PEKIN LIFE INSURANCE COMPANY
2505 COURT STREET PEKIN, ILLINOIS 61558
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Outline of Medicare Supplement Coverage
Benefit Plans A, F, G, and N

This chart shows the benefits included in each of the standard Medicare Supplement plans. Every company must make Plan "A" available. Plans shown in shaded boxes are plans currently available from Pekin Life Insurance Company.

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 insured to pay a portion of the Part B coinsurance or copayments.
- Blood – First three pints each year.
- Hospice – Part A coinsurance.

A	B	C	D	F	F*	G
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
		Skilled nursing facility coinsurance	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
		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

K	L	M	N
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 Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
50% Skilled nursing facility coinsurance	75% Skilled nursing facility coinsurance	Skilled nursing facility coinsurance	Skilled nursing facility coinsurance
50% Part A deductible	75% Part A deductible	50% Part A deductible	Part A deductible
		Foreign travel emergency	Foreign travel emergency
Out-of-pocket limit $5,120; paid at 100% after limit reached	Out-of-pocket limit $2,560; 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 $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.

PREMIUM INFORMATION
2017 ANNUAL PREMIUMS
EFFECTIVE APRIL 15, 2017

	Plan A		Plan F		Plan G		Plan N	
Attained Age	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**
Under 65	4,302	4,950	5,097	5,862	3,924	4,515	3,219	3,705
65	1,434	1,650	1,699	1,954	1,308	1,505	1,073	1,235
66	1,434	1,650	1,699	1,954	1,308	1,505	1,073	1,235
67	1,434	1,650	1,699	1,954	1,308	1,505	1,073	1,235
68	1,496	1,721	1,766	2,030	1,366	1,571	1,121	1,289
69	1,555	1,789	1,835	2,110	1,426	1,640	1,167	1,342
70	1,613	1,856	1,899	2,184	1,481	1,703	1,211	1,393
71	1,663	1,912	1,961	2,255	1,534	1,765	1,256	1,444
72	1,710	1,967	2,023	2,327	1,588	1,826	1,300	1,495
73	1,759	2,022	2,086	2,399	1,641	1,887	1,344	1,546
74	1,806	2,078	2,148	2,469	1,695	1,949	1,388	1,597
75	1,857	2,136	2,211	2,544	1,750	2,012	1,434	1,649
76	1,900	2,185	2,280	2,621	1,806	2,077	1,482	1,705
77	1,944	2,236	2,346	2,699	1,863	2,142	1,532	1,761
78	1,990	2,287	2,418	2,780	1,920	2,208	1,581	1,819
79	2,035	2,340	2,490	2,864	1,979	2,276	1,633	1,877
80	2,080	2,391	2,564	2,949	2,039	2,344	1,684	1,936
81	2,119	2,438	2,642	3,038	2,099	2,413	1,739	1,999
82	2,158	2,483	2,720	3,128	2,160	2,484	1,793	2,062
83	2,198	2,528	2,804	3,223	2,222	2,555	1,850	2,127
84	2,240	2,575	2,888	3,321	2,285	2,628	1,907	2,193
85	2,281	2,622	2,974	3,420	2,349	2,701	1,964	2,259
86	2,312	2,659	3,063	3,523	2,403	2,763	2,014	2,315
87	2,345	2,698	3,155	3,628	2,457	2,826	2,063	2,372
88	2,379	2,735	3,250	3,737	2,512	2,889	2,114	2,430
89	2,412	2,774	3,342	3,843	2,568	2,954	2,164	2,490
90	2,446	2,813	3,434	3,950	2,625	3,019	2,217	2,549
91	2,474	2,845	3,510	4,036	2,677	3,078	2,264	2,604
92	2,501	2,875	3,587	4,124	2,729	3,138	2,312	2,659
93	2,528	2,907	3,658	4,206	2,782	3,199	2,362	2,716
94	2,556	2,940	3,729	4,288	2,835	3,260	2,411	2,773
95	2,584	2,971	3,803	4,374	2,889	3,323	2,462	2,831
96	2,610	3,002	3,879	4,460	2,918	3,356	2,486	2,859
97	2,636	3,031	3,956	4,550	2,948	3,390	2,511	2,888
98	2,661	3,062	4,036	4,640	2,977	3,424	2,536	2,917
99+	2,689	3,092	4,116	4,734	3,007	3,458	2,562	2,946

Add a One-Time Policy Fee of $25
Tobacco User Surcharge = 15%

Important Note: Pekin Life Insurance Company can only raise your premium if we raise the premium for all policies like yours in this state.

PREMIUM INFORMATION (continued)

Area Factors

Zip Codes	Area Factor
700-704; 707-708	1.09
705-706; 709-714	0.92

Modal Factors

Annual	1 x Annual Premium
Semi-Annual	0.5 x Annual Premium
Quarterly	0.25 x Annual Premium
Monthly EFT	0.08333 x Annual Premium

Rate Calculation

Your premium rate will be calculated as: Annual Premium X Area Factor X Modal Factor X Tobacco User Surcharge (if applicable).

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to Pekin Life Insurance Company at 2505 Court Street, Pekin, Illinois 61558. If you send the policy back to us within 30 days after you received 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 Pekin 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 & 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. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

PLAN A
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD*

* A **benefit period** begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,316	$0	$1,316 (Part A Deductible)
61st through 90th day	All but $329 a day	$329 a day	$0
91st day and after:			
While using 60 lifetime reserve days:	All but $658 a day	$658 a day	$0
Once lifetime reserve days are used:			
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
21st Through 100th day	All but $164.50 a day	$0	Up to $164.50 a day
101st 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 certificate of terminal illness.	All but very limited 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 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*	$0	$0	$183 (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 $183 of Medicare-Approved Amounts*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES TEST 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 $183 of Medicare-Approved Amounts*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

PLAN F
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD*

* A **benefit period** begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,316	$1,316 (Part A Deductible)	$0
61st through 90th day	All but $329 a day	$329 a day	$0
91st day and after:			
While using 60 lifetime reserve days:	All but $658 a day	$658 a day	$0
Once lifetime reserve days are used:			
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
21st Through 100th day	All but $164.50 a day	Up to $164.50 a day	$0
101st 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 certificate of terminal illness.	All but very limited 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 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*	$0	$183 (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 $183 of Medicare-Approved Amounts*	$0	$183 (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES TEST 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 $183 of Medicare-Approved Amounts*	$0	$183 (Part B Deductible)	$0
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 G
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD*

* A **benefit period** begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,316	$1,316 (Part A Deductible)	$0
61st through 90th day	All but $329 a day	$329 a day	$0
91st day and after:			
While using 60 lifetime reserve days:	All but $658 a day	$658 a day	$0
Once lifetime reserve days are used:			
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
21st Through 100th day	All but $164.50 a day	Up to $164.50 a day	$0
101st 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 certificate of terminal illness.	All but very limited 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 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*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $183 of Medicare-Approved Amounts*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES TEST 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 $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 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 services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,316	$1,316 (Part A Deductible)	$0
61st through 90th day	All but $329 a day	$329 a day	$0
91st day and after:			
While using 60 lifetime reserve days:	All but $658 a day	$658 a day	$0
Once lifetime reserve days are used:			
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
21st Through 100th day	All but $164.50 a day	Up to $164.50 a day	$0
101st 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 certificate of terminal illness.	All but very limited 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 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*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	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.	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 room 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	$0	All costs	$0
Next $183 of Medicare-Approved Amounts*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES TEST 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 $183 of Medicare-Approved Amounts*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

PLAN N
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR (continued)

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