Lumico
insurance made clear

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 2024[2]						$7060[2]	$3530[2]					

[1]Plans F and G also have a high deductible option which requires first paying a plan deductible of $2800 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	2,283	3,044	2,299	1,802	0-64	2,537	3,382	2,554	2,002
65	2,283	3,044	2,299	1,802	65	2,537	3,382	2,554	2,002
66	2,283	3,044	2,299	1,802	66	2,537	3,382	2,554	2,002
67	2,283	3,044	2,299	1,802	67	2,537	3,382	2,554	2,002
68	2,375	3,166	2,392	1,875	68	2,638	3,517	2,657	2,082
69	2,470	3,292	2,486	1,949	69	2,745	3,658	2,763	2,166
70	2,567	3,424	2,585	2,028	70	2,853	3,805	2,874	2,254
71	2,670	3,561	2,689	2,108	71	2,968	3,958	2,989	2,344
72	2,779	3,704	2,797	2,194	72	3,088	4,116	3,108	2,437
73	2,889	3,853	2,909	2,281	73	3,210	4,280	3,233	2,534
74	3,006	4,007	3,026	2,373	74	3,340	4,452	3,363	2,635
75	3,126	4,167	3,147	2,467	75	3,471	4,629	3,496	2,741
76	3,250	4,333	3,272	2,567	76	3,610	4,814	3,635	2,851
77	3,380	4,507	3,403	2,669	77	3,755	5,007	3,780	2,965
78	3,517	4,688	3,540	2,775	78	3,906	5,207	3,932	3,083
79	3,656	4,875	3,681	2,887	79	4,061	5,415	4,090	3,207
80	3,803	5,069	3,828	3,001	80	4,225	5,632	4,253	3,335
81	3,954	5,272	3,981	3,121	81	4,392	5,857	4,424	3,468
82	4,112	5,483	4,141	3,248	82	4,570	6,092	4,600	3,607
83	4,278	5,703	4,307	3,376	83	4,753	6,336	4,785	3,752
84	4,450	5,932	4,479	3,513	84	4,942	6,590	4,977	3,901
85	4,627	6,168	4,659	3,651	85	5,140	6,853	5,175	4,057
86	4,810	6,414	4,844	3,799	86	5,346	7,127	5,383	4,220
87	5,005	6,672	5,038	3,951	87	5,560	7,412	5,598	4,389
88	5,205	6,939	5,240	4,108	88	5,781	7,707	5,820	4,563
89	5,413	7,217	5,450	4,273	89	6,012	8,016	6,053	4,747
90	5,628	7,505	5,667	4,444	90	6,252	8,337	6,297	4,937
91	5,853	7,804	5,895	4,622	91	6,504	8,670	6,547	5,133
92	6,088	8,117	6,129	4,806	92	6,763	9,018	6,810	5,339
93	6,332	8,442	6,375	4,998	93	7,034	9,378	7,083	5,553
94	6,584	8,779	6,629	5,198	94	7,316	9,754	7,365	5,775
95	6,847	9,130	6,894	5,405	95	7,608	10,145	7,660	6,008
96	7,122	9,494	7,170	5,621	96	7,913	10,551	7,968	6,247
97	7,406	9,874	7,456	5,847	97	8,230	10,972	8,286	6,497
98	7,701	10,269	7,755	6,080	98	8,558	11,411	8,617	6,757
99	8,009	10,679	8,064	6,323	99	8,901	11,867	8,962	7,027

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

Household Discount Factor .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	2,200	2,933	2,215	1,736	0-64	2,444	3,258	2,460	1,929
65	2,200	2,933	2,215	1,736	65	2,444	3,258	2,460	1,929
66	2,200	2,933	2,215	1,736	66	2,444	3,258	2,460	1,929
67	2,200	2,933	2,215	1,736	67	2,444	3,258	2,460	1,929
68	2,288	3,050	2,304	1,807	68	2,541	3,389	2,560	2,006
69	2,380	3,172	2,395	1,878	69	2,644	3,525	2,662	2,087
70	2,473	3,299	2,491	1,954	70	2,749	3,666	2,769	2,171
71	2,573	3,431	2,591	2,031	71	2,859	3,813	2,880	2,259
72	2,677	3,569	2,695	2,114	72	2,975	3,966	2,995	2,348
73	2,784	3,712	2,803	2,198	73	3,093	4,124	3,115	2,442
74	2,896	3,861	2,916	2,287	74	3,218	4,289	3,240	2,539
75	3,012	4,015	3,033	2,377	75	3,345	4,460	3,368	2,641
76	3,131	4,175	3,152	2,473	76	3,479	4,638	3,502	2,747
77	3,256	4,342	3,279	2,572	77	3,618	4,824	3,642	2,857
78	3,389	4,517	3,411	2,674	78	3,764	5,017	3,788	2,971
79	3,523	4,697	3,547	2,781	79	3,912	5,217	3,941	3,090
80	3,664	4,884	3,689	2,892	80	4,070	5,427	4,098	3,213
81	3,809	5,079	3,836	3,007	81	4,232	5,643	4,263	3,342
82	3,962	5,283	3,990	3,129	82	4,403	5,869	4,432	3,475
83	4,122	5,495	4,150	3,253	83	4,579	6,105	4,610	3,615
84	4,287	5,715	4,316	3,385	84	4,761	6,349	4,796	3,759
85	4,458	5,943	4,489	3,518	85	4,952	6,603	4,986	3,909
86	4,635	6,180	4,667	3,660	86	5,151	6,867	5,186	4,066
87	4,822	6,428	4,854	3,807	87	5,357	7,141	5,393	4,229
88	5,015	6,685	5,049	3,958	88	5,570	7,426	5,608	4,397
89	5,215	6,954	5,251	4,117	89	5,792	7,724	5,832	4,573
90	5,423	7,231	5,460	4,282	90	6,024	8,032	6,067	4,756
91	5,640	7,520	5,680	4,453	91	6,266	8,354	6,308	4,946
92	5,866	7,821	5,906	4,631	92	6,516	8,688	6,562	5,144
93	6,101	8,133	6,142	4,816	93	6,777	9,036	6,824	5,350
94	6,344	8,459	6,387	5,009	94	7,049	9,398	7,096	5,564
95	6,597	8,797	6,642	5,208	95	7,330	9,774	7,381	5,788
96	6,862	9,148	6,908	5,416	96	7,624	10,166	7,677	6,019
97	7,136	9,513	7,184	5,633	97	7,929	10,572	7,984	6,260
98	7,420	9,894	7,472	5,858	98	8,246	10,995	8,303	6,511
99	7,716	10,289	7,770	6,092	99	8,576	11,434	8,635	6,771

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

Household Discount Factor .93

LUMICO LIFE INSURANCE COMPANY

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	2,039	2,718	2,052	1,610	0-64	2,264	3,019	2,280	1,788
65	2,039	2,718	2,052	1,610	65	2,264	3,019	2,280	1,788
66	2,039	2,718	2,052	1,610	66	2,264	3,019	2,280	1,788
67	2,039	2,718	2,052	1,610	67	2,264	3,019	2,280	1,788
68	2,130	2,840	2,145	1,682	68	2,355	3,139	2,370	1,858
69	2,224	2,966	2,241	1,756	69	2,449	3,265	2,466	1,934
70	2,321	3,094	2,337	1,833	70	2,546	3,395	2,564	2,011
71	2,418	3,223	2,434	1,908	71	2,647	3,530	2,666	2,091
72	2,516	3,353	2,532	1,985	72	2,754	3,671	2,772	2,175
73	2,607	3,477	2,626	2,058	73	2,865	3,818	2,884	2,260
74	2,697	3,595	2,715	2,129	74	2,979	3,971	2,998	2,351
75	2,783	3,710	2,801	2,197	75	3,097	4,129	3,119	2,445
76	2,865	3,820	2,884	2,262	76	3,221	4,295	3,243	2,543
77	2,949	3,931	2,968	2,327	77	3,351	4,467	3,373	2,645
78	3,029	4,038	3,050	2,390	78	3,485	4,646	3,508	2,751
79	3,101	4,135	3,123	2,449	79	3,624	4,831	3,649	2,861
80	3,170	4,226	3,192	2,503	80	3,769	5,024	3,795	2,974
81	3,233	4,310	3,256	2,553	81	3,918	5,224	3,946	3,094
82	3,298	4,396	3,320	2,603	82	4,076	5,434	4,104	3,217
83	3,362	4,484	3,386	2,656	83	4,238	5,651	4,268	3,347
84	3,431	4,574	3,453	2,709	84	4,410	5,878	4,438	3,480
85	3,500	4,665	3,523	2,762	85	4,585	6,113	4,616	3,619
86	3,568	4,759	3,594	2,818	86	4,768	6,357	4,801	3,764
87	3,641	4,854	3,665	2,875	87	4,959	6,611	4,991	3,915
88	3,713	4,951	3,740	2,931	88	5,157	6,876	5,192	4,071
89	3,788	5,050	3,814	2,991	89	5,363	7,150	5,400	4,233
90	3,864	5,152	3,891	3,051	90	5,577	7,436	5,616	4,403
91	3,940	5,254	3,969	3,111	91	5,800	7,734	5,841	4,579
92	4,020	5,359	4,047	3,174	92	6,033	8,043	6,074	4,762
93	4,101	5,466	4,127	3,237	93	6,275	8,365	6,318	4,954
94	4,181	5,575	4,211	3,301	94	6,525	8,699	6,569	5,150
95	4,265	5,686	4,294	3,366	95	6,784	9,046	6,832	5,356
96	4,350	5,800	4,380	3,434	96	7,057	9,408	7,106	5,571
97	4,438	5,916	4,469	3,503	97	7,339	9,784	7,388	5,794
98	4,526	6,035	4,558	3,573	98	7,631	10,175	7,684	6,025
99	4,616	6,155	4,648	3,645	99	7,936	10,581	7,991	6,266

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

Household Discount Factor .93

LUMICO LIFE INSURANCE COMPANY

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	1,964	2,619	1,977	1,551	0-64	2,181	2,909	2,196	1,723
65	1,964	2,619	1,977	1,551	65	2,181	2,909	2,196	1,723
66	1,964	2,619	1,977	1,551	66	2,181	2,909	2,196	1,723
67	1,964	2,619	1,977	1,551	67	2,181	2,909	2,196	1,723
68	2,053	2,736	2,066	1,621	68	2,269	3,025	2,284	1,790
69	2,143	2,858	2,159	1,692	69	2,360	3,146	2,376	1,863
70	2,236	2,981	2,251	1,766	70	2,453	3,271	2,471	1,937
71	2,330	3,106	2,346	1,838	71	2,551	3,401	2,568	2,015
72	2,424	3,231	2,440	1,912	72	2,654	3,537	2,671	2,095
73	2,512	3,350	2,531	1,983	73	2,760	3,679	2,779	2,178
74	2,598	3,464	2,616	2,051	74	2,870	3,826	2,889	2,265
75	2,681	3,574	2,698	2,117	75	2,984	3,979	3,005	2,356
76	2,760	3,681	2,779	2,180	76	3,104	4,138	3,125	2,450
77	2,841	3,787	2,859	2,242	77	3,229	4,304	3,250	2,549
78	2,918	3,890	2,938	2,303	78	3,357	4,477	3,380	2,651
79	2,988	3,984	3,009	2,359	79	3,492	4,655	3,516	2,757
80	3,054	4,072	3,075	2,412	80	3,631	4,840	3,656	2,865
81	3,115	4,153	3,137	2,460	81	3,775	5,033	3,802	2,981
82	3,177	4,236	3,199	2,508	82	3,927	5,235	3,954	3,099
83	3,240	4,320	3,262	2,559	83	4,083	5,445	4,112	3,225
84	3,306	4,407	3,327	2,610	84	4,249	5,664	4,276	3,353
85	3,372	4,495	3,394	2,661	85	4,418	5,890	4,448	3,487
86	3,438	4,585	3,463	2,715	86	4,594	6,125	4,626	3,627
87	3,508	4,677	3,531	2,770	87	4,778	6,369	4,809	3,772
88	3,578	4,771	3,603	2,824	88	4,969	6,625	5,003	3,922
89	3,650	4,866	3,675	2,882	89	5,167	6,889	5,203	4,079
90	3,723	4,963	3,749	2,940	90	5,373	7,165	5,411	4,242
91	3,797	5,063	3,824	2,997	91	5,588	7,452	5,628	4,412
92	3,874	5,164	3,899	3,058	92	5,812	7,749	5,853	4,588
93	3,951	5,267	3,977	3,119	93	6,046	8,060	6,087	4,773
94	4,028	5,371	4,057	3,180	94	6,287	8,382	6,329	4,962
95	4,109	5,478	4,138	3,243	95	6,537	8,716	6,582	5,160
96	4,192	5,588	4,220	3,309	96	6,799	9,065	6,846	5,368
97	4,276	5,700	4,306	3,375	97	7,071	9,427	7,119	5,582
98	4,361	5,814	4,391	3,442	98	7,352	9,804	7,403	5,805
99	4,447	5,930	4,479	3,512	99	7,646	10,195	7,700	6,037

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

Household Discount Factor .93

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 $1632	$0	$1632 (Part A deductible)
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	$0	Up to $204 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 $240 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 $240 of Medicare Approved Amounts*	$0	$0	$240 (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 $240 of Medicare Approved Amounts*	$0	$0	$240 (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 $240 of Medicare Approved Amounts*	$0	$0	$240 (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 $1632	$1632 (Part A deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 $240 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 $240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 Generally 80%	 $240 (Part B deductible) Generally 20%	 $0 $0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD First 3 pints Next $240 of Medicare Approved amounts* Remainder of Medicare Approved amounts	$0 $0 80%	All costs $240 (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 $240 of Medicare Approved Amounts*	$0	$240 (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 $1632	$1632 (Part A deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 $240 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 $240 of Medicare Approved Amounts*	$0	$0	$240 (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 $240 of Medicare Approved Amounts*	$0	$0	$240 (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 $240 of Medicare Approved Amounts*	$0	$0	$240 (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 $1632	$1632 (Part A deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 $240 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 $240 of Medicare Approved Amounts*	$0	$0	$240 (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 $240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 $0 80%	 All costs $0 20%	 $0 $240 (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 $240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% $0 80%	$0 $0 20%	$0 $240 (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.