

KPS HEALTH PLANS

Outline of Medicare Supplement Coverage - Cover Page Benefit Plans A and F

See Outlines of Coverage sections for details about ALL plans

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A". Some plans may not be available in your state. KPS Health Plans offers only Plans A and F, shaded below.

| Basic Benefits for Plans A through G | | | | | | |
|--|-------------------|--------------------------------------|--------------------------------------|---|-----------|--------------------------------------|
| <ul style="list-style-type: none"> • 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 copayment for hospital outpatient services. • Blood: First three pints of blood each year. • Hospice: Part A coinsurance | | | | | | |
| A | B | C | D | F | F* | G |
| Basic Benefits | Basic Benefits | Basic Benefits | Basic Benefits | Basic Benefits | | Basic Benefits |
| | | 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 |

*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 \$2,000 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed \$2,000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the contract. These expenses include the Medicare deductibles for Part A and Part B but do not include the plan's separate foreign travel emergency deductible. KPS Health Plans does not offer the high deductible Plan F.

KPS HEALTH PLANS
Outline of Medicare Supplement Coverage - Cover Page 2

| 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 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER |
| 50% of Skilled Nursing Facility Coinsurance | 75% of 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 \$4,640; paid at 100% after limit is reached. | Out-of pocket limit \$2,320; paid at 100% after limit is reached. | | |

**EFFECTIVE 7/01/2011
MONTHLY RATES PER PERSON ARE AS FOLLOWS:**

KPS PLAN A (2010 Standardized): \$125.00
KPS PLAN F (2010 Standardized): \$232.00

Should the Subscriber elect to make monthly payments in advance of the current monthly rate due date and the revised rate is to become effective at the beginning of a month for which the Subscriber has already paid, the next billing will include a retroactive adjustment for the revised rate.

PREMIUM INFORMATION

We, KPS Health Plans, can only raise your monthly premium if we raise the premium for all contracts like yours in this state.

DISCLOSURES

Use this outline to compare benefits and premiums among contracts.

READ YOUR CONTRACT VERY CAREFULLY

This is only an outline describing your contract's most important features. The contract is your health care coverage contract. You must read the contract itself to understand all of the rights and duties of both you and KPS Health Plans.

RIGHT TO RETURN CONTRACT

If you find that you are not satisfied with your contract, you may return it to KPS Health Plans, P.O. Box 339, 400 Warren Avenue, Bremerton, Washington, 98337, Attn: Marketing. If you send the contract back to us within thirty days after you receive it, we will treat the contract as if it had never been issued and return all of your payments.

CONTRACT REPLACEMENT

If you are replacing another health insurance contract, do NOT cancel it until you have actually received your new contract and are sure you want to keep it.

NOTICE

This contract may not fully cover all of your medical costs.

Neither KPS Health Plans 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 contract, be sure to answer truthfully and completely all questions about your medical and health history. KPS Health Plans may cancel your contract 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 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 \$1,132 | \$0 | \$1,132 (Part A Deductible) |
| 61st thru 90th day | All but \$283 a day | \$283 a day | \$0 |
| 91st day and after: | | | |
| - While using 60 lifetime reserve days | All but \$566 a day | \$566 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 thru 100th day | All but \$141.50 a day | \$0 | Up to \$141.50 a day |
| 101st day and after | \$0 | \$0 | All Costs |
| BLOOD | | | |
| First 3 pints | \$0 | 100% | \$0 |
| Additional amounts | 100% | \$0 | \$0 |
| HOSPICE CARE | | | |
| Available as long as your doctor certifies you are terminally ill and you elect to receive these services | All but very limited coinsurance for outpatient 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 an additional 365 days as provided in the contract'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 \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

| 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 \$162 of Medicare approved amounts* | \$0 | \$0 | \$162 (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 \$162 of Medicare approved amounts* | \$0 | \$0 | \$162 (Part B Deductible) |
| Remainder of Medicare approved amounts | 80% | 20% | \$0 |
| CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES | 100% | \$0 | \$0 |

PLAN A PARTS A & B

| | | | |
|--|------|-----|---------------------------|
| HOME HEALTH CARE | | | |
| MEDICARE APPROVED SERVICES | | | |
| - Medically necessary skilled care services and medical supplies | 100% | \$0 | \$0 |
| - Durable medical equipment | | | |
| First \$162 of Medicare approved amounts* | \$0 | \$0 | \$162 (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 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 \$1,132 (Part A Deductible) | \$1,132 (Part A Deductible) | \$0 |
| 61st thru 90th day | All but \$283 a day | \$283 a day | \$0 |
| 91st day and after: - While using 60 lifetime reserve days | All but \$566 a day | \$566 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 thru 100th day | All but \$141.50 a day | Up to \$141.50 a day | \$0 |
| 101st day and after | \$0 | \$0 | All Costs |
| BLOOD | | | |
| First 3 pints | \$0 | 100% | \$0 |
| Additional amounts | 100% | \$0 | \$0 |
| HOSPICE CARE | | | |
| Available as long as your doctor certifies you are terminally ill and you elect to receive these services | All but very limited coinsurance for outpatient 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 an additional 365 days as provided in the contract'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 \$162 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

| 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 \$162 of Medicare approved amounts* | \$0 | \$162 (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 \$162 of Medicare approved amounts* | \$0 | \$162 (Part B Deductible) | \$0 |
| Remainder of Medicare approved amounts | 80% | 20% | \$0 |
| CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES | 100% | \$0 | \$0 |

PLAN F PARTS A & B

| | | | |
|--|------|---------------------------|-----|
| HOME HEALTH CARE MEDICARE APPROVED SERVICES | | | |
| - Medically necessary skilled care services and medical supplies | 100% | \$0 | \$0 |
| - Durable medical equipment | | | |
| First \$162 of Medicare Approved Amounts* | \$0 | \$162 (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 | \$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 |

KPS health plans

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