WOODMEN OF THE WORLD

A Legal Reserve Fraternal Benefit Society

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE – COVER PAGE

BENEFIT PLANS A, B, C, D, F, 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.

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 Coinsurance	**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 Emergency	**Foreign Travel Emergency**	**Foreign Travel Emergency**	**Foreign Travel Emergency**

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 Emergency	**Foreign Travel Emergency**
Out-of-pocket limit $4,800; paid at 100% after limit reached	Out-of-pocket limit $2,400; 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 $2,110 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed $2,110. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy/certificate. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

MONTHLY NON-TOBACCO RATES
ZIP CODES: 840 - 847

FEMALE								MALE						
Plan A MTW20	Plan B MTW21	Plan C MTW22	Plan D MTW23	Plan F MTW24	Plan G MTW25	Plan N MTW31	Attained Age	Plan A MTW20	Plan B MTW21	Plan C MTW22	Plan D MTW23	Plan F MTW24	Plan G MTW25	Plan N MTW31
99.98	115.43	141.45	113.46	144.86	106.78	88.04	**65**	114.92	132.68	162.59	130.41	166.51	122.74	101.19
99.98	115.43	141.45	113.46	144.86	106.78	88.04	**66**	114.92	132.68	162.59	130.41	166.51	122.74	101.19
104.42	120.33	147.51	118.30	151.08	111.35	91.77	**67**	120.03	138.30	169.55	135.98	173.65	127.99	105.48
107.85	124.19	152.38	122.20	156.05	115.02	94.79	**68**	123.97	142.75	175.15	140.46	179.37	132.21	108.95
111.17	128.21	157.41	126.26	161.20	118.84	97.98	**69**	127.79	147.37	180.93	145.13	185.29	136.60	112.62
114.33	132.09	162.32	130.24	166.22	122.57	101.10	**70**	131.41	151.82	186.57	149.70	191.06	140.88	116.21
117.34	135.80	167.03	134.07	171.06	126.18	104.12	**71**	134.88	156.10	191.99	154.10	196.62	145.04	119.68
120.17	139.38	171.60	137.76	175.72	129.66	107.04	**72**	138.13	160.21	197.24	158.35	201.98	149.03	123.04
122.72	142.64	175.77	141.17	180.00	132.87	109.76	**73**	141.06	163.95	202.03	162.26	206.90	152.72	126.16
124.95	145.64	179.67	144.37	183.99	135.86	112.29	**74**	143.62	167.41	206.52	165.94	211.48	156.16	129.06
126.83	148.31	183.19	147.23	187.58	138.58	114.63	**75**	145.78	170.47	210.56	169.23	215.61	159.29	131.76
128.63	150.90	186.61	150.08	191.08	141.24	116.91	**76**	147.85	173.45	214.50	172.50	219.63	162.34	134.38
130.28	153.35	189.88	152.78	194.44	143.77	119.11	**77**	149.74	176.26	218.25	175.61	223.49	165.26	136.90
131.85	155.64	192.97	155.34	197.60	146.17	121.18	**78**	151.55	178.90	221.81	178.55	227.12	168.01	139.29
133.31	157.83	195.97	157.82	200.65	148.50	123.20	**79**	153.22	181.41	225.25	181.40	230.63	170.69	141.61
134.77	160.04	198.96	160.31	203.72	150.86	125.23	**80**	154.90	183.95	228.69	184.27	234.16	173.40	143.94
136.14	162.16	201.90	162.75	206.71	153.16	127.21	**81**	156.48	186.39	232.07	187.07	237.60	176.04	146.22
137.39	164.20	204.74	165.12	209.63	155.38	129.17	**82**	157.91	188.74	235.34	189.79	240.96	178.59	148.47
138.53	166.09	207.41	167.36	212.36	157.47	131.01	**83**	159.23	190.90	238.41	192.37	244.10	181.00	150.59
139.58	167.92	210.03	169.58	215.04	159.55	132.85	**84**	160.44	193.01	241.42	194.92	247.17	183.39	152.70
140.57	169.66	212.59	171.71	217.65	161.55	134.61	**85**	161.58	195.01	244.36	197.37	250.17	185.69	154.73
141.52	171.39	215.13	173.85	220.25	163.57	136.39	**86**	162.66	197.00	247.27	199.83	253.16	188.01	156.77
142.49	173.19	217.78	176.07	222.94	165.66	138.26	**87**	163.79	199.07	250.32	202.38	256.25	190.42	158.91
143.46	174.93	220.33	178.26	225.57	167.71	140.06	**88**	164.90	201.07	253.25	204.89	259.28	192.78	160.99
144.45	176.70	222.92	180.51	228.21	169.80	141.88	**89**	166.04	203.10	256.23	207.48	262.31	195.18	163.08
145.46	178.55	225.63	182.83	230.96	172.01	143.82	**90**	167.20	205.22	259.35	210.15	265.47	197.71	165.31
146.50	180.42	228.35	185.20	233.76	174.22	145.79	**91**	168.39	207.37	262.47	212.87	268.69	200.26	167.58
147.55	182.33	231.20	187.66	236.67	176.54	147.85	**92**	169.60	209.57	265.75	215.70	272.03	202.92	169.95
148.64	184.30	234.12	190.18	239.64	178.91	149.95	**93**	170.85	211.84	269.11	218.60	275.45	205.64	172.36
149.77	186.36	237.18	192.84	242.80	181.40	152.18	**94**	172.15	214.20	272.62	221.66	279.08	208.50	174.92
150.88	188.41	240.28	195.50	245.94	183.90	154.40	**95**	173.43	216.56	276.18	224.71	282.69	211.38	177.47
151.95	190.44	243.34	198.16	249.07	186.39	156.63	**96**	174.65	218.89	279.71	227.77	286.28	214.25	180.04
152.92	192.31	246.27	200.71	252.06	188.79	158.78	**97**	175.77	221.05	283.07	230.70	289.72	217.00	182.50
153.86	194.21	249.26	203.30	255.11	191.22	160.97	**98**	176.85	223.23	286.50	233.67	293.23	219.79	185.02
154.82	196.15	252.31	205.98	258.25	193.73	163.23	**99+**	177.96	225.46	290.01	236.76	296.84	222.68	187.62

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

MONTHLY TOBACCO RATES
ZIP CODES: 840 - 847

FEMALE								MALE						
Plan A MTW20	Plan B MTW21	Plan C MTW22	Plan D MTW23	Plan F MTW24	Plan G MTW25	Plan N MTW31	Attained Age	Plan A MTW20	Plan B MTW21	Plan C MTW22	Plan D MTW23	Plan F MTW24	Plan G MTW25	Plan N MTW31
114.92	132.68	162.59	130.41	166.51	122.74	101.19	**65**	132.09	152.51	186.88	149.90	191.39	141.08	116.31
114.92	132.68	162.59	130.41	166.51	122.74	101.19	**66**	132.09	152.51	186.88	149.90	191.39	141.08	116.31
120.03	138.30	169.55	135.98	173.65	127.99	105.48	**67**	137.96	158.97	194.88	156.30	199.60	147.11	121.24
123.97	142.75	175.15	140.46	179.37	132.21	108.95	**68**	142.49	164.08	201.32	161.45	206.17	151.96	125.23
127.79	147.37	180.93	145.13	185.29	136.60	112.62	**69**	146.88	169.39	207.97	166.81	212.98	157.01	129.45
131.41	151.82	186.57	149.70	191.06	140.88	116.21	**70**	151.05	174.51	214.45	172.07	219.61	161.93	133.57
134.88	156.10	191.99	154.10	196.62	145.04	119.68	**71**	155.03	179.42	220.68	177.13	226.00	166.71	137.56
138.13	160.21	197.24	158.35	201.98	149.03	123.04	**72**	158.77	184.15	226.71	182.01	232.16	171.30	141.42
141.06	163.95	202.03	162.26	206.90	152.72	126.16	**73**	162.14	188.45	232.22	186.51	237.81	175.54	145.01
143.62	167.41	206.52	165.94	211.48	156.16	129.06	**74**	165.08	192.42	237.38	190.74	243.08	179.49	148.35
145.78	170.47	210.56	169.23	215.61	159.29	131.76	**75**	167.56	195.94	242.02	194.52	247.83	183.09	151.45
147.85	173.45	214.50	172.50	219.63	162.34	134.38	**76**	169.94	199.37	246.55	198.28	252.45	186.60	154.46
149.74	176.26	218.25	175.61	223.49	165.26	136.90	**77**	172.12	202.60	250.86	201.85	256.89	189.95	157.36
151.55	178.90	221.81	178.55	227.12	168.01	139.29	**78**	174.20	205.63	254.95	205.23	261.06	193.12	160.10
153.22	181.41	225.25	181.40	230.63	170.69	141.61	**79**	176.12	208.52	258.91	208.51	265.09	196.20	162.77
154.90	183.95	228.69	184.27	234.16	173.40	143.94	**80**	178.05	211.44	262.86	211.80	269.15	199.31	165.45
156.48	186.39	232.07	187.07	237.60	176.04	146.22	**81**	179.86	214.24	266.75	215.02	273.10	202.35	168.07
157.91	188.74	235.34	189.79	240.96	178.59	148.47	**82**	181.51	216.94	270.50	218.15	276.96	205.28	170.66
159.23	190.90	238.41	192.37	244.10	181.00	150.59	**83**	183.02	219.43	274.03	221.11	280.57	208.05	173.09
160.44	193.01	241.42	194.92	247.17	183.39	152.70	**84**	184.41	221.85	277.49	224.04	284.10	210.79	175.52
161.58	195.01	244.36	197.37	250.17	185.69	154.73	**85**	185.72	224.15	280.87	226.86	287.55	213.44	177.85
162.66	197.00	247.27	199.83	253.16	188.01	156.77	**86**	186.97	226.44	284.22	229.69	290.99	216.10	180.20
163.79	199.07	250.32	202.38	256.25	190.42	158.91	**87**	188.26	228.82	287.72	232.62	294.54	218.87	182.66
164.90	201.07	253.25	204.89	259.28	192.78	160.99	**88**	189.54	231.11	291.09	235.51	298.02	221.58	185.04
166.04	203.10	256.23	207.48	262.31	195.18	163.08	**89**	190.85	233.45	294.52	238.48	301.50	224.34	187.45
167.20	205.22	259.35	210.15	265.47	197.71	165.31	**90**	192.18	235.89	298.10	241.55	305.14	227.25	190.01
168.39	207.37	262.47	212.87	268.69	200.26	167.58	**91**	193.55	238.36	301.69	244.68	308.84	230.18	192.62
169.60	209.57	265.75	215.70	272.03	202.92	169.95	**92**	194.94	240.89	305.46	247.93	312.68	233.24	195.34
170.85	211.84	269.11	218.60	275.45	205.64	172.36	**93**	196.38	243.49	309.32	251.26	316.61	236.37	198.11
172.15	214.20	272.62	221.66	279.08	208.50	174.92	**94**	197.87	246.21	313.36	254.78	320.78	239.66	201.06
173.43	216.56	276.18	224.71	282.69	211.38	177.47	**95**	199.34	248.92	317.45	258.29	324.93	242.96	203.99
174.65	218.89	279.71	227.77	286.28	214.25	180.04	**96**	200.75	251.60	321.50	261.80	329.06	246.26	206.94
175.77	221.05	283.07	230.70	289.72	217.00	182.50	**97**	202.03	254.08	325.37	265.17	333.01	249.42	209.77
176.85	223.23	286.50	233.67	293.23	219.79	185.02	**98**	203.27	256.58	329.31	268.59	337.04	252.63	212.67
177.96	225.46	290.01	236.76	296.84	222.68	187.62	**99+**	204.55	259.15	333.35	272.14	341.19	255.95	215.65

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

Disclosures

Use this outline to compare benefits and premiums among certificates or policies.

Premium Information

We, Woodmen of the World, can only raise your premium if we raise the premium for all certificates like yours in the same geographic area of the state where you live. Until you are age 99, 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 certificate date. Schedules of rates may vary depending upon your certificate date.

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

Premiums do not include dues.

Read Your Certificate Very Carefully

This is only an outline describing your certificate's most important features. The certificate is your insurance contract. You must read the certificate itself to understand all of the rights and duties of both you and us.

Right to Return Certificate

If you find that you are not satisfied with your certificate, you may return it to us at our administrative office, 3316 Farnam Street, Omaha, NE 68175. If you send the certificate back to us within 30 days after you receive it, we will treat the certificate 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 certificate and are sure you want to keep it.

Notice

The certificate may not fully cover all of your medical costs. Neither we nor our agents are connected with Medicare. This outline 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 certificate, be sure to answer truthfully and completely all questions about your medical and health history. We may cancel your certificate 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.

PLANS A AND B

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	Plan B Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days	All but $1,184	$0	$1,184 (Part A deductible)	$1,184 (Part A deductible)	$0
61st through 90th day	All but $296 a day	$296 a day	$0	$296 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $592 a day	$592 a day	$0	$592 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 $148 a day	$0	Up to $148 a day	$0	Up to $148 a day
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, 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/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 A AND B
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $147 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan A Pays	You Pay	Plan B Pays	You Pay
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First $147 of Medicare-approved amounts*	$0	$0	$147 (Part B deductible)	$0	$147 (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 $147 of Medicare-approved amounts*	$0	$0	$147 (Part B deductible)	$0	$147 (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 $147 of Medicare-approved amounts*	$0	$0	$147 (Part B deductible)	$0	$147 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0	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 $1,184	$1,184 (Part A deductible)	$0	$1,184 (Part A deductible)	$0
61st through 90th day	All but $296 a day	$296 a day	$0	$296 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $592 a day	$592 a day	$0	$592 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 $148 a day	Up to $148 a day	$0	Up to $148 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, 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/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 $147 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan 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 $147 of Medicare-approved amounts*	$0	$147 (Part B deductible)	$0	$0	$147 (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 $147 of Medicare-approved amounts*	$0	$147 (Part B deductible)	$0	$0	$147 (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 $147 of Medicare-approved amounts*	$0	$147 (Part B deductible)	$0	$0	$147 (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 $1,184	$1,184 (Part A deductible)	$0	$1,184 (Part A deductible)	$0
61st through 90th day	All but $296 a day	$296 a day	$0	$296 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $592 a day	$592 a day	$0	$592 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 $148 a day	Up to $148 a day	$0	Up to $148 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, 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/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 $147 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan F Pays	You Pay	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 $147 of Medicare-approved amounts*	$0	$147 (Part B deductible)	$0	$0	$147 (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 $147 of Medicare-approved amounts*	$0	$147 (Part B deductible)	$0	$0	$147 (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 $147 of Medicare-approved amounts*	$0	$147 (Part B deductible)	$0	$0	$147 (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

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 $1,184	$1,184 (Part A deductible)	$0
61st through 90th day	All but $296 a day	$296 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $592 a day	$592 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 $148 a day	Up to $148 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/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 N
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $147 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan 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 $147 of Medicare-approved amounts*	$0	$0	$147 (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 you are 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 you are 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 $147 of Medicare-approved amounts*	$0	$0	$147 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A AND B

HOME HEALTH CARE—MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $147 of Medicare-approved amounts*	$0	$0	$147 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

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

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