GPM HEALTH and LIFE INSURANCE COMPANY

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE – COVER PAGE

BENEFIT PLANS A, F, G AND N

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

Basic Benefits:

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

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

Blood: First 3 pints of blood each year.

Hospice: Part A coinsurance.

Plan A	Plan B	Plan C	Plan D	Plan F F*	Plan G	Plan K	Plan L	Plan M	Plan N
Basic, including 100% Part B Coinsurance	Basic, including 100% Part B Coinsurance	Basic, including 100% Part B Coinsurance	Basic, including 100% Part B Coinsurance	Basic, including 100% Part B Coinsurance*	Basic, including 100% Part B Coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B Co-insurance	Basic, including 100% Part B Coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out-of-pocket limit $5,240; paid at 100% after limit reached	Out-of-pocket limit $2,620; 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 $2,240 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed $2,240. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy/certificate. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

MONTHLY NON-TOBACCO PREMIUMS*

ZIP CODES: 820-831, 834

FEMALE					MALE			
Plan A MTM20	Plan F MTM24	Plan G MTM25	Plan N MTM31	Attained Age	Plan A MTM20	Plan F MTM24	Plan G MTM25	Plan N MTM31
94.93	127.24	99.73	82.20	**65**	109.18	146.32	114.68	94.53
94.93	127.24	99.73	82.20	**66**	109.18	146.32	114.68	94.53
94.93	127.24	99.73	82.20	**67**	109.18	146.32	114.68	94.53
96.96	129.95	101.69	84.03	**68**	111.51	149.45	116.95	96.62
100.82	135.13	105.74	87.37	**69**	115.95	155.40	121.60	100.48
104.89	140.58	110.00	90.89	**70**	120.63	161.66	126.50	104.52
109.16	146.29	114.48	94.59	**71**	125.52	168.23	131.64	108.77
113.41	152.00	118.95	98.28	**72**	130.43	174.80	136.78	113.02
117.81	157.89	123.56	102.09	**73**	135.49	181.58	142.08	117.40
121.74	163.16	127.67	105.49	**74**	140.00	187.62	146.82	121.31
125.54	168.24	131.65	108.78	**75**	144.37	193.48	151.41	125.10
130.48	174.88	136.85	113.07	**76**	150.07	201.12	157.38	130.03
134.14	179.79	140.68	116.24	**77**	154.27	206.75	161.78	133.68
137.70	184.54	144.40	119.32	**78**	158.36	212.23	166.07	137.22
141.28	189.35	148.16	122.42	**79**	162.46	217.74	170.39	140.78
144.81	194.07	151.87	125.48	**80**	166.54	223.19	174.64	144.31
148.29	198.73	155.51	128.49	**81**	170.53	228.54	178.84	147.77
151.69	203.31	159.09	131.45	**82**	174.45	233.80	182.95	151.16
155.03	207.78	162.59	134.34	**83**	178.29	238.95	186.97	154.50
158.29	212.14	166.01	137.16	**84**	182.03	243.96	190.90	157.74
161.30	216.17	169.16	139.77	**85**	185.49	248.59	194.53	160.73
164.20	220.07	172.20	142.28	**86**	188.83	253.07	198.03	163.63
166.83	223.58	174.96	144.56	**87**	191.85	257.13	201.20	166.25
168.83	226.26	177.05	146.29	**88**	194.16	260.21	203.62	168.24
170.52	228.53	178.83	147.76	**89**	196.09	262.81	205.65	169.92
172.23	230.82	180.62	149.23	**90**	198.06	265.44	207.70	171.62
173.61	232.66	182.07	150.43	**91**	199.65	267.57	209.37	172.99
174.82	234.29	183.34	151.48	**92**	201.04	269.43	210.84	174.20
175.69	235.47	184.25	152.24	**93**	202.04	270.78	211.89	175.08
176.54	236.61	185.15	152.98	**94**	203.02	272.10	212.92	175.92
177.18	237.47	185.82	153.54	**95**	203.76	273.08	213.70	176.57
177.83	238.32	186.48	154.09	**96**	204.50	274.08	214.46	177.20
178.53	239.28	187.24	154.70	**97**	205.32	275.16	215.32	177.92
179.18	240.14	187.91	155.26	**98**	206.05	276.16	216.10	178.55
179.46	240.51	188.21	155.51	**99+**	206.38	276.60	216.44	178.84

*See PREMIUM INFORMATION regarding 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: 820-831, 834

FEMALE					MALE			
Plan A MTM20	Plan F MTM24	Plan G MTM25	Plan N MTM31	Attained Age	Plan A MTM20	Plan F MTM24	Plan G MTM25	Plan N MTM31
109.12	146.25	114.63	94.48	**65**	125.49	168.18	131.82	108.66
109.12	146.25	114.63	94.48	**66**	125.49	168.18	131.82	108.66
109.12	146.25	114.63	94.48	**67**	125.49	168.18	131.82	108.66
111.45	149.37	116.89	96.58	**68**	128.17	171.78	134.42	111.06
115.89	155.32	121.54	100.42	**69**	133.28	178.62	139.77	115.49
120.56	161.58	126.44	104.47	**70**	138.65	185.82	145.40	120.14
125.47	168.15	131.58	108.72	**71**	144.28	193.37	151.31	125.02
130.36	174.71	136.72	112.96	**72**	149.92	200.92	157.22	129.91
135.41	181.48	142.02	117.34	**73**	155.73	208.71	163.31	134.94
139.93	187.54	146.75	121.25	**74**	160.92	215.66	168.76	139.44
144.30	193.38	151.32	125.03	**75**	165.94	222.39	174.03	143.79
149.98	201.01	157.30	129.97	**76**	172.49	231.17	180.90	149.46
154.18	206.65	161.70	133.61	**77**	177.32	237.64	185.95	153.65
158.27	212.12	165.98	137.15	**78**	182.02	243.94	190.88	157.72
162.39	217.64	170.30	140.71	**79**	186.74	250.28	195.85	161.82
166.45	223.07	174.56	144.23	**80**	191.42	256.54	200.74	165.87
170.45	228.43	178.75	147.69	**81**	196.01	262.69	205.56	169.85
174.36	233.69	182.86	151.09	**82**	200.52	268.74	210.29	173.75
178.20	238.83	186.88	154.41	**83**	204.93	274.65	214.91	177.58
181.94	243.84	190.81	157.66	**84**	209.23	280.41	219.43	181.31
185.40	248.47	194.44	160.65	**85**	213.21	285.74	223.60	184.75
188.74	252.95	197.93	163.54	**86**	217.04	290.89	227.62	188.08
191.76	256.99	201.10	166.16	**87**	220.52	295.55	231.26	191.09
194.06	260.07	203.51	168.15	**88**	223.17	299.09	234.04	193.38
196.00	262.68	205.55	169.84	**89**	225.39	302.08	236.38	195.31
197.96	265.31	207.61	171.53	**90**	227.65	305.10	238.74	197.26
199.55	267.43	209.27	172.91	**91**	229.48	307.55	240.65	198.84
200.94	269.30	210.73	174.12	**92**	231.08	309.69	242.34	200.23
201.94	270.65	211.78	174.99	**93**	232.23	311.24	243.55	201.24
202.92	271.96	212.81	175.84	**94**	233.36	312.76	244.74	202.21
203.66	272.95	213.58	176.48	**95**	234.21	313.89	245.63	202.95
204.40	273.93	214.35	177.12	**96**	235.06	315.03	246.51	203.68
205.21	275.03	215.22	177.82	**97**	236.00	316.28	247.49	204.50
205.95	276.02	215.99	178.46	**98**	236.84	317.42	248.39	205.23
206.28	276.45	216.33	178.75	**99+**	237.22	317.93	248.78	205.56

*See PREMIUM INFORMATION regarding 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 policies.

Premium Information
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 policy renewal date which coincides with or follows the policy anniversary date.

A premium change for any other reason can occur on any policy renewal date. However, we cannot make such a change unless we make the same change to all policies using this form issued in the same state to persons of the same classification.

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

Household Premium Discount
You are eligible for a household premium discount if: (a) you reside with your spouse (including civil union/domestic partner) of any age or (b) for the past year you have resided with at least one, but not more than three, other adults who are age 60 or older. The discounted premium will be priced 7% lower than the rates illustrated. The policy's household premium discount will be removed if the other adult or spouse no longer resides with you (other than in the case of his or her death).

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 GPM Health and Life Insurance Company at our administrative office, 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 GPM Health and Life Insurance Company 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 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.

Exclusions
Exclusions apply to your coverage. Please be sure to review the exclusions in your policy. This policy does not pay Part A benefits for benefit periods that begin while this policy is not in force, and other exclusions apply.

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 $1,340	$0	$1,340 (Part A deductible)
61st through 90th day	All but $335 a day	$335 a day	$0
91st day and after			
(while using 60 lifetime reserve days):	All but $670 a day	$670 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 $167.50 a day	$0	Up to $167.50 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, we stand in the place of Medicare and will pay whatever amount Medicare would have paid up to an additional 365 days as provided in the policy's/certificate's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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

*Once you have been billed $183 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 $183 of Medicare-approved amounts *	$0	$0	$183 (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 $183 of Medicare-approved amounts *	$0	$0	$183 (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 $183 of Medicare-approved amounts	$0	$0	$183 (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 $1,340	$1,340 (Part A deductible)	$0
61st through 90th day	All but $335 a day	$335 a day	$0
91st day and after (while using 60 lifetime reserve days):	All but $670 a day	$670 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 $167.50 a day	Up to $167.50 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, we stand in the place of Medicare and will pay whatever amount Medicare would have paid up to an additional 365 days as provided in the policy's/certificate's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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

*Once you have been billed $183 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 $183 of Medicare-approved amounts *	$0	$183 (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 $183 of Medicare-approved amounts *	$0	$183 (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 $183 of Medicare-approved amounts	$0	$183 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

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

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 Remainder of charges	$0 $0	$0 80% to a lifetime maximum benefit of $50,000	$250 20% and amounts over the $50,000 lifetime maximum benefit

PLANS G AND 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 G Pays	You Pay	Plan N Pays	You Pay
HOSPITALIZATION* - Semiprivate room and board, general nursing, and miscellaneous services and supplies					
First 60 days	All but $1,340	$1,340 (Part A deductible)	$0	$1,340 (Part A deductible)	$0
61st through 90th day	All but $335 a day	$335 a day	$0	$335 a day	$0
91st day and after (while using 60 lifetime reserve days):	All but $670 a day	$670 a day	$0	$670 a day	$0
Once lifetime reserve days are used (Additional 365 days):	$0	100% of Medicare-eligible expenses	$0**	100% of Medicare-eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs	$0	All costs
SKILLED NURSING FACILITY CARE* - You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.					
First 20 days	All approved amounts	$0	$0	$0	$0
21st through 100th day	All but $167.50 a day	Up to $167.50 a day	$0	Up to $167.50 a day	$0
101st day and after	$0	$0	All costs	$0	All costs
BLOOD					
First 3 pints	$0	3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0	$0	$0
HOSPICE CARE - You must meet Medicare's requirements, including a doctor's certification of terminal illness.					
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0	Medicare copayment/ coinsurance	$0

** NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid up to an additional 365 days as provided in the policy's/certificate's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLANS G AND N
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $183 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	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 $183 of Medicare-approved amounts *	$0	$0	$183 (Part B deductible)	$0	$183 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0	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	100%	$0	$0	All costs
BLOOD					
First 3 pints	$0	All costs	$0	All costs	$0
Next $183 of Medicare-approved amounts *	$0	$0	$183 (Part B deductible)	$0	$183 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES					
	100%	$0	$0	$0	$0

PLANS G AND N
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

PARTS A AND B

Services	Medicare Pays	Plan G Pays	You Pay	Plan N Pays	You Pay
HOME HEALTH CARE – MEDICARE-APPROVED SERVICES					
Medically necessary skilled care services and medical supplies	100%	$0	$0	$0	$0
DURABLE MEDICAL EQUIPMENT					
First $183 of Medicare-approved amounts	$0	$0	$183 (Part B deductible)	$0	$183 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

Services	Medicare Pays	Plan G Pays	You Pay	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	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum benefit	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum benefit