

CIGNA HEALTH AND LIFE INSURANCE COMPANY

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Outline of Medicare Supplement Coverage - Benefit Plans A, F, High-Deductible F, G, and N CHLIC-MS-IA-A-ID, CHLIC-MS-IA-F-ID, CHLIC-MS-IA-HDF-ID, CHLIC-MS-IA-G-ID, CHLIC-MS-IA-N-ID

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.

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	HDF*	G	K	L	M	N
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 co-payment for office visit and up to \$50 copayment for ER visit			
		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 \$5,120; paid at 100% after reached	Out-of-pocket limit \$2,560; paid at 100% after 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 \$2,200 deductible. Benefits from high-deductible Plan F will not begin until out-of-pocket expenses exceed \$2,200. 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.

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Cigna Health and Life Insurance Company

MEDICARE SUPPLEMENT

Idaho

Issue Age Rates -- Effective 7/10/2017 -- Area I (832-838) -- Age 65+

Issue Age Rates -- Effective 1/1/2018 -- Area I (832-838) -- Under Age 65

PREFERRED ANNUAL & MONTHLY BANK DRAFT RATES

FEMALE RATES										Issue Age	MALE RATES											
Plan A		Plan F		Plan HDF		Plan G		Plan N			Annual	Monthly	Plan A		Plan F		Plan HDF		Plan G		Plan N	
Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly				Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly
2,198.16	183.11	2,640.45	219.95	800.14	66.65	2,226.11	185.43	1,861.88	155.09	65	2,198.16	183.11	2,640.45	219.95	800.14	66.65	2,226.11	185.43	1,861.88	155.09	65	
1,465.44	122.07	1,760.30	146.63	533.43	44.43	1,484.07	123.62	1,241.25	103.40	66	1,465.44	122.07	1,760.30	146.63	533.43	44.43	1,484.07	123.62	1,241.25	103.40	66	
1,480.24	123.30	1,778.07	148.11	538.81	44.88	1,499.07	124.87	1,253.79	104.44	67	1,480.24	123.30	1,778.07	148.11	538.81	44.88	1,499.07	124.87	1,253.79	104.44	67	
1,495.19	124.55	1,795.20	149.54	544.00	45.31	1,513.49	126.07	1,265.86	105.45	68	1,495.19	124.55	1,795.20	149.54	544.00	45.31	1,513.49	126.07	1,265.86	105.45	68	
1,510.29	125.81	1,811.84	150.93	549.04	45.73	1,527.52	127.24	1,277.59	106.42	69	1,510.29	125.81	1,811.84	150.93	549.04	45.73	1,527.52	127.24	1,277.59	106.42	69	
1,525.55	127.08	1,843.62	153.57	558.67	46.54	1,554.68	129.50	1,301.07	108.38	70	1,525.55	127.08	1,843.62	153.57	558.67	46.54	1,554.68	129.50	1,301.07	108.38	70	
1,557.61	129.75	1,882.58	156.82	570.48	47.52	1,579.73	131.59	1,320.31	109.98	71	1,557.61	129.75	1,882.58	156.82	570.48	47.52	1,579.73	131.59	1,320.31	109.98	71	
1,591.72	132.59	1,923.79	160.25	582.97	48.56	1,614.86	134.52	1,351.92	112.62	72	1,591.72	132.59	1,923.79	160.25	582.97	48.56	1,614.86	134.52	1,351.92	112.62	72	
1,625.91	135.44	1,965.09	163.69	595.48	49.60	1,650.05	137.45	1,381.32	115.06	73	1,625.91	135.44	1,965.09	163.69	595.48	49.60	1,650.05	137.45	1,381.32	115.06	73	
1,661.76	138.42	2,008.42	167.30	608.61	50.70	1,686.90	140.52	1,412.14	117.63	74	1,661.76	138.42	2,008.42	167.30	608.61	50.70	1,686.90	140.52	1,412.14	117.63	74	
1,699.22	141.55	2,053.68	171.07	622.32	51.84	1,725.38	143.72	1,444.32	120.31	75	1,699.22	141.55	2,053.68	171.07	622.32	51.84	1,725.38	143.72	1,444.32	120.31	75	
1,744.24	145.29	2,108.02	175.60	638.79	53.21	1,773.19	147.71	1,475.68	122.92	76	1,744.24	145.29	2,108.02	175.60	638.79	53.21	1,773.19	147.71	1,475.68	122.92	76	
1,789.80	149.09	2,162.97	180.18	655.44	54.60	1,823.82	151.92	1,508.55	125.66	77	1,789.80	149.09	2,162.97	180.18	655.44	54.60	1,823.82	151.92	1,508.55	125.66	77	
1,828.26	152.29	2,218.42	184.79	672.25	56.00	1,868.87	155.68	1,560.36	129.98	78	1,828.26	152.29	2,218.42	184.79	672.25	56.00	1,868.87	155.68	1,560.36	129.98	78	
1,860.34	154.97	2,271.20	189.19	688.24	57.33	1,905.95	158.77	1,607.73	133.92	79	1,860.34	154.97	2,271.20	189.19	688.24	57.33	1,905.95	158.77	1,607.73	133.92	79	
1,869.64	155.74	2,327.29	193.86	705.24	58.75	1,941.39	161.72	1,654.86	137.85	80	1,869.64	155.74	2,327.29	193.86	705.24	58.75	1,941.39	161.72	1,654.86	137.85	80	
1,878.99	156.52	2,384.18	198.60	722.48	60.18	1,981.98	165.10	1,702.29	141.80	81	1,878.99	156.52	2,384.18	198.60	722.48	60.18	1,981.98	165.10	1,702.29	141.80	81	
1,888.38	157.30	2,402.57	200.13	728.05	60.65	2,019.31	168.21	1,727.96	143.94	82	1,888.38	157.30	2,402.57	200.13	728.05	60.65	2,019.31	168.21	1,727.96	143.94	82	
1,897.83	158.09	2,421.04	201.67	733.64	61.11	2,022.01	168.43	1,734.82	144.51	83	1,897.83	158.09	2,421.04	201.67	733.64	61.11	2,022.01	168.43	1,734.82	144.51	83	
1,907.32	158.88	2,431.92	202.58	736.95	61.39	2,022.93	168.51	1,758.21	146.46	84	1,907.32	158.88	2,431.92	202.58	736.95	61.39	2,022.93	168.51	1,758.21	146.46	84	
1,916.86	159.67	2,442.50	203.46	740.15	61.65	2,028.57	168.98	1,767.43	147.23	85	1,916.86	159.67	2,442.50	203.46	740.15	61.65	2,028.57	168.98	1,767.43	147.23	85	
1,928.39	160.64	2,450.99	204.17	742.73	61.87	2,035.90	169.59	1,768.35	147.30	86	1,928.39	160.64	2,450.99	204.17	742.73	61.87	2,035.90	169.59	1,768.35	147.30	86	
1,938.61	161.49	2,463.88	205.24	746.64	62.19	2,049.56	170.73	1,781.69	148.41	87	1,938.61	161.49	2,463.88	205.24	746.64	62.19	2,049.56	170.73	1,781.69	148.41	87	
1,949.67	162.41	2,477.86	206.41	750.87	62.55	2,064.12	171.94	1,796.63	149.66	88	1,949.67	162.41	2,477.86	206.41	750.87	62.55	2,064.12	171.94	1,796.63	149.66	88	
1,960.14	163.28	2,491.08	207.51	754.88	62.88	2,078.04	173.10	1,810.93	150.85	89	1,960.14	163.28	2,491.08	207.51	754.88	62.88	2,078.04	173.10	1,810.93	150.85	89	
1,972.88	164.34	2,507.18	208.85	759.75	63.29	2,094.35	174.46	1,827.22	152.21	90	1,972.88	164.34	2,507.18	208.85	759.75	63.29	2,094.35	174.46	1,827.22	152.21	90	
1,987.93	165.59	2,526.22	210.43	765.52	63.77	2,113.10	176.02	1,845.58	153.74	91	1,987.93	165.59	2,526.22	210.43	765.52	63.77	2,113.10	176.02	1,845.58	153.74	91	
2,002.15	166.78	2,544.24	211.94	770.98	64.22	2,130.22	177.45	1,863.44	155.22	92	2,002.15	166.78	2,544.24	211.94	770.98	64.22	2,130.22	177.45	1,863.44	155.22	92	
2,016.01	167.93	2,561.79	213.40	776.30	64.67	2,146.97	178.84	1,880.85	156.67	93	2,016.01	167.93	2,561.79	213.40	776.30	64.67	2,146.97	178.84	1,880.85	156.67	93	
2,035.47	169.55	2,586.47	215.45	783.78	65.29	2,169.71	180.74	1,903.41	158.55	94	2,035.47	169.55	2,586.47	215.45	783.78	65.29	2,169.71	180.74	1,903.41	158.55	94	
2,054.56	171.15	2,610.67	217.47	791.11	65.90	2,192.07	182.60	1,925.54	160.40	95	2,054.56	171.15	2,610.67	217.47	791.11	65.90	2,192.07	182.60	1,925.54	160.40	95	
2,073.25	172.70	2,634.34	219.44	798.28	66.50	2,214.04	184.43	1,947.23	162.20	96	2,073.25	172.70	2,634.34	219.44	798.28	66.50	2,214.04	184.43	1,947.23	162.20	96	
2,073.25	172.70	2,634.34	219.44	798.28	66.50	2,214.04	184.43	1,947.23	162.20	97	2,073.25	172.70	2,634.34	219.44	798.28	66.50	2,214.04	184.43	1,947.23	162.20	97	
2,073.25	172.70	2,634.34	219.44	798.28	66.50	2,214.04	184.43	1,947.23	162.20	98	2,073.25	172.70	2,634.34	219.44	798.28	66.50	2,214.04	184.43	1,947.23	162.20	98	
2,073.25	172.70	2,634.34	219.44	798.28	66.50	2,214.04	184.43	1,947.23	162.20	99	2,073.25	172.70	2,634.34	219.44	798.28	66.50	2,214.04	184.43	1,947.23	162.20	99	

Policies may be issued on an annual, semi-annual, quarterly or monthly mode.
To obtain semi-annual premiums, multiply the above-quoted annual premium by 0.52. To obtain quarterly premiums, multiply the above quoted premium by 0.265.

Applicants sold on or before 12/31/2017 who qualify for Household Discount multiply above rates by 0.93.

Cigna Health and Life Insurance Company

MEDICARE SUPPLEMENT

Idaho

Issue Age Rates -- Effective 7/10/2017 -- Area I (832-838) -- Age 65+

Issue Age Rates -- Effective 1/1/2018 -- Area I (832-838) -- Under Age 65

STANDARD ANNUAL & MONTHLY BANK DRAFT RATES

FEMALE RATES										Issue Age	MALE RATES									
Plan A		Plan F		Plan HDF		Plan G		Plan N			Plan A		Plan F		Plan HDF		Plan G		Plan N	
Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly		Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly
2,417.97	201.42	2,904.49	241.94	880.15	73.32	2,448.73	203.98	2,048.07	170.60	65	2,417.97	201.42	2,904.49	241.94	880.15	73.32	2,448.73	203.98	2,048.07	170.60
1,611.98	134.28	1,936.32	161.30	586.77	48.88	1,632.48	135.99	1,365.38	113.74	66	1,611.98	134.28	1,936.32	161.30	586.77	48.88	1,632.48	135.99	1,365.38	113.74
1,628.26	135.63	1,955.88	162.93	592.69	49.37	1,648.97	137.36	1,379.17	114.89	67	1,628.26	135.63	1,955.88	162.93	592.69	49.37	1,648.97	137.36	1,379.17	114.89
1,644.71	137.00	1,974.72	164.49	598.40	49.85	1,664.84	138.68	1,392.45	115.99	68	1,644.71	137.00	1,974.72	164.49	598.40	49.85	1,664.84	138.68	1,392.45	115.99
1,661.33	138.39	1,993.02	166.02	603.94	50.31	1,680.28	139.97	1,405.36	117.07	69	1,661.33	138.39	1,993.02	166.02	603.94	50.31	1,680.28	139.97	1,405.36	117.07
1,678.11	139.79	2,027.97	168.93	614.54	51.19	1,710.15	142.46	1,431.19	119.22	70	1,678.11	139.79	2,027.97	168.93	614.54	51.19	1,710.15	142.46	1,431.19	119.22
1,713.37	142.72	2,070.84	172.50	627.52	52.27	1,737.71	144.75	1,452.34	120.98	71	1,713.37	142.72	2,070.84	172.50	627.52	52.27	1,737.71	144.75	1,452.34	120.98
1,750.89	145.85	2,116.17	176.28	641.27	53.42	1,776.35	147.97	1,487.11	123.88	72	1,750.89	145.85	2,116.17	176.28	641.27	53.42	1,776.35	147.97	1,487.11	123.88
1,788.50	148.98	2,161.60	180.06	655.03	54.56	1,815.05	151.19	1,519.44	126.57	73	1,788.50	148.98	2,161.60	180.06	655.03	54.56	1,815.05	151.19	1,519.44	126.57
1,827.94	152.27	2,209.26	184.03	669.47	55.77	1,855.59	154.57	1,553.36	129.39	74	1,827.94	152.27	2,209.26	184.03	669.47	55.77	1,855.59	154.57	1,553.36	129.39
1,869.15	155.70	2,259.04	188.18	684.56	57.02	1,897.92	158.10	1,588.76	132.34	75	1,869.15	155.70	2,259.04	188.18	684.56	57.02	1,897.92	158.10	1,588.76	132.34
1,918.66	159.82	2,318.82	193.16	702.68	58.53	1,950.51	162.48	1,623.25	135.22	76	1,918.66	159.82	2,318.82	193.16	702.68	58.53	1,950.51	162.48	1,623.25	135.22
1,968.77	164.00	2,379.26	198.19	720.99	60.06	2,006.20	167.12	1,659.40	138.23	77	1,968.77	164.00	2,379.26	198.19	720.99	60.06	2,006.20	167.12	1,659.40	138.23
2,011.08	167.52	2,440.27	203.27	739.48	61.60	2,055.76	171.24	1,716.40	142.98	78	2,011.08	167.52	2,440.27	203.27	739.48	61.60	2,055.76	171.24	1,716.40	142.98
2,046.37	170.46	2,498.32	208.11	757.07	63.06	2,096.54	174.64	1,768.50	147.32	79	2,046.37	170.46	2,498.32	208.11	757.07	63.06	2,096.54	174.64	1,768.50	147.32
2,056.60	171.32	2,560.02	213.25	775.76	64.62	2,135.53	177.89	1,820.34	151.63	80	2,056.60	171.32	2,560.02	213.25	775.76	64.62	2,135.53	177.89	1,820.34	151.63
2,066.89	172.17	2,622.60	218.46	794.72	66.20	2,180.19	181.61	1,872.51	155.98	81	2,066.89	172.17	2,622.60	218.46	794.72	66.20	2,180.19	181.61	1,872.51	155.98
2,077.22	173.03	2,642.83	220.15	800.86	66.71	2,221.24	185.03	1,900.76	158.33	82	2,077.22	173.03	2,642.83	220.15	800.86	66.71	2,221.24	185.03	1,900.76	158.33
2,087.61	173.90	2,663.14	221.84	807.01	67.22	2,224.21	185.28	1,908.30	158.96	83	2,087.61	173.90	2,663.14	221.84	807.01	67.22	2,224.21	185.28	1,908.30	158.96
2,098.05	174.77	2,675.11	222.84	810.64	67.53	2,225.22	185.36	1,934.03	161.10	84	2,098.05	174.77	2,675.11	222.84	810.64	67.53	2,225.22	185.36	1,934.03	161.10
2,108.54	175.64	2,686.75	223.81	814.16	67.82	2,231.43	185.88	1,944.17	161.95	85	2,108.54	175.64	2,686.75	223.81	814.16	67.82	2,231.43	185.88	1,944.17	161.95
2,121.23	176.70	2,696.09	224.58	817.00	68.06	2,239.48	186.55	1,945.18	162.03	86	2,121.23	176.70	2,696.09	224.58	817.00	68.06	2,239.48	186.55	1,945.18	162.03
2,132.47	177.63	2,710.27	225.77	821.29	68.41	2,254.52	187.80	1,959.86	163.26	87	2,132.47	177.63	2,710.27	225.77	821.29	68.41	2,254.52	187.80	1,959.86	163.26
2,144.64	178.65	2,725.65	227.05	825.96	68.80	2,270.53	189.14	1,976.30	164.63	88	2,144.64	178.65	2,725.65	227.05	825.96	68.80	2,270.53	189.14	1,976.30	164.63
2,156.16	179.61	2,740.19	228.26	830.36	69.17	2,285.84	190.41	1,992.02	165.94	89	2,156.16	179.61	2,740.19	228.26	830.36	69.17	2,285.84	190.41	1,992.02	165.94
2,170.17	180.78	2,757.90	229.73	835.73	69.62	2,303.78	191.90	2,009.95	167.43	90	2,170.17	180.78	2,757.90	229.73	835.73	69.62	2,303.78	191.90	2,009.95	167.43
2,186.72	182.15	2,778.84	231.48	842.08	70.14	2,324.42	193.62	2,030.14	169.11	91	2,186.72	182.15	2,778.84	231.48	842.08	70.14	2,324.42	193.62	2,030.14	169.11
2,202.37	183.46	2,798.67	233.13	848.08	70.65	2,343.25	195.19	2,049.79	170.75	92	2,202.37	183.46	2,798.67	233.13	848.08	70.65	2,343.25	195.19	2,049.79	170.75
2,217.60	184.73	2,817.96	234.74	853.93	71.13	2,361.66	196.73	2,068.93	172.34	93	2,217.60	184.73	2,817.96	234.74	853.93	71.13	2,361.66	196.73	2,068.93	172.34
2,239.02	186.51	2,845.12	237.00	862.16	71.82	2,386.68	198.81	2,093.75	174.41	94	2,239.02	186.51	2,845.12	237.00	862.16	71.82	2,386.68	198.81	2,093.75	174.41
2,260.02	188.26	2,871.73	239.22	870.22	72.49	2,411.28	200.86	2,118.10	176.44	95	2,260.02	188.26	2,871.73	239.22	870.22	72.49	2,411.28	200.86	2,118.10	176.44
2,280.57	189.97	2,897.78	241.39	878.11	73.15	2,435.43	202.87	2,141.94	178.42	96	2,280.57	189.97	2,897.78	241.39	878.11	73.15	2,435.43	202.87	2,141.94	178.42
2,280.57	189.97	2,897.78	241.39	878.11	73.15	2,435.43	202.87	2,141.94	178.42	97	2,280.57	189.97	2,897.78	241.39	878.11	73.15	2,435.43	202.87	2,141.94	178.42
2,280.57	189.97	2,897.78	241.39	878.11	73.15	2,435.43	202.87	2,141.94	178.42	98	2,280.57	189.97	2,897.78	241.39	878.11	73.15	2,435.43	202.87	2,141.94	178.42
2,280.57	189.97	2,897.78	241.39	878.11	73.15	2,435.43	202.87	2,141.94	178.42	99	2,280.57	189.97	2,897.78	241.39	878.11	73.15	2,435.43	202.87	2,141.94	178.42

Policies may be issued on an annual, semi-annual, quarterly or monthly mode.

To obtain semi-annual premiums, multiply the above-quoted annual premium by 0.52. To obtain quarterly premiums, multiply the above quoted premium by 0.265.

Applicants sold on or before 12/31/2017 who qualify for Household Discount multiply above rates by 0.93.

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Locate appropriate Area according to the Applicant's ZIP Code in the ZIP Code chart below.

IDAHO ZIP CODES:

<u>Area</u>	<u>3-digit ZIP Codes</u>
Area I	832-838

PREMIUM INFORMATION

We, Cigna Health and Life Insurance Company, can raise Your premium if (a) We change the rates or discounts which apply to all policies of this form issued by Us and in force in the state where Your policy was issued; or (b) coverage under Medicare changes. We will send You a written notice at least thirty (30) days in advance when We change the premium rates or discounts for all policies of this form issued by Us and in force in the state where Your policy was issued.

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 Cigna Health and Life Insurance Company.

30-DAY RIGHT TO RETURN POLICY

If You find that You are not satisfied with Your policy, You may return it to Cigna Health and Life Insurance Company, PO Box 26580, Austin, TX 78755-0580. 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 premiums.

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 Cigna Health and 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. We 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.

RENEWABILITY

The policy is guaranteed renewable for life.

HOUSEHOLD DISCOUNT

Affiliate means an insurance company that is under common ownership or control with Cigna Health and Life Insurance Company and that is a member of the same insurance holding company system.

Household Discount is a discount that is available when more than one member of Your household is actively enrolled in a Medicare Supplement policy provided by or through an Affiliate of Cigna Health and Life Insurance Company. Household is defined as a condominium unit, a single-family home, or an apartment unit within an apartment complex. Assisted Living facilities, Group Homes, Adult Day Care facilities and Nursing Homes, or any other health residential facility are not included in the definition of "Household."

The household premium discount will be removed if the other Medicare Supplement policyholder whose policy status entitles You to the discount no longer resides with You or no longer has a Medicare Supplement policy through Cigna Health and Life Insurance Company or an Affiliate of Cigna Health and Life Insurance Company. However, if that person becomes deceased, Your discount will still apply. The addition or removal of the discount will occur on the billing cycle following the date We learn Your eligibility has changed.

EXCLUSIONS AND LIMITATIONS

The benefits of this policy will not duplicate any benefits paid by Medicare. The combined benefits of this policy and the benefits paid by Medicare may not exceed one hundred percent (100%) of the Medicare eligible expenses incurred. This policy will not pay benefits for the following:

1. any expense which You are not legally obligated to pay or services for which no charge is normally made in the absence of insurance;
2. any services that are not medically necessary as determined by Medicare;
3. any portion of any expense for which payment is made by Medicare or other government programs (except Medicaid) or for which payment would have been made by Medicare if You were enrolled in Parts A and B of Medicare;
4. any type of expense not a Medicare eligible expense except as provided previously in this policy;
5. Any deductible, coinsurance, or copayment not covered by Medicare unless such coverage is listed as a benefit in this policy; or
6. Pre-Existing Conditions: We will not pay for any expenses incurred for care or treatment of a Pre-Existing Condition for the first six (6) months from the effective date of coverage. This exclusion does not apply if You applied for and were issued this policy under guaranteed issue status; if, on the date of application for this policy, You had at least six (6) months of prior Creditable Coverage; or if this policy is replacing another Medicare Supplement policy and a six (6) month waiting period has already been satisfied. Evidence of prior coverage or replacement must have been disclosed on the application for this policy.

If You had less than six (6) months prior Creditable Coverage, the Pre-Existing Conditions limitation will be reduced by the aggregate amount of Creditable Coverage. If this policy is replacing another Medicare Supplement policy, credit will be given for any portion of the waiting period that has been satisfied.

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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 A PAYS	YOU PAY
HOSPITALIZATION* Semi-private 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 \$1,316 All but \$329 per day All but \$658 per day \$0 \$0	\$0 \$329 per day \$658 per day 100% of Medicare eligible expenses \$0	\$1,316 (Part A deductible) \$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 entering 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 \$164.50 per day \$0	\$0 \$0 \$0	\$0 Up to \$164.50 per 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 copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

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

PLAN A

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

*Once You have been billed \$183 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 A 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 \$183 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$183 (Part B deductible) \$0
PART B EXCESS CHARGES (above Medicare-approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$183 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$183 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES Tests for diagnostic services	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically-necessary skilled care services and medical supplies – Durable medical equipment First \$183 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$183 (Part B deductible) \$0

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 F PAYS	YOU PAY
HOSPITALIZATION* Semi-private 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 \$1,316 All but \$329 per day All but \$658 per day \$0 \$0	\$1,316 (Part A deductible) \$329 per day \$658 per 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 entering 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 \$164.50 per day \$0	\$0 Up to \$164.50 per 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 copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

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

PLAN F

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

*Once You have been billed \$183 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 F 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 \$183 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$183 (Part B deductible) Generally 20%	\$0 \$0
PART B EXCESS CHARGES (above Medicare-approved amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$183 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$183 (Part B deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES Tests for diagnostic services	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically-necessary skilled care services and medical supplies – Durable medical equipment First \$183 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$183 (Part B deductible) 20%	\$0 \$0 \$0

PLAN F
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR (CONT'D.)

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN F 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 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

**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 \$2,200 deductible. Benefits from the high-deductible Plan F will not begin until out-of-pocket expenses are \$2,200. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductible for Part A and Part B, but does not include the plan’s separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,200 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO \$2,200 DEDUCTIBLE**, YOU PAY
HOSPITALIZATION* Semi-private 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 \$1,316 All but \$329 per day All but \$658 per day \$0 \$0	\$1,316 (Part A deductible) \$329 per day \$658 per 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 entering 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 \$164.50 per day \$0	\$0 Up to \$164.50 per 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 copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

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

**HIGH-Deductible PLAN F
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

*Once You have been billed \$183 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 \$2,200 deductible. Benefits from the high-deductible Plan F will not begin until out-of-pocket expenses are \$2,200. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductible for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,200 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO \$2,200 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 \$183 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$183 (Part B deductible) Generally 20%	\$0 \$0
PART B EXCESS CHARGES (above Medicare-approved amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$183 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$183 (Part B deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES Tests for diagnostic services	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,200 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO \$2,200 DEDUCTIBLE**, YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically-necessary skilled care services and medical supplies – Durable medical equipment First \$183 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$183 (Part B deductible) 20%	\$0 \$0 \$0

**HIGH-DEDUCTIBLE PLAN F
 MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR (CONT'D.)**

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,200 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO \$2,200 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 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

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 G PAYS	YOU PAY
HOSPITALIZATION* Semi-private 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 \$1,316 All but \$329 per day All but \$658 per day \$0 \$0	\$1,316 (Part A deductible) \$329 per day \$658 per 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 entering 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 \$164.50 per day \$0	\$0 Up to \$164.50 per 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 copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

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

PLAN G

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

*Once You have been billed \$183 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 G 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 \$183 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$183 (Part B deductible) \$0
PART B EXCESS CHARGES (above Medicare-approved amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$183 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$183 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES Tests for diagnostic services	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically-necessary skilled care services and medical supplies – Durable medical equipment First \$183 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$183 (Part B deductible) \$0

PLAN G
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR (CONT'D.)
OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN G 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 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

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 N PAYS	YOU PAY
HOSPITALIZATION* Semi-private 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 \$1,316 All but \$329 per day All but \$658 per day \$0 \$0	\$1,316 (Part A deductible) \$329 per day \$658 per 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 entering 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 \$164.50 per day \$0	\$0 Up to \$164.50 per 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 copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

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

PLAN N

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

*Once You have been billed \$183 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 N 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 \$183 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 room visit. The copayment of up to \$50 is waived if the Insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	\$183 (Part B deductible) Up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the Insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
PART B EXCESS CHARGES (above Medicare-approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$183 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$183 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES Tests for diagnostic services	100%	\$0	\$0

PLAN N
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR (CONT'D.)

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically-necessary skilled care services and medical supplies – Durable medical equipment	100%	\$0	\$0
First \$183 of Medicare-approved amounts*	\$0	\$0	\$183 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN N 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