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LUMICO LIFE INSURANCE COMPANY
Outline of Medicare Supplement Coverage
Benefit Plans A, F, G, and N

Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020

This chart shows the benefits included in each of the standard Medicare supplement plans. 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		
	A	B	D	G	G[1]	K	L	M	N	C	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)	✓	✓	✓	✓		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 2022[2]						$6620[2]	$3310[2]					

[1]Plans F and G also have a high deductible option which requires first paying a plan deductible of $2490 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. The annual OOP limits are determined in accordance with section 1882(w)(2) of the Social Security Act. That provision prescribed an OOP limit for 2006 of $4,000 for Plan K and $2,000 for Plan L, and directed that these amounts increase each subsequent year by an appropriate inflation adjustment specified by the Secretary of the United States Department of Health & Human Services. For 2020 the calculation of the OOP limits is based on estimates of the United States Per Capita Costs (USPCC) of the Medicare program developed by CMS as published with the announcement of Calendar Year (CY) 2018 and CY 2020 Medicare Advantage (MA) payment rates.

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

LUMICO LIFE INSURANCE COMPANY

OREGON Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 970-973

	Preferred					Standard			
Attained Age	Plan A	Plan F	Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	Plan N
0-64	2,085	2,780	2,100	1,645	0-64	2,317	3,088	2,332	1,828
65	2,085	2,780	2,100	1,645	65	2,317	3,088	2,332	1,828
66	2,085	2,780	2,100	1,645	66	2,317	3,088	2,332	1,828
67	2,085	2,780	2,100	1,645	67	2,317	3,088	2,332	1,828
68	2,169	2,891	2,184	1,713	68	2,409	3,212	2,426	1,902
69	2,256	3,006	2,270	1,780	69	2,506	3,341	2,524	1,978
70	2,344	3,127	2,361	1,852	70	2,606	3,475	2,624	2,058
71	2,439	3,252	2,455	1,925	71	2,710	3,614	2,730	2,141
72	2,538	3,383	2,554	2,003	72	2,820	3,759	2,839	2,225
73	2,639	3,518	2,657	2,083	73	2,931	3,909	2,952	2,314
74	2,745	3,659	2,764	2,167	74	3,050	4,065	3,071	2,406
75	2,855	3,806	2,874	2,253	75	3,170	4,227	3,193	2,503
76	2,968	3,957	2,988	2,344	76	3,297	4,396	3,319	2,603
77	3,086	4,116	3,108	2,438	77	3,430	4,572	3,452	2,708
78	3,212	4,281	3,233	2,535	78	3,567	4,755	3,590	2,816
79	3,339	4,452	3,362	2,636	79	3,708	4,945	3,735	2,928
80	3,473	4,630	3,496	2,741	80	3,858	5,143	3,884	3,046
81	3,611	4,814	3,636	2,850	81	4,011	5,349	4,040	3,167
82	3,755	5,008	3,782	2,966	82	4,173	5,563	4,201	3,294
83	3,907	5,208	3,933	3,083	83	4,341	5,786	4,370	3,427
84	4,064	5,417	4,091	3,208	84	4,513	6,018	4,545	3,563
85	4,226	5,633	4,255	3,335	85	4,694	6,258	4,726	3,705
86	4,393	5,858	4,424	3,469	86	4,882	6,509	4,916	3,853
87	4,570	6,093	4,601	3,608	87	5,077	6,769	5,112	4,008
88	4,753	6,337	4,786	3,752	88	5,279	7,039	5,315	4,168
89	4,943	6,591	4,977	3,902	89	5,490	7,321	5,528	4,335
90	5,140	6,854	5,175	4,058	90	5,710	7,613	5,750	4,508
91	5,346	7,127	5,383	4,221	91	5,939	7,918	5,979	4,688
92	5,560	7,413	5,598	4,389	92	6,176	8,235	6,220	4,875
93	5,783	7,709	5,822	4,564	93	6,424	8,564	6,468	5,071
94	6,013	8,017	6,054	4,747	94	6,681	8,907	6,726	5,274
95	6,253	8,338	6,296	4,936	95	6,948	9,265	6,996	5,486
96	6,504	8,671	6,548	5,133	96	7,227	9,636	7,277	5,705
97	6,763	9,017	6,809	5,340	97	7,516	10,020	7,567	5,933
98	7,033	9,378	7,082	5,552	98	7,815	10,421	7,870	6,171
99	7,314	9,752	7,364	5,774	99	8,129	10,837	8,185	6,418

Modal Factors: Semi Annual: 0.5000 Quarterly: 0.25000 Monthly: Divide by 12

Household Discount Factor 0.93

LUMICO LIFE INSURANCE COMPANY

OREGON Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 970-973

	Preferred					Standard			
Attained Age	Plan A	Plan F	Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	Plan N
0-64	2,009	2,678	2,023	1,585	0-64	2,232	2,975	2,247	1,762
65	2,009	2,678	2,023	1,585	65	2,232	2,975	2,247	1,762
66	2,009	2,678	2,023	1,585	66	2,232	2,975	2,247	1,762
67	2,009	2,678	2,023	1,585	67	2,232	2,975	2,247	1,762
68	2,089	2,786	2,104	1,650	68	2,321	3,095	2,338	1,832
69	2,173	2,897	2,187	1,715	69	2,415	3,219	2,431	1,906
70	2,259	3,012	2,275	1,784	70	2,511	3,348	2,528	1,983
71	2,350	3,133	2,366	1,855	71	2,611	3,482	2,630	2,063
72	2,445	3,259	2,461	1,930	72	2,717	3,622	2,735	2,144
73	2,543	3,390	2,560	2,007	73	2,824	3,766	2,845	2,230
74	2,645	3,526	2,663	2,088	74	2,939	3,917	2,959	2,319
75	2,751	3,667	2,769	2,171	75	3,054	4,073	3,076	2,412
76	2,860	3,813	2,879	2,258	76	3,177	4,236	3,198	2,508
77	2,974	3,966	2,995	2,349	77	3,304	4,405	3,326	2,609
78	3,095	4,125	3,115	2,442	78	3,437	4,582	3,459	2,713
79	3,217	4,290	3,239	2,540	79	3,573	4,764	3,599	2,822
80	3,346	4,461	3,369	2,641	80	3,717	4,956	3,743	2,934
81	3,479	4,639	3,503	2,746	81	3,865	5,154	3,893	3,052
82	3,618	4,825	3,644	2,858	82	4,021	5,360	4,048	3,174
83	3,764	5,018	3,790	2,971	83	4,182	5,575	4,210	3,302
84	3,915	5,219	3,941	3,091	84	4,348	5,798	4,379	3,433
85	4,071	5,427	4,099	3,213	85	4,523	6,030	4,553	3,570
86	4,232	5,644	4,262	3,342	86	4,704	6,272	4,736	3,713
87	4,404	5,870	4,433	3,476	87	4,892	6,522	4,926	3,862
88	4,580	6,105	4,611	3,615	88	5,087	6,782	5,121	4,015
89	4,763	6,350	4,796	3,760	89	5,290	7,054	5,326	4,177
90	4,952	6,604	4,987	3,910	90	5,501	7,335	5,540	4,344
91	5,150	6,867	5,187	4,067	91	5,723	7,629	5,761	4,517
92	5,357	7,142	5,393	4,229	92	5,951	7,935	5,993	4,698
93	5,572	7,428	5,609	4,398	93	6,189	8,252	6,232	4,886
94	5,793	7,725	5,833	4,574	94	6,438	8,582	6,481	5,081
95	6,025	8,034	6,066	4,756	95	6,694	8,926	6,741	5,286
96	6,266	8,354	6,309	4,946	96	6,963	9,284	7,011	5,497
97	6,517	8,688	6,561	5,145	97	7,242	9,655	7,291	5,717
98	6,777	9,036	6,823	5,349	98	7,530	10,041	7,582	5,946
99	7,047	9,396	7,096	5,563	99	7,832	10,442	7,886	6,184

Modal Factors: Semi Annual: 0.5000 Quarterly: 0.25000 Monthly: Divide by 12

Household Discount Factor 0.93

OREGON Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 970-973

	Preferred					Standard			
Attained Age	**Plan A**	**Plan F**	**Plan G**	**Plan N**	**Attained Age**	**Plan A**	**Plan F**	**Plan G**	**Plan N**
0-64	1,862	2,482	1,874	1,470	0-64	2,068	2,757	2,082	1,633
65	1,862	2,482	1,874	1,470	65	2,068	2,757	2,082	1,633
66	1,862	2,482	1,874	1,470	66	2,068	2,757	2,082	1,633
67	1,862	2,482	1,874	1,470	67	2,068	2,757	2,082	1,633
68	1,946	2,594	1,958	1,536	68	2,151	2,867	2,165	1,697
69	2,031	2,708	2,046	1,603	69	2,236	2,982	2,252	1,766
70	2,120	2,825	2,134	1,674	70	2,325	3,100	2,342	1,836
71	2,209	2,944	2,223	1,742	71	2,418	3,224	2,434	1,910
72	2,297	3,062	2,312	1,813	72	2,515	3,353	2,532	1,986
73	2,381	3,175	2,399	1,880	73	2,616	3,487	2,634	2,064
74	2,463	3,283	2,480	1,944	74	2,721	3,626	2,738	2,147
75	2,541	3,388	2,558	2,006	75	2,829	3,771	2,848	2,233
76	2,616	3,489	2,634	2,066	76	2,942	3,923	2,962	2,322
77	2,693	3,590	2,710	2,125	77	3,060	4,079	3,081	2,416
78	2,766	3,687	2,785	2,183	78	3,182	4,243	3,204	2,513
79	2,832	3,776	2,852	2,236	79	3,309	4,412	3,332	2,613
80	2,895	3,860	2,915	2,286	80	3,442	4,588	3,465	2,716
81	2,952	3,936	2,973	2,331	81	3,578	4,771	3,603	2,825
82	3,012	4,015	3,032	2,377	82	3,722	4,962	3,748	2,938
83	3,071	4,095	3,092	2,425	83	3,870	5,161	3,897	3,057
84	3,133	4,177	3,154	2,474	84	4,027	5,368	4,053	3,178
85	3,196	4,260	3,217	2,522	85	4,187	5,582	4,216	3,305
86	3,259	4,346	3,282	2,574	86	4,354	5,805	4,385	3,438
87	3,325	4,433	3,347	2,625	87	4,529	6,037	4,558	3,575
88	3,391	4,522	3,415	2,677	88	4,710	6,279	4,742	3,718
89	3,459	4,612	3,483	2,732	89	4,898	6,530	4,932	3,866
90	3,529	4,705	3,553	2,786	90	5,093	6,791	5,128	4,021
91	3,599	4,799	3,625	2,841	91	5,297	7,063	5,335	4,182
92	3,672	4,894	3,696	2,899	92	5,509	7,345	5,547	4,349
93	3,745	4,992	3,769	2,957	93	5,730	7,639	5,770	4,524
94	3,818	5,091	3,845	3,014	94	5,959	7,944	5,999	4,704
95	3,895	5,192	3,922	3,074	95	6,196	8,261	6,239	4,891
96	3,973	5,297	4,000	3,136	96	6,445	8,592	6,489	5,088
97	4,053	5,403	4,081	3,199	97	6,702	8,935	6,747	5,291
98	4,133	5,511	4,162	3,263	98	6,969	9,292	7,017	5,502
99	4,215	5,621	4,245	3,328	99	7,248	9,663	7,298	5,722

Modal Factors: Semi Annual: 0.5000 Quarterly: 0.25000 Monthly: Divide by 12

OREGON Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 970-973

	Preferred					Standard			
Attained Age	Plan A	Plan F	Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	Plan N
0-64	1,794	2,391	1,806	1,417	0-64	1,992	2,657	2,006	1,573
65	1,794	2,391	1,806	1,417	65	1,992	2,657	2,006	1,573
66	1,794	2,391	1,806	1,417	66	1,992	2,657	2,006	1,573
67	1,794	2,391	1,806	1,417	67	1,992	2,657	2,006	1,573
68	1,875	2,499	1,887	1,480	68	2,073	2,762	2,086	1,635
69	1,957	2,610	1,971	1,545	69	2,155	2,873	2,170	1,701
70	2,042	2,722	2,056	1,613	70	2,240	2,987	2,256	1,769
71	2,128	2,836	2,142	1,679	71	2,329	3,106	2,345	1,840
72	2,214	2,950	2,228	1,747	72	2,423	3,231	2,439	1,914
73	2,294	3,059	2,311	1,811	73	2,521	3,360	2,538	1,989
74	2,373	3,163	2,389	1,873	74	2,621	3,494	2,638	2,069
75	2,449	3,264	2,464	1,933	75	2,725	3,633	2,744	2,152
76	2,521	3,361	2,538	1,990	76	2,835	3,779	2,854	2,237
77	2,595	3,459	2,611	2,048	77	2,949	3,930	2,968	2,328
78	2,665	3,553	2,683	2,103	78	3,066	4,088	3,087	2,421
79	2,729	3,638	2,748	2,155	79	3,189	4,251	3,211	2,517
80	2,789	3,719	2,809	2,203	80	3,316	4,420	3,339	2,617
81	2,845	3,793	2,865	2,246	81	3,447	4,597	3,472	2,722
82	2,902	3,868	2,921	2,290	82	3,586	4,781	3,611	2,831
83	2,959	3,945	2,979	2,337	83	3,729	4,973	3,755	2,945
84	3,019	4,024	3,039	2,383	84	3,880	5,172	3,905	3,062
85	3,080	4,105	3,100	2,430	85	4,034	5,379	4,062	3,184
86	3,140	4,187	3,162	2,480	86	4,196	5,593	4,225	3,312
87	3,204	4,271	3,225	2,529	87	4,363	5,817	4,392	3,445
88	3,267	4,357	3,290	2,579	88	4,538	6,050	4,569	3,582
89	3,333	4,444	3,356	2,632	89	4,719	6,292	4,752	3,725
90	3,400	4,533	3,423	2,684	90	4,907	6,543	4,941	3,874
91	3,467	4,623	3,492	2,737	91	5,103	6,805	5,140	4,029
92	3,538	4,716	3,561	2,793	92	5,308	7,077	5,345	4,190
93	3,608	4,810	3,632	2,849	93	5,521	7,361	5,559	4,359
94	3,679	4,905	3,705	2,904	94	5,741	7,654	5,780	4,532
95	3,752	5,003	3,779	2,962	95	5,969	7,960	6,011	4,713
96	3,828	5,103	3,854	3,022	96	6,209	8,279	6,252	4,902
97	3,905	5,206	3,932	3,082	97	6,458	8,609	6,501	5,098
98	3,982	5,310	4,010	3,144	98	6,715	8,953	6,761	5,301
99	4,061	5,416	4,090	3,207	99	6,983	9,311	7,032	5,514

Modal Factors: Semi Annual: 0.5000 Quarterly: 0.25000 Monthly: Divide by 12

PREMIUM INFORMATION

We, Lumico Life Insurance Company, can only raise your premium if we raise the premium for all policies like yours in this State. The change in premium will apply to all covered persons in the same class. Class is defined as attained age, gender, underwriting class, state of issue, and your most recent zip code of residence in the state of issue. This type of premium change can occur on any premium due date, but will only occur once in a 12 month period. Premiums are based on your attained age and will change on your policy anniversary date.

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 Lumico Life Insurance Company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to: Lumico Life Insurance Company, Medicare Supplement Administration, P.O. Box 10875, Clearwater, Florida 33757-8875. 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

This policy may not fully cover all of your medical costs. Neither Lumico 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 and 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. Lumico Life Insurance 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.

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 PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1556	$0	$1556 (Part A deductible)
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $778 a day	$778 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 $194.50 a day	$0	Up to $194.50 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 co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

****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

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

*Once you have been billed $233 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 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 $233 of Medicare Approved Amounts*	$0	$0	$233 (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 $233 of Medicare Approved Amounts*	$0	$0	$233 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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 $233 of Medicare Approved Amounts*	$0	$0	$233 (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 PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1556	$1556 (Part A deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $778 a day	$778 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 $194.50 a day	Up to $194.50 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, 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

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

*Once you have been billed $233 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 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 $233 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 Generally 80%	 $233 (Part B deductible) Generally 20%	 $0 $0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD First 3 pints Next $233 of Medicare Approved amounts* Remainder of Medicare Approved amounts	$0 $0 80%	All costs $233 (Part B deductible) 20%	$0 $0 $0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN F

PARTS A & B

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 $233 of Medicare Approved Amounts*	$0	$233 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

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% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

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 PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1556	$1556 (Part A deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $778 a day	$778 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 $194.50 a day	Up to $194.50 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, 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 G

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

*Once you have been billed $233 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 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 $233 of Medicare Approved Amounts*	$0	$0	$233 (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 $233 of Medicare Approved Amounts*	$0	$0	$233 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN G

PARTS A & B

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 $233 of Medicare Approved Amounts*	$0	$0	$233 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

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% to a lifetime maximum benefit of $50,000.	20% and amounts over the $50,000 lifetime maximum

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 PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1556	$1556 (Part A deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $778 a day	$778 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 $194.50 a day	Up to $194.50 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, 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 N

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

*Once you have been billed $233 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 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 $233 of Medicare Approved Amounts*	$0	$0	$233 (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 Next $233 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	$0 $0 80%	All costs $0 20%	$0 $233 (Part B deductible) $0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First $233 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% $0 80%	$0 $0 20%	$0 $233 (Part B deductible) $0

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 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.