

American Republic Corp Insurance Company / National Headquarters, Des Moines, Iowa 50309

Outline of Medicare Supplement Coverage - Benefit Plans A, F, K & L

This chart shows 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.

BASIC BENEFITS included in A, B, C, D, F, F*, G, M and N. **Hospitalization:** Part A coinsurance plus coverage for 365 additional days after Medicare benefits end. **Medical Expenses:** Part B coinsurance (20% of Medicare approved expenses, or, in the case of hospital outpatient department services paid under a prospective payment system, applicable copayments). **Blood:** First 3 pints of blood each year. **Hospice:** Part A coinsurance.

A	B	C	D	F	F*	G	K**	L**	M	N
Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, 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 Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for Emergency Room
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				Part B Excess (100%)		Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket limit*** \$4,620; paid at 100% after limit reached	Out-of-pocket limit*** \$2,310; 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. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan’s separate foreign travel emergency deductible.

**Plans K and L cost share differently than Plans A, B, C, D, F, F*, G, M or N. Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare Approved Amounts, called “Excess Charges”. You will be responsible for paying “Excess Charges”.

***The out-of-pocket annual limit will increase each year for inflation.

PREMIUM INFORMATION

We guarantee to renew your policy as long as you live if you pay your premiums when due.

We may change the premiums on your policy from time to time. We may not change the premiums unless we do so on all policies of this form issued to persons of your class. Premiums may change because of a change in residence or as Medicare benefits change. We will notify you of the new premium at least 31 days before the next due date. Premiums are based on your attained age and will increase annually beginning at age 66.

The premium for _____
Applicant's Name
at issue age _____ for each plan available on _____ is :
Applicant's Age Date

APP PREMIUMS

Plan A	Plan F	Plan K	Plan L
_____	_____	_____	_____

MODE FACTORS

Monthly Direct Bill: 1.044
Quarterly: 3
Semiannual: 6
Annual: 12

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

Please read this policy and the attached Application carefully. If you find that you are not satisfied with your policy, you may return it to American Republic Corp Insurance Company, P.O. Box 2780, Omaha, Nebraska 68103-2780, together with a request for cancellation within 30 days after you receive it. You will be sent a full refund of any premium paid less the amount of any claims paid. If the amount of claims paid by us exceeds the amount of premiums paid by you, you shall reimburse us the difference. Then, the policy will be void from the beginning as if no policy had been issued.

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 American Republic Corp 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 the "Medicare & You" government publication 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. This paragraph does not apply to you if you are 65 or older and within 6 months of becoming eligible for Medicare. 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*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>HOSPITALIZATION*</p> <p>Semiprivate room and board, general nursing and miscellaneous services and supplies</p> <p>First 60 days</p> <p>61st thru 90th day</p> <p>91st day and after:</p> <ul style="list-style-type: none"> • While using 60 lifetime reserve days • Once lifetime reserve days are used: <ul style="list-style-type: none"> • Additional 365 days • Beyond the additional 365 days 	<p>All but \$1,100</p> <p>All but \$275 a day</p> <p>All but \$550</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>\$275 a day</p> <p>\$550 a day</p> <p>100% of Medicare Eligible expenses</p> <p>\$0</p>	<p>\$1,100 (Part A deductible)</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p>SKILLED NURSING FACILITY CARE*</p> <p>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</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$137.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$137.50 a day</p> <p>All costs</p>
<p>BLOOD</p> <p>First 3 pints</p> <p>Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p>HOSPICE CARE</p> <p>You must meet Medicare's requirements, including a physician's certification of terminal illness.</p>	<p>All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care</p>	<p>Medicare copayment/ coinsurance</p>	<p>\$0</p>

* 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.

** **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'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 (continued)
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN 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 \$155 of Medicare Approved Amounts* (Part B deductible)	\$0	\$0	\$155 (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 \$155 of Medicare Approved Amounts* (Part B deductible)	\$0	\$0	\$155 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

Medicare (Parts A and B) - Home Health Care

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE - MEDICARE APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	\$0	\$0
• Durable medical equipment			
First \$155 of Medicare Approved Amounts*	\$0	\$0	\$155 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

* Once you have been billed \$155 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.

PLAN F

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: <ul style="list-style-type: none"> • While using 60 lifetime reserve days • Once lifetime reserve days are used: <ul style="list-style-type: none"> • Additional 365 days • Beyond the additional 365 days 	All but \$1,100 All but \$275 a day All but \$550 \$0 \$0	\$1,100 (Part A deductible) \$275 a day \$550 a day 100% of Medicare Eligible expenses \$0	\$0 \$0 \$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 21st thru 100th day 101st day and after	All approved amounts All but \$137.50 a day \$0	\$0 Up to \$137.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a physician's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

*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.

*** **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'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 (continued)

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

SERVICES	MEDICARE PAYS	PLAN 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 \$155 of Medicare Approved Amounts*	\$0	\$155 (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 \$155 of Medicare Approved Amounts*	\$0	\$155 (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

MEDICARE (PARTS A AND B) - HOME HEALTH CARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE - MEDICARE APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	\$0	\$0
• Durable medical equipment			
First \$155 of Medicare Approved Amounts*	\$0	\$155 (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

* Once you have been billed \$155 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.

PLAN F (continued)
OTHER BENEFITS NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN 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% of a lifetime Maximum Benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN K

* You will pay half of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$4,620 each calendar year. The amounts that count toward your annual limit are noted with diamonds (◆) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare Approved Amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION**			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,100	\$550 (50% of Part A deductible)	\$550 (50% of Part A deductible)◆
61st thru 90th day	All but \$275 a day	\$275 a day	\$0
91st day and after:			
• While using 60 lifetime reserve days	All but \$550	\$550 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 thru 100th day	All but \$137.50 a day	Up to \$68.75 a day	Up to \$68.75 a day◆
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	50%	50%◆
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare’s requirements, including a physician’s certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	50% of copayment/coinsurance	50% of Medicare copayment/coinsurance◆

**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.

*** **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’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 K (continued)

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

SERVICES	MEDICARE PAYS	PLAN 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 \$155 of Medicare Approved Amounts****	\$0	\$0	\$155 (Part B deductible)****◆
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10%◆
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of \$4,620)*
BLOOD First 3 pints	\$0	50%	50%◆
Next \$155 of Medicare Approved Amounts****	\$0	\$0	\$155 (Part B deductible)◆
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10%◆
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

*This plan limits your annual out-of-pocket payments for Medicare Approved Amounts to \$4,620 per year. However, this limit does NOT include charges from your provider that exceed Medicare Approved Amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

**** Once you have been billed \$155 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.

PLAN K (continued)
MEDICARE (PARTS A AND B) - HOME HEALTH SERVICES

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES			
<ul style="list-style-type: none"> • Medically necessary skilled care services and medical supplies • Durable medical equipment 	100%	\$0	\$0
First \$155 of Medicare Approved Amounts*****	\$0	\$0	\$155 (Part B deductible)◆
Remainder of Medicare Approved Amounts	80%	10%	10%◆

*****Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

PLAN L

* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$2,310 each calendar year. The amounts that count toward your annual limit are noted with diamonds (◆) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare Approved Amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION**			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,100	\$825 (75% of Part A Deductible)	\$275 (25% of Part A Deductible)◆
61st thru 90th day	All but \$275 a day	\$275 a day	\$0
91st day and after:			
• While using 60 lifetime reserve days	All but \$550	\$550 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 thru 100th day	All but \$137.50 a day	Up to \$103.13 a day	Up to \$34.37 a day◆
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	75%	25%◆
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare’s requirements, including a physician’s certification of terminal illness.			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	75% of copayment/coinsurance	25% of Medicare copayment/coinsurance◆

** 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.

*** **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’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 L (continued)
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN 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 \$155 of Medicare Approved Amounts****	\$0	\$0	\$155 (Part B deductible)****◆
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	5%◆
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of \$2,310)*
BLOOD First 3 pints	\$0	75%	25%◆
Next \$155 of Medicare Approved Amounts****	\$0	\$0	\$155 (Part B deductible)◆
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5%◆
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

*This plan limits your annual out-of-pocket payments for Medicare Approved Amounts to \$2,310 per year. However, this limit does NOT include charges from your provider that exceed Medicare Approved Amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

**** Once you have been billed \$155 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.

PLAN L (continued)
MEDICARE (PARTS A & B) - HOME HEALTH SERVICES

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES			
<ul style="list-style-type: none"> • Medically necessary skilled care services and medical supplies • Durable medical equipment 	100%	\$0	\$0
First \$155 of Medicare Approved Amounts****	\$0	\$0	\$155 (Part B deductible)♦
Remainder of Medicare Approved Amounts	80%	15%	5%♦

****Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.