

ASSURED LIFE ASSOCIATION
A Legal Reserve Fraternal Benefit Society
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE – COVER PAGE
STANDARDIZED BENEFIT PLAN A AND SELECT BENEFIT PLANS B, C, D, F, AND G

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan A available. Some plans may not be available in your state.

Basic Benefits:

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

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

Blood: First 3 pints of blood each year.

Hospice: Part A coinsurance.

Plan A	Plan B*	Plan C*	Plan D*	Plan F*	F**	Plan G*	Plan K	Plan L	Plan M	Plan N
Basic, including 100% Part B Co-insurance	Basic, including 100% Part B Co-insurance	Basic, including 100% Part B Co-insurance	Basic, including 100% Part B Co-insurance	Basic, including 100% Part B Co-insurance *		Basic, including 100% Part B Co-insurance	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
		Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance		Skilled Nursing Facility Co-insurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% 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			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket limit \$4,940; paid at 100% after limit reached	Out-of-pocket limit \$2,470; paid at 100% after limit reached		

*SELECT PLANS B, C, D, F, AND G contain restrictions on your use of providers. Standardized Plan A is also available. NOTICE TO BUYER: The policy/certificate may not cover all costs associated with medical care incurred during the period of coverage. You are advised to review all policy/certificate limitations. **Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2,140 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed \$2,140. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy/certificate. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

MONTHLY NON-TOBACCO RATES
ZIP CODES: 304-310, 312, 315-319, 398

FEMALE						Issue Age	MALE					
Plan A MTA20	Plan B MTA40†	Plan C MTA41†	Plan D MTA42†	Plan F MTA43†	Plan G MTA44†		Plan A MTA20	Plan B MTA40†	Plan C MTA41†	Plan D MTA42†	Plan F MTA43†	Plan G MTA44†
1,054.53	1,012.52	1,259.47	1,057.86	1,289.90	1,016.35	Thru 64‡	1,212.10	1,163.82	1,447.66	1,215.93	1,482.65	1,168.22
117.18	112.51	139.94	117.55	143.33	112.92	65	134.69	129.32	160.85	135.11	164.74	129.80
117.18	112.51	139.94	117.55	143.33	112.92	66	134.69	129.32	160.85	135.11	164.74	129.80
117.18	112.51	139.94	117.55	143.33	112.92	67	134.69	129.32	160.85	135.11	164.74	129.80
121.16	116.31	144.68	121.51	148.19	116.77	68	139.26	133.69	166.30	139.67	170.33	134.22
125.82	120.79	150.25	126.21	153.88	121.27	69	144.62	138.84	172.70	145.06	176.87	139.39
128.89	123.75	153.93	129.29	157.66	124.24	70	148.15	142.25	176.93	148.61	181.21	142.80
131.04	125.80	156.47	131.44	160.27	126.29	71	150.62	144.59	179.86	151.08	184.21	145.16
133.10	127.79	158.96	133.53	162.81	128.29	72	152.99	146.88	182.72	153.48	187.14	147.46
134.94	129.57	161.16	135.36	165.06	130.06	73	155.10	148.93	185.24	155.59	189.72	149.49
136.67	131.23	163.23	137.11	167.15	131.72	74	157.10	150.84	187.62	157.59	192.13	151.40
138.26	132.76	165.13	138.70	169.12	133.27	75	158.91	152.60	189.80	159.43	194.39	153.18
142.06	136.39	169.64	142.49	173.75	136.91	76	163.28	156.77	194.99	163.79	199.72	157.37
143.58	137.85	171.47	144.03	175.62	138.39	77	165.04	158.45	197.09	165.55	201.86	159.07
145.08	139.30	173.26	145.53	177.45	139.83	78	166.75	160.12	199.14	167.28	203.96	160.72
146.01	140.20	174.37	146.45	178.58	140.72	79	167.82	161.15	200.42	168.34	205.27	161.75
146.47	140.63	174.92	146.93	179.14	141.16	80	168.35	161.65	201.06	168.88	205.91	162.26
147.70	141.82	176.40	148.16	180.66	142.36	81	169.77	163.01	202.75	170.30	207.65	163.63
148.78	142.84	177.68	149.24	181.98	143.40	82	171.02	164.19	204.22	171.54	209.17	164.83
149.84	143.88	178.95	150.31	183.28	144.44	83	172.23	165.38	205.69	172.77	210.67	166.02
150.84	144.83	180.14	151.31	184.49	145.39	84	173.37	166.47	207.05	173.91	212.06	167.11
155.12	148.93	185.25	155.61	189.76	149.51	85	178.30	171.18	212.93	178.86	218.11	171.85
156.19	149.98	186.54	156.68	191.05	150.54	86	179.52	172.39	214.41	180.09	219.60	173.03
157.28	150.99	187.81	157.76	192.36	151.58	87	180.78	173.56	215.87	181.33	221.10	174.23
158.25	151.95	189.00	158.75	193.57	152.54	88	181.90	174.65	217.24	182.47	222.49	175.33
159.34	152.97	190.28	159.81	194.87	153.56	89	183.14	175.83	218.71	183.69	223.99	176.51
160.23	153.85	191.35	160.73	195.99	154.45	90	184.17	176.84	219.95	184.74	225.28	177.52
161.06	154.63	192.34	161.56	197.00	155.24	91	185.13	177.73	221.08	185.70	226.44	178.44
161.80	155.35	193.22	162.30	197.90	155.94	92	185.97	178.57	222.09	186.55	227.47	179.25
162.29	155.82	193.82	162.80	198.50	156.43	93	186.54	179.10	222.78	187.13	228.16	179.80
162.62	156.14	194.21	163.13	198.91	156.74	94	186.92	179.47	223.23	187.50	228.63	180.16
162.62	156.14	194.21	163.13	198.91	156.74	95	186.92	179.47	223.23	187.50	228.63	180.16
162.62	156.14	194.21	163.13	198.91	156.74	96	186.92	179.47	223.23	187.50	228.63	180.16
162.62	156.14	194.21	163.13	198.91	156.74	97	186.92	179.47	223.23	187.50	228.63	180.16
162.62	156.14	194.21	163.13	198.91	156.74	98	186.92	179.47	223.23	187.50	228.63	180.16
162.62	156.14	194.21	163.13	198.91	156.74	99+	186.92	179.47	223.23	187.50	228.63	180.16

†SELECT Plans ‡Only individuals who are Disabled or have End Stage Renal Disease are eligible for coverage under the age of 65.
 To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

MONTHLY TOBACCO RATES
ZIP CODES: 304-310, 312, 315-319, 398

FEMALE						Issue Age	MALE					
Plan A MTA20	Plan B MTA40†	Plan C MTA41†	Plan D MTA42†	Plan F MTA43†	Plan G MTA44†		Plan A MTA20	Plan B MTA40†	Plan C MTA41†	Plan D MTA42†	Plan F MTA43†	Plan G MTA44†
1,212.10	1,163.82	1,447.66	1,215.93	1,482.65	1,168.22	Thru 64‡	1,393.22	1,337.72	1,663.98	1,397.62	1,704.19	1,342.78
134.69	129.32	160.85	135.11	164.74	129.80	65	154.81	148.64	184.88	155.30	189.36	149.19
134.69	129.32	160.85	135.11	164.74	129.80	66	154.81	148.64	184.88	155.30	189.36	149.19
134.69	129.32	160.85	135.11	164.74	129.80	67	154.81	148.64	184.88	155.30	189.36	149.19
139.26	133.69	166.30	139.67	170.33	134.22	68	160.07	153.67	191.15	160.54	195.78	154.27
144.62	138.84	172.70	145.06	176.87	139.39	69	166.23	159.59	198.51	166.74	203.30	160.22
148.15	142.25	176.93	148.61	181.21	142.80	70	170.29	163.50	203.37	170.81	208.29	164.14
150.62	144.59	179.86	151.08	184.21	145.16	71	173.13	166.20	206.73	173.66	211.74	166.85
152.99	146.88	182.72	153.48	187.14	147.46	72	175.85	168.83	210.02	176.41	215.10	169.49
155.10	148.93	185.24	155.59	189.72	149.49	73	178.28	171.18	212.92	178.84	218.07	171.83
157.10	150.84	187.62	157.59	192.13	151.40	74	180.57	173.38	215.65	181.14	220.84	174.02
158.91	152.60	189.80	159.43	194.39	153.18	75	182.66	175.40	218.16	183.25	223.44	176.07
163.28	156.77	194.99	163.79	199.72	157.37	76	187.68	180.20	224.13	188.26	229.56	180.88
165.04	158.45	197.09	165.55	201.86	159.07	77	189.70	182.13	226.54	190.29	232.02	182.84
166.75	160.12	199.14	167.28	203.96	160.72	78	191.67	184.04	228.90	192.27	234.44	184.74
167.82	161.15	200.42	168.34	205.27	161.75	79	192.90	185.23	230.37	193.49	235.94	185.92
168.35	161.65	201.06	168.88	205.91	162.26	80	193.51	185.80	231.10	194.12	236.68	186.50
169.77	163.01	202.75	170.30	207.65	163.63	81	195.14	187.37	233.05	195.75	238.68	188.08
171.02	164.19	204.22	171.54	209.17	164.83	82	196.57	188.72	234.74	197.17	240.43	189.46
172.23	165.38	205.69	172.77	210.67	166.02	83	197.96	190.09	236.43	198.59	242.15	190.83
173.37	166.47	207.05	173.91	212.06	167.11	84	199.28	191.35	237.99	199.90	243.75	192.08
178.30	171.18	212.93	178.86	218.11	171.85	85	204.94	196.76	244.75	205.59	250.70	197.53
179.52	172.39	214.41	180.09	219.60	173.03	86	206.35	198.15	246.45	207.00	252.41	198.89
180.78	173.56	215.87	181.33	221.10	174.23	87	207.79	199.49	248.13	208.43	254.14	200.26
181.90	174.65	217.24	182.47	222.49	175.33	88	209.08	200.75	249.70	209.74	255.74	201.53
183.14	175.83	218.71	183.69	223.99	176.51	89	210.51	202.10	251.39	211.14	257.46	202.88
184.17	176.84	219.95	184.74	225.28	177.52	90	211.69	203.26	252.81	212.35	258.94	204.05
185.13	177.73	221.08	185.70	226.44	178.44	91	212.79	204.29	254.12	213.45	260.27	205.10
185.97	178.57	222.09	186.55	227.47	179.25	92	213.76	205.25	255.28	214.43	261.46	206.03
186.54	179.10	222.78	187.13	228.16	179.80	93	214.41	205.86	256.07	215.09	262.25	206.67
186.92	179.47	223.23	187.50	228.63	180.16	94	214.85	206.29	256.59	215.52	262.79	207.08
186.92	179.47	223.23	187.50	228.63	180.16	95	214.85	206.29	256.59	215.52	262.79	207.08
186.92	179.47	223.23	187.50	228.63	180.16	96	214.85	206.29	256.59	215.52	262.79	207.08
186.92	179.47	223.23	187.50	228.63	180.16	97	214.85	206.29	256.59	215.52	262.79	207.08
186.92	179.47	223.23	187.50	228.63	180.16	98	214.85	206.29	256.59	215.52	262.79	207.08
186.92	179.47	223.23	187.50	228.63	180.16	99+	214.85	206.29	256.59	215.52	262.79	207.08

†SELECT Plans ‡Only individuals who are Disabled or have End Stage Renal Disease are eligible for coverage under the age of 65.
 To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

MONTHLY NON-TOBACCO RATES
ZIP CODES: 300-303, 311, 313-314, 399

FEMALE						Issue Age	MALE					
Plan A MTA20	Plan B MTA40†	Plan C MTA41†	Plan D MTA42†	Plan F MTA43†	Plan G MTA44†		Plan A MTA20	Plan B MTA40†	Plan C MTA41†	Plan D MTA42†	Plan F MTA43†	Plan G MTA44†
1,181.07	1,134.02	1,410.60	1,184.80	1,444.69	1,138.31	Thru 64‡	1,357.55	1,303.48	1,621.38	1,361.84	1,660.56	1,308.41
131.24	126.01	156.73	131.65	160.53	126.47	65	150.85	144.84	180.15	151.32	184.51	145.37
131.24	126.01	156.73	131.65	160.53	126.47	66	150.85	144.84	180.15	151.32	184.51	145.37
131.24	126.01	156.73	131.65	160.53	126.47	67	150.85	144.84	180.15	151.32	184.51	145.37
135.70	130.27	162.04	136.09	165.97	130.78	68	155.97	149.74	186.26	156.43	190.77	150.32
140.92	135.29	168.28	141.35	172.34	135.82	69	161.97	155.50	193.43	162.47	198.10	156.12
144.36	138.60	172.40	144.80	176.57	139.15	70	165.93	159.31	198.16	166.44	202.96	159.94
146.77	140.89	175.25	147.22	179.50	141.44	71	168.70	161.95	201.44	169.21	206.32	162.58
149.07	143.12	178.04	149.55	182.35	143.68	72	171.35	164.51	204.64	171.89	209.59	165.15
151.13	145.11	180.50	151.61	184.86	145.67	73	173.72	166.80	207.47	174.26	212.49	167.43
153.07	146.98	182.81	153.56	187.21	147.52	74	175.95	168.94	210.13	176.50	215.19	169.57
154.85	148.69	184.94	155.35	189.42	149.26	75	177.98	170.91	212.58	178.56	217.72	171.56
159.10	152.76	190.00	159.59	194.60	153.34	76	182.88	175.59	218.39	183.44	223.68	176.25
160.81	154.40	192.04	161.32	196.69	155.00	77	184.84	177.47	220.74	185.42	226.08	178.16
162.48	156.02	194.05	162.99	198.74	156.61	78	186.76	179.33	223.04	187.35	228.44	180.01
163.53	157.03	195.29	164.03	200.01	157.61	79	187.96	180.49	224.47	188.54	229.90	181.16
164.04	157.51	195.91	164.56	200.64	158.10	80	188.56	181.04	225.18	189.15	230.62	181.73
165.43	158.84	197.56	165.94	202.34	159.44	81	190.14	182.57	227.08	190.74	232.57	183.27
166.64	159.98	199.00	167.15	203.82	160.61	82	191.54	183.89	228.73	192.12	234.28	184.61
167.82	161.14	200.43	168.35	205.28	161.77	83	192.89	185.22	230.38	193.51	235.95	185.95
168.94	162.21	201.75	169.46	206.63	162.83	84	194.18	186.45	231.90	194.78	237.51	187.16
173.73	166.80	207.48	174.28	212.53	167.45	85	199.69	191.72	238.48	200.33	244.28	192.47
174.93	167.98	208.92	175.48	213.98	168.60	86	201.07	193.08	240.14	201.70	245.95	193.80
176.15	169.11	210.35	176.69	215.44	169.77	87	202.47	194.38	241.78	203.09	247.63	195.13
177.24	170.18	211.68	177.80	216.80	170.84	88	203.73	195.61	243.31	204.37	249.19	196.37
178.46	171.33	213.11	178.99	218.26	171.99	89	205.12	196.93	244.95	205.74	250.87	197.69
179.46	172.31	214.31	180.02	219.51	172.98	90	206.27	198.06	246.34	206.91	252.31	198.83
180.39	173.18	215.42	180.95	220.64	173.87	91	207.34	199.06	247.61	207.99	253.61	199.85
181.21	174.00	216.41	181.78	221.65	174.66	92	208.29	200.00	248.75	208.94	254.77	200.76
181.76	174.51	217.08	182.34	222.32	175.20	93	208.92	200.59	249.51	209.58	255.54	201.38
182.13	174.88	217.52	182.70	222.77	175.55	94	209.35	201.01	250.02	210.00	256.06	201.78
182.13	174.88	217.52	182.70	222.77	175.55	95	209.35	201.01	250.02	210.00	256.06	201.78
182.13	174.88	217.52	182.70	222.77	175.55	96	209.35	201.01	250.02	210.00	256.06	201.78
182.13	174.88	217.52	182.70	222.77	175.55	97	209.35	201.01	250.02	210.00	256.06	201.78
182.13	174.88	217.52	182.70	222.77	175.55	98	209.35	201.01	250.02	210.00	256.06	201.78
182.13	174.88	217.52	182.70	222.77	175.55	99+	209.35	201.01	250.02	210.00	256.06	201.78

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MONTHLY TOBACCO RATES
ZIP CODES: 300-303, 311, 313-314, 399

FEMALE						Issue Age	MALE					
Plan A MTA20	Plan B MTA40†	Plan C MTA41†	Plan D MTA42†	Plan F MTA43†	Plan G MTA44†		Plan A MTA20	Plan B MTA40†	Plan C MTA41†	Plan D MTA42†	Plan F MTA43†	Plan G MTA44†
1,357.55	1,303.48	1,621.38	1,361.84	1,660.56	1,308.40	Thru 64‡	1,560.41	1,498.25	1,863.66	1,565.33	1,908.69	1,503.91
150.85	144.84	180.15	151.32	184.51	145.37	65	173.39	166.48	207.07	173.94	212.08	167.09
150.85	144.84	180.15	151.32	184.51	145.37	66	173.39	166.48	207.07	173.94	212.08	167.09
150.85	144.84	180.15	151.32	184.51	145.37	67	173.39	166.48	207.07	173.94	212.08	167.09
155.97	149.74	186.26	156.43	190.77	150.32	68	179.28	172.11	214.09	179.81	219.27	172.78
161.97	155.50	193.43	162.47	198.10	156.12	69	186.18	178.74	222.33	186.75	227.70	179.45
165.93	159.31	198.16	166.44	202.96	159.94	70	190.73	183.12	227.77	191.31	233.29	183.84
168.70	161.95	201.44	169.21	206.32	162.58	71	193.91	186.14	231.54	194.50	237.15	186.87
171.35	164.51	204.64	171.89	209.59	165.15	72	196.95	189.09	235.22	197.58	240.91	189.83
173.72	166.80	207.47	174.26	212.49	167.43	73	199.67	191.72	238.47	200.30	244.24	192.45
175.95	168.94	210.13	176.50	215.19	169.57	74	202.24	194.19	241.53	202.88	247.34	194.90
177.98	170.91	212.58	178.56	217.72	171.56	75	204.58	196.45	244.34	205.24	250.25	197.20
182.88	175.59	218.39	183.44	223.68	176.25	76	210.20	201.82	251.03	210.85	257.11	202.59
184.84	177.47	220.74	185.42	226.08	178.16	77	212.46	203.99	253.73	213.13	259.86	204.78
186.76	179.33	223.04	187.35	228.44	180.01	78	214.67	206.13	256.37	215.34	262.57	206.91
187.96	180.49	224.47	188.54	229.90	181.16	79	216.05	207.46	258.01	216.71	264.25	208.23
188.56	181.04	225.18	189.15	230.62	181.73	80	216.73	208.10	258.83	217.41	265.08	208.88
190.14	182.57	227.08	190.74	232.57	183.27	81	218.56	209.85	261.02	219.24	267.32	210.65
191.54	183.89	228.73	192.12	234.28	184.61	82	220.16	211.37	262.91	220.83	269.28	212.20
192.89	185.22	230.38	193.51	235.95	185.95	83	221.72	212.90	264.80	222.42	271.21	213.73
194.18	186.45	231.90	194.78	237.51	187.16	84	223.19	214.31	266.55	223.89	273.00	215.13
199.69	191.72	238.48	200.33	244.28	192.47	85	229.53	220.37	274.12	230.26	280.78	221.23
201.07	193.08	240.14	201.70	245.95	193.80	86	231.11	221.93	276.02	231.84	282.70	222.76
202.47	194.38	241.78	203.09	247.63	195.13	87	232.73	223.43	277.91	233.44	284.64	224.29
203.73	195.61	243.31	204.37	249.19	196.37	88	234.17	224.84	279.66	234.91	286.43	225.71
205.12	196.93	244.95	205.74	250.87	197.69	89	235.77	226.35	281.56	236.48	288.36	227.23
206.27	198.06	246.34	206.91	252.31	198.83	90	237.09	227.65	283.15	237.83	290.01	228.54
207.34	199.06	247.61	207.99	253.61	199.85	91	238.33	228.81	284.61	239.06	291.50	229.71
208.29	200.00	248.74	208.94	254.77	200.76	92	239.41	229.88	285.91	240.16	292.84	230.75
208.92	200.59	249.51	209.58	255.54	201.38	93	240.14	230.56	286.80	240.90	293.72	231.47
209.35	201.01	250.02	210.00	256.06	201.78	94	240.63	231.05	287.38	241.38	294.33	231.93
209.35	201.01	250.02	210.00	256.06	201.78	95	240.63	231.05	287.38	241.38	294.33	231.93
209.35	201.01	250.02	210.00	256.06	201.78	96	240.63	231.05	287.38	241.38	294.33	231.93
209.35	201.01	250.02	210.00	256.06	201.78	97	240.63	231.05	287.38	241.38	294.33	231.93
209.35	201.01	250.02	210.00	256.06	201.78	98	240.63	231.05	287.38	241.38	294.33	231.93
209.35	201.01	250.02	210.00	256.06	201.78	99+	240.63	231.05	287.38	241.38	294.33	231.93

†SELECT Plans ‡Only individuals who are Disabled or have End Stage Renal Disease are eligible for coverage under the age of 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, Assured Life Association, 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.

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.

Restricted Network Provisions

The benefits under our Medicare Select certificates are payable in full if you are hospitalized in a hospital participating in our network. Reduced benefits are payable if you are hospitalized in a non-participating hospital. If you use the services of a non-participating hospital, we will not pay the Medicare Part A deductible amount unless:

- (a) you are hospitalized for symptoms requiring emergency care or hospitalization is immediately required for an unforeseen sickness, injury, or condition;
- (b) it is not reasonable for you to obtain services through a participating hospital; or
- (c) you require covered services that are not available through a participating hospital.

The reduced benefits require you to pay the entire Part A deductible amount.

Emergency Care and Urgently Needed Care

The full benefits of your coverage will be paid anywhere if hospitalization is for emergency care. Emergency care is defined as care which is needed immediately because of an injury or sickness of sudden and unexpected onset.

Referrals

There are no restrictions on referrals to other hospitals if referred by a network hospital and this referral is approved by us. Additionally, there are no restrictions on referrals for outpatient providers regardless of whether that provider is in the service area.

Availability of Other Medicare Supplement Plans

We also offer standard Medicare supplement plans A, B, C, D, F, G, and N, which do not contain restricted network provisions. We offer the Medicare Select coverage under plans B, C, D, F, and G. These plans do have a restricted network provision. You have the right to initially or subsequently purchase any of the plans for standard or Select coverage.

If you purchase one of the Select plans, you will have the right to convert to a standard plan offered by us which is of comparable or lesser benefits. You will not have to provide evidence of insurability after the Medicare Select plan has been in force for six months.

In the event the Secretary of Health and Human Services determines that Medicare Select certificates should be discontinued due to either the failure of the Medicare Select program to be re-authorized or its substantial amendment, your coverage can be continued. Your Medicare Select certificate can be converted to a Medicare supplement certificate offered by us which has comparable or lesser benefits and which does not contain a restricted network provision.

Quality Assurance

All participating hospitals within the network must be approved for reimbursement of Medicare benefits. They must also comply with the criteria set forth by The Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Grievance Procedure

We have a customer service program which provides information to you, handles complaints, and helps to satisfy your concerns. This grievance procedure is intended to provide an opportunity for you to achieve mutual agreement for settlement of disputes that have not been settled through the customer service program, or that you desire to have settled by means of a written grievance.

The following procedures are aimed at achieving mutual agreement for settlement of disputes:

- (a) All grievances shall be presented to us in written form and must contain the words "This is a grievance" or other words that clearly state that the intention of the communication is to serve as a written grievance to be handled according to this procedure.
- (b) A grievance shall be filed by submitting the complete details in writing to:
 - Grievance Review
 - Assured Life Association
 - P. O. Box 3608
 - Omaha, Nebraska 68103-0608
- (c) Each grievance shall be processed within a maximum of 60 days after it is first received by us. Each level of the grievance process shall have a person with problem-solving authority. A physician, other than your primary care physician, must be involved in reviewing any medically related grievances.
- (d) If a grievance is found to be valid, corrective action shall be taken promptly.
- (e) All concerned parties will be notified about the results of a grievance.
- (f) You have the right to appeal to the Department of Insurance after first completing our grievance process.
- (g) Any meeting with you shall be scheduled at a location or in a manner which is convenient and does not necessitate excessive travel or hardship for you.
- (h) The time for filing a grievance shall be limited to a period of not less than one year from the date of occurrence.

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 \$1,216	\$0	\$1,216 (Part A deductible)	\$1,216 (Part A deductible)	\$0
61 st through 90 th day	All but \$304 a day	\$304 a day	\$0	\$304 a day	\$0
91 st day and after: While using 60 lifetime reserve days	All but \$608 a day	\$608 a day	\$0	\$608 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
21 st through 100 th day	All but \$152 a day	\$0	Up to \$152 a day	\$0	Up to \$152 a day
101 st 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 \$1,216	\$1,216 (Part A deductible)	\$0	\$1,216 (Part A deductible)	\$0
61 st through 90 th day	All but \$304 a day	\$304 a day	\$0	\$304 a day	\$0
91 st day and after: While using 60 lifetime reserve days	All but \$608 a day	\$608 a day	\$0	\$608 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
21 st through 100 th day	All but \$152 a day	Up to \$152 a day	\$0	Up to \$152 a day	\$0
101 st 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 \$1,216	\$1,216 (Part A deductible)	\$0	\$1,216 (Part A deductible)	\$0
61 st through 90 th day	All but \$304 a day	\$304 a day	\$0	\$304 a day	\$0
91 st day and after: While using 60 lifetime reserve days	All but \$608 a day	\$608 a day	\$0	\$608 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
21 st through 100 th day	All but \$152 a day	Up to \$152 a day	\$0	Up to \$152 a day	\$0
101 st 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