UNITED WORLD LIFE INSURANCE COMPANY
OMAHA, NEBRASKA
A Mutual of Omaha Company
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE – COVER PAGE

The Commissioner of Insurance of the State of Minnesota has established four categories of Medicare supplements and minimum standards for each, with the Extended Basic Medicare Supplement being the most comprehensive and the Basic Medicare Supplement being the least comprehensive. This chart shows the benefits in each plan.

Basic-- **Policy Form WM26**	**Extended Basic--** **Policy Form WM27**	**50% Coverage--** **Policy Form WM32**
Hospitalization: Part A Coinsurance	Hospitalization: Part A Coinsurance	Hospitalization: Part A Coinsurance
Medical Expenses: Part B Coinsurance	Medical Expenses: Part B Coinsurance	Medical Expenses: Part B Coinsurance
Blood: First 3 pints of blood each year	Blood: First 3 pints of blood each year	Blood: First 3 pints of blood each year
Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance for the 21st through 100th day
_____*	Part A Deductible	50 % of the Part A Deductible
_____*	Part B Deductible	
_____*		
Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
Hospice Care	Hospice Care	Hospice Care
_____*	Preventive Care	

Premium Information

We, United World, will renew the policy each time you pay us the premium. It must be paid by the date it is due or during the 31 days that follow. Your policy stays in force during this 31-day period. Your premium cannot be changed unless we make the same change on all policies of the same form owned by persons in your classification which are renewed in the state where you live at the time we change the premium. Any such change can be made on any renewal date. We will give you 30 days advance written notice prior to any premium change. Schedules of rates may vary depending on your policy date.

"Persons in your classification" means all persons having the same benefits.

*Optional riders available for Medicare Part A Deductible, Medicare Part B Deductible, and Preventive Health Services.

UNITED WORLD LIFE INSURANCE COMPANY
OMAHA, NEBRASKA
MONTHLY PREMIUMS

ZIP CODES: 55002, 55006-009, 55012-013, 55017-019, 55021, 55026-027, 55029-030, 55032, 55036-037, 55040-041, 55045-046, 55049, 55051-053, 55056-057, 55060, 55063, 55066-067, 55069, 55072, 55074, 55078-080, 55084, 55087-089, 55092, 55301-302, 55307-310, 55312-314, 55319-321, 55324-325, 55328-330, 55332-336, 55338, 55341-342, 55349-350, 55353-355, 55358, 55362-363, 55365-366, 55370-371, 55373, 55376-377, 55380-382, 55385, 55389-390, 55393, 55395-396, 55398, 556-567

NON-TOBACCO—MONTHLY PREMIUMS		TOBACCO—MONTHLY PREMIUMS	
Basic—Policy Form WM26 All Ages	$ 187.99	**Basic—Policy Form WM26** All Ages	$ 216.08
Optional Riders		Optional Riders	
Part A Deductible Rider 0MJ1W	$ 30.28	Part A Deductible Rider 0MJ1W	$ 34.80
Preventative Medical Care Rider 0MJ3W	$ 6.14	Preventative Medical Care Rider 0MJ3W	$ 7.06
Part B Excess Rider 0MJ4W	$ -	Part B Excess Rider 0MJ4W	$ -
Part B Deductible Rider 0MJ2W	$ 11.66	Part B Deductible Rider 0MJ2W	$ 11.66
Extended Basic—Policy Form WM27 All Ages	$ 448.92	**Extended Basic—Policy Form WM27** All Ages	$ 516.00
50% Coverage—Policy Form WM32 All Ages	$ 151.29	**50% Coverage—Policy Form WM32** All Ages	$ 173.89

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

The policy provides an anticipated loss ratio of 73%. This means that, on average, Policyholders may expect that $73.00 of every $100.00 in premium will be returned as benefits to the Policyholders over the life of the contract.

UNITED WORLD LIFE INSURANCE COMPANY
OMAHA, NEBRASKA
MONTHLY PREMIUMS

ZIP CODES: 55001, 55003, 55010, 55016, 55020, 55024-025, 55031, 55033, 55038, 55042-044, 55047, 55054-055, 55065, 55068, 55071, 55073, 55075-077, 55082-083, 55085, 55090, 55118, 55120-125, 55128-129, 55150, 55306, 55315, 55317-318, 55322, 55337, 55339, 55352, 55360, 55367-368, 55372, 55378-379, 55383, 55386-388, 55394, 55397, 55399, 55473

NON-TOBACCO—MONTHLY PREMIUMS		TOBACCO—MONTHLY PREMIUMS	
Basic—Policy Form WM26 All Ages	$ 201.92	**Basic—Policy Form WM26** All Ages	$ 232.09
Optional Riders		Optional Riders	
Part A Deductible Rider 0MJ1W	$ 30.28	Part A Deductible Rider 0MJ1W	$ 34.80
Preventative Medical Care Rider 0MJ3W	$ 6.14	Preventative Medical Care Rider 0MJ3W	$ 7.06
Part B Excess Rider 0MJ4W	$ -	Part B Excess Rider 0MJ4W	$ -
Part B Deductible Rider 0MJ2W	$ 11.66	Part B Deductible Rider 0MJ2W	$ 11.66
Extended Basic—Policy Form WM27 All Ages	$ 482.18	**Extended Basic—Policy Form WM27** All Ages	$ 554.23
50% Coverage—Policy Form WM32 All Ages	$ 162.49	**50% Coverage—Policy Form WM32** All Ages	$ 186.77

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

The policy provides an anticipated loss ratio of 73%. This means that, on average, Policyholders may expect that $73.00 of every $100.00 in premium will be returned as benefits to the Policyholders over the life of the contract.

UNITED WORLD LIFE INSURANCE COMPANY
OMAHA, NEBRASKA
MONTHLY PREMIUMS

ZIP CODES: 55005, 55011, 55014, 55070, 55101-117, 55119, 55126-127, 55130, 55133, 55144-146, 55155, 55161, 55164-166, 55168-172, 55175, 55177, 55182, 55187-188, 55303-305, 55311, 55316, 55323, 55327, 55331, 55340, 55343-348, 55356-357, 55359, 55361, 55364, 55369, 55374-375, 55384, 55391-392, 55401-450, 55454-455, 55458-460, 55467-468, 55470, 55472, 55474, 55478-480, 55483-55488

NON-TOBACCO—MONTHLY PREMIUMS		TOBACCO—MONTHLY PREMIUMS	
Basic—Policy Form WM26 All Ages	$ 218.17	**Basic—Policy Form WM26** All Ages	$ 250.76
Optional Riders		Optional Riders	
Part A Deductible Rider 0MJ1W	$ 30.28	Part A Deductible Rider 0MJ1W	$ 34.80
Preventative Medical Care Rider 0MJ3W	$ 6.14	Preventative Medical Care Rider 0MJ3W	$ 7.06
Part B Excess Rider 0MJ4W	$ -	Part B Excess Rider 0MJ4W	$ -
Part B Deductible Rider 0MJ2W	$ 11.66	Part B Deductible Rider 0MJ2W	$ 11.66
Extended Basic—Policy Form WM27 All Ages	$ 520.97	**Extended Basic—Policy Form WM27** All Ages	$ 598.82
50% Coverage—Policy Form WM32 All Ages	$ 175.57	**50% Coverage—Policy Form WM32** All Ages	$ 201.80

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

The policy provides an anticipated loss ratio of 73%. This means that, on average, Policyholders may expect that $73.00 of every $100.00 in premium will be returned as benefits to the Policyholders over the life of the contract.

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

Read Your Policy Very Carefully
This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

Right to Return Policy
If you find that you are not satisfied with your policy, you may return it to United World Life Insurance Company, 3316 Farnam Street, Omaha, NE 68175. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

Policy Replacement
If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

Notice
The policy may not fully cover all of your medical costs. Neither United World 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
Review the application carefully before you sign it. Be certain that all information has been properly recorded.

THE POLICY DOES NOT COVER ALL MEDICAL EXPENSES BEYOND THOSE COVERED BY MEDICARE. THE POLICY DOES NOT COVER ALL SKILLED NURSING HOME CARE EXPENSES AND DOES NOT COVER CUSTODIAL OR RESIDENTIAL NURSING CARE. READ YOUR POLICY CAREFULLY TO DETERMINE WHICH NURSING HOME FACILITIES AND EXPENSES ARE COVERED BY YOUR POLICY.

We will not pay for services for which a charge is normally not made where there is no insurance. In addition, no benefits are payable for expense incurred before the coverage effective date.

Limitation on out-of-pocket expense
When your out-of-pocket expense equals $1,000.00 in a calendar year, we will pay 100% of additional covered expense you incur during the remainder of such calendar year (WM27 only).

BASIC PLAN - WM26
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 WM26 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 with optional Part A Deductible Benefit Rider 0MJ1W	$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

BASIC PLAN - WM26
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

Services	Medicare Pays	Plan WM26 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 with optional Part B Deductible Benefit Rider 0MJ2W	$147 (Part B deductible) $0
Remainder of Medicare-approved amounts	80%	20%**	$0
BLOOD First 3 pints	$0	All costs	$0
Next $147 of Medicare-approved amounts*	$0	$0 $147 with optional Part B Deductible Benefit Rider 0MJ2W	$147 (Part B deductible) $0
Remainder of Medicare-approved amounts	80%	20%**	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

*Once you have been billed $147 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.
**Part B coinsurance (generally 20% of Medicare-approved expenses), or in the case of hospital outpatient department services paid under a prospective payment system, applicable copayments.

BASIC PLAN - WM26
PARTS A AND B

Services	Medicare Pays	Plan WM26 Pays	You Pay
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 with optional Part B Deductible Benefit Rider 0MJ2W	$147 (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 travel outside the USA	$0	80% of covered expenses	Expenses not paid by Medicare or the policy
PREVENTIVE MEDICAL CARE BENEFIT-- NOT COVERED BY MEDICARE Annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare First $120 each calendar year	$0	$0 $120 with optional Preventive Health Benefit Rider 0MJ3W	$120 $0
Additional charges	$0	$0	All costs

*Once you have been billed $147 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.
**Part B coinsurance (generally 20% of Medicare-approved expenses), or in the case of hospital outpatient department services paid under a prospective payment system, applicable copayments.

EXTENDED BASIC PLAN - WM27
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 WM27 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:	$0	100% of Medicare-eligible expenses	$0
Additional 365 days			
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	Expenses not paid by Medicare or the policy
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

EXTENDED BASIC PLAN - WM27
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

Services	Medicare Pays	Plan WM27 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
Remainder of Medicare-approved amounts	80%	20%**	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $147 of Medicare-approved amounts*	$0	$147 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%**	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

*Once you have been billed $147 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.
**Part B coinsurance (generally 20% of Medicare-approved expenses), or in the case of hospital outpatient department services paid under a prospective payment system, applicable copayments.

EXTENDED BASIC PLAN - WM27
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR (continued)
PARTS A AND B

Services	Medicare Pays	Plan WM27 Pays	You Pay
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	$147 (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 care services during travel outside the USA	$0	80% of covered expenses	Expenses not paid by Medicare or the policy
PREVENTIVE MEDICAL CARE BENEFIT— NOT COVERED BY MEDICARE Annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs

*Once you have been billed $147 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.
**Part B coinsurance (generally 20% of Medicare-approved expenses), or in the case of hospital outpatient department services paid under a prospective payment system, applicable copayments.

50% COVERAGE - WM32
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 WM32 Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,184	$592 (50% of the Part A deductible)	$592 (50% of the Part A deductible)
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:	$0	100% of Medicare-eligible expenses	$0
Additional 365 days			
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

50% COVERAGE - WM32
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

Services	Medicare Pays	Plan WM32 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	80%	20%**	$0
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

*Once you have been billed $147 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.
**Part B coinsurance (generally 20% of Medicare-approved expenses), or in the case of hospital outpatient department services paid under a prospective payment system, applicable copayments.

50% COVERAGE - WM32
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR (continued)
PARTS A AND B

Services	Medicare Pays	Plan WM32 Pays	You Pay
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

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services during travel outside the USA	$0	80% of covered expenses	Expenses not paid by Medicare or the policy

*Once you have been billed $147 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.
**Part B coinsurance (generally 20% of Medicare-approved expenses), or in the case of hospital outpatient department services paid under a prospective payment system, applicable copayments.

The charts summarizing Medicare benefits only briefly describe the benefits. The Health Care Financing Administration or its Medicare publication should be consulted for further details and limitations.

Your Policy also provides the following benefits:

1. Alcoholism and Chemical Dependency Treatment Benefit. We will pay the Usual and Customary Charge for the treatment of alcoholism and chemical dependency on the same basis as any other Sickness or Injury when treatment is provided for: (a) outpatient alcoholism and chemical dependency services that must not place a greater financial burden on you, or be more restrictive than those requirements and limitations for outpatient medical services; and (b) inpatient hospital and residential alcoholism and chemical dependency services that must not place a greater financial burden on you, or be more restrictive than those requirements and limitations for inpatient hospital medical services. Benefits are not payable for that portion of expense paid by Medicare or paid under any other part of this policy.

2. Scalp Hair Prosthesis. We will pay the expense incurred on the same basis as any other Sickness or Injury and as if Medicare paid benefits for a scalp hair prosthesis needed because of hair loss suffered as a result of alopecia areata. Only the first $350.00 of expense incurred in a calendar year will be considered as expense under this part of your policy. Amounts in excess of the Usual and Customary Charge are not considered expense. Benefits are not payable for that portion of expense that is paid by Medicare or paid under any other part of this policy.

3. Routine Screening Procedures for Cancer. We will pay the expense incurred that is not paid by Medicare or paid under any other part of your policy for routine screening procedures for cancer, including colorectal, mammograms and Pap smear.

4. Temporomandibular Joint Disorder and Craniomandibular Disorder. Benefits are payable for the surgical and nonsurgical treatment of temporomandibular joint disorder and craniomandibular disorder on the same basis as that for treatment to any other joint in the body. Such treatment must be administered or prescribed by a physician or dentist. Benefits are not payable under this part of your policy for any expense payable under another part of the policy.

5. Reconstructive Surgery. Benefits are payable for reconstructive surgery on the same basis as that for any other surgery if the reconstructive surgery is incidental to or follows surgery resulting from injury, sickness or other disease of the involved part. Benefits are not payable under this policy for an expense payable under another part of the policy.

6. Surgical Center Services. Benefits are payable for surgical center services for health care treatment or service rendered by a freestanding ambulatory surgical center or facilities offering ambulatory medical service 24 hours a day, 7 days a week, which are not part of a hospital, but have been reviewer and approved by the state commissioner of commerce to provide the treatment or service on the same basis as coverage provided for the same health care treatment or service rendered by a hospital. Benefits are not payable under this part of your policy for an expense payable under another part of the policy.

7. Immunization Benefits. We will pay the expense incurred for an immunization received by you. Benefits are not payable for that portion of expense for which benefits were paid by Medicare or under any other portion of the policy.

8. Phenylketonuria Treatment. Benefits are payable for special dietary treatment for phenylketonuria when recommended by a physician.

9. Diabetes Equipment and Supplies. We will pay the Usual and Customary charge for expense incurred for all Physician prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes, not otherwise covered under Medicare or Part D of the Medicare Program. Coverage must include persons with gestational, type I, or type II diabetes. Benefits will be limited to 80% of the Usual and Customary Charge not covered by Medicare or Part D of the Medicare Program.

10. Routine Prostate Cancer Screening. We will pay the expense incurred for prostate cancer screening. Benefits are limited to at least one screening per year for any insured male 50 years of age or older, and at least one screening per year for any insured male 40 years of age or older who is symptomatic.

11. Outpatient Mental Health Coverage. We will pay the allowable amount not paid by Medicare, less the Part B Deductible if applicable.

12. Physical and Occupational Therapy Services. We will pay the allowable amount not paid by Medicare, less the Part Be Deductible if appllicable.

13. Treatment of Lyme Disease. We will pay benefits for diagnosed Lyme disease as any other medical service. Benefits will not be payable for that portion of expense that is paid by Medicare or under any other part of your policy.

ADDITIONAL BENEFITS UNDER EXTENDED BASIC PLAN - WM27

We will pay 80% of the usual and customary charges for the following articles and services prescribed by a physician which are not paid by Medicare or payable under any other provision of your policy.

1. Hospital services.
2. Professional services for the diagnosis or treatment of injuries, sickness or conditions when such services are given by a physician or are under a physician's direction. Outpatient mental or dental services are not covered.
3. Services of a nursing home for not more than 120 days each year. Such services must qualify as reimbursable under Medicare.
4. Services of a home health agency. Such services must qualify as reimbursable under Medicare.
5. Use of radium or other radioactive materials.
6. Oxygen.
7. Anesthetics.
8. Prosthetic devices other than dental.
9. Rental or purchase, as appropriate, of durable medical equipment other than eyeglasses and hearing aids.
10. Diagnostic X-rays and lab tests.
11. Oral surgery for: (a) partially or completely unerupted impacted teeth, (b) a tooth root without the extraction of the entire root or (c) the gums or tissues of the mouth when not performed in connection with the extraction or repair of teeth.
12. Services of a physical therapist.
13. Professional ambulance for service to the nearest facility qualified to treat the condition, or a reasonable mileage rate for transportation to a kidney dialysis center for treatment.
14. Well-baby care.
15. Up to $500.00 for a second surgical opinion. Not included is the repetition of diagnostic tests.
16. Services of an occupational therapist.

The above Additional Benefits are not payable for: (a) injuries or sickness for which any benefits are provided for by workers' compensation or employer's liability laws, (b) cosmetic surgery, except for repair of an injury or a birth defect, (c) care which is primarily for custodial or for domiciliary purposes which would not qualify as eligible services under Medicare, (d) any charge for confinement in a private room to the extent it is in excess of the institutions' charge for its most common semiprivate room unless the private room is prescribed as medically necessary by a physician or (e) any charges for services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles.

LIMITATIONS

The policy DOES NOT cover the following:

a) Private Duty Nursing.
b) Custodial nursing home care costs.
c) Intermediate nursing home care costs.
d) Physicians charges above Medicare's approved charges, except as explained in the Additional Benefits section of this outline.

OPTIONAL COVERAGE AVAILABLE FOR BASIC PLAN - WM26 (check if applied for)

□ **0MJ4W - Part B Excess Rider**

If you incur services or supplies, outside of Minnesota, that are eligible under the Medicare Part B, we will pay that portion of the usual and customary charge which:

a) is in excess of the Medicare Part B approved charge and

b) you are required to pay.

□ **0MJ1W - Medicare Part A Hospital Deductible Benefits Rider**

When you are hospital confined for a covered condition, we will pay the Medicare Part A Hospital Deductible of $[1,068.00] that you incur.

□ **0MJ3W - Preventive Medical Care Rider**

We will pay the Medicare-approved amount for each of the following preventive health services, as if Medicare were to cover the service, as identified in the American Medical Association's current procedural terminology (AMA CPT) codes, to a maximum of $120.00 annually under this benefit:

a) an annual clinical preventive medical history and physical exam that may include tests and services from item (b) below and patient education to address preventive health care measures;

b) any one or combination of the following preventive screening tests or preventive services, as often as medically necessary; fecal occult blood test and/or digital rectal exam; dipstick urinalysis for hematuria, bacteriuria, and proteinuria; pure tone (air only) hearing screening test, ordered or administered by a physician; serum cholesterol screening every five years; thyroid function test; diabetes screening; and/or any other tests or preventive measures determined appropriate by the attending physician.

Benefits for Preventive Health Services will not duplicate any payment for a procedure that is already covered by Medicare.

□ **0MJ2W - Medicare Part B Deductible Rider**

When you incur expense that is applied to the Medicare Part B deductible and Medicare does not pay the deductible, we will pay the entire Medicare Part B annual deductible.