WOODMEN OF THE WORLD LIFE INSURANCE SOCIETY

A Fraternal Benefit Society

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE – COVER PAGE

BENEFIT PLANS A, B, F, G, HIGH DEDUCTIBLE G AND N

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plans A, B and D or G available. Some plans may not be available in your state. Only applicants **first** eligible for Medicare before 2020 may purchase Plans C, F and High Deductible F.

Note: A ✓ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants									Medicare first eligible before 2020 only		
	PLAN A	**PLAN B**	**PLAN D**	**PLAN G**	**G[1]**	PLAN K	PLAN L	PLAN M	**PLAN N**	**PLAN C**	**PLAN F**	**F[1]**
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	
Medicare Part B coinsurance or Copayment	✓	✓	✓	✓		50%	75%	✓	✓ copays apply[3]	✓	✓	
Blood (first three pints each year)	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓	
Part A hospice care coinsurance or copayment	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓	
Skilled nursing facility coinsurance			✓	✓		50%	75%	✓	✓	✓	✓	
Medicare Part A deductible		✓	✓	✓		50%	75%	50%	✓	✓	✓	
Medicare Part B deductible										✓	✓	
Medicare Part B excess charges				✓							✓	
Foreign travel emergency (up to plan limits)			✓	✓				✓	✓	✓	✓	
Out-of-pocket limit in 2024[2]						$7,060[2]	$3,530[2]					

[1]Plans F and G also have a high deductible option which require first paying a plan deductible $2,800 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

[2]Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

[3]Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to $20 for some office visits and up to a $50 co-payment for emergency room visits that do not result in an inpatient admission.

MONTHLY NON-TOBACCO PREMIUMS* ZIP CODES: 155, 166, 170-188, 195-196

These premiums are used when applying during an Open Enrollment or Guaranteed Issue Period

FEMALE							MALE					
Plan A MTD20	Plan B MTD21	Plan F MTD24	Plan G MTD25	Plan High G MTD36	Plan N MTD31	Attained Age	Plan A MTD20	Plan B MTD21	Plan F MTD24	Plan G MTD25	Plan High G MTD36	Plan N MTD31
113.93	114.50	142.51	115.07	42.58	87.72	**Thru 64**	131.02	131.67	163.89	132.34	48.97	100.88
113.93	114.50	142.51	115.07	42.58	87.72	**65**	131.02	131.67	163.89	132.34	48.97	100.88
113.93	114.50	142.51	115.07	42.58	87.72	**66**	131.02	131.67	163.89	132.34	48.97	100.88
113.93	114.50	142.51	115.07	42.58	87.72	**67**	131.02	131.67	163.89	132.34	48.97	100.88
113.93	114.50	142.51	115.07	42.58	87.72	**68**	131.02	131.67	163.89	132.34	48.97	100.88
114.69	115.27	142.51	115.85	43.27	88.59	**69**	131.89	132.56	163.89	133.23	49.76	101.88
115.58	116.16	142.51	116.75	44.02	89.71	**70**	132.91	133.58	163.89	134.26	50.62	103.16
118.48	119.07	150.01	119.67	45.09	92.47	**71**	136.25	136.94	172.51	137.62	51.86	106.35
121.30	121.92	154.60	122.53	46.15	96.15	**72**	139.51	140.21	177.79	140.92	53.06	110.58
125.32	125.95	159.19	126.59	47.64	99.83	**73**	144.12	144.85	183.08	145.57	54.79	114.80
131.92	132.59	163.79	133.25	50.12	103.50	**74**	151.71	152.48	188.36	153.24	57.64	119.02
138.74	139.44	168.38	140.14	52.69	108.78	**75**	159.55	160.35	193.64	161.16	60.59	125.09
144.46	145.19	174.99	145.91	54.91	113.30	**76**	166.12	166.97	201.24	167.80	63.15	130.29
150.35	151.11	181.79	151.87	57.21	117.93	**77**	172.90	173.78	209.07	174.65	65.79	135.62
157.95	158.76	188.80	159.55	59.57	123.28	**78**	181.65	182.56	217.12	183.48	68.51	141.78
165.88	166.72	196.01	167.56	62.01	128.80	**79**	190.76	191.73	225.41	192.69	71.31	148.12
174.14	175.02	203.44	175.89	64.52	134.48	**80**	200.26	201.27	233.96	202.28	74.20	154.66
182.66	183.59	211.00	184.51	67.11	140.97	**81**	210.06	211.13	242.66	212.18	77.17	162.12
191.55	192.51	218.79	193.48	69.77	147.70	**82**	220.27	221.39	251.60	222.50	80.24	169.85
200.80	201.81	229.02	202.82	72.52	154.68	**83**	230.92	232.08	263.37	233.25	83.39	177.88
210.43	211.49	239.67	212.55	75.34	161.91	**84**	241.99	243.21	275.62	244.44	86.64	186.19
220.45	221.57	250.75	222.68	78.26	169.40	**85**	253.52	254.80	288.37	256.08	89.99	194.81
229.84	230.99	261.17	232.16	80.94	176.19	**86**	264.31	265.64	300.34	266.98	93.07	202.62
239.58	240.78	271.99	242.00	83.69	183.21	**87**	275.51	276.90	312.78	278.29	96.25	210.70
249.69	250.96	283.22	252.22	86.53	190.48	**88**	287.15	288.60	325.70	290.05	99.50	219.04
260.21	261.52	294.88	262.83	89.45	197.99	**89**	299.24	300.75	339.11	302.26	102.86	227.68
271.12	272.50	306.99	273.86	92.44	205.75	**90**	311.80	313.37	353.04	314.94	106.31	236.62
281.77	283.20	318.83	284.62	95.34	213.18	**91**	324.04	325.68	366.66	327.32	109.63	245.15
292.82	294.30	331.11	295.78	98.30	220.84	**92**	336.74	338.45	380.78	340.14	113.05	253.96
301.32	302.84	343.85	304.36	101.35	228.76	**93**	346.51	348.27	395.42	350.02	116.55	263.07
310.04	311.61	357.04	313.17	104.48	236.93	**94**	356.55	358.35	410.59	360.15	120.15	272.46
318.99	320.61	370.72	322.22	107.70	245.36	**95**	366.84	368.70	426.32	370.55	123.85	282.17
328.20	329.86	384.92	331.52	111.02	254.10	**96**	377.43	379.34	442.66	381.25	127.67	292.22
337.68	339.38	399.67	341.10	114.43	263.15	**97**	388.33	390.30	459.61	392.25	131.60	302.62
347.43	349.19	414.98	350.94	117.96	272.52	**98**	399.55	401.56	477.23	403.58	135.65	313.40
357.46	359.27	430.88	361.07	121.59	282.23	**99+**	411.08	413.16	495.50	415.23	139.83	324.56

*See PREMIUM INFORMATION regarding Risk Class and Household Premium Discount rating.

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

MONTHLY TOBACCO PREMIUMS* ZIP CODES: 155, 166, 170-188, 195-196

FEMALE							MALE					
Plan A MTD20	Plan B MTD21	Plan F MTD24	Plan G MTD25	Plan High G MTD36	Plan N MTD31	Attained Age	Plan A MTD20	Plan B MTD21	Plan F MTD24	Plan G MTD25	Plan High G MTD36	Plan N MTD31
130.95	131.61	163.80	132.27	48.95	100.83	**Thru 64**	150.59	151.35	188.37	152.12	56.29	115.95
130.95	131.61	163.80	132.27	48.95	100.83	**65**	150.59	151.35	188.37	152.12	56.29	115.95
130.95	131.61	163.80	132.27	48.95	100.83	**66**	150.59	151.35	188.37	152.12	56.29	115.95
130.95	131.61	163.80	132.27	48.95	100.83	**67**	150.59	151.35	188.37	152.12	56.29	115.95
130.95	131.61	163.80	132.27	48.95	100.83	**68**	150.59	151.35	188.37	152.12	56.29	115.95
131.83	132.49	163.80	133.16	49.73	101.83	**69**	151.60	152.37	188.37	153.13	57.19	117.11
132.85	133.52	163.80	134.19	50.60	103.11	**70**	152.78	153.54	188.37	154.32	58.18	118.57
136.18	136.87	172.43	137.56	51.83	106.29	**71**	156.61	157.40	198.29	158.19	59.61	122.24
139.43	140.14	177.70	140.84	53.04	110.52	**72**	160.35	161.16	204.36	161.97	60.99	127.10
144.05	144.77	182.98	145.50	54.76	114.74	**73**	165.66	166.49	210.43	167.33	62.97	131.95
151.63	152.40	188.27	153.16	57.61	118.96	**74**	174.38	175.26	216.50	176.14	66.25	136.81
159.47	160.27	193.54	161.08	60.56	125.03	**75**	183.39	184.31	222.58	185.24	69.65	143.78
166.05	166.88	201.14	167.71	63.12	130.23	**76**	190.94	191.91	231.31	192.88	72.59	149.76
172.82	173.69	208.96	174.56	65.76	135.55	**77**	198.73	199.74	240.31	200.74	75.62	155.89
181.56	182.48	217.01	183.39	68.47	141.70	**78**	208.79	209.84	249.56	210.90	78.75	162.96
190.66	191.63	225.30	192.59	71.28	148.04	**79**	219.27	220.37	259.10	221.48	81.97	170.25
200.16	201.17	233.84	202.18	74.16	154.58	**80**	230.18	231.35	268.91	232.51	85.28	177.77
209.96	211.02	242.53	212.08	77.13	162.04	**81**	241.45	242.68	278.91	243.89	88.70	186.35
220.17	221.28	251.48	222.39	80.19	169.77	**82**	253.19	254.47	289.20	255.75	92.23	195.23
230.80	231.97	263.24	233.13	83.35	177.79	**83**	265.42	266.76	302.73	268.10	95.86	204.46
241.87	243.09	275.48	244.31	86.60	186.10	**84**	278.15	279.55	316.80	280.96	99.59	214.01
253.39	254.67	288.22	255.95	89.95	194.72	**85**	291.41	292.87	331.46	294.35	103.44	223.92
264.18	265.51	300.20	266.85	93.03	202.52	**86**	303.80	305.34	345.22	306.87	106.98	232.90
275.37	276.76	312.63	278.16	96.20	210.59	**87**	316.68	318.28	359.52	319.88	110.63	242.18
287.00	288.46	325.54	289.90	99.45	218.94	**88**	330.05	331.72	374.37	333.39	114.37	251.77
299.09	300.59	338.95	302.11	102.81	227.57	**89**	343.95	345.69	389.79	347.43	118.23	261.71
311.63	313.21	352.86	314.78	106.25	236.50	**90**	358.39	360.19	405.79	362.00	122.19	271.98
323.87	325.51	366.48	327.15	109.58	245.03	**91**	372.46	374.34	421.45	376.22	126.01	281.79
336.57	338.28	380.59	339.98	112.99	253.84	**92**	387.06	389.02	437.67	390.97	129.94	291.91
346.35	348.09	395.23	349.84	116.50	262.94	**93**	398.29	400.31	454.50	402.32	133.97	302.38
356.37	358.17	410.39	359.97	120.10	272.33	**94**	409.83	411.90	471.94	413.97	138.11	313.17
366.66	368.51	426.11	370.37	123.79	282.03	**95**	421.66	423.79	490.03	425.92	142.36	324.33
377.24	379.15	442.44	381.06	127.60	292.07	**96**	433.83	436.03	508.80	438.22	146.74	335.88
388.14	390.10	459.39	392.06	131.53	302.48	**97**	446.36	448.62	528.29	450.87	151.26	347.84
399.35	401.37	476.99	403.38	135.59	313.24	**98**	459.25	461.57	548.54	463.88	155.92	360.23
410.87	412.95	495.26	415.02	139.76	324.40	**99+**	472.51	474.89	569.55	477.28	160.72	373.06

*See PREMIUM INFORMATION regarding Risk Class and Household Premium Discount rating.

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

MONTHLY NON-TOBACCO PREMIUMS* ZIP CODES: 150-154, 156-165, 167-169

These premiums are used when applying during an Open Enrollment or Guaranteed Issue Period

FEMALE							MALE					
Plan A MTD20	Plan B MTD21	Plan F MTD24	Plan G MTD25	Plan High G MTD36	Plan N MTD31	Attained Age	Plan A MTD20	Plan B MTD21	Plan F MTD24	Plan G MTD25	Plan High G MTD36	Plan N MTD31
125.67	126.30	157.20	126.94	46.97	96.77	**Thru 64**	144.52	145.25	180.78	145.98	54.02	111.28
125.67	126.30	157.20	126.94	46.97	96.77	**65**	144.52	145.25	180.78	145.98	54.02	111.28
125.67	126.30	157.20	126.94	46.97	96.77	**66**	144.52	145.25	180.78	145.98	54.02	111.28
125.67	126.30	157.20	126.94	46.97	96.77	**67**	144.52	145.25	180.78	145.98	54.02	111.28
125.67	126.30	157.20	126.94	46.97	96.77	**68**	144.52	145.25	180.78	145.98	54.02	111.28
126.52	127.15	157.20	127.79	47.73	97.73	**69**	145.49	146.23	180.78	146.96	54.89	112.39
127.50	128.14	157.20	128.78	48.56	98.95	**70**	146.62	147.35	180.78	148.10	55.84	113.79
130.69	131.35	165.48	132.01	49.74	102.01	**71**	150.29	151.06	190.29	151.81	57.20	117.31
133.81	134.49	170.54	135.17	50.90	106.07	**72**	153.89	154.66	196.12	155.44	58.54	121.98
138.24	138.94	175.61	139.64	52.55	110.12	**73**	158.98	159.78	201.95	160.58	60.43	126.63
145.52	146.25	180.68	146.99	55.29	114.17	**74**	167.35	168.20	207.78	169.04	63.58	131.29
153.04	153.81	185.74	154.59	58.12	119.99	**75**	176.00	176.88	213.60	177.77	66.84	137.99
159.35	160.15	193.03	160.95	60.57	124.98	**76**	183.25	184.18	221.98	185.10	69.66	143.72
165.85	166.69	200.53	167.53	63.11	130.08	**77**	190.72	191.69	230.62	192.65	72.57	149.61
174.24	175.12	208.26	176.00	65.71	135.99	**78**	200.38	201.38	239.50	202.40	75.57	156.39
182.98	183.91	216.22	184.83	68.40	142.07	**79**	210.43	211.49	248.65	212.55	78.66	163.39
192.09	193.06	224.41	194.03	71.17	148.35	**80**	220.90	222.02	258.07	223.14	81.84	170.61
201.49	202.52	232.75	203.53	74.03	155.51	**81**	231.72	232.89	267.67	234.06	85.12	178.84
211.30	212.36	241.35	213.43	76.96	162.93	**82**	242.98	244.21	277.54	245.44	88.51	187.36
221.50	222.62	252.63	223.73	79.99	170.62	**83**	254.72	256.01	290.53	257.29	91.99	196.22
232.12	233.29	264.38	234.47	83.11	178.60	**84**	266.94	268.29	304.03	269.64	95.58	205.38
243.18	244.41	276.60	245.64	86.32	186.87	**85**	279.66	281.07	318.10	282.48	99.27	214.90
253.53	254.81	288.10	256.09	89.28	194.35	**86**	291.56	293.03	331.31	294.50	102.67	223.51
264.27	265.60	300.03	266.95	92.32	202.10	**87**	303.91	305.45	345.03	306.98	106.17	232.42
275.44	276.83	312.42	278.22	95.45	210.11	**88**	316.75	318.35	359.28	319.95	109.76	241.62
287.03	288.48	325.28	289.93	98.67	218.40	**89**	330.09	331.75	374.07	333.42	113.47	251.16
299.07	300.59	338.63	302.10	101.97	226.96	**90**	343.94	345.67	389.43	347.41	117.27	261.02
310.82	312.39	351.70	313.97	105.16	235.15	**91**	357.45	359.25	404.46	361.06	120.93	270.43
323.00	324.64	365.25	326.27	108.43	243.61	**92**	371.46	373.34	420.03	375.21	124.70	280.15
332.39	334.06	379.30	335.74	111.80	252.34	**93**	382.24	384.17	436.18	386.10	128.57	290.19
342.00	343.74	393.85	345.46	115.26	261.35	**94**	393.31	395.30	452.92	397.28	132.54	300.55
351.88	353.66	408.94	355.44	118.80	270.66	**95**	404.66	406.71	470.27	408.75	136.62	311.26
362.04	363.87	424.60	365.70	122.46	280.29	**96**	416.35	418.45	488.29	420.55	140.83	322.34
372.49	374.37	440.87	376.26	126.23	290.28	**97**	428.36	430.53	507.00	432.69	145.16	333.82
383.25	385.19	457.76	387.12	130.12	300.62	**98**	440.74	442.96	526.42	445.18	149.63	345.71
394.31	396.30	475.30	398.30	134.12	311.32	**99+**	453.46	455.75	546.59	458.04	154.24	358.02

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MONTHLY TOBACCO PREMIUMS* ZIP CODES: 150-154, 156-165, 167-169

FEMALE							MALE					
Plan A MTD20	Plan B MTD21	Plan F MTD24	Plan G MTD25	Plan High G MTD36	Plan N MTD31	Attained Age	Plan A MTD20	Plan B MTD21	Plan F MTD24	Plan G MTD25	Plan High G MTD36	Plan N MTD31
144.45	145.18	180.69	145.91	53.99	111.23	**Thru 64**	166.12	166.95	207.79	167.80	62.09	127.91
144.45	145.18	180.69	145.91	53.99	111.23	**65**	166.12	166.95	207.79	167.80	62.09	127.91
144.45	145.18	180.69	145.91	53.99	111.23	**66**	166.12	166.95	207.79	167.80	62.09	127.91
144.45	145.18	180.69	145.91	53.99	111.23	**67**	166.12	166.95	207.79	167.80	62.09	127.91
144.45	145.18	180.69	145.91	53.99	111.23	**68**	166.12	166.95	207.79	167.80	62.09	127.91
145.42	146.15	180.69	146.89	54.86	112.33	**69**	167.23	168.08	207.79	168.92	63.09	129.18
146.55	147.29	180.69	148.02	55.81	113.74	**70**	168.53	169.37	207.79	170.23	64.18	130.80
150.22	150.98	190.20	151.74	57.17	117.25	**71**	172.75	173.63	218.73	174.50	65.75	134.84
153.80	154.58	196.02	155.36	58.51	121.92	**72**	176.88	177.77	225.43	178.67	67.28	140.20
158.90	159.70	201.85	160.50	60.40	126.57	**73**	182.74	183.66	232.13	184.58	69.46	145.55
167.26	168.11	207.68	168.95	63.55	131.23	**74**	192.35	193.33	238.82	194.30	73.08	150.91
175.91	176.80	213.50	177.68	66.80	137.92	**75**	202.29	203.31	245.52	204.34	76.83	158.61
183.16	184.08	221.88	185.00	69.63	143.66	**76**	210.63	211.70	255.15	212.76	80.07	165.20
190.63	191.59	230.50	192.56	72.54	149.52	**77**	219.22	220.33	265.08	221.44	83.42	171.96
200.27	201.29	239.38	202.29	75.53	156.31	**78**	230.32	231.47	275.29	232.64	86.86	179.76
210.32	211.39	248.53	212.45	78.62	163.30	**79**	241.87	243.09	285.81	244.31	90.42	187.81
220.79	221.91	257.95	223.02	81.80	170.52	**80**	253.91	255.20	296.64	256.48	94.07	196.10
231.60	232.78	267.53	233.95	85.09	178.74	**81**	266.34	267.69	307.67	269.03	97.84	205.56
242.87	244.09	277.41	245.32	88.46	187.27	**82**	279.29	280.70	319.01	282.12	101.74	215.36
254.60	255.88	290.38	257.16	91.95	196.12	**83**	292.78	294.26	333.94	295.74	105.74	225.54
266.80	268.15	303.88	269.50	95.53	205.29	**84**	306.82	308.37	349.46	309.93	109.86	236.07
279.52	280.93	317.93	282.34	99.22	214.79	**85**	321.45	323.07	365.63	324.69	114.11	247.01
291.41	292.88	331.14	294.36	102.62	223.40	**86**	335.12	336.82	380.81	338.51	118.01	256.91
303.76	305.29	344.86	306.83	106.11	232.30	**87**	349.32	351.09	396.59	352.85	122.03	267.15
316.59	318.20	359.10	319.79	109.71	241.51	**88**	364.08	365.92	412.97	367.76	126.16	277.73
329.92	331.58	373.89	333.25	113.41	251.03	**89**	379.41	381.33	429.97	383.24	130.42	288.69
343.76	345.50	389.23	347.24	117.21	260.88	**90**	395.33	397.32	447.62	399.32	134.79	300.02
357.26	359.07	404.26	360.88	120.88	270.29	**91**	410.86	412.93	464.89	415.01	139.00	310.84
371.27	373.15	419.83	375.02	124.63	280.01	**92**	426.96	429.12	482.80	431.27	143.34	322.01
382.05	383.98	435.97	385.91	128.51	290.05	**93**	439.35	441.58	501.36	443.79	147.78	333.55
393.11	395.10	452.70	397.08	132.48	300.40	**94**	452.08	454.37	520.60	456.64	152.35	345.46
404.46	406.50	470.04	408.55	136.55	311.10	**95**	465.13	467.48	540.54	469.83	157.03	357.77
416.13	418.24	488.05	420.34	140.76	322.18	**96**	478.56	480.98	561.26	483.39	161.87	370.51
428.15	430.31	506.75	432.48	145.09	333.66	**97**	492.37	494.86	582.75	497.35	166.86	383.70
440.52	442.75	526.16	444.97	149.57	345.54	**98**	506.59	509.15	605.09	511.71	171.99	397.37
453.23	455.52	546.32	457.81	154.17	357.84	**99+**	521.22	523.85	628.26	526.48	177.29	411.52

*See PREMIUM INFORMATION regarding Risk Class and Household Premium Discount rating.

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

MONTHLY NON-TOBACCO PREMIUMS* ZIP CODES: 189 - 194

These premiums are used when applying during an Open Enrollment or Guaranteed Issue Period

FEMALE							MALE					
Plan A MTD20	Plan B MTD21	Plan F MTD24	Plan G MTD25	Plan High G MTD36	Plan N MTD31	Attained Age	Plan A MTD20	Plan B MTD21	Plan F MTD24	Plan G MTD25	Plan High G MTD36	Plan N MTD31
140.94	141.65	176.30	142.36	52.68	108.52	**Thru 64**	162.08	162.90	202.75	163.72	60.58	124.80
140.94	141.65	176.30	142.36	52.68	108.52	**65**	162.08	162.90	202.75	163.72	60.58	124.80
140.94	141.65	176.30	142.36	52.68	108.52	**66**	162.08	162.90	202.75	163.72	60.58	124.80
140.94	141.65	176.30	142.36	52.68	108.52	**67**	162.08	162.90	202.75	163.72	60.58	124.80
140.94	141.65	176.30	142.36	52.68	108.52	**68**	162.08	162.90	202.75	163.72	60.58	124.80
141.89	142.60	176.30	143.32	53.53	109.60	**69**	163.17	163.99	202.75	164.82	61.55	126.04
142.99	143.71	176.30	144.43	54.46	110.98	**70**	164.43	165.26	202.75	166.09	62.62	127.62
146.57	147.31	185.58	148.05	55.78	114.40	**71**	168.55	169.41	213.42	170.26	64.15	131.57
150.07	150.83	191.26	151.59	57.09	118.95	**72**	172.58	173.45	219.95	174.33	65.65	136.80
155.03	155.82	196.94	156.60	58.93	123.50	**73**	178.29	179.19	226.49	180.09	67.78	142.02
163.20	164.02	202.63	164.85	62.00	128.04	**74**	187.68	188.63	233.02	189.58	71.31	147.25
171.63	172.50	208.31	173.37	65.18	134.57	**75**	197.38	198.37	239.56	199.37	74.96	154.75
178.71	179.61	216.48	180.51	67.93	140.17	**76**	205.51	206.56	248.95	207.59	78.12	161.18
186.00	186.94	224.90	187.88	70.77	145.89	**77**	213.89	214.98	258.64	216.06	81.39	167.78
195.41	196.40	233.56	197.38	73.70	152.51	**78**	224.72	225.85	268.60	226.99	84.75	175.39
205.21	206.25	242.49	207.29	76.71	159.34	**79**	236.00	237.19	278.86	238.38	88.22	183.24
215.43	216.52	251.68	217.60	79.81	166.37	**80**	247.74	248.99	289.43	250.25	91.79	191.33
225.97	227.12	261.03	228.26	83.02	174.40	**81**	259.87	261.19	300.19	262.49	95.46	200.56
236.97	238.16	270.67	239.36	86.31	182.72	**82**	272.51	273.88	311.26	275.26	99.26	210.13
248.41	249.66	283.32	250.92	89.71	191.36	**83**	285.67	287.11	325.82	288.55	103.17	220.05
260.32	261.64	296.50	262.95	93.21	200.30	**84**	299.37	300.88	340.97	302.40	107.19	230.34
272.72	274.10	310.20	275.48	96.81	209.57	**85**	313.64	315.22	356.75	316.80	111.33	241.01
284.33	285.76	323.10	287.20	100.13	217.97	**86**	326.98	328.63	371.56	330.28	115.14	250.66
296.38	297.87	336.48	299.38	103.53	226.65	**87**	340.84	342.56	386.95	344.28	119.07	260.66
308.90	310.46	350.38	312.02	107.04	235.64	**88**	355.23	357.03	402.93	358.82	123.10	270.98
321.91	323.53	364.81	325.15	110.65	244.93	**89**	370.19	372.06	419.52	373.93	127.25	281.67
335.41	337.11	379.78	338.80	114.36	254.54	**90**	385.73	387.67	436.75	389.62	131.51	292.73
348.58	350.35	394.43	352.11	117.94	263.72	**91**	400.88	402.90	453.60	404.93	135.63	303.28
362.25	364.09	409.62	365.91	121.61	273.21	**92**	416.59	418.70	471.06	420.79	139.85	314.18
372.77	374.65	425.38	376.53	125.38	283.00	**93**	428.68	430.85	489.18	433.01	144.19	325.45
383.56	385.50	441.70	387.43	129.26	293.10	**94**	441.09	443.32	507.95	445.55	148.64	337.07
394.63	396.63	458.62	398.62	133.24	303.54	**95**	453.83	456.12	527.41	458.41	153.22	349.07
406.02	408.08	476.19	410.13	137.34	314.35	**96**	466.93	469.29	547.62	471.65	157.94	361.51
417.75	419.86	494.44	421.98	141.57	325.55	**97**	480.41	482.84	568.59	485.26	162.80	374.38
429.82	431.99	513.38	434.16	145.93	337.14	**98**	494.28	496.78	590.38	499.27	167.81	387.71
442.22	444.45	533.05	446.69	150.42	349.15	**99+**	508.55	511.12	613.00	513.69	172.98	401.52

*See PREMIUM INFORMATION regarding Risk Class and Household Premium Discount rating.

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

MONTHLY TOBACCO PREMIUMS* ZIP CODES: 189 - 194

FEMALE							MALE					
Plan A MTD20	Plan B MTD21	Plan F MTD24	Plan G MTD25	Plan High G MTD36	Plan N MTD31	Attained Age	Plan A MTD20	Plan B MTD21	Plan F MTD24	Plan G MTD25	Plan High G MTD36	Plan N MTD31
162.00	162.82	202.64	163.63	60.55	124.74	**Thru 64**	186.30	187.24	233.04	188.18	69.64	143.45
162.00	162.82	202.64	163.63	60.55	124.74	**65**	186.30	187.24	233.04	188.18	69.64	143.45
162.00	162.82	202.64	163.63	60.55	124.74	**66**	186.30	187.24	233.04	188.18	69.64	143.45
162.00	162.82	202.64	163.63	60.55	124.74	**67**	186.30	187.24	233.04	188.18	69.64	143.45
162.00	162.82	202.64	163.63	60.55	124.74	**68**	186.30	187.24	233.04	188.18	69.64	143.45
163.09	163.91	202.64	164.74	61.52	125.98	**69**	187.55	188.50	233.04	189.44	70.75	144.88
164.35	165.18	202.64	166.01	62.59	127.56	**70**	189.00	189.95	233.04	190.91	71.98	146.69
168.47	169.32	213.31	170.17	64.12	131.50	**71**	193.74	194.72	245.30	195.70	73.74	151.22
172.49	173.36	219.84	174.24	65.62	136.73	**72**	198.37	199.37	252.82	200.38	75.46	157.24
178.20	179.10	226.37	180.00	67.74	141.95	**73**	204.94	205.97	260.33	207.00	77.90	163.24
187.58	188.53	232.91	189.48	71.27	147.17	**74**	215.72	216.82	267.84	217.91	81.96	169.25
197.28	198.28	239.44	199.27	74.92	154.68	**75**	226.87	228.01	275.35	229.16	86.16	177.88
205.42	206.45	248.83	207.48	78.08	161.11	**76**	236.22	237.42	286.15	238.61	89.80	185.27
213.79	214.87	258.50	215.95	81.35	167.69	**77**	245.86	247.10	297.29	248.34	93.55	192.85
224.60	225.74	268.46	226.87	84.71	175.30	**78**	258.30	259.60	308.74	260.90	97.42	201.60
235.87	237.07	278.72	238.26	88.18	183.14	**79**	271.26	272.63	320.53	274.00	101.40	210.62
247.62	248.87	289.28	250.12	91.74	191.23	**80**	284.76	286.20	332.68	287.64	105.50	219.92
259.74	261.06	300.04	262.37	95.42	200.46	**81**	298.70	300.22	345.05	301.72	109.73	230.53
272.38	273.74	311.11	275.12	99.20	210.02	**82**	313.22	314.81	357.77	316.39	114.10	241.52
285.53	286.97	325.66	288.41	103.12	219.95	**83**	328.36	330.01	374.51	331.67	118.58	252.94
299.22	300.73	340.80	302.24	107.14	230.23	**84**	344.10	345.84	391.92	347.58	123.20	264.76
313.48	315.06	356.56	316.64	111.28	240.89	**85**	360.50	362.32	410.05	364.14	127.97	277.02
326.82	328.46	371.38	330.12	115.09	250.54	**86**	375.84	377.74	427.08	379.63	132.35	288.12
340.67	342.38	386.76	344.11	119.00	260.52	**87**	391.76	393.74	444.77	395.72	136.86	299.60
355.06	356.86	402.73	358.64	123.04	270.85	**88**	408.31	410.38	463.14	412.44	141.49	311.47
370.01	371.87	419.32	373.74	127.19	281.53	**89**	425.51	427.66	482.21	429.80	146.27	323.76
385.52	387.48	436.52	389.42	131.45	292.57	**90**	443.36	445.60	502.01	447.84	151.16	336.47
400.67	402.70	453.37	404.72	135.56	303.13	**91**	460.78	463.10	521.38	465.43	155.89	348.60
416.38	418.49	470.83	420.59	139.78	314.03	**92**	478.84	481.26	541.45	483.67	160.75	361.13
428.47	430.63	488.94	432.79	144.12	325.28	**93**	492.73	495.23	562.27	497.71	165.73	374.08
440.87	443.10	507.70	445.32	148.57	336.90	**94**	507.00	509.57	583.85	512.12	170.86	387.43
453.60	455.89	527.15	458.18	153.14	348.90	**95**	521.64	524.28	606.22	526.91	176.11	401.23
466.69	469.06	547.34	471.41	157.86	361.32	**96**	536.70	539.41	629.45	542.12	181.54	415.52
480.17	482.59	568.32	485.03	162.72	374.20	**97**	552.19	554.99	653.56	557.77	187.13	430.32
494.04	496.54	590.09	499.03	167.74	387.52	**98**	568.14	571.01	678.60	573.88	192.89	445.64
508.30	510.86	612.70	513.43	172.90	401.32	**99+**	584.54	587.50	704.59	590.45	198.83	461.52

*See PREMIUM INFORMATION regarding Risk Class and Household Premium Discount rating.

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.

PREMIUM INFORMATION

The premium for your certificate will change. Because the premium rate is based on your attained age, the premium will increase each year as you age. This annual premium change will occur on the first certificate renewal date which coincides with or follows the certificate anniversary date.

We may also change the premium for your certificate for reasons other than your attained age, including, but not limited to, changes in the table of rates or changes in Medicare. A premium change for any other reason can occur on any certificate renewal date. However, we cannot make such a change unless we make the same change to all certificates of this form issued in the same state to persons of the same classification. We will give you the advance written notice required by your state before we change your premium.

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

HOUSEHOLD PREMIUM DISCOUNT

You are eligible for a household premium discount if you reside with your legal spouse (including civil union/domestic partner when such partnerships are valid and recognized in your state of residence). The discounted premium will be priced 10% lower than the rates illustrated. The certificate's household premium discount will be removed if your legal spouse no longer resides with you (other than in the case of his or her death).

RISK CLASS RATING

If, according to our underwriting standards, you are overweight or underweight for your height, you will be considered to be a greater insurable risk. In such a case, your premium will be priced either as Class I – 10% or Class II – 20% higher than the rates illustrated, based on your Body Mass Index (BMI) reading. Risk class rating will not be applicable when you apply for coverage during open enrollment or guaranteed issue period.

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 your insurance company.

RIGHT TO RETURN CERTIFICATE

If you find that you are not satisfied with your certificate, you may return it to Woodmen of the World Life Insurance Society at our administrative office, P.O. Box 2944, Omaha, NE 68103-2944. 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 Woodmen of the World Life Insurance Society nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult "Medicare & You" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new certificate, be sure to answer truthfully and completely all questions about your medical and health history. The company 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.

EXCLUSIONS

Exclusions apply to your coverage. Please be sure to review the exclusions in your certificate.

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 $1,632	$0	$1,632 (Part A deductible)
61st through 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	$0	Up to $204 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, 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 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 $240 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 $240 of Medicare-approved amounts*	$0	$0	$240 (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 $240 of Medicare-approved amounts*	$0	$0	$240 (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

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
HOME HEALTH CARE - MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
DURABLE MEDICAL EQUIPMENT			
First $240 of Medicare-approved amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN 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 B PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A deductible)	$0
61st through 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	$0	Up to $204 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, 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 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 B

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

*Once you have been billed $240 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 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 $240 of Medicare-approved amounts*	$0	$0	$240 (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 $240 of Medicare-approved amounts*	$0	$0	$240 (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

SERVICES	MEDICARE PAYS	PLAN B PAYS	YOU PAY
HOME HEALTH CARE - MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
DURABLE MEDICAL EQUIPMENT			
First $240 of Medicare-approved amounts*	$0	$0	$240 (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 $1,632	$1,632 (Part A deductible)	$0
61st through 90th day	All but $408 a day	$408 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 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 $240 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 $240 of Medicare-approved amounts*	$0	$240 (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 $240 of Medicare-approved amounts*	$0	$240 (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

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
HOME HEALTH CARE - MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
DURABLE MEDICAL EQUIPMENT First $240 of Medicare-approved amounts*	$0	$240 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN F 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

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 $1,632	$1,632 (Part A deductible)	$0
61st through 90th day	All but $408 a day	$408 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 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 $240 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 $240 of Medicare-approved amounts*	$0	$0	$240 (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 $240 of Medicare-approved amounts*	$0	$0	$240 (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

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
HOME HEALTH CARE - MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
DURABLE MEDICAL EQUIPMENT First $240 of Medicare-approved amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum benefit

HIGH DEDUCTIBLE 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.

***This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $2,800 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2,800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the certificate. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A deductible)	$0
61st through 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 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.

HIGH DEDUCTIBLE PLAN G
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $240 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.

***This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $2,800 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2,800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the certificate. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE*** 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 $240 of Medicare-approved amounts*	$0	$0	$240 (Unless Part B deductible has been met)
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 $240 of Medicare-approved amounts*	$0	$0	$240 (Unless Part B deductible has been met)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

HIGH DEDUCTIBLE PLAN G
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

***This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $2,800 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2,800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the certificate. This does not include the plan's separate foreign travel emergency deductible.

PARTS A AND B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE - MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable Medical Equipment			
First $240 of Medicare-approved amounts*	$0	$0	$240 (Unless Part B deductible has been met)
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE*** 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

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 $1,632	$1,632 (Part A deductible)	$0
61st through 90th day	All but $408 a day	$408 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 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 $240 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 $240 of Medicare-approved amounts*	$0	$0	$240 (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 insured is 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 the insured is 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 $240 of Medicare-approved amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

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

PARTS A AND B

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
HOME HEALTH CARE - MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
DURABLE MEDICAL EQUIPMENT First $240 of Medicare-approved amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

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