

STERLING INVESTORS LIFE INSURANCE COMPANY
Outline of Medicare Supplement Coverage
Benefit Plans A, B, C, D, F, G, M, N and High Deductible Plan F
Benefit Chart of Medicare Supplement Plans Sold for Effective Dates on or After June 1, 2010

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan “A” available. Some plans may not be available in your state. Plans E, H, I, and J are no longer available for sale.

Basic Benefits:

- Hospitalization – Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- Medical Expenses – Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or copayments.
- Blood – First three pints of blood each year.
- Hospice – Part A coinsurance

A	B	C	D	F	F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance*		Basic, including 100% Part B coinsurance	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 coinsurance	Basic, including 100 % Part B coinsurance except up to \$20 copayment for office visit, and up to \$50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				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
							Out-of-pocket limit \$4620 paid at 100% after limit reached	Out-of-Pocket limit \$2310 paid at 100% after limit reached		

*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 \$2000 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed \$2000. 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.

STERLING INVESTORS LIFE INSURANCE COMPANY

OREGON Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 970-972

Attained Age	Non-Tobacco User									Attained Age	Tobacco User								
	Plan A	Plan B	Plan C	Plan D	Plan F	High Plan F	Plan G	Plan M	Plan N		Plan A	Plan B	Plan C	Plan D	Plan F	High Plan F	Plan G	Plan M	Plan N
Under 65	859	1,003	1,201	1,051	1,249	491	1,057	946	874	Under 65	954	1,114	1,335	1,168	1,387	546	1,175	1,051	971
65	859	1,003	1,201	1,051	1,249	491	1,057	946	874	65	954	1,114	1,335	1,168	1,387	546	1,175	1,051	971
66	859	1,003	1,201	1,051	1,249	491	1,057	946	874	66	954	1,114	1,335	1,168	1,387	546	1,175	1,051	971
67	900	1,051	1,258	1,103	1,304	513	1,108	992	913	67	1,001	1,168	1,398	1,224	1,448	570	1,232	1,102	1,014
68	942	1,099	1,314	1,153	1,357	534	1,159	1,037	950	68	1,047	1,222	1,461	1,281	1,508	593	1,287	1,153	1,055
69	982	1,146	1,371	1,201	1,410	555	1,209	1,082	987	69	1,091	1,273	1,523	1,336	1,568	617	1,342	1,202	1,097
70	1,022	1,192	1,429	1,250	1,466	577	1,257	1,125	1,026	70	1,136	1,325	1,587	1,389	1,629	641	1,396	1,251	1,141
71	1,061	1,238	1,487	1,299	1,525	600	1,305	1,169	1,068	71	1,178	1,376	1,653	1,442	1,695	667	1,451	1,299	1,187
72	1,100	1,283	1,547	1,346	1,585	624	1,353	1,211	1,109	72	1,223	1,427	1,719	1,497	1,761	694	1,504	1,346	1,233
73	1,138	1,328	1,607	1,392	1,646	648	1,400	1,253	1,152	73	1,265	1,476	1,785	1,547	1,829	719	1,556	1,393	1,280
74	1,176	1,374	1,664	1,440	1,702	670	1,447	1,296	1,191	74	1,306	1,525	1,848	1,599	1,890	744	1,608	1,440	1,323
75	1,213	1,416	1,720	1,485	1,756	690	1,492	1,337	1,229	75	1,348	1,574	1,910	1,650	1,951	768	1,658	1,485	1,365
76	1,250	1,459	1,770	1,529	1,806	710	1,538	1,377	1,264	76	1,388	1,620	1,967	1,699	2,006	789	1,708	1,528	1,405
77	1,284	1,500	1,820	1,572	1,853	729	1,581	1,415	1,297	77	1,428	1,666	2,023	1,747	2,059	810	1,756	1,572	1,442
78	1,319	1,539	1,869	1,615	1,898	747	1,623	1,453	1,328	78	1,466	1,711	2,075	1,793	2,109	830	1,803	1,615	1,477
79	1,350	1,574	1,912	1,651	1,943	764	1,661	1,487	1,360	79	1,500	1,750	2,125	1,835	2,158	850	1,844	1,651	1,511
80	1,378	1,609	1,953	1,688	1,982	780	1,697	1,519	1,387	80	1,533	1,788	2,171	1,875	2,203	866	1,885	1,688	1,542
81	1,407	1,642	1,993	1,721	2,019	794	1,731	1,549	1,413	81	1,563	1,825	2,214	1,912	2,244	883	1,922	1,721	1,571
82	1,433	1,672	2,030	1,753	2,056	809	1,761	1,578	1,439	82	1,592	1,858	2,257	1,948	2,284	898	1,958	1,753	1,598
83	1,456	1,700	2,065	1,782	2,087	822	1,792	1,604	1,461	83	1,618	1,888	2,295	1,979	2,319	912	1,990	1,782	1,623
84	1,478	1,724	2,098	1,808	2,117	833	1,818	1,628	1,482	84	1,642	1,917	2,330	2,010	2,353	926	2,020	1,808	1,647
85	1,500	1,750	2,129	1,834	2,147	845	1,843	1,651	1,503	85	1,665	1,944	2,365	2,039	2,385	939	2,049	1,835	1,670
86	1,519	1,773	2,155	1,859	2,173	854	1,870	1,673	1,521	86	1,688	1,970	2,395	2,065	2,414	950	2,076	1,859	1,690
87	1,537	1,793	2,180	1,880	2,198	864	1,889	1,692	1,538	87	1,707	1,993	2,423	2,089	2,442	961	2,100	1,880	1,710
88	1,552	1,812	2,203	1,900	2,221	873	1,910	1,711	1,556	88	1,724	2,013	2,449	2,111	2,468	971	2,122	1,900	1,728
89	1,567	1,829	2,224	1,917	2,242	882	1,928	1,725	1,569	89	1,741	2,032	2,471	2,130	2,490	979	2,142	1,918	1,743
90	1,580	1,843	2,241	1,934	2,257	888	1,944	1,741	1,580	90	1,756	2,049	2,490	2,148	2,508	986	2,161	1,934	1,756
91	1,592	1,859	2,257	1,948	2,272	894	1,959	1,754	1,591	91	1,770	2,065	2,508	2,166	2,524	992	2,176	1,949	1,767
92	1,604	1,872	2,271	1,963	2,285	899	1,974	1,767	1,599	92	1,782	2,080	2,523	2,180	2,539	999	2,192	1,963	1,778
93	1,615	1,884	2,284	1,975	2,298	904	1,986	1,778	1,609	93	1,793	2,094	2,537	2,195	2,553	1,004	2,207	1,975	1,788
94	1,625	1,897	2,295	1,989	2,308	908	1,999	1,790	1,616	94	1,806	2,107	2,550	2,209	2,565	1,009	2,221	1,989	1,796
95	1,634	1,907	2,304	2,000	2,317	911	2,011	1,800	1,622	95	1,816	2,120	2,560	2,222	2,575	1,013	2,234	2,000	1,802
96	1,642	1,918	2,312	2,011	2,326	915	2,021	1,809	1,629	96	1,825	2,130	2,569	2,234	2,584	1,016	2,246	2,011	1,808
97	1,650	1,925	2,319	2,018	2,333	918	2,030	1,816	1,633	97	1,833	2,139	2,576	2,244	2,593	1,020	2,255	2,019	1,815
98	1,655	1,932	2,326	2,025	2,341	921	2,037	1,823	1,639	98	1,839	2,146	2,584	2,251	2,600	1,023	2,262	2,026	1,820
99+	1,660	1,936	2,330	2,030	2,344	923	2,041	1,828	1,642	99+	1,843	2,152	2,587	2,256	2,605	1,025	2,268	2,030	1,824

Modal Factors: Semi Annual: 0.5000 Quarterly: 0.25000 Monthly: Divide by 12

STERLING INVESTORS LIFE INSURANCE COMPANY

OREGON Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 970-972

Attained Age	Non-Tobacco User									Attained Age	Tobacco User								
	High										High								
	Plan A	Plan B	Plan C	Plan D	Plan F	Plan F	Plan G	Plan M	Plan N		Plan A	Plan B	Plan C	Plan D	Plan F	Plan F	Plan G	Plan M	Plan N
Under 65	828	966	1,157	1,013	1,203	473	1,018	912	842	Under 65	920	1,074	1,286	1,125	1,337	526	1,132	1,013	935
65	828	966	1,157	1,013	1,203	473	1,018	912	842	65	920	1,074	1,286	1,125	1,337	526	1,132	1,013	935
66	828	966	1,157	1,013	1,203	473	1,018	912	842	66	920	1,074	1,286	1,125	1,337	526	1,132	1,013	935
67	867	1,013	1,212	1,063	1,256	494	1,067	956	879	67	965	1,125	1,347	1,179	1,395	549	1,187	1,062	976
68	908	1,059	1,266	1,111	1,307	514	1,117	999	916	68	1,009	1,177	1,408	1,234	1,453	571	1,240	1,111	1,017
69	946	1,104	1,321	1,157	1,359	535	1,164	1,042	951	69	1,051	1,226	1,467	1,287	1,510	594	1,293	1,158	1,057
70	984	1,149	1,377	1,204	1,413	556	1,211	1,084	988	70	1,094	1,277	1,529	1,338	1,570	618	1,345	1,205	1,099
71	1,022	1,193	1,433	1,251	1,469	578	1,258	1,126	1,029	71	1,135	1,326	1,593	1,390	1,633	642	1,398	1,251	1,143
72	1,060	1,236	1,491	1,297	1,527	601	1,304	1,167	1,069	72	1,178	1,375	1,656	1,442	1,697	668	1,449	1,297	1,188
73	1,097	1,280	1,548	1,341	1,586	624	1,349	1,207	1,110	73	1,219	1,422	1,720	1,491	1,762	693	1,499	1,342	1,233
74	1,133	1,323	1,603	1,387	1,639	645	1,394	1,248	1,147	74	1,258	1,469	1,781	1,541	1,821	717	1,549	1,387	1,275
75	1,168	1,364	1,657	1,431	1,691	665	1,438	1,288	1,184	75	1,299	1,516	1,840	1,589	1,879	739	1,597	1,431	1,315
76	1,204	1,405	1,706	1,473	1,740	684	1,481	1,326	1,218	76	1,337	1,561	1,895	1,637	1,932	760	1,646	1,473	1,353
77	1,237	1,445	1,754	1,514	1,785	702	1,523	1,364	1,250	77	1,375	1,605	1,949	1,683	1,984	781	1,692	1,514	1,389
78	1,270	1,483	1,800	1,556	1,829	720	1,563	1,400	1,280	78	1,413	1,648	1,999	1,728	2,032	799	1,737	1,556	1,423
79	1,300	1,517	1,842	1,591	1,872	736	1,601	1,432	1,310	79	1,445	1,686	2,048	1,768	2,079	818	1,777	1,591	1,456
80	1,328	1,550	1,882	1,626	1,909	751	1,635	1,464	1,337	80	1,477	1,723	2,092	1,806	2,122	834	1,816	1,626	1,485
81	1,356	1,582	1,920	1,658	1,945	765	1,668	1,492	1,361	81	1,506	1,758	2,133	1,842	2,162	851	1,852	1,658	1,514
82	1,380	1,611	1,956	1,689	1,981	780	1,697	1,520	1,386	82	1,533	1,790	2,174	1,876	2,200	865	1,887	1,689	1,540
83	1,403	1,638	1,989	1,717	2,011	792	1,726	1,545	1,408	83	1,559	1,819	2,211	1,907	2,234	878	1,917	1,717	1,563
84	1,424	1,661	2,021	1,742	2,040	803	1,751	1,568	1,428	84	1,582	1,847	2,245	1,936	2,267	892	1,947	1,742	1,587
85	1,445	1,686	2,051	1,767	2,068	814	1,776	1,590	1,448	85	1,604	1,873	2,278	1,964	2,298	905	1,974	1,768	1,608
86	1,464	1,708	2,076	1,791	2,094	823	1,801	1,612	1,465	86	1,626	1,898	2,308	1,989	2,326	916	2,000	1,791	1,628
87	1,480	1,727	2,100	1,811	2,117	833	1,820	1,630	1,482	87	1,645	1,920	2,334	2,012	2,353	926	2,023	1,811	1,647
88	1,495	1,746	2,123	1,830	2,140	841	1,840	1,648	1,499	88	1,661	1,939	2,359	2,033	2,378	935	2,045	1,830	1,665
89	1,510	1,762	2,142	1,847	2,160	850	1,857	1,662	1,512	89	1,677	1,958	2,380	2,052	2,399	943	2,063	1,848	1,680
90	1,522	1,776	2,159	1,863	2,175	856	1,873	1,677	1,522	90	1,691	1,974	2,399	2,070	2,416	950	2,082	1,863	1,691
91	1,534	1,791	2,174	1,877	2,189	861	1,887	1,690	1,533	91	1,705	1,989	2,416	2,086	2,432	956	2,097	1,878	1,702
92	1,545	1,804	2,188	1,891	2,201	866	1,902	1,702	1,541	92	1,717	2,003	2,431	2,101	2,446	962	2,112	1,891	1,713
93	1,556	1,815	2,200	1,903	2,214	871	1,913	1,713	1,550	93	1,728	2,018	2,444	2,115	2,459	967	2,126	1,903	1,722
94	1,566	1,827	2,211	1,916	2,224	875	1,926	1,725	1,557	94	1,740	2,030	2,457	2,128	2,471	972	2,140	1,916	1,730
95	1,574	1,838	2,220	1,927	2,233	878	1,937	1,734	1,563	95	1,750	2,042	2,466	2,141	2,481	976	2,152	1,927	1,736
96	1,582	1,848	2,228	1,937	2,241	882	1,947	1,743	1,569	96	1,759	2,052	2,475	2,152	2,489	979	2,164	1,937	1,742
97	1,589	1,855	2,234	1,944	2,248	884	1,955	1,750	1,574	97	1,766	2,061	2,482	2,161	2,498	983	2,173	1,945	1,748
98	1,594	1,861	2,241	1,951	2,255	887	1,962	1,756	1,579	98	1,772	2,067	2,489	2,169	2,505	986	2,180	1,952	1,754
99+	1,599	1,865	2,244	1,956	2,259	889	1,966	1,761	1,582	99+	1,776	2,073	2,492	2,173	2,510	988	2,185	1,955	1,757

Modal Factors: Semi Annual: 0.5000 Quarterly: 0.25000 Monthly: Divide by 12

OREGON Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 970-972

Attained Age	Non-Tobacco User									Attained Age	Tobacco User								
	Plan A	Plan B	Plan C	Plan D	Plan F	High Plan F	Plan G	Plan M	Plan N		Plan A	Plan B	Plan C	Plan D	Plan F	High Plan F	Plan G	Plan M	Plan N
Under 65	747	872	1,045	914	1,085	427	919	822	759	Under 65	830	968	1,160	1,015	1,206	475	1,022	914	845
65	747	872	1,045	914	1,085	427	919	822	759	65	830	968	1,160	1,015	1,206	475	1,022	914	845
66	747	872	1,045	914	1,085	427	919	822	759	66	830	968	1,160	1,015	1,206	475	1,022	914	845
67	783	914	1,094	958	1,134	446	964	862	794	67	871	1,016	1,217	1,066	1,260	496	1,071	959	882
68	819	956	1,143	1,002	1,179	464	1,008	901	826	68	909	1,062	1,270	1,114	1,310	515	1,119	1,002	918
69	854	996	1,191	1,045	1,226	482	1,050	941	859	69	948	1,108	1,325	1,161	1,362	535	1,168	1,045	954
70	888	1,036	1,242	1,087	1,276	502	1,093	979	893	70	988	1,153	1,381	1,209	1,417	558	1,214	1,087	991
71	923	1,077	1,293	1,129	1,326	522	1,134	1,016	928	71	1,025	1,197	1,437	1,255	1,474	580	1,261	1,129	1,032
72	956	1,116	1,346	1,171	1,378	543	1,177	1,053	965	72	1,063	1,241	1,494	1,301	1,532	603	1,307	1,171	1,072
73	990	1,155	1,397	1,211	1,432	563	1,218	1,091	1,002	73	1,100	1,283	1,552	1,346	1,591	626	1,353	1,211	1,114
74	1,023	1,194	1,446	1,252	1,479	582	1,258	1,127	1,036	74	1,137	1,327	1,607	1,392	1,644	647	1,398	1,252	1,151
75	1,055	1,232	1,494	1,291	1,526	601	1,299	1,162	1,068	75	1,173	1,369	1,661	1,434	1,697	667	1,442	1,291	1,187
76	1,087	1,269	1,539	1,329	1,570	617	1,337	1,196	1,099	76	1,208	1,409	1,711	1,478	1,744	686	1,486	1,330	1,221
77	1,117	1,304	1,583	1,367	1,611	634	1,374	1,231	1,128	77	1,241	1,448	1,759	1,519	1,791	705	1,527	1,367	1,254
78	1,147	1,339	1,624	1,404	1,651	649	1,410	1,264	1,155	78	1,275	1,487	1,805	1,560	1,834	722	1,568	1,404	1,283
79	1,173	1,369	1,663	1,436	1,689	664	1,444	1,292	1,183	79	1,304	1,523	1,848	1,596	1,877	738	1,605	1,436	1,314
80	1,199	1,399	1,698	1,467	1,724	678	1,475	1,320	1,207	80	1,332	1,556	1,888	1,631	1,916	754	1,639	1,468	1,341
81	1,223	1,428	1,733	1,497	1,756	690	1,505	1,346	1,230	81	1,359	1,586	1,925	1,663	1,952	768	1,672	1,497	1,366
82	1,246	1,454	1,765	1,524	1,788	703	1,533	1,372	1,251	82	1,384	1,615	1,962	1,694	1,986	781	1,702	1,524	1,390
83	1,266	1,478	1,796	1,549	1,815	713	1,558	1,394	1,270	83	1,407	1,642	1,995	1,721	2,016	793	1,732	1,549	1,411
84	1,285	1,501	1,825	1,573	1,841	724	1,582	1,416	1,289	84	1,428	1,667	2,027	1,747	2,046	804	1,757	1,573	1,432
85	1,304	1,522	1,851	1,595	1,866	734	1,604	1,435	1,306	85	1,448	1,691	2,057	1,772	2,075	816	1,782	1,595	1,452
86	1,320	1,541	1,874	1,616	1,889	744	1,625	1,455	1,323	86	1,468	1,713	2,083	1,796	2,099	826	1,806	1,616	1,469
87	1,336	1,560	1,897	1,634	1,911	752	1,643	1,471	1,337	87	1,485	1,732	2,107	1,816	2,123	836	1,826	1,634	1,487
88	1,351	1,575	1,916	1,652	1,932	759	1,661	1,487	1,352	88	1,501	1,750	2,130	1,836	2,146	845	1,846	1,652	1,502
89	1,362	1,590	1,934	1,667	1,948	767	1,676	1,501	1,364	89	1,514	1,767	2,148	1,852	2,166	852	1,862	1,666	1,516
90	1,374	1,604	1,948	1,681	1,963	772	1,691	1,513	1,374	90	1,526	1,782	2,166	1,869	2,180	858	1,878	1,681	1,526
91	1,384	1,616	1,963	1,695	1,975	777	1,703	1,525	1,383	91	1,538	1,795	2,180	1,883	2,195	863	1,893	1,695	1,537
92	1,395	1,628	1,975	1,706	1,988	781	1,715	1,536	1,392	92	1,549	1,808	2,194	1,897	2,208	869	1,907	1,707	1,546
93	1,404	1,638	1,986	1,718	1,998	786	1,727	1,546	1,399	93	1,560	1,820	2,207	1,908	2,221	873	1,919	1,718	1,555
94	1,413	1,650	1,995	1,729	2,008	790	1,738	1,556	1,405	94	1,570	1,832	2,218	1,921	2,231	877	1,931	1,729	1,561
95	1,421	1,658	2,004	1,739	2,016	793	1,748	1,566	1,411	95	1,579	1,843	2,225	1,933	2,239	881	1,943	1,739	1,568
96	1,429	1,667	2,011	1,748	2,023	795	1,758	1,574	1,416	96	1,587	1,852	2,235	1,943	2,248	884	1,952	1,748	1,574
97	1,434	1,674	2,016	1,755	2,029	799	1,765	1,579	1,420	97	1,593	1,861	2,241	1,951	2,255	886	1,961	1,756	1,579
98	1,440	1,679	2,023	1,761	2,035	800	1,770	1,585	1,424	98	1,599	1,866	2,248	1,957	2,262	890	1,967	1,761	1,583
99+	1,443	1,683	2,025	1,765	2,039	802	1,774	1,589	1,428	99+	1,603	1,871	2,250	1,962	2,266	891	1,971	1,766	1,586

Modal Factors: Semi Annual: 0.5000 Quarterly: 0.25000 Monthly: Divide by 12

OREGON Standard Plans FEMALE Rates - ANNUAL
 FOR USE IN ZIP CODES: ALL EXCEPT 970-972

Attained Age	Non-Tobacco User									Attained Age	Tobacco User								
	Plan A	Plan B	Plan C	Plan D	Plan F	High Plan F	Plan G	Plan M	Plan N		Plan A	Plan B	Plan C	Plan D	Plan F	High Plan F	Plan G	Plan M	Plan N
Under 65	720	841	1,006	881	1,045	412	886	792	732	Under 65	799	933	1,118	978	1,162	457	984	881	814
65	720	841	1,006	881	1,045	412	886	792	732	65	799	933	1,118	978	1,162	457	984	881	814
66	720	841	1,006	881	1,045	412	886	792	732	66	799	933	1,118	978	1,162	457	984	881	814
67	754	881	1,054	923	1,093	430	929	830	765	67	839	979	1,172	1,027	1,213	478	1,032	924	850
68	789	921	1,101	965	1,136	447	971	868	796	68	876	1,023	1,224	1,073	1,262	496	1,078	965	884
69	822	960	1,148	1,006	1,181	465	1,012	906	827	69	913	1,067	1,277	1,119	1,312	516	1,125	1,006	919
70	856	999	1,197	1,048	1,229	483	1,053	943	860	70	952	1,111	1,330	1,164	1,365	537	1,170	1,048	955
71	889	1,038	1,246	1,088	1,277	502	1,093	979	894	71	988	1,153	1,384	1,209	1,420	559	1,215	1,088	995
72	921	1,075	1,296	1,128	1,328	523	1,134	1,014	930	72	1,024	1,195	1,439	1,253	1,476	581	1,259	1,128	1,033
73	954	1,113	1,346	1,167	1,379	542	1,173	1,051	965	73	1,060	1,236	1,495	1,296	1,533	603	1,304	1,167	1,073
74	985	1,150	1,394	1,206	1,425	561	1,212	1,085	998	74	1,095	1,278	1,548	1,341	1,584	623	1,347	1,206	1,109
75	1,017	1,187	1,439	1,243	1,470	579	1,251	1,119	1,029	75	1,130	1,319	1,601	1,382	1,635	642	1,390	1,243	1,144
76	1,047	1,222	1,483	1,281	1,513	595	1,288	1,153	1,059	76	1,164	1,357	1,648	1,424	1,680	661	1,431	1,281	1,176
77	1,076	1,256	1,525	1,317	1,552	611	1,324	1,186	1,087	77	1,196	1,395	1,695	1,464	1,725	679	1,471	1,317	1,208
78	1,105	1,290	1,565	1,352	1,590	626	1,359	1,217	1,113	78	1,228	1,433	1,739	1,503	1,767	695	1,510	1,352	1,236
79	1,130	1,319	1,602	1,383	1,627	640	1,391	1,245	1,140	79	1,256	1,467	1,781	1,537	1,808	711	1,546	1,383	1,266
80	1,155	1,348	1,636	1,413	1,661	653	1,421	1,272	1,163	80	1,283	1,499	1,819	1,571	1,845	726	1,579	1,414	1,292
81	1,179	1,376	1,669	1,442	1,692	665	1,450	1,297	1,185	81	1,309	1,528	1,855	1,602	1,881	739	1,611	1,443	1,316
82	1,200	1,401	1,701	1,469	1,722	677	1,477	1,322	1,205	82	1,334	1,556	1,890	1,632	1,913	752	1,640	1,469	1,339
83	1,220	1,424	1,730	1,492	1,748	687	1,501	1,343	1,224	83	1,356	1,582	1,922	1,658	1,943	764	1,668	1,492	1,360
84	1,238	1,446	1,758	1,515	1,774	698	1,524	1,364	1,242	84	1,376	1,606	1,953	1,683	1,971	775	1,693	1,515	1,379
85	1,256	1,466	1,783	1,537	1,798	707	1,545	1,383	1,258	85	1,395	1,629	1,982	1,707	1,999	786	1,717	1,537	1,399
86	1,272	1,484	1,805	1,557	1,820	717	1,566	1,401	1,274	86	1,414	1,650	2,007	1,730	2,022	796	1,740	1,557	1,416
87	1,287	1,503	1,827	1,574	1,841	724	1,583	1,417	1,288	87	1,431	1,668	2,030	1,750	2,045	805	1,759	1,574	1,432
88	1,301	1,518	1,846	1,592	1,861	732	1,601	1,433	1,303	88	1,446	1,686	2,052	1,769	2,067	814	1,778	1,592	1,447
89	1,312	1,532	1,863	1,606	1,877	739	1,615	1,446	1,314	89	1,458	1,702	2,070	1,784	2,086	821	1,794	1,605	1,461
90	1,323	1,545	1,877	1,620	1,891	743	1,629	1,458	1,324	90	1,470	1,717	2,086	1,800	2,101	826	1,809	1,620	1,470
91	1,334	1,557	1,891	1,633	1,903	749	1,641	1,469	1,332	91	1,482	1,729	2,100	1,814	2,115	832	1,823	1,633	1,480
92	1,344	1,568	1,903	1,644	1,915	753	1,653	1,480	1,341	92	1,492	1,742	2,113	1,827	2,127	837	1,837	1,645	1,489
93	1,352	1,578	1,913	1,655	1,925	758	1,664	1,489	1,348	93	1,503	1,754	2,126	1,838	2,139	841	1,849	1,655	1,498
94	1,361	1,589	1,922	1,666	1,935	761	1,675	1,499	1,354	94	1,513	1,765	2,137	1,851	2,150	845	1,860	1,666	1,504
95	1,369	1,597	1,931	1,676	1,942	764	1,684	1,509	1,360	95	1,522	1,775	2,144	1,862	2,157	848	1,872	1,676	1,510
96	1,377	1,606	1,938	1,684	1,949	766	1,694	1,516	1,364	96	1,529	1,785	2,153	1,872	2,165	852	1,881	1,684	1,516
97	1,382	1,613	1,943	1,691	1,954	769	1,701	1,522	1,368	97	1,535	1,793	2,159	1,879	2,173	854	1,889	1,691	1,521
98	1,387	1,618	1,949	1,697	1,961	771	1,706	1,527	1,372	98	1,541	1,798	2,165	1,885	2,179	857	1,895	1,696	1,525
99+	1,390	1,622	1,951	1,701	1,964	773	1,710	1,531	1,375	99+	1,544	1,803	2,168	1,890	2,183	859	1,899	1,702	1,528

Modal Factors: Semi Annual: 0.5000 Quarterly: 0.25000 Monthly: Divide by 12

PREMIUM INFORMATION

Sterling Investors Life Insurance Company may change your premium on any premium due date if a new table of rates is applicable to the policy. The change in the table of rates will apply to all covered persons in the same class. Class is defined as attained age, sex, underwriting class, state and zip code of residence.

Premiums are based on your attained age and will change on Your Policy Anniversary Date.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

This outline shows benefits and premiums of Policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I, and J are no longer available for sale.

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 Sterling Investors Life Insurance Company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your Policy, you may return it to: Sterling Investors Life Insurance Company, Medicare Supplement Administration, P.O. Box 10848, Clearwater, Florida 33757-8848. 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 Sterling Investors 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 *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. Sterling Investors Life Insurance 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.

Please refer to your Policy for details.

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
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days</p> <p>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</p>	<p>All but \$1100</p> <p>All but \$275 a day</p> <p>All but \$550 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>\$275 a day</p> <p>\$550 a day</p> <p>100% of Medicare eligible expenses</p> <p>\$0</p>	<p>\$1100 (Part A deductible)</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p>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</p> <p>First 20 days 21st thru 100th day 101st day and after</p>	<p>All approved amounts</p> <p>All but \$137.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$137.50 a day</p> <p>All costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p>HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.</p>	<p>All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care</p>	<p>Medicare copayment/coinsurance</p>	<p>\$0</p>

****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 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

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$155 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
MEDICAL EXPENSES – 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 \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$155 (Part B deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$155 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$155 (Part B deductible) \$0

PLAN B

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 61 st thru 90 th day 91 st 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 \$1100 All but \$275 a day All but \$550 a day \$0 \$0	\$1100 (Part A deductible) \$275 a day \$550 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$137.50 a day \$0	\$0 \$0 \$0	\$0 Up to \$137.50 a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE 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

****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 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 B

MEDICARE (PART B) – MEDICAL SERVICES-PER – CALENDAR YEAR

*Once you have been billed \$155 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
MEDICAL EXPENSES – 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 \$155 of Medicare Approved Amounts*	\$0	\$0	\$155 (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 \$155 of Medicare Approved Amounts*	\$0	\$0	\$155 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment First \$155 of Medicare Approved Amounts*	\$0	\$0	\$155 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$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 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 61 st thru 90 th day 91 st 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 \$1100 All but \$275 a day All but \$550 a day \$0 \$0	\$1100 (Part A deductible) \$275 a day \$550 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$137.50 a day \$0	\$0 Up to \$137.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE 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

****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 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

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$155 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
MEDICAL EXPENSES – 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 \$155 of Medicare Approved Amounts*	\$0	\$155 (Part B deductible)	\$0
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 \$155 of Medicare Approved Amounts*	\$0	\$155 (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment First \$155 of Medicare Approved Amounts*	\$0	\$155 (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 Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000.	\$250 20% and amounts over the \$50,000 lifetime maximum.
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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 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 61 st thru 90 th day 91 st 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 \$1100 All but \$275 a day All but \$550 a day \$0 \$0	\$1100 (Part A deductible) \$275 a day \$550 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$137.50 a day \$0	\$0 Up to \$137.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE 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

****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 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

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$155 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
MEDICAL EXPENSES – 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 \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$0 Generally 20%	 \$155 (Part B deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$155 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

**PLAN D
PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment			
First \$155 of Medicare Approved Amounts*	\$0	\$0	\$155 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st 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 \$1100 All but \$275 a day All but \$550 a day \$0 \$0	\$1100 (Part A deductible) \$275 a day \$550 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$137.50 a day \$0	\$0 Up to \$137.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE 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

****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 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

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$155 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
MEDICAL EXPENSES – 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 \$155 of Medicare Approved Amounts*	\$0	\$155 (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 \$155 of Medicare Approved amounts*	\$0	\$155 (Part B deductible)	\$0
Remainder of Medicare Approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN F
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment First \$155 of Medicare Approved Amounts*	\$0	\$155 (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER SERVICES – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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

**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 for 60 days in a row.

**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2000 deductible. Benefits from the high deductible plan F will not begin until the out-of-pocket expenses are \$2000. 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 \$2000 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2000 DEDUCTIBLE** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st 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 \$1100 All but \$275 a day All but \$550 a day \$0 \$0	\$1100 (Part A deductible) \$275 a day \$550 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$137.50 a day \$0	\$0 Up to \$137.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE 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

*****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 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

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$155 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 \$2000 deductible. Benefits from the high deductible plan F will not begin until the out-of-pocket expenses are \$2000. 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 \$2000 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2000 DEDUCTIBLE** YOU PAY
MEDICAL EXPENSES – 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 \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$155 (Part B deductible) Generally 20%	\$0 \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$155 of Medicare Approved amounts* Remainder of Medicare Approved amounts	\$0 \$0 80%	All costs \$155 (Part B deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2000 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2000 DEDUCTIBLE** YOU PAY
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment			
First \$155 of Medicare Approved Amounts*	\$0	\$155 (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER SERVICES – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2000 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2000 DEDUCTIBLE** YOU PAY
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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st 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 \$1100 All but \$275 a day All but \$550 a day \$0 \$0	\$1100 (Part A deductible) \$275 a day \$550 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$137.50 a day \$0	\$0 Up to \$137.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE 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

****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 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

MEDICARE (PART B) – MEDICAL SERVICES-PER – CALENDAR YEAR

*Once you have been billed \$155 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
MEDICAL EXPENSES – 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 \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$155 (Part B deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$155 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

**PLAN G
PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment			
First \$155 of Medicare Approved Amounts*	\$0	\$0	\$155 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 M

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 \$1100	\$550 (50% of Part A deductible)	\$550 (50% of Part A deductible)
61 st thru 90 th day 91 st day and after:	All but \$275 a day	\$275 a day	\$0
— While using 60 lifetime reserve days — Once lifetime reserve days are used:	All but \$550 a day	\$550 a day	\$0
— 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
21 st thru 100 th day	All but \$137.50 a day	Up to \$137.50 a day	\$0
101 st 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 co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/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 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 M

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$155 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
MEDICAL EXPENSES – 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 \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$0 Generally 20%	 \$155 (Part B deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 \$0 80%	 All costs \$0 20%	 \$0 \$155 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN M
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment			
First \$155 of Medicare Approved Amounts*	\$0	\$0	\$155 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 61 st thru 90 th day 91 st 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 \$1100 All but \$275 a day All but \$550 a day \$0 \$0	\$1100 (Part A deductible) \$275 a day \$550 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$137.50 a day \$0	\$0 Up to \$137.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE 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

****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 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

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$155 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
MEDICAL EXPENSES – 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 \$155 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 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.	\$155 (Part B deductible) Up to \$20 per office visit and up to \$50 per emergency 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.
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$155 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

**PLAN N
PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment			
First \$155 of Medicare Approved Amounts*	\$0	\$0	\$155 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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.