# GERBER LIFE INSURANCE COMPANY

## OUTLINE OF MEDICARE SUPPLEMENT COVERAGE – COVER PAGE

## BENEFIT PLANS A, F, AND G

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 3 pints of blood each year.

Hospice: Part A coinsurance.

| **Plan A** | Plan B | Plan C | Plan D | **Plan F** F* | **Plan G** |
|---|---|---|---|---|---|
| **Basic, including 100% Part B Co-insurance** | Basic, including 100% Part B Co-insurance | Basic, including 100% Part B Co-insurance | Basic, including 100% Part B Co-insurance | **Basic, including 100% Part B Co-insurance *** | **Basic, including 100% Part B Co-insurance** |
| | | Skilled Nursing Facility Co-insurance | Skilled Nursing Facility Co-insurance | **Skilled Nursing Facility Co-insurance** | **Skilled Nursing Facility Co-insurance** |
| | 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 Emer-gency | Foreign Travel Emer-gency | **Foreign Travel Emer-gency** | **Foreign Travel Emer-gency** |
| | | | | | |

| Plan K | Plan L | Plan M | Plan 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 Co-insurance | Basic, including 100% 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 Co-insurance | 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 $4,940; paid at 100% after limit reached | Out-of-pocket limit $2,470; 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 $2,140 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed $2,140. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy/certificate. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

## MONTHLY NON-TOBACCO RATES

| FEMALE | | | | MALE | | |
|---|---|---|---|---|---|---|
| **Plan A MTG20** | **Plan F MTG24** | **Plan G MTG25** | **Attained Age** | **Plan A MTG20** | **Plan F MTG24** | **Plan G MTG25** |
| 172.16 | | | **Thru 64** | 197.88 | | |
| 137.69 | 192.19 | 153.02 | **65** | 158.26 | 220.91 | 175.88 |
| 142.40 | 198.50 | 157.98 | **66** | 163.68 | 228.16 | 181.59 |
| 148.74 | 207.01 | 164.70 | **67** | 170.96 | 237.95 | 189.31 |
| 153.62 | 213.85 | 170.12 | **68** | 176.58 | 245.80 | 195.54 |
| 158.34 | 220.92 | 175.80 | **69** | 182.00 | 253.93 | 202.07 |
| 162.86 | 227.77 | 181.35 | **70** | 187.20 | 261.81 | 208.44 |
| 167.12 | 234.40 | 186.70 | **71** | 192.09 | 269.42 | 214.59 |
| 171.15 | 240.79 | 191.85 | **72** | 196.72 | 276.77 | 220.52 |
| 174.78 | 246.64 | 196.63 | **73** | 200.89 | 283.50 | 226.01 |
| 177.92 | 252.09 | 201.07 | **74** | 204.51 | 289.75 | 231.12 |
| 180.60 | 256.98 | 205.11 | **75** | 207.58 | 295.37 | 235.76 |
| 183.12 | 261.78 | 209.10 | **76** | 210.48 | 300.90 | 240.35 |
| 185.48 | 266.35 | 212.89 | **77** | 213.19 | 306.15 | 244.70 |
| 187.67 | 270.68 | 216.47 | **78** | 215.72 | 311.12 | 248.82 |
| 189.73 | 274.85 | 219.96 | **79** | 218.08 | 315.91 | 252.83 |
| 191.80 | 279.05 | 223.46 | **80** | 220.46 | 320.75 | 256.85 |
| 193.72 | 283.15 | 226.88 | **81** | 222.67 | 325.46 | 260.78 |
| 195.51 | 287.12 | 230.23 | **82** | 224.72 | 330.03 | 264.63 |
| 197.11 | 290.85 | 233.37 | **83** | 226.57 | 334.31 | 268.24 |
| 198.57 | 294.52 | 236.48 | **84** | 228.24 | 338.53 | 271.81 |
| 199.96 | 298.05 | 239.49 | **85** | 229.84 | 342.59 | 275.28 |
| 201.29 | 301.61 | 242.50 | **86** | 231.37 | 346.68 | 278.74 |
| 202.67 | 305.29 | 245.64 | **87** | 232.95 | 350.91 | 282.34 |
| 204.03 | 308.87 | 248.69 | **88** | 234.52 | 355.02 | 285.86 |
| 205.40 | 312.48 | 251.86 | **89** | 236.09 | 359.17 | 289.49 |
| 206.82 | 316.23 | 255.13 | **90** | 237.73 | 363.49 | 293.25 |
| 208.25 | 320.05 | 258.47 | **91** | 239.36 | 367.87 | 297.10 |
| 209.75 | 324.02 | 261.93 | **92** | 241.09 | 372.44 | 301.06 |
| 211.28 | 328.09 | 265.47 | **93** | 242.85 | 377.11 | 305.14 |
| 212.85 | 332.37 | 269.21 | **94** | 244.65 | 382.03 | 309.44 |
| 214.41 | 336.66 | 272.96 | **95** | 246.45 | 386.97 | 313.75 |
| 215.91 | 340.94 | 276.70 | **96** | 248.17 | 391.88 | 318.05 |
| 217.25 | 345.03 | 280.27 | **97** | 249.72 | 396.59 | 322.14 |
| 218.58 | 349.17 | 283.92 | **98** | 251.24 | 401.35 | 326.35 |
| 219.92 | 353.45 | 287.69 | **99+** | 252.78 | 406.26 | 330.68 |

To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

## MONTHLY TOBACCO RATES

| FEMALE | | | | MALE | | |
|---|---|---|---|---|---|---|
| **Plan A MTG20** | **Plan F MTG24** | **Plan G MTG25** | **Attained Age** | **Plan A MTG20** | **Plan F MTG24** | **Plan G MTG25** |
| 197.88 | | | **Thru 64** | 227.45 | | |
| 158.26 | 220.91 | 175.88 | **65** | 181.91 | 253.92 | 202.16 |
| 163.68 | 228.16 | 181.59 | **66** | 188.14 | 262.25 | 208.72 |
| 170.96 | 237.95 | 189.31 | **67** | 196.51 | 273.50 | 217.60 |
| 176.58 | 245.80 | 195.54 | **68** | 202.96 | 282.53 | 224.76 |
| 182.00 | 253.93 | 202.07 | **69** | 209.20 | 291.87 | 232.26 |
| 187.20 | 261.81 | 208.44 | **70** | 215.17 | 300.93 | 239.59 |
| 192.09 | 269.42 | 214.59 | **71** | 220.79 | 309.68 | 246.66 |
| 196.72 | 276.77 | 220.52 | **72** | 226.12 | 318.13 | 253.47 |
| 200.89 | 283.50 | 226.01 | **73** | 230.91 | 325.86 | 259.78 |
| 204.51 | 289.75 | 231.12 | **74** | 235.07 | 333.05 | 265.65 |
| 207.58 | 295.37 | 235.76 | **75** | 238.60 | 339.51 | 270.99 |
| 210.48 | 300.90 | 240.35 | **76** | 241.93 | 345.86 | 276.26 |
| 213.19 | 306.15 | 244.70 | **77** | 245.05 | 351.90 | 281.26 |
| 215.72 | 311.12 | 248.82 | **78** | 247.95 | 357.61 | 286.00 |
| 218.08 | 315.91 | 252.83 | **79** | 250.67 | 363.12 | 290.61 |
| 220.46 | 320.75 | 256.85 | **80** | 253.40 | 368.68 | 295.23 |
| 222.67 | 325.46 | 260.78 | **81** | 255.94 | 374.09 | 299.75 |
| 224.72 | 330.03 | 264.63 | **82** | 258.30 | 379.34 | 304.17 |
| 226.57 | 334.31 | 268.24 | **83** | 260.42 | 384.26 | 308.32 |
| 228.24 | 338.53 | 271.81 | **84** | 262.35 | 389.11 | 312.43 |
| 229.84 | 342.59 | 275.28 | **85** | 264.18 | 393.78 | 316.41 |
| 231.37 | 346.68 | 278.74 | **86** | 265.94 | 398.48 | 320.39 |
| 232.95 | 350.91 | 282.34 | **87** | 267.76 | 403.34 | 324.53 |
| 234.52 | 355.02 | 285.86 | **88** | 269.56 | 408.07 | 328.57 |
| 236.09 | 359.17 | 289.49 | **89** | 271.37 | 412.84 | 332.75 |
| 237.73 | 363.49 | 293.25 | **90** | 273.25 | 417.80 | 337.07 |
| 239.36 | 367.87 | 297.10 | **91** | 275.13 | 422.84 | 341.49 |
| 241.09 | 372.44 | 301.06 | **92** | 277.11 | 428.09 | 346.05 |
| 242.85 | 377.11 | 305.14 | **93** | 279.14 | 433.46 | 350.73 |
| 244.65 | 382.03 | 309.44 | **94** | 281.21 | 439.12 | 355.68 |
| 246.45 | 386.97 | 313.75 | **95** | 283.27 | 444.79 | 360.63 |
| 248.17 | 391.88 | 318.05 | **96** | 285.25 | 450.44 | 365.57 |
| 249.72 | 396.59 | 322.14 | **97** | 287.03 | 455.85 | 370.28 |
| 251.24 | 401.35 | 326.35 | **98** | 288.78 | 461.32 | 375.11 |
| 252.78 | 406.26 | 330.68 | **99+** | 290.55 | 466.97 | 380.09 |

To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

**Premium Information**
We, Gerber Life, can only raise your premium if we raise the premium for all the policies like yours in the same state where you live. Until you are age 99, your premium will change each year. The new premium will be based upon your age at that time. This change will only be made on the first renewal date that coincides with or follows each anniversary of the policy date. Schedules of rates may vary depending upon your policy date.

There will be a one-time enrollment fee of $25.00 added to the first premium.

**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 Gerber Life Insurance Company at our administrative office, 3316 Farnam Street, Omaha, NE 68175. 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**
The policy may not fully cover all of your medical costs. Neither Gerber Life 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 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*** Semiprivate room and board, general nursing and miscellaneous services and supplies<br>First 60 days | All but $1,216 | $0 | $1,216 (Part A Deductible) |
| 61st through 90th day | All but $304 a day | $304 a day | $0 |
| 91st day and after:<br>While using 60 lifetime reserve days | All but $608 a day | $608 a day | $0 |
| Once lifetime reserve days are used:<br>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.<br>First 20 days | All approved amounts | $0 | $0 |
| 21st through 100th day | All but $152 a day | $0 | Up to $152 a day |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD**<br>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 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/certificate'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 $147 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<br>First $147 of Medicare Approved Amounts* | $0 | $0 | $147 (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**<br>First 3 pints | $0 | All costs | $0 |
| Next $147 of Medicare Approved Amounts* | $0 | $0 | $147 (Part B Deductible) |
| Remainder of Medicare Approved Amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES**—TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

### PARTS A AND B

| | | | |
|---|---|---|---|
| **HOME HEALTH CARE**—MEDICARE APPROVED SERVICES<br>Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| Durable medical equipment<br>First $147 of Medicare Approved Amounts* | $0 | $0 | $147 (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 F Pays | You Pay |
|---|---|---|---|
| **HOSPITALIZATION*** Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $1,216 | $1,216 (Part A Deductible) | $0 |
| 61st through 90th day | All but $304 a day | $304 a day | $0 |
| 91st day and after: | | | |
| While using 60 lifetime reserve days | All but $608 a day | $608 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 $152 a day | Up to $152 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 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/certificate'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 $147 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 $147 of Medicare Approved Amounts* | $0 | $147 (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 $147 of Medicare Approved Amounts* | $0 | $147 (Part B Deductible) | $0 |
| Remainder of Medicare Approved Amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES**—TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

## PARTS A AND B

| | | | |
|---|---|---|---|
| **HOME HEALTH CARE**—MEDICARE APPROVED SERVICES<br>Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| Durable medical equipment | | | |
| First $147 of Medicare Approved Amounts* | $0 | $147 (Part B Deductible) | $0 |
| Remainder of Medicare Approved Amounts | 80% | 20% | $0 |

## OTHER BENEFITS – NOT COVERED BY MEDICARE

| Services | Medicare Pays | Plan F Pays | You Pay |
|---|---|---|---|
| **FOREIGN TRAVEL**—NOT COVERED BY MEDICARE<br>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 Benefit |

# 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*** Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $1,216 | $1,216 (Part A Deductible) | $0 |
| 61st through 90th day | All but $304 a day | $304 a day | $0 |
| 91st day and after: | | | |
| While using 60 lifetime reserve days | All but $608 a day | $608 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 $152 a day | Up to $152 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 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/certificate'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 $147 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<br>First $147 of Medicare Approved Amounts* | $0 | $0 | $147 (Part B Deductible) |
| Remainder of Medicare Approved Amounts | Generally 80% | Generally 20% | $0 |
| **Part B Excess Charges** (above Medicare Approved Amounts) | $0 | 100% | $0 |
| **BLOOD**<br>First 3 pints | $0 | All costs | $0 |
| Next $147 of Medicare Approved Amounts* | $0 | $0 | $147 (Part B Deductible) |
| Remainder of Medicare Approved Amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES**—TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

### PARTS A AND B

| | | | |
|---|---|---|---|
| **HOME HEALTH CARE**—MEDICARE APPROVED SERVICES<br>Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| Durable medical equipment<br>First $147 of Medicare Approved Amounts* | $0 | $0 | $147 (Part B Deductible) |
| Remainder of Medicare Approved Amounts | 80% | 20% | $0 |

### OTHER BENEFITS – NOT COVERED BY MEDICARE

| Services | Medicare Pays | Plan G Pays | You Pay |
|---|---|---|---|
| **FOREIGN TRAVEL**—NOT COVERED BY MEDICARE<br>Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA<br>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 Benefit |