UNITED WORLD LIFE INSURANCE COMPANY
OMAHA, NEBRASKA
A Mutual of Omaha Company
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE – COVER PAGE

The Commissioner of Insurance of the State of Minnesota has established four categories of Medicare Supplements and minimum standards for each, with the extended basic Medicare Supplement being the most comprehensive and the basic Medicare Supplement being the least comprehensive. This chart shows the benefits in each plan.

Basic-- **Policy Form WM26**	**Extended Basic--** **Policy Form WM27**	**50% Coverage--** **Policy Form WM32**
Hospitalization: Part A Coinsurance	Hospitalization: Part A Coinsurance	Hospitalization: Part A Coinsurance
Medical Expenses: Part B Coinsurance	Medical Expenses: Part B Coinsurance	Medical Expenses: Part B Coinsurance
Blood: First 3 pints of blood each year	Blood: First 3 pints of blood each year	Blood: First 3 pints of blood each year
Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance for the 21st through 100th day
_____*	Part A Deductible	50 % of the Part A Deductible
_____*	Part B Deductible	
_____*	Part B Excess (100%)	Part B Excess (100%)
Foreign Travel Emergency	Foreign Travel Care Benefit	Foreign Travel Emergency
Hospice Care	Hospice Care	Hospice Care
_____*	Preventive Care	

Premium Information

We, United World, will renew the policy each time you pay us the premium. It must be paid by the date it is due or during the 31 days that follow. Your policy stays in force during this 31-day period. Your premium cannot be changed unless we make the same change on all policies of this form owned by persons in your classification which are renewed in the state where you live at the time we change the premium. Any such change can be made on any renewal date. We will give you 30 days advance written notice required by your state prior to any premium change. Schedules of rates may vary depending on your Policy Date.

"Persons in Your Classification" means all persons having the same benefits.

*Optional riders available for part A Deductible, Part B Excess, Medicare Part B Deductible and Preventive Health Services.

UNITED WORLD LIFE INSURANCE COMPANY
OMAHA, NEBRASKA
MONTHLY PREMIUMS

ZIP CODES: 55002, 55006-009, 55012-013, 55017-019, 55021, 55026-027, 55029-030, 55032, 55036-037, 55040-041, 55045-046, 55049, 55051-053, 55056-057, 55060, 55063, 55066-067, 55069, 55072, 55074, 55078-080, 55084, 55087-089, 55092, 55301-302, 55307-310, 55312-314, 55319-321, 55324-325, 55328-330, 55332-336, 55338, 55341-342, 55349-350, 55353-355, 55358, 55362-363, 55365-366, 55370-371, 55373, 55376-377, 55380-382, 55385, 55389-390, 55393, 55395-396, 55398, 556-567

NON-TOBACCO--MONTHLY PREMIUMS			TOBACCO--MONTHLY PREMIUMS		
Basic--Policy Form WM26			**Basic--Policy Form WM26**		
ALL AGES	$	156.66	ALL AGES	$	180.07
Optional Riders			Optional Riders		
Part A Deductible Rider 0MJ1W	$	28.97	Part A Deductible Rider 0MJ1W	$	33.30
Preventative Medical Care Rider 0MJ3W	$	6.14	Preventative Medical Care Rider 0MJ3W	$	7.06
Part B Excess Rider OMJ4W	$	-	Part B Excess Rider OMJ4W	$	-
Part B Deductible Rider 0MJ2W	$	13.49	Part B Deductible Rider 0MJ2W	$	13.49
Extended Basic--Policy Form WM27			**Extended Basic--Policy Form WM27**		
ALL AGES	$	390.37	ALL AGES	$	448.70
50% Coverage--Policy Form WM32			**50% Coverage--Policy Form WM32**		
ALL AGES	$	131.55	ALL AGES	$	151.21

To obtain quarterly, semiannual, or annual premiums, multiply the Monthly Premium Amount by 3, 6, and 12 respectively.

The policy provides an anticipated loss ratio of 73%. This means that, on average, Policyholders may expect that $73.00 of every $100.00 in premium will be returned as benefits to the Policyholders over the life of the contract.

UNITED WORLD LIFE INSURANCE COMPANY
OMAHA, NEBRASKA
MONTHLY PREMIUMS

ZIP CODES: 55001, 55003, 55010, 55016, 55020, 55024-025, 55031, 55033, 55038, 55042-044, 55047, 55054-055, 55065, 55068, 55071, 55073, 55075-077, 55082-083, 55085, 55090, 55118, 55120-125, 55128-129, 55150, 55306, 55315, 55317-318, 55322, 55337, 55339, 55352, 55360, 55367-368, 55372, 55378-379, 55383, 55386-388, 55394, 55397, 55399, 55473

NON-TOBACCO--MONTHLY PREMIUMS			TOBACCO--MONTHLY PREMIUMS		
Basic--Policy Form WM26			**Basic--Policy Form WM26**		
ALL AGES	$	168.27	ALL AGES	$	193.41
Optional Riders			Optional Riders		
Part A Deductible Rider 0MJ1W	$	28.97	Part A Deductible Rider 0MJ1W	$	33.30
Preventative Medical Care Rider 0MJ3W	$	6.14	Preventative Medical Care Rider 0MJ3W	$	7.06
Part B Excess Rider OMJ4W	$	-	Part B Excess Rider OMJ4W	$	-
Part B Deductible Rider 0MJ2W	$	13.49	Part B Deductible Rider 0MJ2W	$	13.49
Extended Basic--Policy Form WM27			**Extended Basic--Policy Form WM27**		
ALL AGES	$	419.29	ALL AGES	$	481.94
50% Coverage--Policy Form WM32			**50% Coverage--Policy Form WM32**		
ALL AGES	$	141.30	ALL AGES	$	162.41

To obtain quarterly, semiannual, or annual premiums, multiply the Monthly Premium Amount by 3, 6, and 12 respectively.

The policy provides an anticipated loss ratio of 73%. This means that, on average, Policyholders may expect that $73.00 of every $100.00 in premium will be returned as benefits to the Policyholders over the life of the contract.

UNITED WORLD LIFE INSURANCE COMPANY
OMAHA, NEBRASKA
MONTHLY PREMIUMS

ZIP CODES: 55005, 55011, 55014, 55070, 55101-117, 55119, 55126-127, 55130, 55133, 55144-146, 55155, 55161, 55164-166, 55168-172, 55175, 55177, 55182, 55187-188, 55190-191, 55199, 55303-305, 55311, 55316, 55323, 55327, 55331, 55340, 55343-348, 55356-357, 55359, 55361, 55364, 55369, 55374-375, 55384, 55391-392, 55400-450, 55454-455, 55458-460, 55467-468, 55470, 55472, 55474, 55478-480, 55483-488

NON-TOBACCO--MONTHLY PREMIUMS			TOBACCO--MONTHLY PREMIUMS		
Basic--Policy Form WM26			**Basic--Policy Form WM26**		
ALL AGES	$	181.81	ALL AGES	$	208.97
Optional Riders			Optional Riders		
Part A Deductible Rider 0MJ1W	$	28.97	Part A Deductible Rider 0MJ1W	$	33.30
Preventative Medical Care Rider 0MJ3W	$	6.14	Preventative Medical Care Rider 0MJ3W	$	7.06
Part B Excess Rider OMJ4W	$	-	Part B Excess Rider OMJ4W	$	-
Part B Deductible Rider 0MJ2W	$	13.49	Part B Deductible Rider 0MJ2W	$	13.49
Extended Basic--Policy Form WM27			**Extended Basic--Policy Form WM27**		
ALL AGES	$	453.02	ALL AGES	$	520.71
50% Coverage--Policy Form WM32			**50% Coverage--Policy Form WM32**		
ALL AGES	$	152.67	ALL AGES	$	175.48

To obtain quarterly, semiannual, or annual premiums, multiply the Monthly Premium Amount by 3, 6, and 12 respectively.

The policy provides an anticipated loss ratio of 73%. This means that, on average, Policyholders may expect that $73.00 of every $100.00 in premium will be returned as benefits to the Policyholders over the life of the contract.

DISCLOSURES
Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY
This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY
If you find that you are not satisfied with your policy, you may return it to United World Life Insurance Company, 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, within 10 days.

POLICY REPLACEMENT
If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE
The policy may not fully cover all of your medical costs. Neither United World 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
Review the application carefully before you sign it. Be certain that all information has been properly recorded.

THE POLICY DOES NOT COVER ALL MEDICAL EXPENSES BEYOND THOSE COVERED BY MEDICARE. THE POLICY DOES NOT COVER ALL SKILLED NURSING HOME CARE EXPENSES AND DOES NOT COVER CUSTODIAL OR RESIDENTIAL NURSING CARE. READ YOUR POLICY CAREFULLY TO DETERMINE WHICH NURSING HOME FACILITIES AND EXPENSES ARE COVERED BY YOUR POLICY.

We will not pay for services for which a charge is normally not made where there is no insurance. In addition, no benefits are payable for expense incurred before the coverage effective date.

LIMITATION ON OUT-OF-POCKET EXPENSE
When your out-of-pocket expense equals $1,000.00 in a calendar year, we will pay 100% of additional covered expense you incur during the remainder of such calendar year (WM27 only).

BASIC PLAN - WM26
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 WM26 Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,132	$0 $1,132 with Optional Part A Deductible Benefit Rider 0MJ1W	$1,132 (Part A Deductible) $0
61st through 90th day	All but $283 a day	$283 a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but $566 a day	$566 a day	$0
Beyond the additional 150 days	$0	100% of Medicare Eligible Expenses	$0
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $141.50 a day	Up to $141.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

BASIC PLAN - WM26
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

Services	Medicare Pays	Plan WM26 Pays	You Pay
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $162 of Medicare Approved Amounts**	$0	$0 $162 with Optional Benefit Rider 0MJ2W	$162 (Part B Deductible) $0
Remainder of Medicare Approved Amounts	80%	20%**	$0
Part B Excess Charges (above Medicare Approved Amounts)	$0	$0 100% with Rider 0MJ4W	All costs $0
BLOOD			
First 3 pints	$0	All costs	$0
Next $162 of Medicare Approved Amounts*	$0	$0 $162 with Optional Benefit Rider 0MJ2W	$162 (Part B Deductible) $0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

*Once you have been billed $162 of Medicare Approved Amounts for covered services, your Part B Deductible will have been met for the calendar year.
**Part B coinsurance (generally 20% of Medicare approved expenses), or in the case of hospital outpatient department services under a prospective payment system, applicable copayments.

BASIC PLAN - WM26
PARTS A AND B

Services	Medicare Pays	Plan WM26 Pays	You Pay
HOME HEALTH CARE—MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $162 of Medicare Approved Amounts*	$0	$0 $162 with Optional Benefit Rider 0MJ2W	$162 (Part B Deductible) $0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during travel outside the USA (hospital, medical expense and supplies)	$0	80% of covered expenses	Expenses not paid by Medicare or the policy
PREVENTIVE MEDICAL CARE BENEFIT-- NOT COVERED BY MEDICARE Annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare. First $120 each calendar year	$0	$0 $120 with Optional Benefit Rider 0MJ3W	$120 $0
Additional Charges	$0	$0 $0 with Optional Benefit Rider 0MJ3W	All Costs All Costs

EXTENDED BASIC PLAN - WM27
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 WM27 Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but $1,132	$1,132 (Part A Deductible)	$0
61st through 90th day	All but $283 a day	$283 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $566 a day	$566 a day	$0
Beyond the additional 150 days	$0	100% of Medicare Eligible Expenses	$0
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital. First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $141.50 a day	Up to $141.50 a day	$0
101st day and after	$0	80% of covered expenses up to 120 days per year	Expenses not paid by policy
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

EXTENDED BASIC PLAN - WM27
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

Services	Medicare Pays	Plan WM27 Pays	You Pay
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $162 of Medicare Approved Amounts**	$0	$162 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%**	$0
Part B Excess Charges (above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $162 of Medicare Approved Amounts*	$0	$162 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

*Once you have been billed $162 of Medicare Approved Amounts for covered services, your Part B Deductible will have been met for the calendar year.
**Part B coinsurance (generally 20% of Medicare approved expenses), or in the case of hospital outpatient department services under a prospective payment system, applicable copayments.

EXTENDED BASIC PLAN - WM27
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR (continued)
PARTS A AND B

*Once you have been billed $162 of Medicare Approved Amounts for covered services, your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan WM27 Pays	You Pay
HOME HEALTH CARE—MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $162 of Medicare Approved Amounts*	$0	$162 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary care services during travel outside the USA	$0	80% of covered expenses	Expenses not paid by Medicare or the policy
PREVENTIVE MEDICAL CARE BENEFIT-- NOT COVERED BY MEDICARE Annual physical and preventive tests and services such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare.			
First $120 each calendar year	$0	$120	$0
Additional Charges	$0	$0	All Costs

50% COVERAGE - WM32
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 WM32 Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but $1,132	$566 (50% of the Part A Deductible)	$566 (50% of the Part A Deductible)
61st through 90th day	All but $283 a day	$283 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $566 a day	$566 a day	$0
Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital. First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $141.50 a day	Up to $141.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

50% COVERAGE - WM32
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

Services	Medicare Pays	Plan WM32 Pays	You Pay
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $162 of Medicare Approved Amounts**	$0	$0	$162 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%***	$0
Part B Excess Charges (above Medicare Approved Amounts)	$0	0%	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $162 of Medicare Approved Amounts*	$0	$0	$162 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

*Once you have been billed $162 of Medicare Approved Amounts for covered services, your Part B Deductible will have been met for the calendar year.
**Part B coinsurance (generally 20% of Medicare approved expenses), or in the case of hospital outpatient department services under a prospective payment system, applicable copayments.

50% COVERAGE - WM32
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR (continued)
PARTS A AND B

*Once you have been billed $162 of Medicare Approved Amounts for covered services, your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan WM32 Pays	You Pay
HOME HEALTH CARE—MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $162 of Medicare Approved Amounts*	$0	$0	$162 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services during travel outside the USA	$0	80% of covered expenses	Expenses not paid by Medicare or the policy