UNITED WORLD LIFE INSURANCE COMPANY

A Mutual of Omaha Company

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE – COVER PAGE

BENEFIT PLANS A, F, G, HIGH DEDUCTIBLE G AND N

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. Only applicants **first** eligible for Medicare before 2020 may purchase Plans C, F and High Deductible F.

Note: A ✓ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only		
	PLAN A	PLAN B	PLAN D	**PLAN G**	**G**[1]	PLAN K	PLAN L	PLAN M	**PLAN N**	PLAN C	**PLAN F**	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	
Medicare Part B coinsurance or Copayment	✓	✓	✓	✓		50%	75%	✓	✓ copays apply[3]	✓	✓	
Blood (first three pints each year)	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓	
Part A hospice care coinsurance or copayment	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓	
Skilled nursing facility coinsurance			✓	✓		50%	75%	✓	✓	✓	✓	
Medicare Part A deductible		✓	✓	✓		50%	75%	50%	✓	✓	✓	
Medicare Part B deductible										✓	✓	
Medicare Part B excess charges				✓							✓	
Foreign travel emergency (up to plan limits)			✓	✓				✓	✓	✓	✓	
Out-of-pocket limit in 2024[2]						$7,060[2]	$3,530[2]					

[1]Plans F and G also have a high deductible option which require first paying a plan deductible $2,800 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

[2]Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

[3]Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to $20 for some office visits and up to a $50 co-payment for emergency room visits that do not result in an inpatient admission.

MONTHLY PREMIUMS*

ZIP CODES: 932, 934-940, 950-953, 956-961

NON-TOBACCO						TOBACCO				
Plan A WM20	**Plan F WM24**	**Plan G WM25**	**Plan High G WM36**	**Plan N WM35**	**Attained Age**	**Plan A WM20**	**Plan F WM24**	**Plan G WM25**	**Plan High G WM36**	**Plan N WM35**
311.32	457.82	364.54		271.07	**Thru 64**	357.83	526.24	419.02		311.58
124.53	183.13	145.82	48.94	108.43	**65**	143.14	210.49	167.60	56.25	124.64
124.53	183.13	145.82	48.94	108.43	**66**	143.14	210.49	167.60	56.25	124.64
136.98	201.45	160.40	48.94	119.27	**67**	157.45	231.55	184.37	56.25	137.10
142.73	209.91	167.46	50.91	124.52	**68**	164.06	241.27	192.48	58.51	143.12
148.49	218.37	174.52	52.86	129.77	**69**	170.68	251.00	200.60	60.76	149.16
154.24	226.83	181.57	54.82	135.02	**70**	177.28	260.72	208.70	63.01	155.19
159.99	235.29	188.63	56.77	140.26	**71**	183.90	270.44	216.82	65.25	161.22
165.74	243.75	195.69	58.65	145.50	**72**	190.51	280.18	224.93	67.41	167.25
172.71	253.98	203.91	60.56	151.62	**73**	198.52	291.93	234.38	69.61	174.28
179.66	264.22	212.13	62.63	157.73	**74**	206.51	303.71	243.83	71.99	181.30
186.64	274.46	220.34	64.69	163.84	**75**	214.52	315.47	253.27	74.36	188.33
193.59	284.70	228.57	66.92	169.95	**76**	222.52	327.24	262.72	76.92	195.35
200.55	294.93	236.79	69.15	176.07	**77**	230.52	339.00	272.17	79.48	202.38
207.77	305.55	245.31	71.38	182.41	**78**	238.82	351.21	281.96	82.04	209.66
214.99	316.17	253.83	73.57	188.74	**79**	247.11	363.41	291.75	84.56	216.95
222.22	326.79	262.35	75.80	195.08	**80**	255.43	375.62	301.55	87.13	224.23
229.44	337.40	270.87	78.13	201.42	**81**	263.72	387.82	311.35	89.80	231.51
236.65	348.02	279.41	80.52	207.76	**82**	272.01	400.03	321.16	92.55	238.80
245.17	360.55	289.46	82.97	214.82	**83**	281.81	414.43	332.72	95.36	246.92
253.70	373.08	299.52	85.49	221.89	**84**	291.61	428.83	344.28	98.27	255.04
262.21	385.61	309.58	88.10	228.96	**85**	301.39	443.23	355.84	101.27	263.17
270.74	398.14	319.64	90.78	236.02	**86**	311.19	457.63	367.40	104.35	271.29
279.25	410.67	329.69	93.54	243.08	**87**	320.98	472.04	378.96	107.52	279.40
284.84	418.88	336.30	96.39	247.94	**88**	327.40	481.47	386.55	110.80	284.99
290.53	427.25	343.02	99.32	252.89	**89**	333.94	491.10	394.27	114.16	290.68
296.35	435.80	349.88	102.35	257.96	**90**	340.63	500.92	402.16	117.64	296.51
302.26	444.51	356.88	105.46	263.11	**91**	347.43	510.94	410.20	121.22	302.43
308.32	453.40	364.01	108.66	268.37	**92**	354.39	521.15	418.40	124.90	308.47
314.49	462.48	371.30	111.97	273.74	**93**	361.48	531.59	426.78	128.70	314.64
320.77	471.72	378.73	115.36	279.21	**94**	368.70	542.21	435.32	132.60	320.93
327.19	481.16	386.29	118.87	284.80	**95**	376.08	553.06	444.01	136.63	327.36
333.73	490.78	394.01	122.47	290.51	**96**	383.60	564.11	452.89	140.77	333.91
340.41	500.60	401.90	126.18	296.31	**97**	391.28	575.40	461.95	145.04	340.59
347.22	510.61	409.93	130.02	302.23	**98**	399.10	586.91	471.19	149.45	347.40
354.16	520.82	418.14	133.95	308.28	**99+**	407.08	598.65	480.62	153.96	354.35

*See PREMIUM INFORMATION regarding Household Premium Discount rating.

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

MONTHLY PREMIUMS*

ZIP CODES: 919-925, 930-931, 933, 941-943, 945, 947-949, 954-955

NON-TOBACCO						TOBACCO				
Plan A WM20	**Plan F WM24**	**Plan G WM25**	**Plan High G WM36**	**Plan N WM35**	**Attained Age**	**Plan A WM20**	**Plan F WM24**	**Plan G WM25**	**Plan High G WM36**	**Plan N WM35**
366.25	538.62	428.88		318.91	**Thru 64**	420.98	619.10	492.96		366.56
146.51	215.45	171.55	57.58	127.57	**65**	168.40	247.64	197.18	66.18	146.63
146.51	215.45	171.55	57.58	127.57	**66**	168.40	247.64	197.18	66.18	146.63
161.15	237.00	188.70	57.58	140.32	**67**	185.23	272.41	216.90	66.18	161.29
167.92	246.95	197.01	59.89	146.49	**68**	193.01	283.85	226.45	68.84	168.38
174.70	256.90	205.32	62.19	152.67	**69**	200.80	295.29	236.00	71.48	175.48
181.46	266.86	213.61	64.49	158.85	**70**	208.57	306.73	245.53	74.13	182.58
188.22	276.81	221.92	66.79	165.01	**71**	216.35	318.17	255.08	76.77	189.67
194.99	286.77	230.22	69.00	171.18	**72**	224.13	329.62	264.62	79.31	196.76
203.19	298.80	239.89	71.24	178.38	**73**	233.55	343.45	275.74	81.89	205.03
211.37	310.85	249.57	73.68	185.56	**74**	242.95	357.30	286.86	84.69	213.29
219.57	322.89	259.23	76.11	192.76	**75**	252.38	371.14	297.96	87.48	221.56
227.76	334.94	268.90	78.73	199.94	**76**	261.79	384.99	309.08	90.49	229.82
235.94	346.97	278.57	81.35	207.14	**77**	271.20	398.82	320.20	93.51	238.09
244.44	359.48	288.60	83.97	214.59	**78**	280.96	413.19	331.72	96.52	246.66
252.93	371.96	298.62	86.55	222.05	**79**	290.72	427.54	343.24	99.48	255.23
261.44	384.45	308.65	89.18	229.51	**80**	300.50	441.90	354.77	102.50	263.80
269.93	396.95	318.67	91.92	236.96	**81**	310.26	456.26	366.29	105.65	272.37
278.41	409.44	328.71	94.73	244.42	**82**	320.01	470.62	377.83	108.88	280.94
288.44	424.18	340.54	97.61	252.73	**83**	331.54	487.56	391.43	112.19	290.49
298.47	438.92	352.38	100.58	261.04	**84**	343.07	504.50	405.03	115.61	300.05
308.49	453.66	364.22	103.65	269.36	**85**	354.58	521.45	418.64	119.14	309.61
318.52	468.40	376.05	106.80	277.67	**86**	366.11	538.39	432.24	122.76	319.16
328.53	483.15	387.87	110.05	285.98	**87**	377.62	555.34	445.83	126.49	328.71
335.11	492.80	395.64	113.40	291.69	**88**	385.18	566.44	454.76	130.35	335.28
341.80	502.65	403.55	116.85	297.52	**89**	392.87	577.76	463.85	134.31	341.98
348.64	512.71	411.62	120.41	303.48	**90**	400.74	589.32	473.13	138.40	348.83
355.60	522.96	419.85	124.07	309.55	**91**	408.74	601.10	482.59	142.61	355.80
362.73	533.41	428.25	127.84	315.73	**92**	416.93	613.12	492.24	146.94	362.91
369.99	544.10	436.82	131.73	322.05	**93**	425.27	625.40	502.09	151.41	370.17
377.38	554.96	445.56	135.72	328.49	**94**	433.77	637.89	512.14	156.00	377.57
384.93	566.07	454.46	139.84	335.06	**95**	442.45	650.66	522.37	160.74	385.13
392.62	577.38	463.55	144.08	341.77	**96**	451.29	663.66	532.81	165.61	392.84
400.49	588.94	472.82	148.45	348.60	**97**	460.33	676.94	543.47	170.63	400.69
408.49	600.72	482.28	152.96	355.57	**98**	469.53	690.48	554.34	175.82	408.70
416.66	612.73	491.92	157.58	362.69	**99+**	478.92	704.29	565.43	181.13	416.88

*See PREMIUM INFORMATION regarding Household Premium Discount rating.

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

MONTHLY PREMIUMS*
ZIP CODES: 900-918, 926-928, 944, 946

NON-TOBACCO						TOBACCO				
Plan A WM20	**Plan F WM24**	**Plan G WM25**	**Plan High G WM36**	**Plan N WM35**	**Attained Age**	**Plan A WM20**	**Plan F WM24**	**Plan G WM25**	**Plan High G WM36**	**Plan N WM35**
399.22	587.09	467.47		347.61	**Thru 64**	458.87	674.82	537.33		399.55
159.69	234.84	186.99	62.76	139.05	**65**	183.56	269.93	214.93	72.14	159.83
159.69	234.84	186.99	62.76	139.05	**66**	183.56	269.93	214.93	72.14	159.83
175.65	258.33	205.69	62.76	152.95	**67**	201.90	296.93	236.42	72.14	175.81
183.03	269.18	214.74	65.28	159.68	**68**	210.38	309.40	246.83	75.04	183.53
190.42	280.02	223.80	67.79	166.41	**69**	218.87	321.87	257.24	77.91	191.27
197.79	290.87	232.84	70.30	173.14	**70**	227.34	334.34	267.63	80.80	199.01
205.17	301.72	241.89	72.80	179.86	**71**	235.82	346.81	278.04	83.68	206.74
212.54	312.58	250.94	75.21	186.59	**72**	244.30	359.29	288.44	86.45	214.47
221.48	325.69	261.48	77.66	194.43	**73**	254.57	374.36	300.56	89.26	223.48
230.39	338.83	272.03	80.31	202.26	**74**	264.82	389.46	312.68	92.31	232.49
239.33	351.95	282.56	82.96	210.11	**75**	275.09	404.54	324.78	95.35	241.50
248.26	365.09	293.10	85.81	217.94	**76**	285.35	419.64	336.90	98.63	250.50
257.18	378.20	303.65	88.68	225.78	**77**	295.61	434.71	349.02	101.93	259.52
266.44	391.83	314.57	91.53	233.91	**78**	306.25	450.38	361.58	105.21	268.86
275.69	405.44	325.49	94.34	242.04	**79**	316.89	466.02	374.13	108.43	278.20
284.96	419.05	336.43	97.20	250.16	**80**	327.55	481.67	386.70	111.73	287.54
294.22	432.67	347.35	100.19	258.29	**81**	338.18	497.32	399.26	115.16	296.88
303.47	446.29	358.30	103.25	266.42	**82**	348.81	512.98	411.84	118.68	306.23
314.40	462.35	371.19	106.39	275.47	**83**	361.38	531.44	426.66	122.29	316.63
325.33	478.42	384.09	109.63	284.54	**84**	373.95	549.91	441.48	126.02	327.05
336.25	494.49	397.00	112.98	293.60	**85**	386.49	568.38	456.32	129.86	337.48
347.18	510.56	409.89	116.41	302.66	**86**	399.06	586.85	471.14	133.81	347.88
358.10	526.63	422.78	119.95	311.72	**87**	411.61	605.32	485.96	137.87	358.29
365.27	537.16	431.25	123.61	317.95	**88**	419.85	617.42	495.69	142.08	365.46
372.56	547.89	439.87	127.37	324.30	**89**	428.23	629.76	505.60	146.40	372.76
380.02	558.85	448.67	131.24	330.80	**90**	436.81	642.36	515.71	150.86	380.23
387.61	570.02	457.64	135.24	337.41	**91**	445.53	655.20	526.02	155.45	387.82
395.37	581.42	466.79	139.34	344.15	**92**	454.45	668.30	536.54	160.17	395.57
403.28	593.07	476.13	143.58	351.03	**93**	463.54	681.69	547.28	165.04	403.49
411.34	604.91	485.66	147.94	358.05	**94**	472.81	695.30	558.23	170.04	411.55
419.58	617.02	495.36	152.43	365.22	**95**	482.27	709.22	569.38	175.21	419.79
427.96	629.35	505.26	157.05	372.53	**96**	491.91	723.39	580.76	180.52	428.20
436.53	641.94	515.37	161.81	379.98	**97**	501.76	737.87	592.38	185.99	436.75
445.26	654.78	525.68	166.73	387.57	**98**	511.79	752.62	604.23	191.64	445.48
454.16	667.88	536.20	171.77	395.33	**99+**	522.02	767.68	616.32	197.43	454.40

*See PREMIUM INFORMATION regarding Household Premium Discount rating.

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

Premium Information
The premium for your policy will change. Because the premium rate is based on your attained age, the premium will increase each year as you age. A premium change for any other reason can occur on any policy renewal date. However, we cannot make such a change unless we make the same change to all policies of this form issued in the same state to persons of the same classification.

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.

Thirty Day Right to Return Policy
If you find that you are not satisfied with your policy, you may return it to 3300 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 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.

Household Premium Discount
You are eligible for a household premium discount if: (a) you reside with your spouse (including civil union/domestic partner) of any age or (b) for the past year you have resided with at least one, but not more than three, other adults who are age 60 or older. The discounted premium will be priced 12% lower than the rates illustrated. The policy's household premium discount will be removed if the other adult or spouse no longer resides with you (other than in the case of his or her death).

Disclosures
The policy may not fully cover all of your medical costs. Neither United World 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. For additional information concerning policy benefits, contact the Health Insurance Counseling and Advocacy Program (HICAP) or your agent. Call the HICAP toll-free telephone number, 1-800-434-0222, for referral to your local HICAP office. HICAP is a service provided free of charge by the State of California. You may also contact the Consumer Affairs department of the California Department of Insurance after first contacting your agent or the insurance company for resolution of any problems. Mutual of Omaha's toll-free customer service telephone number is shown on the face page of your policy. You can contact the Consumer Affairs department at California Department of Insurance, Consumer Service Division, 300 South Spring Street, South Tower, Los Angeles, CA 90013, 1-800-927-HELP(4357).

Notice
The policy may not fully cover all of your medical costs. United World 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.

Exclusions
Exclusions apply to your coverage. Please be sure to review the exclusions in your policy. This policy does not cover Part A benefits for benefit periods that begin while this policy is not in force, and other exclusions apply.

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 $1,632	$0	$1,632 (Part A deductible)
61st through 90th day	All but $408 a day	$408 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	$0	Up to $204 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, we stand in the place of Medicare and will pay whatever amount Medicare would have paid 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 $240 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 $240 of Medicare-approved amounts*	$0	$0	$240 (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 $240 of Medicare-approved amounts*	$0	$0	$240 (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 $240 of Medicare-approved amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN F
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD
Medicare first eligible before 2020 only

*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 $1,632	$1,632 (Part A deductible)	$0
61st through 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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, we stand in the place of Medicare and will pay whatever amount Medicare would have paid 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

Medicare first eligible before 2020 only

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 $240 of Medicare-approved amounts*	$0	$240 (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 $240 of Medicare-approved amounts*	$0	$240 (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 Medically necessary skilled care services and medical supplies	100%	$0	$0
DURABLE MEDICAL EQUIPMENT			
First $240 of Medicare-approved amounts*	$0	$240 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN F

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

Medicare first eligible before 2020 only

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$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 $1,632	$1,632 (Part A deductible)	$0
61st through 90th day	All but $408 a day	$408 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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, we stand in the place of Medicare and will pay whatever amount Medicare would have paid 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 $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-approved amounts*	$0	$0	$240 (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			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-approved amounts*	$0	$0	$240 (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 $240 of Medicare-approved amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year	$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

HIGH DEDUCTIBLE 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.

***This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $2,800 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2,800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A deductible)	$0
61st through 90th day	All but $408 a day	$408 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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, we stand in the place of Medicare and will pay whatever amount Medicare would have paid up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

HIGH DEDUCTIBLE PLAN G

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

*Once you have been billed $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

***This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $2,800 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2,800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE*** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-approved amounts*	$0	$0	$240 (Unless Part B deductible has been met)
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 $240 of Medicare-approved amounts*	$0	$0	$240 (Unless Part B deductible has been met)
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 $240 of Medicare-approved amounts*	$0	$0	$240 (Unless Part B deductible has been met)
Remainder of Medicare-approved amounts	80%	20%	$0

HIGH DEDUCTIBLE PLAN G

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

***This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $2,800 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2,800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE*** YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year	$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 N

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

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

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A deductible)	$0
61st through 90th day	All but $408 a day	$408 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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, we stand in the place of Medicare and will pay whatever amount Medicare would have paid 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 $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-approved amounts*	$0	$0	$240 (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 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 $240 of Medicare-approved amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

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

PARTS A AND B

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
DURABLE MEDICAL EQUIPMENT			
First $240 of Medicare-approved amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum benefit