as indicated.**

Extended Basic Medicare Supplement Coverage:

- **Total Maximum Out of Pocket Expenses are limited to $1,000 in a calendar year.**
- **Pays 100% after you spend $1,000 in out-of-pocket costs for a calendar year.**

Hospitalization:	Includes all Basic Plan coverage, plus coverage for the Part A Deductible
Skilled Nursing:	Includes all Basic Plan coverage, plus 80% for eligible charges in days 101-120
Medical Expenses:	Includes all Basic Plan coverage, plus coverage for 100% of the Excess Usual and Customary Expenses and the Part B Deductible.
Travel Outside United States/Foreign Travel Medical Care* Services not covered by Medicare	Coverage for health care received outside the United States.
Blood: (Part A&B)	Includes all Basic Plan coverage
Preventive Medical Care	Coverage for an annual examination and preventive screening tests or services.
Hospice	Includes all Basic Plan coverage
Home Health Care	Includes all Basic Plan coverage

Additional Benefits*:	• Includes all Basic Plan coverage, plus: • Hospital Services • Ambulance Transportation • Nursing Home Services • Oral Surgery • Other Services and Supplies including: use of radium and radioactive materials; oxygen; anesthetics and their administration; prostheses; rental or purchase of durable medical equipment, and diagnostic x-rays and laboratory tests.

* **To the extent not paid by Medicare or otherwise under this policy, we will pay benefits as indicated.**

** Reimbursement shall be for the actual charges up to 100% of the Medicare-approved amount for each service as if Medicare were to cover the service as identified in the American Medical Association current procedural terminology (AMA CPT) codes to a maximum of $120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

Optional Benefit Riders:

- **Riders are purchased in addition to your Basic or Extended Basic Medicare Supplement Coverage.**
- **Riders currently offered by Sterling are check marked below:**
  - ☑ *** **Part A Deductible** – Pays the inpatient hospital deductible for each benefit period.
  - ☑ **Part B Deductible** – Pays the Medicare part B medical annual deductible.
  - ☑ *** **Preventive Care** – Pays up to $120 a year for covered preventive screening tests and services and an annual physical examination.
  - ☑ **Excess Part B Usual and Customary Expenses** –Pays 100% of the difference between the actual Medicare Part B charges as billed and the Medicare-approved Part B charge, up to the charge limitation established by Medicare.

*** This rider is only available with the Basic plan. Optional rider benefits are included with the Extended Basic plan.

OUTLINE OF BASIC AND EXTENDED BASIC MEDICARE SUPPLEMENT COVERAGE DISCLOSURES

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

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.

LOSS RATIO STATEMENT This Policy provides an anticipated loss ratio of sixty-five percent (65%). This means that, on the average, policyholders may expect that $65 of every $100 in premium will be returned as benefits to policyholders over the life of the contract.

RENEWAL CONDITIONS You may renew Your policy for Yourself as long as You may live. To renew, just pay the renewal premiums on or before the renewal date or during the thirty-one (31) days that follow. We cannot refuse to renew this policy or place any restrictions on it if You pay the premiums on time. We cannot cancel or refuse to renew Your plan based on the deterioration of Your health. We will provide You with a minimum of thirty (30) days notice in advance of a change in Your premium rate.

RIGHT TO RETURN POLICY If You find that You are not satisfied with Your policy, You may return it to P.O. Box 5348, Bellingham, WA 98227-5348. If You send the policy back to Us within thirty (30) days after You receive it, We will treat the policy as if it had never been issued and return all of Your payments within ten (10) days.

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 Sterling Life 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.

THIS POLICY DOES NOT COVER ALL MEDICAL EXPENSES BEYOND THOSE COVERED BY MEDICARE. THIS POLICY DOES NOT COVER ALL SKILLED NURSING HOME CARE EXPENSES AND DOES NOT COVER CUSTODIAL OR RESIDENTIAL NURSING CARE. READ YOUR POLICY CAREFULLY TO DETERMINE WHICH NURSING HOME FACILITIES AND EXPENSES ARE COVERED BY YOUR POLICY.

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.

LIMITATIONS OF COVERAGE

This is a Medicare supplement policy. For Medicare covered services some of Your coverage is conditional on Medicare's approval of Medicare Eligible Expenses. Services eligible for coverage must therefore be deemed as medically necessary by Medicare. If Medicare does not consider services rendered or expenses incurred as medically necessary, no benefits will be paid. We will not place any limitations on benefits that are more restrictive than Medicare's limitations and restrictions, except as otherwise noted in this policy.

No benefits will be paid under Medicare Part A that duplicates payments under Medicare Part B. No benefits will be paid under Medicare Part B that duplicates payments under Medicare Part A. No benefits will duplicate payment made directly by Medicare.

BASIC AND EXTENDED BASIC - BENEFITS CHART

MEDICARE (PART A) - HOSPITAL SERVICES - PER CALENDAR YEAR

* A benefit period begins the first day You receive services 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.

** **Indicates your liability for covered charges. You are responsible for all other non-covered charges.**

*** **Pays 100% after you spend $1,000 in out-of-pocket costs for a calendar year.**

SERVICES	MEDICARE PAYS	BASIC Plan Pays	YOU PAY**	EXTENDED BASIC Plan Pays***	YOU PAY**
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies. First 60 days	All but $1,132	$0; or **$1,132 (with Optional Part A Deductible Rider*****)**	$1,132 (Part A Deductible); or $0	$1,132 (Part A Deductible)	$0
61st thru 90th day	All but $283 a day	$283 a day	$0	$283 a day	$0
91st day thru 150th day: While using 60 lifetime reserve days	All but $566 a day	$566 a day	$0	$566 a day	$0
151st day and after	$0	100% of Medicare eligible expenses	$0	100% of Medicare eligible expenses	$0
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	$0	$0
21st thru 100th day	All but $141.50	Up to $141.50 per day	$0	Up to $141.50 per day	$0
101st day thru 120th day	$0	$0	All Costs	80%	20%
BLOOD First 3 pints	$0	3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0	$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 cost sharing	$0	Medicare cost sharing	$0

**** This is an optional rider which can be purchased in addition to your Medicare Supplement plan.

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 "Basic Benefits".

BASIC AND EXTENDED BASIC - BENEFITS CHART (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.

** **Indicates your liability for covered charges. You are responsible for all other non-covered charges.**

*** **Pays 100% after you spend $1,000 in out-of-pocket costs for a calendar year.**

SERVICES	MEDICARE PAYS	BASIC Plan Pays	YOU PAY**	EXTENDED BASIC Plan Pays***	YOU PAY**
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL & OUTPATIENT HOSPITAL TREATMENT, such as Physician's services; inpatient and outpatient medical and surgical services and supplies; physical, speech and occupational therapy; diagnostic tests; durable medical equipment.	$0	$0; or **$162 (with Optional Part B Deductible Rider****)**	$162 (Part B Deductible); or $0	$0; or **$162 (with Optional Part B Deductible Rider****)**	$162; or $0
First $162 of Medicare Approved Amounts*					
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%; or **Charges exceeding eligible charges (with Optional Medicare Part B Excess Charges Rider****)**	Charges exceeding eligible charges; or $0	Generally 20%; or **Charges exceeding eligible charges (with Optional Medicare Part B Excess Charges Rider****)**	Charges exceeding eligible charges; or $0
BLOOD					
First 3 pints	$0	All Costs	$0	All Costs	$0
Next $162 of Medicare Approved Amounts*	$0	$0; or **$162 (with Optional Part B Deductible Rider****)**	$162 (Part B Deductible); or $0	$0; or **$162 (with Optional Part B Deductible Rider****)**	$162; or $0
Remainder of Medicare Approved Amounts	80%	20%	$0	20%	$0
CLINICAL LABORATORY SERVICES					
Blood Tests For Diagnostic Services	100%	$0	$0	$0	$0

**** This is an optional rider which can be purchased in addition to your Medicare Supplement plan.

BASIC AND EXTENDED BASIC - BENEFITS CHART (Continued)

MEDICARE (PARTS A & 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.

** **Indicates your liability for covered charges. You are responsible for all other non-covered charges.**

*** **Pays 100% after you spend $1,000 in out-of-pocket costs for a calendar year.**

SERVICES	MEDICARE PAYS	BASIC Plan Pays	YOU PAY**	EXTENDED BASIC Plan Pays***	YOU PAY**
HOME HEALTH CARE					
MEDICARE APPROVED SERVICES					
Medically necessary skilled care services and medical supplies	100%	$0	$0	$0	$0
Durable medical equipment					
First $162 of Medicare Approved Amounts*	$0	$0	$162 (Part B Deductible)	$162 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0	20%	$0

BASIC AND EXTENDED BASIC - BENEFITS CHART (Continued)

OTHER BENEFITS – NOT COVERED BY MEDICARE

* **Indicates your liability for covered charges. You are responsible for all other non-covered charges.**

** **Pays 100% after you spend $1,000 in out-of-pocket costs for a calendar year.**

SERVICES	MEDICARE PAYS	BASIC Plan Pays	YOU PAY*	EXTENDED BASIC Plan Pays**	YOU PAY*
TRAVEL OUTSIDE UNITED STATES/FOREIGN TRAVEL Services Not Covered by Medicare	$0	80%****	20%	80%	20%
PREVENTIVE MEDICAL CARE BENEFIT – Some annual physical and preventive tests and services administered or ordered by Your doctor when not covered by Medicare.** First $120 each calendar year	$0	$0; or **Up to 100% of the Medicare approved amount for each service (with Optional Preventive Care Rider***)**	All costs over the Medicare approved amount for each service; or $0	Up to 100% of the Medicare approved amount for each service	All costs over the Medicare approved amount for each service
Additional charges	$0	$0	All costs over the Medicare approved amount for each service	$0	All costs over the Medicare approved amount for each service

*** This is an optional rider which can be purchased in addition to your Medicare Supplement plan.

**** Hospital and medical expenses and supplies incurred during foreign travel as a result of a medical emergency only.

BASIC AND EXTENDED BASIC - BENEFITS CHART (Continued)

ADDITIONAL BENEFITS

To the extent not paid by Medicare or otherwise under this policy, we will pay benefits as indicated for the following:

SERVICES	MEDICARE PAYS	Basic Plan Pays	YOU PAY	Extended Basic Plan Pays	YOU PAY
• **Alcoholism, Chemical Dependency, or Drug Addiction Includes:** (a) Outpatient mental health, outpatient chemical dependency and alcoholism services; and (b) Inpatient hospital mental health, inpatient hospital and residential chemical dependency and alcoholism services. Cost-sharing requirements and benefit or service limitations will not place a greater financial burden on You, or be more restrictive than the requirements and limitations of Medicare.	$0	80% of the usual and customary charge	20% of the usual and customary charge	80% of the usual and customary charge	20% of the usual and customary charge
• **Outpatient Facility Services:** For services at an outpatient facility equipped to provide surgery or other health care treatment whether or not the facility is part of a hospital. Coverage is provided on the same basis as coverage provided for the same health care treatment or service in a hospital.	$0	80% of the usual and customary charge	20% of the usual and customary charge	80% of the usual and customary charge	20% of the usual and customary charge
• **Ventilator Dependent:** Coverage for up to 120 hours of services provided by a private duty nurse or personal care assistant to the ventilator-dependent person during the time the ventilator-dependent person is in a hospital licensed under chapter 144. The personal care assistant or private duty nurse shall perform only the services of communicator or interpreter for the ventilator-dependent patient during a transition period of up to 120 hours to assure adequate training of the hospital staff to communicate with the patient and to understand the unique comfort, safety, and personal care needs of the patient.	$0	80% of the usual and customary charge	20% of the usual and customary charge	80% of the usual and customary charge	20% of the usual and customary charge
• **Reconstructive Surgery:** When the surgery is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part.	$0	80% of the usual and customary charge	20% of the usual and customary charge	80% of the usual and customary charge	20% of the usual and customary charge

To the extent not paid by Medicare or otherwise under this policy, we will pay benefits as indicated for the following:

SERVICES	MEDICARE PAYS	Basic Plan Pays	YOU PAY		Extended Basic Plan Pays	YOU PAY
• **Lyme Disease:** Coverage for treatment of diagnosed Lyme disease.	$0	80% of the usual and customary charge	20% of the usual and customary charge		80% of the usual and customary charge	20% of the usual and customary charge
• **Scalp Hair Prostheses:** Worn for hair loss suffered as a result of alopecia areata, limited to a maximum of $350 in any benefit year.	$0	80% of the usual and customary charge	20% of the usual and customary charge		80% of the usual and customary charge	20% of the usual and customary charge
• **Diabetes:** Physician prescribed equipment and supplies used for the management and treatment of gestational, Type I or Type II diabetes	$0	80% of the usual and customary charge	20% of the usual and customary charge		80% of the usual and customary charge	20% of the usual and customary charge
• **Immunizations:** Preventive immunizations and vaccines not otherwise covered under Part D	$0	$100% of the usual and customary charge	$0		100% of the usual and customary charge	$0
• **Cancer Screening:** Routine screening procedures for cancer when ordered or performed by a physician	$0	$100% of the usual and customary charge	$0		100% of the usual and customary charge	$0
• **Ovarian Cancer Screening:** Coverage for routine screening procedures for cancer, including mammograms, surveillance tests for ovarian cancer for women who are at risk for ovarian cancer as defined in subdivision 3, pap smears and colorectal screening tests for men and women, when ordered or provided by a physician in accordance with the standard practice of medicine.	$0	100% of the usual and customary charge	$0		100% of the usual and customary charge	$0
• **Prostate Cancer Screening:** Coverage for prostate cancer screening for men 40 years of age or over who are symptomatic or in a high-risk category and for all men 50 years of age or older. The screening must consist at a minimum of a prostate-specific antigen blood test and a digital rectal examination. This coverage is subject to any deductible, coinsurance, copayment, or other limitation on coverage applicable to other coverages under the plan.	$0	100% of the usual and customary charge	$0		100% of the usual and customary charge	$0
• **Phenylketonuria (PKU) Formula:** For special dietary treatment for phenylketonuria when recommended by a physician.	$0	80% of the usual and customary charge	20% of the usual and customary charge		80% of the usual and customary charge	20% of the usual and customary charge

To the extent not paid by Medicare or otherwise under this policy, we will pay benefits as indicated for the following:

SERVICES	MEDICARE PAYS	Basic Plan Pays	YOU PAY	Extended Basic Plan Pays	YOU PAY
• **Temporomandibular Joint Disorder and Craniomandibular Disorder**: Treatment for these conditions shall be the same as that for treatment to any other joint in the body, and shall apply if the treatment is administered or prescribed by a physician or dentist.	$0	100% of the usual and customary charge	$0	100% of the usual and customary charge	$0
• **Hospital Services:** Hospital services to the extent not paid by Medicare or otherwise under this policy, excluding any charge for confinement in a private room in excess of a hospital's charge for a semiprivate room.	$0	$0	All charges	80% of the usual and customary charge	20% of the usual and customary charge
• **Ambulance Transportation:** For ambulance transportation provided by a licensed ambulance to the nearest facility qualified to treat the condition; or a reasonable mileage rate for transportation to a kidney dialysis center for treatment.	$0	$0	All charges	80% of the usual and customary charge	20% of the usual and customary charge
• **Nursing Home Services:** For nursing home services for not more than 120 days in a calendar year if the services would qualify as reimbursable services under Medicare.	$0	$0	All charges	80% of the usual and customary charge	20% of the usual and customary charge
• **Oral Surgery:** For oral surgery for partially or completely unerupted impacted teeth, a tooth root without the extraction of the entire tooth, or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.	$0	$0	All charges	80% of the usual and customary charge	20% of the usual and customary charge
• **Other Services and Supplies:** The following additional services and/or supplies: 1. Use of radium or other radioactive materials; 2. Oxygen; 3. Anesthetics and their administration; 4. Artificial limbs, eyes, larynx and other prosthetic devices; 5. Rental or purchase of durable medical equipment other than eyeglasses and hearing aids. 6. Diagnostic x-rays and laboratory tests.	$0	$0	All charges	80% of the usual and customary charge	20% of the usual and customary charge