Outline of Medicare Supplement Coverage – Cover Page 1 of 2

ATTAINED AGE BENEFIT PLANS A, C, F, H, I, J

These charts show the benefits included in each of the standard line of Medicare Supplement plans. Every company must make available Plan "A." Some plans may not be available in your state.

See Outline of Coverage sections for details about all plans.

Basic Benefits for Plans A – J:

- Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- Medical Expenses: Part B coinsurance (20% of Medicare-approved expenses), copayments for hospital outpatient services.
- Blood: First three pints of blood each year.

Benefits	***Standard Medicare Supplement Plans*** (Highlighted Plans are offered by New West Health Services)											
	A	B	**C**	D	E	**F**	F*	G	**H**	**I**	**J**	J*
Basic Benefits	**Yes**	Yes	**Yes**	Yes	Yes	**Yes**		Yes	**Yes**	**Yes**	**Yes**	
Skilled Nursing Facility Coinsurance			**Yes**	Yes	Yes	**Yes**		Yes	**Yes**	**Yes**	**Yes**	
Part A Deductible		Yes	**Yes**	Yes	Yes	**Yes**		Yes	**Yes**	**Yes**	**Yes**	
Part B Deductible			**Yes**			**Yes**					**Yes**	
Part B Excess Charge (100%)						**Yes**		Yes		**Yes**	**Yes**	
Foreign Travel Emergency			**Yes**	Yes	Yes	**Yes**		Yes	**Yes**	**Yes**	**Yes**	
At-Home Recovery				Yes				Yes		**Yes**	**Yes**	
Preventive Care Not Covered by Medicare					Yes						**Yes**	

*Plans F and J have an option called a high deductible plan F and a high deductible plan J (not offered by New West). These high deductible plans pay the same benefits as plans F and J after one has paid a calendar year $1,900 deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses exceed $1,900. 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.

PREMIUM INFORMATION

New West Health Services can only raise your premium every twelve months, except in the event of a change in federal law. If we raise the premium, we will raise the premium for all policies like yours in this State. Your premium rates will change automatically on the policy renewal date after you enter a new age rating level.

NEW WEST HEALTH SERVICES
Outline of Medicare Supplement Coverage – Cover Page 2

Benefits	Basic Benefits for Plans K and L: include similar services as plans A – J, but cost sharing for the basic benefits is at different levels.	
	K**	**L****
Basic Benefits	100% of Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end 50% hospice cost-sharing 50% of Medicare-eligible expenses for the first three pints of blood 50% Part B coinsurance, except 100% coinsurance for Part B preventive service	100% of Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end 75% hospice cost-sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B coinsurance, except 100% coinsurance for Part B preventive service
Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
	$4,620 Out-of-Pocket Annual Limit***	$2,310 Out-of-Pocket Annual Limit***

**Plans K and L provide for different cost-sharing for items and services than Plan A – J.

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.

See Outlines of Coverage for details and exceptions.

Monthly Premium Rates Per Person

Attained Age	Plan A	Plan C	Plan F	Plan H	Plan I	Plan J
65	$91.00	$105.00	$125.00	$106.00	$113.00	$124.00
66	$95.00	$109.00	$133.00	$113.00	$122.00	$132.00
67	$98.00	$113.00	$142.00	$120.00	$128.00	$141.00
68	$101.00	$123.00	$151.00	$129.00	$138.00	$150.00
69	$105.00	$130.00	$162.00	$139.00	$146.00	$161.00
70	$109.00	$140.00	$171.00	$147.00	$155.00	$171.00
71	$112.00	$147.00	$181.00	$155.00	$163.00	$180.00
72	$116.00	$155.00	$191.00	$163.00	$171.00	$189.00
73	$119.00	$163.00	$202.00	$171.00	$179.00	$197.00
74	$123.00	$171.00	$211.00	$179.00	$187.00	$207.00
75	$128.00	$179.00	$219.00	$187.00	$196.00	$218.00
76	$131.00	$184.00	$225.00	$191.00	$203.00	$224.00
77	$134.00	$190.00	$230.00	$195.00	$208.00	$229.00
78	$139.00	$195.00	$236.00	$200.00	$213.00	$235.00
79	$142.00	$202.00	$242.00	$205.00	$219.00	$240.00
80+	$143.00	$207.00	$246.00	$211.00	$225.00	$246.00

Same rates apply to manual and automatic payment plans. Rates for other premium modes (quarterly, semi-annual and annual) are obtained by multiplying the rates stated above by the number of months paid.

NOTICE

This policy may not cover all of your medical costs. Neither New West Health Services 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 Handbook" for more details.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing the Policies' most important features. The Policy is your benefits contract. You must read the Policy itself to understand all of the rights and duties of both you and your Medicare Supplement company.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to New West Health Services, P0 Box 548, Kalispell, Montana 59903. 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 your payments less any amounts paid for any claims.

POLICY REPLACEMENT

If you are replacing another health coverage policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it (see "Right to Return Policy" above).

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 before you sign it. Be certain that all information has been properly recorded.

Medicare (Part A) Hospital Services Per Benefit Period*
Plans A, C & F

Services	Medicare Pays	Plan	Plan Pays	You Pay
HOSPITALIZATION* Semi-private room and board, general nursing and miscellaneous services and supplies				
First 60 days	All but $1,068 (Part A Deductible)	A	$0	$1,068
		C, F	$1,068	$0
61st through 90th day	All but $267 per day	A, C & F	$267 per day	$0
91st day and after: • While using 60 lifetime reserve days	All but $534 per day	A, C & F	$534 per day	$0
• Once lifetime reserve days are used: Additional 365 days	$0	A & C	100% of Medicare Eligible Expenses	$0**
		F	100% of Medicare Eligible Expenses	$0
Beyond additional 365 days	$0	A, C & F	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including being in a hospital for at least 3 days and entering a Medicare-approved facility within 30 days after leaving the hospital.				
First 20 days	All approved amounts	A, C & F	$0	$0
21st through 100th day	All but $133.50 a day	A	$0	Up to $133.50 per day
		C & F	Up to $133.50 per day	$0
101st day & after	$0	A, C & F	$0	All costs
BLOOD				
First 3 pints	$0	A, C & F	All costs	$0
Additional amounts	100%	A, C & F	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care	A, C & F	$0	Balance

* 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.

** 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.

Medicare (Part A) Hospital Services Per Benefit Period*
Plans H, I & J

Services	Medicare Pays	Plan	Plan Pays	You Pay
HOSPITALIZATION* Semi-private room and board, general nursing and miscellaneous services and supplies				
First 60 days	All but $1,068 (Part A Deductible)	H, I, & J	$1,068	$0
61st through 90th day	All but $267 per day	H, I, & J	$267 per day	$0
91st day and after: • While using 60 lifetime reserve days	All but $534 per day	H, I, & J	$534 per day	$0
• Once lifetime reserve days are used: Additional 365 days	$0	H, I, & J	100% of Medicare Eligible Expenses	$0**
Beyond additional 365 days	$0	H, I, & J	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including being in a hospital for at least 3 days and entering a Medicare-approved facility within 30 days after leaving the hospital.				
First 20 days	All approved amounts	H, I, & J	$0	$0
21st through 100th day	All but $133.50 a day	H, I, & J	Up to $133.50 per day	$0
101st day & after	$0	H, I, & J	$0	All costs
BLOOD				
First 3 pints	$0	H, I, & J	All costs	$0
Additional amounts	100%	H, I, & J	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care	H, I, & J	$0	Balance

* 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.

** 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.

Medicare (Part B) Medical Services Per Calendar Year
Plans A, C & F

Services	Medicare Pays	Plan	Plan Pays	You Pay
MEDICAL EXPENSES In or out of the hospital and outpatient hospital treatment such as physician services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, and durable medical equipment				
First $135 of Medicare approved amounts*	$0	A	$0	$135†
		C & F	$135†	$0
Remainder of Medicare approved amounts	Generally 80%	A, C & F	Generally 20%	$0
Part B Excess Charges (above Medicare approved amounts)	$0	A & C	$0	All costs
		F	100%	$0
BLOOD				
First 3 pints	$0	A, C & F	All costs‡	$0
Next $135 of Medicare approved amounts*	$0	A	$0	$135†
		C & F	$135†	$0
Remainder of Medicare approved amounts	80%	A, C & F	20%	$0
CLINICAL LABORATORY SERVICES				
Tests for diagnostic services	100%	A, C & F	$0	$0

† This is the Medicare Part B deductible.

* Once you have been billed $135 of Medicare approved amounts for covered services, your Part B deductible will have been met for the calendar year.

‡ Not replaced in accordance with Federal Regulations or already paid under Part A, and subject to the $135 annual deductible and coinsurance amounts.

Medicare (Part B) Medical Services Per Calendar Year
Plans H, I & J

Services	Medicare Pays	Plan	Plan Pays	You Pay
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care	J	$0	Balance
MEDICAL EXPENSES In or out of the hospital and outpatient hospital treatment such as physician services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, and durable medical equipment				
First $135 of Medicare approved amounts*	$0	H & I	$0	$135†
		J	$135†	$0
Remainder of Medicare approved amounts	Generally 80%	H, I & J	Generally 20%	$0
Part B Excess Charges (above Medicare approved amounts)	$0	H	$0	All costs
		I & J	100%	$0
BLOOD				
First 3 pints	$0	H, I & J	All costs‡	$0
Next $135 of Medicare approved amounts*	$0	H & I	$0	$135†
		J	$135†	$0
Remainder of Medicare approved amounts	80%	H, I & J	20%	$0
CLINICAL LABORATORY SERVICES				
Tests for diagnostic services	100%	H, I & J	$0	$0

† This is the Medicare Part B deductible.

* Once you have been billed $135 of Medicare approved amounts for covered services, your Part B deductible will have been met for the calendar year.

‡ Not replaced in accordance with Federal Regulations or already paid under Part A, and subject to the $135 annual deductible and coinsurance amounts.

Medicare (Parts A & B) Hospital and Medical Services
Plans A, C & F

Services	Medicare Pays	Plan	Plan Pays	You Pay
HOME HEALTH CARE: MEDICARE APPROVED SERVICES				
Medically necessary skilled care services and medical supplies	100%	A, C & F	$0	$0
Durable medical equipment – First $135 of Medicare approved amounts*	$0	A	$0	$135†
		C & F	$135†	$0
Remainder of Medicare approved amounts	80%	A, C & F	20%	$0

† This is the Medicare Part B deductible.

* Once you have been billed $135 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.

Other Benefits – Not Covered By Medicare
Plans A, C & F

Services	Medicare Pays	Plan	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	A, C & F	$0	$250
Remainder of charges	$0	A	$0	All Costs
		C & F	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Medicare (Parts A & B) Hospital and Medical Services
Plans H, I & J

Services	Medicare Pays	Plan	Plan Pays	You Pay
HOME HEALTH CARE: MEDICARE APPROVED SERVICES				
Medically necessary skilled care services and medical supplies	100%	H, I & J	$0	$0
Durable medical equipment – First $135 of Medicare approved amounts*	$0	H & I	$0	$135†
		J	$135†	$0
Durable medical equipment – Remainder of Medicare approved amounts	80%	H, I & J	20%	$0

† This is the Medicare Part B deductible.

* Once you have been billed $135 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.

Other Benefits – Not Covered By Medicare
Plans H, I & J

Services	Medicare Pays	Plan	Plan Pays	You Pay
AT-HOME RECOVERY SERVICES – NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan				
Benefit for each visit	$0	I & J	Actual charges up to $40	Balance
		H	$0	All Costs
Number of visits covered (Must be received within 8 weeks of last Medicare approved home healthcare visit)	$0	I & J	Up to the number of Medicare approved visits, not to exceed 7 visits each week	Balance
		H	$0	All Costs
Calendar year maximum	$0	I & J	$1,600	Balance
		H	$0	All Costs
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	H, I & J	$0	$250
Remainder of charges	$0	H, I & J	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
PREVENTIVE MEDICAL CARE BENEFIT – NOT COVERED BY MEDICARE*** Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare				
First $120 each calendar year	$0	J	$120	$0
Additional charges	$0	H, I & J	$0	All Costs

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