UNITED OF OMAHA LIFE INSURANCE COMPANY

A Mutual of Omaha Company

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE – COVER PAGE

BENEFIT PLANS A, F, G AND M

Benefit Chart of Medicare Supplement Plans Sold for Effective Dates on or After June 1, 2010.

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A." Some plans may not be available in your state. Plans E, H, I, and J are no longer available for sale.

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
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
		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 Emer-gency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emer-gency

Plan K	Plan L	Plan M	Plan 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 $4,640; paid at 100% after limit reached	Out-of-pocket limit $2,320; 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 $2,000 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed $2,000. 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 plans' separate foreign travel emergency deductible.

MONTHLY PREMIUMS*

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

NON-TOBACCO					TOBACCO			
Plan A UM20	**Plan F UM23**	**Plan G UM24**	**Plan M UM30**	**Attained Age**	**Plan A UM20**	**Plan F UM23**	**Plan G UM24**	**Plan M UM30**
177.16				**Thru 64**	203.63			
75.29	109.13	91.91	86.76	**65**	86.54	125.43	105.64	99.72
75.29	109.13	91.91	86.76	**66**	86.54	125.43	105.64	99.72
78.60	113.92	95.95	90.57	**67**	90.34	130.94	110.29	104.10
82.08	118.95	100.19	94.56	**68**	94.35	136.72	115.16	108.69
85.70	124.20	104.61	98.74	**69**	98.51	142.76	120.24	113.49
89.31	129.44	109.03	102.90	**70**	102.65	148.78	125.32	118.28
92.92	134.67	113.43	107.06	**71**	106.80	154.79	130.37	123.06
96.63	140.04	117.96	111.34	**72**	111.07	160.97	135.59	127.97
100.39	145.49	122.54	115.67	**73**	115.39	167.23	140.85	132.95
104.19	150.99	127.18	120.04	**74**	119.75	173.56	146.18	137.98
107.83	156.26	131.62	124.23	**75**	123.94	179.61	151.29	142.79
111.05	160.94	135.55	127.95	**76**	127.64	184.99	155.81	147.07
112.98	163.73	137.90	130.17	**77**	129.86	188.20	158.51	149.62
114.90	166.51	140.25	132.38	**78**	132.07	191.39	161.21	152.16
116.99	169.56	142.81	134.79	**79**	134.47	194.90	164.15	154.94
119.01	172.46	145.27	137.11	**80**	136.79	198.23	166.98	157.60
120.96	175.30	147.65	139.37	**81**	139.03	201.49	169.71	160.19
122.82	178.00	149.92	141.50	**82**	141.17	204.60	172.32	162.65
124.57	180.54	152.07	143.52	**83**	143.18	207.51	174.79	164.97
126.24	182.96	154.10	145.45	**84**	145.11	210.29	177.13	167.18
127.80	185.23	156.00	147.25	**85**	146.90	212.90	179.31	169.25
129.25	187.32	157.77	148.92	**86**	148.56	215.31	181.35	171.17
130.59	189.26	159.40	150.46	**87**	150.10	217.54	183.22	172.94
131.81	191.03	160.90	151.86	**88**	151.51	219.57	184.94	174.56
132.91	192.62	162.24	153.13	**89**	152.77	221.40	186.48	176.01
133.85	193.98	163.39	154.22	**90+**	153.86	222.97	187.80	177.26

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

CO51.B-TX

MONTHLY PREMIUMS*

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

NON-TOBACCO					TOBACCO			
Plan A UM20	**Plan F UM23**	**Plan G UM24**	**Plan M UM30**	**Attained Age**	**Plan A UM20**	**Plan F UM23**	**Plan G UM24**	**Plan M UM30**
200.78				**Thru 64**	230.79			
85.33	123.68	104.16	98.32	**65**	98.08	142.16	119.73	113.02
85.33	123.68	104.16	98.32	**66**	98.08	142.16	119.73	113.02
89.08	129.11	108.74	102.65	**67**	102.39	148.40	124.99	117.98
93.03	134.81	113.55	107.17	**68**	106.93	154.95	130.52	123.19
97.13	140.76	118.56	111.90	**69**	111.64	161.79	136.27	128.62
101.22	146.70	123.56	116.62	**70**	116.34	168.62	142.03	134.05
105.31	152.62	128.55	121.33	**71**	121.04	175.43	147.76	139.47
109.51	158.71	133.69	126.18	**72**	125.88	182.43	153.66	145.03
113.77	164.89	138.88	131.09	**73**	130.77	189.53	159.63	150.67
118.08	171.13	144.13	136.05	**74**	135.72	196.70	165.67	156.38
122.20	177.10	149.17	140.80	**75**	140.46	203.56	171.46	161.83
125.85	182.40	153.63	145.01	**76**	144.66	209.65	176.58	166.68
128.04	185.56	156.29	147.52	**77**	147.18	213.29	179.64	169.57
130.22	188.72	158.95	150.03	**78**	149.68	216.91	182.70	172.45
132.59	192.17	161.85	152.77	**79**	152.40	220.88	186.04	175.59
134.88	195.46	164.64	155.39	**80**	155.03	224.67	189.24	178.61
137.09	198.67	167.34	157.95	**81**	157.57	228.36	192.34	181.55
139.20	201.73	169.91	160.37	**82**	160.00	231.88	195.30	184.33
141.18	204.61	172.34	162.66	**83**	162.27	235.18	198.09	186.97
143.08	207.35	174.65	164.84	**84**	164.46	238.33	200.75	189.48
144.84	209.92	176.80	166.88	**85**	166.48	241.29	203.22	191.82
146.48	212.29	178.81	168.78	**86**	168.37	244.02	205.53	193.99
148.00	214.49	180.66	170.52	**87**	170.12	246.54	207.65	196.00
149.39	216.50	182.35	172.11	**88**	171.71	248.85	209.60	197.83
150.63	218.30	183.87	173.55	**89**	173.14	250.92	211.34	199.48
151.70	219.85	185.17	174.78	**90+**	174.37	252.70	212.84	200.90

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

CO51.B-TX

MONTHLY PREMIUMS*
ZIP CODES: 770-773, 775

NON-TOBACCO					TOBACCO			
Plan A UM20	**Plan F UM23**	**Plan G UM24**	**Plan M UM30**	**Attained Age**	**Plan A UM20**	**Plan F UM23**	**Plan G UM24**	**Plan M UM30**
228.34				**Thru 64**	262.46			
97.05	140.65	118.46	111.82	**65**	111.55	161.67	136.16	128.53
97.05	140.65	118.46	111.82	**66**	111.55	161.67	136.16	128.53
101.30	146.83	123.67	116.73	**67**	116.44	168.77	142.15	134.18
105.79	153.31	129.14	121.88	**68**	121.60	176.22	148.43	140.09
110.46	160.08	134.83	127.26	**69**	126.96	184.00	154.98	146.28
115.11	166.83	140.52	132.63	**70**	132.31	191.76	161.52	152.45
119.76	173.57	146.19	137.99	**71**	137.66	199.51	168.04	158.61
124.55	180.50	152.04	143.50	**72**	143.16	207.47	174.75	164.94
129.39	187.52	157.94	149.08	**73**	148.72	215.54	181.54	171.36
134.28	194.61	163.91	154.72	**74**	154.35	223.69	188.41	177.84
138.98	201.41	169.65	160.12	**75**	159.74	231.50	195.00	184.05
143.12	207.43	174.71	164.91	**76**	164.51	238.43	200.82	189.56
145.62	211.03	177.74	167.77	**77**	167.38	242.57	204.30	192.84
148.09	214.62	180.77	170.63	**78**	170.22	246.69	207.78	196.12
150.79	218.54	184.07	173.73	**79**	173.32	251.20	211.57	199.69
153.39	222.29	187.24	176.72	**80**	176.31	255.50	215.22	203.13
155.90	225.94	190.30	179.63	**81**	179.20	259.70	218.74	206.47
158.30	229.42	193.23	182.38	**82**	181.96	263.70	222.11	209.64
160.55	232.69	196.00	184.99	**83**	184.54	267.46	225.28	212.63
162.71	235.81	198.62	187.47	**84**	187.03	271.05	228.30	215.48
164.72	238.74	201.06	189.79	**85**	189.34	274.41	231.11	218.15
166.59	241.43	203.35	191.94	**86**	191.48	277.51	233.74	220.62
168.31	243.93	205.45	193.93	**87**	193.47	280.38	236.15	222.91
169.89	246.21	207.38	195.73	**88**	195.27	283.01	238.37	224.98
171.30	248.26	209.11	197.37	**89**	196.90	285.36	240.35	226.86
172.52	250.02	210.59	198.77	**90+**	198.30	287.38	242.06	228.47

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

CO51.B-TX

Premium Information

We, United of Omaha, can only raise your premium if we raise the premium for all the policies like yours in this state. Until you are age 90, your premium may change each year. This change will only be made on the first renewal date that coincides with or follows each anniversary of the policy date. Schedules of premiums may vary depending upon your policy date.

Disclosures

Use this outline to compare benefits and premiums among policies.

This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010, have different benefits and premiums. Plans E, H, I, and J are no longer available for sale.

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 of Omaha Life Insurance Company, Mutual of Omaha Plaza, Omaha, NE 68175. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

Policy Replacement

If you are replacing another health insurance policy, 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 of Omaha nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult "Medicare & You" for more details.

Limitations and Exclusions

We will not pay benefits for:
(a) services for which a charge is normally not made when there is no insurance;
(b) expense incurred before the policy date;
(c) expense incurred which is paid for by Medicare;
(d) expense incurred while this policy is not in force;
(e) services for non-Medicare Eligible Expenses; or
(f) loss or expense payable under any other Medicare supplement insurance policy or certificate.

Refund of Premium

In the event of cancellation or death, we will promptly return the unearned portion of any premium paid.

Complete Answers Are Very Important

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The Company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. Review the application carefully before you sign it. Be certain that all information has been properly recorded.

PLAN A
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

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

Services	Medicare Pays	Plan A Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but $1,132	$0	$1,132 (Part A Deductible)
61st through 90th day	All but $283 a day	$283 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $566 a day	$566 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 $141.50 a day	$0	Up to $141.50 a day
101st day and after	$0	$0	All costs
BLOOD First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy/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 A
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $162 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan A Pays	You Pay
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First $162 of Medicare Approved Amounts*	$0	$0	$162 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Medicare Approved Amounts)	$0	$0	All costs
BLOOD First 3 pints	$0	All costs	$0
Next $162 of Medicare Approved Amounts*	$0	$0	$162 (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 $162 of Medicare Approved Amounts*	$0	$0	$162 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN F

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

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

Services	Medicare Pays	Plan F Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but $1,132	$1,132 (Part A Deductible)	$0
61st through 90th day	All but $283 a day	$283 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $566 a day	$566 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 $141.50 a day	Up to $141.50 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, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy/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 F

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

*Once you have been billed $162 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
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 $162 of Medicare Approved Amounts*	$0	$162 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Medicare Approved Amounts)	$0	100%	$0
BLOOD First 3 pints	$0	All costs	$0
Next $162 of Medicare Approved Amounts*	$0	$162 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A AND B

HOME HEALTH CARE—MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $162 of Medicare Approved Amounts*	$0	$162 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN G

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

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

Services	Medicare Pays	Plan G Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,132	$1,132 (Part A Deductible)	$0
61st through 90th day	All but $283 a day	$283 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $566 a day	$566 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 $141.50 a day	Up to $141.50 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, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy/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 G
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $162 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan G Pays	You Pay
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First $162 of Medicare Approved Amounts*	$0	$0	$162 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Medicare Approved Amounts)	$0	100%	$0
BLOOD First 3 pints	$0	All costs	$0
Next $162 of Medicare Approved Amounts*	$0	$0	$162 (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 $162 of Medicare Approved Amounts*	$0	$0	$162 (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 beginning during the first 60 days of each trip outside the USA First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime Maximum Benefit of $50,000	20% and amounts over the $50,000 lifetime Maximum Benefit

PLAN M

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 M Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but $1,132	$566 (50% of Part A Deductible)	$566 (50% of Part A deductible)
61st through 90th day	All but $283 a day	$283 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $566 a day	$566 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 $141.50 a day	Up to $141.50 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, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy/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 M
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $162 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 M 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 $162 of Medicare Approved Amounts*	$0	$0	$162 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Medicare Approved Amounts)	$0	$0	All costs
BLOOD First 3 pints	$0	All costs	$0
Next $162 of Medicare Approved Amounts*	$0	$0	$162 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

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

PARTS A AND B

Services	Medicare Pays	Plan M Pays	You Pay
HOME HEALTH CARE—MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $162 of Medicare Approved Amounts*	$0	$0	$162 (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 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