UNITED OF OMAHA LIFE INSURANCE COMPANY

A Mutual of Omaha Company

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE - COVER PAGE 1

BENEFIT PLANS A, F AND G

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.

Basic Benefits for Plans A through J:

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.

Blood: First 3 pints of blood each year.

A	B	C	D	E	**F**	F*	**G**	H	I	J	J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	**Basic Benefits**		**Basic Benefits**	Basic Benefits	Basic Benefits	Basic Benefits	
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	**Skilled Nursing Facility Coinsurance**		**Skilled Nursing Facility Coinsurance**	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	**Part A Deductible**		**Part A Deductible**	Part A Deductible	Part A Deductible	Part A Deductible	
		Part B Deductible			**Part B Deductible**					Part B Deductible	
					Part B Excess (100%)		**Part B Excess (80%)**		Part B Excess (100%)	Part B Excess (100%)	
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	**Foreign Travel Emergency**		**Foreign Travel Emergency**	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	
			At-home Recovery				**At-home Recovery**		At-home Recovery	At-home Recovery	
				Preventive Care NOT Covered by Medicare						Preventive Care NOT Covered by Medicare	

*Plans F and J also have an option called a high deductible Plan F and a high deductible Plan J. These high deductible plans pay the same benefits as Plans F and J after one has paid a calendar year $1,900 deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses are $1,900. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plans separate foreign travel emergency deductible.

UNITED OF OMAHA LIFE INSURANCE COMPANY

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE – COVER PAGE 2

Basic Benefits: Basic Benefits for Plans K and L include similar services as Plans A through J, but cost sharing for the basic benefits is at different levels.

J	K**	L**
Basic Benefits	100% of Part A Hospitalization Coinsurance plus coverage for 365 days after Medicare Benefits end 50% Hospice cost-sharing 50% of Medicare eligible expenses for the first three pints of Blood 50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	100% of Part A Hospitalization Coinsurance plus coverage for 365 days after Medicare Benefits end 75% Hospice cost-sharing 75% of Medicare eligible expenses for the first three pints of Blood 75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services
Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT Covered by Medicare		
	$4,440 Out of Pocket Annual Limit ***	$2,220 Out of Pocket Annual Limit ***

**Plans K and L provide for different cost-sharing for items and services than Plans A through J. Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges". You will be responsible for paying excess charges.

***The out-of-pocket annual limit will increase each year for inflation.

See Outlines of Coverage for details and exceptions.

UNITED OF OMAHA LIFE INSURANCE COMPANY

MONTHLY RATES*

ZIP CODES: 754-759, 762-769, 778-781, 783, 785-792, 795-799 and 885

NON-TOBACCO

FEMALE				MALE		
Plan A-UM1	**Plan F-UM4**	**Plan G-UM5**	**Attained Age**	**Plan A-UM1**	**Plan F-UM4**	**Plan G-UM5**
$150.02			**Under 65**	$166.69		
65.33	$94.68	$80.48	**65**	68.76	$99.66	$84.71
65.33	94.68	80.48	**66**	68.76	99.66	84.71
67.87	98.37	83.62	**67**	72.21	104.65	88.95
70.54	102.23	86.90	**68**	75.85	109.93	93.44
73.30	106.22	90.29	**69**	79.67	115.46	98.14
76.01	110.16	93.64	**70**	83.52	121.05	102.89
78.68	114.04	96.93	**71**	87.43	126.71	107.70
81.41	117.98	100.29	**72**	91.47	132.56	112.68
84.13	121.94	103.65	**73**	95.61	138.57	117.78
86.86	125.88	107.00	**74**	99.84	144.69	122.99
89.41	129.58	110.15	**75**	103.97	150.67	128.08
91.58	132.72	112.81	**76**	107.73	156.14	132.72
93.17	135.03	114.77	**77**	109.61	158.86	135.03
94.75	137.32	116.72	**78**	111.48	161.56	137.32
96.48	139.83	118.85	**79**	113.50	164.50	139.83
98.14	142.23	120.90	**80**	115.46	167.34	142.23
100.30	145.36	123.56	**81**	116.63	169.03	143.67
102.39	148.39	126.13	**82**	117.69	170.57	144.98
104.41	151.32	128.62	**83**	118.64	171.95	146.16
106.36	154.14	131.02	**84**	119.50	173.19	147.21
108.22	156.84	133.31	**85**	120.25	174.27	148.13
110.00	159.42	135.51	**86**	120.88	175.19	148.91
111.69	161.87	137.59	**87**	121.40	175.95	149.55
113.28	164.18	139.55	**88**	121.81	176.54	150.05
114.77	166.34	141.39	**89**	122.10	176.96	150.41
116.14	168.31	143.06	**90 and Over**	122.24	177.16	150.59

*See PREMIUM INFORMATION regarding Two-Person Household rating.

To obtain annual, semiannual or quarterly premiums, multiply the Monthly Premium Amount by 12, 6 and 3 respectively.

UNITED OF OMAHA LIFE INSURANCE COMPANY

MONTHLY RATES*

ZIP CODES: 754-759, 762-769, 778-781, 783, 785-792, 795-799 and 885

TOBACCO

FEMALE				MALE		
Plan A-UM1	**Plan F-UM4**	**Plan G-UM5**	**Attained Age**	**Plan A-UM1**	**Plan F-UM4**	**Plan G-UM5**
$172.43			**Under 65**	$191.60		
75.09	$108.83	$92.50	**65**	79.04	$114.55	$97.37
75.09	108.83	92.50	**66**	79.04	114.55	97.37
78.01	113.07	96.11	**67**	83.00	120.29	102.24
81.08	117.50	99.88	**68**	87.18	126.35	107.40
84.25	122.09	103.78	**69**	91.58	132.71	112.81
87.37	126.62	107.63	**70**	96.00	139.14	118.27
90.44	131.08	111.41	**71**	100.49	145.64	123.80
93.57	135.61	115.27	**72**	105.14	152.37	129.52
96.71	140.16	119.13	**73**	109.90	159.27	135.38
99.84	144.69	122.99	**74**	114.76	166.31	141.36
102.77	148.94	126.60	**75**	119.50	173.19	147.21
105.26	152.55	129.67	**76**	123.83	179.47	152.55
107.09	155.21	131.92	**77**	125.99	182.59	155.21
108.91	157.84	134.16	**78**	128.13	185.70	157.84
110.90	160.72	136.61	**79**	130.46	189.08	160.72
112.81	163.49	138.96	**80**	132.71	192.34	163.49
115.29	167.09	142.02	**81**	134.06	194.28	165.14
117.69	170.57	144.98	**82**	135.28	196.06	166.64
120.01	173.93	147.83	**83**	136.37	197.64	167.99
122.25	177.17	150.60	**84**	137.36	199.07	169.21
124.39	180.28	153.23	**85**	138.21	200.31	170.26
126.43	183.24	155.75	**86**	138.94	201.37	171.16
128.38	186.06	158.15	**87**	139.55	202.24	171.90
130.21	188.71	160.41	**88**	140.01	202.91	172.48
131.92	191.20	162.51	**89**	140.35	203.40	172.89
133.49	193.46	164.44	**90 and Over**	140.51	203.63	173.09

*See PREMIUM INFORMATION regarding Two-Person Household rating.
To obtain annual, semiannual or quarterly premiums, multiply the Monthly Premium Amount by 12, 6 and 3 respectively.

UNITED OF OMAHA LIFE INSURANCE COMPANY

MONTHLY RATES*

ZIP CODES: 733, 750-753, 760, 761, 774, 776, 777, 782, 784, 793 and 794
NON-TOBACCO

FEMALE				MALE		
Plan A-UM1	**Plan F-UM4**	**Plan G-UM5**	**Attained Age**	**Plan A-UM1**	**Plan F-UM4**	**Plan G-UM5**
$170.02			**Under 65**	$188.92		
74.04	$107.30	$91.21	**65**	77.93	$112.95	$96.01
74.04	107.30	91.21	**66**	77.93	112.95	96.01
76.92	111.48	94.77	**67**	81.84	118.60	100.81
79.95	115.86	98.48	**68**	85.96	124.58	105.89
83.07	120.39	102.33	**69**	90.29	130.86	111.23
86.15	124.85	106.12	**70**	94.66	137.19	116.61
89.18	129.24	109.85	**71**	99.09	143.60	122.06
92.26	133.71	113.66	**72**	103.67	150.24	127.71
95.35	138.20	117.47	**73**	108.36	157.04	133.48
98.44	142.67	121.26	**74**	113.15	163.98	139.38
101.33	146.86	124.83	**75**	117.83	170.76	145.15
103.79	150.41	127.86	**76**	122.10	176.96	150.41
105.59	153.03	130.08	**77**	124.23	180.04	153.03
107.38	155.63	132.29	**78**	126.34	183.10	155.63
109.35	158.47	134.70	**79**	128.64	186.43	158.47
111.23	161.20	137.02	**80**	130.86	189.65	161.20
113.68	164.75	140.03	**81**	132.18	191.56	162.83
116.05	168.18	142.95	**82**	133.39	193.31	164.31
118.33	171.49	145.76	**83**	134.46	194.87	165.64
120.54	174.69	148.49	**84**	135.44	196.28	166.84
122.65	177.76	151.09	**85**	136.28	197.51	167.88
124.66	180.67	153.57	**86**	137.00	198.55	168.77
126.58	183.45	155.93	**87**	137.59	199.41	169.49
128.39	186.07	158.16	**88**	138.05	200.07	170.06
130.08	188.52	160.24	**89**	138.38	200.55	170.47
131.62	190.75	162.14	**90 and Over**	138.54	200.78	170.67

*See PREMIUM INFORMATION regarding Two-Person Household rating.
To obtain annual, semiannual or quarterly premiums, multiply the Monthly Premium Amount by 12, 6 and 3 respectively.

UNITED OF OMAHA LIFE INSURANCE COMPANY

MONTHLY RATES*

ZIP CODES: 733, 750-753, 760, 761, 774, 776, 777, 782, 784, 793 and 794
TOBACCO

FEMALE				MALE		
Plan A-UM1	**Plan F-UM4**	**Plan G-UM5**	**Attained Age**	**Plan A-UM1**	**Plan F-UM4**	**Plan G-UM5**
$195.42			**Under 65**	$217.15		
85.10	$123.34	$104.84	**65**	89.58	$129.83	$110.35
85.10	123.34	104.84	**66**	89.58	129.83	110.35
88.41	128.14	108.93	**67**	94.06	136.32	115.87
91.89	133.17	113.20	**68**	98.81	143.20	121.72
95.48	138.37	117.62	**69**	103.79	150.41	127.85
99.02	143.50	121.98	**70**	108.80	157.69	134.04
102.50	148.55	126.27	**71**	113.89	165.06	140.30
106.05	153.69	130.64	**72**	119.16	172.69	146.79
109.60	158.85	135.02	**73**	124.55	180.51	153.43
113.15	163.99	139.38	**74**	130.06	188.49	160.21
116.47	168.80	143.48	**75**	135.44	196.28	166.84
119.30	172.89	146.96	**76**	140.34	203.40	172.89
121.37	175.90	149.51	**77**	142.79	206.94	175.90
123.43	178.89	152.05	**78**	145.22	210.46	178.89
125.68	182.15	154.83	**79**	147.86	214.29	182.15
127.85	185.28	157.49	**80**	150.41	217.98	185.28
130.66	189.36	160.96	**81**	151.93	220.19	187.16
133.39	193.31	164.31	**82**	153.32	222.20	188.86
136.01	197.12	167.55	**83**	154.55	223.99	190.39
138.55	200.80	170.68	**84**	155.67	225.61	191.77
140.97	204.32	173.67	**85**	156.64	227.02	192.96
143.29	207.67	176.52	**86**	157.47	228.22	193.98
145.49	210.87	179.23	**87**	158.15	229.20	194.82
147.57	213.87	181.80	**88**	158.68	229.97	195.47
149.51	216.69	184.18	**89**	159.06	230.52	195.94
151.29	219.25	186.36	**90 and Over**	159.24	230.79	196.17

*See PREMIUM INFORMATION regarding Two-Person Household rating.
To obtain annual, semiannual or quarterly premiums, multiply the Monthly Premium Amount by 12, 6 and 3 respectively.

UNITED OF OMAHA LIFE INSURANCE COMPANY

MONTHLY RATES*

ZIP CODES: 770-773 and 775
NON-TOBACCO

FEMALE				MALE		
Plan A-UM1	**Plan F-UM4**	**Plan G-UM5**	**Attained Age**	**Plan A-UM1**	**Plan F-UM4**	**Plan G-UM5**
$193.35			**Under 65**	$214.85		
84.20	$122.03	$103.73	**65**	88.63	128.45	109.19
84.20	122.03	103.73	**66**	88.63	128.45	109.19
87.48	126.79	107.77	**67**	93.07	134.88	114.65
90.92	131.76	112.00	**68**	97.76	141.68	120.43
94.47	136.91	116.37	**69**	102.69	148.82	126.49
97.97	141.98	120.69	**70**	107.65	156.02	132.62
101.41	146.98	124.93	**71**	112.69	163.31	138.82
104.93	152.07	129.26	**72**	117.89	170.86	145.23
108.44	157.16	133.59	**73**	123.23	178.60	151.80
111.95	162.25	137.91	**74**	128.68	186.49	158.52
115.24	167.01	141.96	**75**	134.00	194.20	165.07
118.04	171.06	145.41	**76**	138.86	201.25	171.06
120.09	174.04	147.93	**77**	141.28	204.75	174.04
122.12	176.99	150.44	**78**	143.68	208.23	176.99
124.35	180.22	153.19	**79**	146.29	212.02	180.22
126.49	183.32	155.82	**80**	148.82	215.68	183.32
129.28	187.36	159.25	**81**	150.32	217.86	185.18
131.97	191.26	162.57	**82**	151.69	219.84	186.86
134.57	195.03	165.77	**83**	152.91	221.62	188.38
137.08	198.67	168.87	**84**	154.02	223.23	189.74
139.48	202.15	171.83	**85**	154.98	224.62	190.92
141.77	205.47	174.65	**86**	155.80	225.80	191.93
143.95	208.63	177.34	**87**	156.48	226.78	192.76
146.01	211.61	179.87	**88**	157.00	227.53	193.40
147.93	214.39	182.23	**89**	157.37	228.08	193.87
149.68	216.93	184.39	**90 and Over**	157.56	228.34	194.09

*See PREMIUM INFORMATION regarding Two-Person Household rating.
To obtain annual, semiannual or quarterly premiums, multiply the Monthly Premium Amount by 12, 6 and 3 respectively.

UNITED OF OMAHA LIFE INSURANCE COMPANY

MONTHLY RATES*

ZIP CODES: 770-773 and 775
TOBACCO

FEMALE				MALE		
Plan A-UM1	**Plan F-UM4**	**Plan G-UM5**	**Attained Age**	**Plan A-UM1**	**Plan F-UM4**	**Plan G-UM5**
$222.24			**Under 65**	$246.95		
96.78	$140.27	$119.23	**65**	101.87	$147.65	$125.50
96.78	140.27	119.23	**66**	101.87	147.65	125.50
100.55	145.73	123.88	**67**	106.98	155.03	131.78
104.50	151.45	128.74	**68**	112.37	162.85	138.42
108.59	157.37	133.76	**69**	118.03	171.05	145.39
112.61	163.20	138.72	**70**	123.74	179.34	152.44
116.57	168.94	143.60	**71**	129.53	187.71	159.56
120.61	174.79	148.57	**72**	135.51	196.39	166.94
124.64	180.65	153.55	**73**	141.65	205.29	174.49
128.68	186.49	158.51	**74**	147.91	214.36	182.20
132.46	191.97	163.18	**75**	154.03	223.22	189.74
135.67	196.62	167.13	**76**	159.60	231.32	196.62
138.03	200.04	170.03	**77**	162.39	235.34	200.04
140.37	203.44	172.92	**78**	165.15	239.34	203.44
142.94	207.15	176.08	**79**	168.15	243.70	207.15
145.39	210.71	179.10	**80**	171.05	247.90	210.71
148.60	215.35	183.05	**81**	172.78	250.41	212.85
151.69	219.84	186.86	**82**	174.36	252.69	214.79
154.67	224.17	190.54	**83**	175.76	254.74	216.53
157.56	228.36	194.10	**84**	177.04	256.58	218.09
160.32	232.36	197.50	**85**	178.14	258.18	219.45
162.96	236.18	200.75	**86**	179.08	259.54	220.61
165.46	239.81	203.84	**87**	179.86	260.66	221.56
167.83	243.23	206.75	**88**	180.46	261.53	222.30
170.03	246.43	209.46	**89**	180.89	262.16	222.84
172.05	249.34	211.94	**90 and Over**	181.10	262.46	223.09

*See PREMIUM INFORMATION regarding Two-Person Household rating.
To obtain annual, semiannual or quarterly premiums, multiply the Monthly Premium Amount by 12, 6 and 3 respectively.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

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. Until you are age 90, your premium may change each year. 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.

Two-Person Household Premium Discount: If you have resided with another adult for at least one year, or you are married, and the other adult or your spouse also owns or is issued a Medicare supplement policy underwritten by United of Omaha or its affiliates, you will be eligible for a discounted premium. The discounted premium will be priced 7% lower than the rates illustrated This two-person household premium discount will be removed if you cease to reside with the other adult or spouse, or if that person's coverage with us terminated for any reason.

READ YOUR POLICY 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 the United of Omaha Life 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 or other health insurance coverage, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

EXCEPTIONS AND LIMITATIONS

We will not pay for: (a) services for which a charge is normally not made when there is no insurance; (b) expense incurred before the Policy Date; or (c) expense incurred which is paid for by Medicare.

REFUND OF UNEARNED PREMIUM

In the event of cancellation or death, we will promptly return the unearned portion of any premium paid. Termination of coverage will not affect any claim originating while this policy is in force.

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.

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.

****$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

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 $1,024	$0	$1,024 (Part A Deductible)
61st through 90th day	All but $256 a day	$256 a day	$0**
91st day and after: • While using 60 lifetime reserve days	All but $512 a day	$512 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 $128 a day	$0	Up to $128 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 Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

+NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

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

* Once you have been billed $135 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.

****$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

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 $135 of Medicare Approved Amounts*	$0	$0	$135 (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 $135 of Medicare Approved Amounts*	$0	$0	$135 (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 $135 of Medicare Approved Amounts*	$0	$0	$135 (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.

**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

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 $1,024	$1,024 (Part A Deductible)	$0**
61st through 90th day	All but $256 a day	$256 a day	$0**
91st day and after: ●While using 60 lifetime reserve days	All but $512 a day	$512 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 $128 a day	Up to $128 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 Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

+NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F

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

*Once you have been billed $135 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.

**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

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 $135 of Medicare Approved Amounts*	$0	$135 (Part B Deductible)	$0**
Remainder of Medicare Approved Amounts	Generally80%	Generally20%	$0**
Part B Excess Charges (above Medicare Approved Amounts)	$0	100%	$0**
BLOOD First 3 pints	$0	All costs	$0**
Next $135 of Medicare Approved Amounts*	$0	$135 (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 $135 of Medicare Approved Amounts*	$0	$135 (Part B Deductible)	$0**
● Remainder of Medicare Approved Amounts	80%	20%	$0**

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime Maximum Benefit of $50,000	20% and amounts over the $50,000 lifetime Maximum 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.

**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

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 $1,024	$1,024 (Part A Deductible)	$0**
61st through 90th day	All but $256 a day	$256 a day	$0**
91st day and after: •While using 60 lifetime reserve days	All but $512 a day	$512 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 $128 a day	Up to $128 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 Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

+NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G

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

*Once you have been billed $135of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

**** $0 indicates your liability for covered charges. You are responsible for all other non-covered charges.**

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 $135 of Medicare Approved Amounts*	$0	$0	$135 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0**
Part B Excess Charges (above Medicare Approved Amounts)	$0	80%	20%
BLOOD First 3 pints	$0	All costs	$0**
Next $135 of Medicare Approved Amounts*	$0	$0	$135 (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 $135 of Medicare Approved Amounts*	$0	$0	$135 (Part B Deductible)
• Remainder of Medicare Approved Amounts	80%	20%	$0**
HOME HEALTH CARE—AT-HOME RECOVERY SERVICES NOT COVERED BY MEDICARE Home care certified by your doctor for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
• Benefit for each visit	$0	Actual charges to $40 a visit	Balance
• Number of visits covered (must be received with 8 weeks of last Medicare approved visit)	$0	Up to the number of Medicare approved visits, not to exceed 7 each week	Balance
• Calendar year maximum	$0	$1,600	Balance

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