UNITED OF OMAHA LIFE INSURANCE COMPANY

A Mutual of Omaha Company

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE – COVER PAGE

BENEFIT PLANS A, C, D, F, G, M AND N

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. See Outlines of Coverage sections for details about ALL plans. Plans E, H, I, and J are no longer available for sale.

Basic Benefits:

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or copayments.

Blood: First 3 pints of blood each year.

Hospice: Part A coinsurance.

A	B	C	D	F	F*	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**

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 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 Emer-gency	**Foreign Travel Emergency**
Out-of-pocket limit $4,640; paid at 100% after limit reached	Out-of-pocket limit $2,320; 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 $2,000 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 policy/certificate. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plans' separate foreign travel emergency deductible.

MONTHLY NON-TOBACCO RATES*

ZIP CODES: 634-639, 644-658

FEMALE								MALE						
Plan A UM20	**Plan C UM21**	**Plan D UM22**	**Plan F UM23**	**Plan G UM24**	**Plan M UM30**	**Plan N UM31**	**Issue Age**	**Plan A UM20**	**Plan C UM21**	**Plan D UM22**	**Plan F UM23**	**Plan G UM24**	**Plan M UM30**	**Plan N UM31**
119.42	187.31	148.35	172.68	148.63	118.92	134.24	**Thru 64**	133.06	207.95	165.55	191.88	165.19	128.15	149.30
102.45	133.63	113.59	148.48	126.21	106.24	102.99	**65**	111.42	145.33	123.54	161.48	137.26	115.54	112.01
106.76	139.26	118.37	154.73	131.52	110.71	107.33	**66**	117.38	153.11	130.14	170.11	144.60	121.72	118.00
111.14	144.96	123.22	161.06	136.90	115.24	111.72	**67**	123.42	160.97	136.82	178.86	152.03	127.97	124.06
115.49	150.64	128.05	167.38	142.27	119.76	116.09	**68**	129.43	168.82	143.49	187.57	159.43	134.21	130.10
119.79	156.26	132.81	173.62	147.58	124.23	120.43	**69**	135.30	176.47	150.00	196.08	166.67	140.29	136.01
124.00	161.74	137.48	179.71	152.75	128.58	124.65	**70**	140.91	183.81	156.23	204.22	173.59	146.12	141.65
127.22	165.93	141.04	184.37	156.71	131.91	127.88	**71**	145.31	189.53	161.11	210.59	179.00	150.68	146.07
130.32	169.99	144.48	188.87	160.53	135.13	131.00	**72**	149.44	194.94	165.69	216.60	184.10	154.97	150.24
133.26	173.83	147.75	193.14	164.17	138.19	133.97	**73**	153.24	199.89	169.91	222.10	188.78	158.92	154.06
136.03	177.42	150.81	197.14	167.56	141.05	136.73	**74**	156.61	204.29	173.64	226.98	192.93	162.40	157.45
138.58	180.76	153.64	200.83	170.72	143.70	139.31	**75**	159.45	207.99	176.79	231.09	196.42	165.35	160.29
140.95	183.85	156.27	204.28	173.64	146.16	141.69	**76**	161.71	210.92	179.29	234.35	199.20	167.68	162.55
143.26	186.86	158.83	207.63	176.48	148.56	144.01	**77**	163.56	213.33	181.34	237.03	201.48	169.59	164.41
145.58	189.89	161.41	210.99	179.35	150.96	146.35	**78**	165.24	215.53	183.19	239.47	203.55	171.35	166.11
147.90	192.91	163.98	214.35	182.20	153.37	148.68	**79**	166.70	217.44	184.83	241.60	205.36	172.87	167.58
150.21	195.93	166.54	217.70	185.05	155.77	151.00	**80**	167.89	218.98	186.14	243.32	206.82	174.09	168.77
152.46	198.86	169.03	220.95	187.81	158.09	153.26	**81**	168.84	220.23	187.19	244.70	207.99	175.08	169.72
154.54	201.57	171.33	223.96	190.37	160.25	155.34	**82**	169.66	221.30	188.11	245.89	209.00	175.93	170.55
156.45	204.07	173.46	226.74	192.73	162.24	157.27	**83**	170.37	222.21	188.88	246.90	209.87	176.66	171.25
158.18	206.32	175.37	229.25	194.86	164.02	159.01	**84**	170.93	222.95	189.51	247.72	210.56	177.25	171.82
159.70	208.31	177.07	231.46	196.74	165.61	160.55	**85**	171.37	223.54	190.01	248.38	211.12	177.71	172.28
161.02	210.03	178.52	233.36	198.36	166.97	161.87	**86**	171.71	223.98	190.39	248.86	211.54	178.06	172.62
162.08	211.42	179.71	234.91	199.68	168.08	162.94	**87**	171.96	224.29	190.66	249.22	211.83	178.31	172.86
162.89	212.46	180.59	236.06	200.66	168.91	163.74	**88**	172.11	224.49	190.81	249.44	212.02	178.47	173.01
163.40	213.13	181.16	236.81	201.29	169.44	164.25	**89**	172.19	224.59	190.90	249.54	212.11	178.55	173.09
163.59	213.38	181.37	237.09	201.53	169.64	164.46	**90+**	172.20	224.61	190.91	249.57	212.12	178.57	173.11

*See PREMIUM INFORMATION regarding Risk Class and Household Premium Discount rating.

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

RP39.12.B

MONTHLY TOBACCO RATES*

ZIP CODES: 634-639, 644-658

FEMALE								MALE						
Plan A UM20	**Plan C UM21**	**Plan D UM22**	**Plan F UM23**	**Plan G UM24**	**Plan M UM30**	**Plan N UM31**	**Issue Age**	**Plan A UM20**	**Plan C UM21**	**Plan D UM22**	**Plan F UM23**	**Plan G UM24**	**Plan M UM30**	**Plan N UM31**
129.11	202.50	160.38	186.68	160.68	128.56	145.12	**Thru 64**	143.85	224.81	178.97	207.44	178.58	138.54	161.41
110.76	144.47	122.79	160.52	136.44	114.85	111.34	**65**	120.45	157.11	133.55	174.57	148.39	124.91	121.09
115.42	150.55	127.97	167.28	142.18	119.69	116.03	**66**	126.90	165.52	140.69	183.91	156.33	131.59	127.57
120.15	156.71	133.21	174.12	148.00	124.58	120.78	**67**	133.42	174.03	147.91	193.36	164.36	138.35	134.12
124.85	162.85	138.43	180.95	153.81	129.47	125.51	**68**	139.92	182.51	155.13	202.78	172.36	145.09	140.65
129.51	168.93	143.58	187.69	159.54	134.30	130.19	**69**	146.27	190.78	162.16	211.98	180.18	151.67	147.04
134.05	174.85	148.63	194.28	165.14	139.01	134.76	**70**	152.34	198.71	168.90	220.78	187.67	157.97	153.14
137.54	179.38	152.48	199.32	169.42	142.61	138.24	**71**	157.09	204.90	174.17	227.66	193.51	162.89	157.91
140.89	183.77	156.20	204.18	173.55	146.09	141.62	**72**	161.56	210.75	179.13	234.16	199.03	167.54	162.42
144.07	187.93	159.73	208.80	177.48	149.40	144.83	**73**	165.67	216.10	183.68	240.11	204.09	171.80	166.55
147.06	191.81	163.04	213.12	181.15	152.48	147.82	**74**	169.31	220.85	187.72	245.39	208.58	175.57	170.21
149.81	195.41	166.10	217.12	184.56	155.35	150.60	**75**	172.37	224.85	191.12	249.83	212.35	178.75	173.28
152.38	198.76	168.94	220.84	187.71	158.01	153.18	**76**	174.82	228.02	193.83	253.35	215.36	181.27	175.73
154.87	202.01	171.71	224.46	190.79	160.60	155.69	**77**	176.82	230.62	196.04	256.25	217.82	183.34	177.74
157.38	205.29	174.50	228.10	193.89	163.20	158.22	**78**	178.64	233.00	198.04	258.89	220.06	185.24	179.57
159.89	208.56	177.28	231.73	196.97	165.80	160.74	**79**	180.22	235.07	199.81	261.19	222.01	186.88	181.17
162.39	211.81	180.04	235.36	200.05	168.40	163.24	**80**	181.51	236.74	201.23	263.04	223.58	188.21	182.45
164.82	214.98	182.74	238.86	203.03	170.91	165.68	**81**	182.53	238.08	202.37	264.54	224.86	189.27	183.48
167.07	217.91	185.23	242.12	205.81	173.24	167.94	**82**	183.42	239.24	203.36	265.83	225.95	190.20	184.38
169.13	220.61	187.52	245.13	208.35	175.39	170.02	**83**	184.18	240.22	204.20	266.91	226.88	190.98	185.14
171.01	223.05	189.59	247.83	210.66	177.32	171.90	**84**	184.78	241.03	204.88	267.80	227.64	191.62	185.76
172.65	225.20	191.43	250.23	212.69	179.04	173.56	**85**	185.27	241.67	205.42	268.52	228.24	192.12	186.25
174.07	227.06	193.00	252.28	214.45	180.51	174.99	**86**	185.63	242.14	205.82	269.04	228.69	192.50	186.61
175.22	228.56	194.28	253.95	215.87	181.71	176.15	**87**	185.91	242.47	206.12	269.42	229.01	192.77	186.87
176.09	229.68	195.24	255.20	216.93	182.60	177.02	**88**	186.06	242.69	206.29	269.66	229.21	192.94	187.03
176.65	230.41	195.85	256.01	217.61	183.18	177.57	**89**	186.15	242.80	206.37	269.78	229.30	193.03	187.12
176.85	230.68	196.08	256.31	217.87	183.40	177.79	**90+**	186.16	242.82	206.39	269.80	229.32	193.05	187.14

*See PREMIUM INFORMATION regarding Risk Class and Household Premium Discount rating.

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

RP39.12.B

MONTHLY NON-TOBACCO RATES*

ZIP CODES: 630-631, 633, 640-641

FEMALE								MALE						
Plan A UM20	**Plan C UM21**	**Plan D UM22**	**Plan F UM23**	**Plan G UM24**	**Plan M UM30**	**Plan N UM31**	**Issue Age**	**Plan A UM20**	**Plan C UM21**	**Plan D UM22**	**Plan F UM23**	**Plan G UM24**	**Plan M UM30**	**Plan N UM31**
136.98	214.86	170.17	198.07	170.49	136.41	153.98	**Thru 64**	152.63	238.53	189.89	220.10	189.48	146.99	171.26
117.52	153.28	130.29	170.32	144.77	121.86	118.14	**65**	127.80	166.70	141.70	185.22	157.45	132.53	128.48
122.46	159.74	135.78	177.49	150.86	126.99	123.11	**66**	134.64	175.62	149.28	195.13	165.87	139.62	135.35
127.48	166.28	141.34	184.75	157.03	132.19	128.15	**67**	141.57	184.65	156.94	205.16	174.39	146.79	142.30
132.47	172.79	146.88	191.99	163.20	137.37	133.17	**68**	148.46	193.64	164.60	215.16	182.88	153.95	149.24
137.41	179.24	152.34	199.15	169.28	142.50	138.14	**69**	155.20	202.42	172.06	224.91	191.18	160.92	156.01
142.23	185.52	157.70	206.13	175.22	147.49	142.98	**70**	161.64	210.84	179.21	234.26	199.12	167.61	162.48
145.93	190.33	161.78	211.48	179.75	151.31	146.68	**71**	166.67	217.40	184.80	241.56	205.32	172.84	167.55
149.49	194.99	165.73	216.65	184.14	155.01	150.27	**72**	171.42	223.61	190.06	248.45	211.18	177.76	172.33
152.86	199.39	169.48	221.54	188.31	158.51	153.67	**73**	175.78	229.29	194.89	254.76	216.54	182.29	176.71
156.03	203.51	172.99	226.13	192.20	161.79	156.84	**74**	179.64	234.33	199.18	260.36	221.31	186.28	180.60
158.95	207.34	176.23	230.37	195.82	164.83	159.79	**75**	182.89	238.57	202.79	265.08	225.31	189.66	183.86
161.68	210.89	179.25	234.32	199.17	167.66	162.53	**76**	185.49	241.93	205.66	268.82	228.50	192.34	186.46
164.32	214.34	182.19	238.16	202.43	170.40	165.19	**77**	187.61	244.70	208.00	271.89	231.11	194.53	188.59
166.98	217.81	185.15	242.02	205.72	173.16	167.87	**78**	189.55	247.22	210.13	274.69	233.49	196.54	190.53
169.65	221.28	188.10	245.87	208.99	175.92	170.55	**79**	191.22	249.42	212.01	277.13	235.56	198.29	192.22
172.30	224.74	191.03	249.72	212.26	178.67	173.20	**80**	192.58	251.18	213.51	279.10	237.23	199.70	193.59
174.88	228.10	193.89	253.44	215.43	181.34	175.79	**81**	193.67	252.61	214.72	280.69	238.58	200.82	194.68
177.27	231.21	196.53	256.90	218.37	183.82	178.19	**82**	194.61	253.85	215.77	282.05	239.74	201.80	195.63
179.45	234.08	198.97	260.09	221.07	186.10	180.40	**83**	195.42	254.88	216.66	283.20	240.73	202.63	196.44
181.44	236.66	201.16	262.96	223.51	188.15	182.39	**84**	196.06	255.74	217.38	284.15	241.53	203.31	197.09
183.19	238.95	203.11	265.50	225.67	189.96	184.16	**85**	196.57	256.41	217.96	284.91	242.17	203.85	197.62
184.70	240.92	204.78	267.68	227.53	191.52	185.67	**86**	196.96	256.92	218.38	285.46	242.65	204.25	198.00
185.92	242.51	206.13	269.45	229.04	192.80	186.90	**87**	197.25	257.27	218.69	285.87	242.99	204.53	198.28
186.84	243.70	207.15	270.77	230.17	193.74	187.82	**88**	197.42	257.50	218.87	286.12	243.20	204.72	198.45
187.43	244.47	207.81	271.64	230.90	194.36	188.41	**89**	197.51	257.62	218.97	286.24	243.30	204.81	198.54
187.65	244.76	208.05	271.96	231.16	194.59	188.64	**90+**	197.53	257.64	218.98	286.27	243.32	204.83	198.56

*See PREMIUM INFORMATION regarding Risk Class and Household Premium Discount rating.

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

RP39.12.B

MONTHLY TOBACCO RATES*

ZIP CODES: 630-631, 633, 640-641

FEMALE								MALE						
Plan A UM20	**Plan C UM21**	**Plan D UM22**	**Plan F UM23**	**Plan G UM24**	**Plan M UM30**	**Plan N UM31**	**Issue Age**	**Plan A UM20**	**Plan C UM21**	**Plan D UM22**	**Plan F UM23**	**Plan G UM24**	**Plan M UM30**	**Plan N UM31**
148.09	232.28	183.96	214.13	184.31	147.47	166.46	**Thru 64**	165.00	257.87	205.29	237.95	204.84	158.91	185.14
127.05	165.71	140.85	184.13	156.51	131.74	127.72	**65**	138.16	180.22	153.19	200.24	170.21	143.28	138.90
132.39	172.69	146.79	191.88	163.09	137.29	133.09	**66**	145.56	189.86	161.38	210.95	179.31	150.94	146.33
137.82	179.76	152.79	199.73	169.77	142.90	138.54	**67**	153.04	199.62	169.67	221.79	188.53	158.69	153.84
143.21	186.80	158.79	207.56	176.43	148.51	143.97	**68**	160.50	209.34	177.94	232.60	197.71	166.43	161.34
148.55	193.78	164.70	215.30	183.00	154.05	149.34	**69**	167.78	218.84	186.01	243.15	206.68	173.97	168.66
153.76	200.56	170.49	222.85	189.42	159.45	154.57	**70**	174.74	227.93	193.74	253.25	215.26	181.20	175.66
157.76	205.76	174.90	228.63	194.33	163.58	158.57	**71**	180.19	235.03	199.78	261.14	221.97	186.85	181.13
161.61	210.80	179.17	234.21	199.07	167.58	162.45	**72**	185.32	241.74	205.47	268.59	228.30	192.18	186.30
165.25	215.56	183.22	239.51	203.58	171.37	166.13	**73**	190.03	247.88	210.69	275.42	234.10	197.07	191.04
168.68	220.02	187.01	244.46	207.78	174.91	169.56	**74**	194.20	253.33	215.33	281.47	239.25	201.39	195.24
171.84	224.15	190.52	249.05	211.70	178.20	172.75	**75**	197.72	257.92	219.23	286.57	243.58	205.04	198.77
174.79	227.99	193.78	253.32	215.32	181.25	175.70	**76**	200.53	261.55	222.33	290.61	247.03	207.93	201.58
177.65	231.72	196.96	257.47	218.85	184.22	178.58	**77**	202.82	264.54	224.87	293.94	249.85	210.30	203.88
180.52	235.47	200.16	261.64	222.40	187.20	181.48	**78**	204.91	267.27	227.17	296.96	252.42	212.48	205.98
183.40	239.23	203.35	265.81	225.94	190.19	184.38	**79**	206.72	269.64	229.20	299.60	254.65	214.37	207.81
186.27	242.96	206.52	269.97	229.47	193.16	187.25	**80**	208.20	271.55	230.83	301.73	256.46	215.89	209.28
189.06	246.60	209.61	273.99	232.89	196.05	190.05	**81**	209.37	273.09	232.13	303.44	257.92	217.11	210.47
191.64	249.96	212.46	277.73	236.08	198.72	192.64	**82**	210.39	274.43	233.27	304.92	259.18	218.17	211.50
194.00	253.06	215.10	281.17	238.99	201.19	195.02	**83**	211.26	275.55	234.23	306.17	260.25	219.06	212.36
196.15	255.85	217.47	284.28	241.64	203.40	197.18	**84**	211.96	276.47	235.01	307.19	261.11	219.80	213.07
198.04	258.32	219.58	287.02	243.97	205.37	199.09	**85**	212.51	277.20	235.63	308.01	261.81	220.37	213.64
199.67	260.45	221.38	289.38	245.98	207.05	200.73	**86**	212.93	277.75	236.09	308.61	262.32	220.81	214.06
200.99	262.17	222.85	291.30	247.61	208.43	202.05	**87**	213.24	278.13	236.43	309.04	262.69	221.11	214.35
201.99	263.46	223.95	292.73	248.83	209.45	203.05	**88**	213.42	278.38	236.62	309.32	262.92	221.32	214.54
202.63	264.30	224.66	293.66	249.62	210.12	203.68	**89**	213.53	278.51	236.72	309.45	263.02	221.41	214.64
202.86	264.61	224.91	294.01	249.90	210.37	203.94	**90+**	213.54	278.53	236.74	309.48	263.05	221.43	214.66

*See PREMIUM INFORMATION regarding Risk Class and Household Premium Discount rating.

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

RP39.12.B

Disclosures
Use this outline to compare benefits and premiums among policies.

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

Premium Information
We, United of Omaha, can only raise your premium if we raise the premium for all the policies like yours in the same geographic area of the state where you live.

Risk Class Rating
If, according to our underwriting standards, you are overweight or underweight for your height, you will be considered to be a greater insurable risk. In such a case, your premium will be priced either as Class I - 10% or Class II - 20% higher than the rates illustrated, based on your Body Mass Index (BMI) reading. Risk class rating will not be applicable when you apply for coverage during an open enrollment or guaranteed issue period.

Household Premium Discount
If you reside with your spouse or domestic partner at the time of application, you may be eligible for the household premium discount. The discounted premium will be priced 12% lower than the rates illustrated.

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 United of Omaha Life Insurance Company, Mutual of Omaha Plaza, 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 United of Omaha 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.

Renewability of Policy
We will renew this policy each time you pay the premium. It must be paid by the date it is due or during the 31 days that follow. Nonrenewal will not affect an existing claim.

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 First 60 days	All but $1,132	$0	$1,132 (Part A Deductible)
61st through 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 through 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	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 $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 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 $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

PARTS A AND 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

PLANS C AND D

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

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

Services	Medicare Pays	Plan C Pays	You Pay	Plan D Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but $1,132	$1,132 (Part A Deductible)	$0	$1,132 (Part A Deductible)	$0
61st through 90th day	All but $283 a day	$283 a day	$0	$283 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $566 a day	$566 a day	$0	$566 a day	$0
Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**	100% of Medicare Eligible Expenses	$0**
Beyond the additional 365 days	$0	$0	All costs	$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	$0	$0
21st through 100th day	All but $141.50 a day	Up to $141.50 a day	$0	Up to $141.50 a day	$0
101st day and after	$0	$0	All costs	$0	All costs
BLOOD First 3 pints	$0	3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$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	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.

PLANS C AND D
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 C Pays	You Pay	Plan D 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	$0	$162 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0	Generally 20%	$0
Part B Excess Charges (above Medicare Approved Amounts)	$0	$0	All costs	$0	All costs
BLOOD First 3 pints	$0	All costs	$0	All costs	$0
Next $162 of Medicare Approved Amounts*	$0	$162 (Part B Deductible)	$0	$0	$162 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0	$0	$0

PARTS A AND B

HOME HEALTH CARE—MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0	$0	$0
Durable medical equipment First $162 of Medicare Approved Amounts*	$0	$162 (Part B Deductible)	$0	$0	$162 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0	20%	$0

PLANS C AND D
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

OTHER BENEFITS – NOT COVERED BY MEDICARE

Services	Medicare Pays	Plan C Pays	You Pay	Plan D 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	$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	80% to a lifetime Maximum Benefit of $50,000	20% and amounts over the $50,000 lifetime Maximum Benefit

PLANS F AND 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 F Pays	You Pay	Plan G Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but $1,132	$1,132 (Part A Deductible)	$0	$1,132 (Part A Deductible)	$0
61st through 90th day	All but $283 a day	$283 a day	$0	$283 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $566 a day	$566 a day	$0	$566 a day	$0
Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**	100% of Medicare Eligible Expenses	$0**
Beyond the additional 365 days	$0	$0	All costs	$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	$0	$0
21st through 100th day	All but $141.50 a day	Up to $141.50 a day	$0	Up to $141.50 a day	$0
101st day and after	$0	$0	All costs	$0	All costs
BLOOD First 3 pints	$0	3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$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	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.

PLANS F AND G
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 F Pays	You Pay	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 $162 of Medicare Approved Amounts*	$0	$162 (Part B Deductible)	$0	$0	$162 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0	Generally 20%	$0
Part B Excess Charges (above Medicare Approved Amounts)	$0	100%	$0	100%	$0
BLOOD First 3 pints	$0	All costs	$0	All costs	$0
Next $162 of Medicare Approved Amounts*	$0	$162 (Part B Deductible)	$0	$0	$162 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0	$0	$0

PARTS A AND B

HOME HEALTH CARE—MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0	$0	$0
Durable medical equipment First $162 of Medicare Approved Amounts*	$0	$162 (Part B Deductible)	$0	$0	$162 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0	20%	$0

PLANS F AND G
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

OTHER BENEFITS – NOT COVERED BY MEDICARE

Services	Medicare Pays	Plan F Pays	You Pay	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	$0	$0	$250	$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	80% to a lifetime Maximum Benefit of $50,000	20% and amounts over the $50,000 lifetime Maximum Benefit

PLANS M AND 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 M Pays	You Pay	Plan N Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but $1,132	$566 (50% of Part A Deductible)	$566 (50% of Part A deductible)	$1,132 (Part A Deductible)	$0
61st through 90th day	All but $283 a day	$283 a day	$0	$283 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $566 a day	$566 a day	$0	$566 a day	$0
Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**	100% of Medicare Eligible Expenses	$0**
Beyond the additional 365 days	$0	$0	All costs	$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	$0	$0
21st through 100th day	All but $141.50 a day	Up to $141.50 a day	$0	Up to $141.50 a day	$0
101st day and after	$0	$0	All costs	$0	All costs
BLOOD First 3 pints	$0	3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$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	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.

PLANS M AND N
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 M Pays	You Pay	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 $162 of Medicare Approved Amounts*	$0	$0	$162 (Part B Deductible)	$0	$162 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$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.	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	$0	All costs
BLOOD First 3 pints	$0	All costs	$0	All costs	$0
Next $162 of Medicare Approved Amounts*	$0	$0	$162 (Part B Deductible)	$0	$162 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0	$0	$0

PLANS M AND N
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

PARTS A AND B

Services	Medicare Pays	Plan M Pays	You Pay	Plan N Pays	You Pay
HOME HEALTH CARE—MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0	$0	$0
Durable medical equipment First $162 of Medicare Approved Amounts*	$0	$0	$162 (Part B Deductible)	$0	$162 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0	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	$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	80% to a lifetime Maximum Benefit of $50,000	20% and amounts over the $50,000 lifetime Maximum Benefit