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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 2020[2]						$5880[2]	$2940[2]					

[1]Plans F and G also have a high deductible option which requires first paying a plan deductible of $2340 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	1,913	2,550	1,972	1,545	0-64	2,125	2,833	2,190	1,717
65	1,913	2,550	1,972	1,545	65	2,125	2,833	2,190	1,717
66	1,913	2,550	1,972	1,545	66	2,125	2,833	2,190	1,717
67	1,913	2,550	1,972	1,545	67	2,125	2,833	2,190	1,717
68	1,989	2,653	2,051	1,608	68	2,210	2,947	2,278	1,786
69	2,069	2,758	2,132	1,671	69	2,299	3,065	2,370	1,858
70	2,151	2,868	2,217	1,739	70	2,391	3,188	2,464	1,932
71	2,237	2,983	2,306	1,808	71	2,486	3,316	2,563	2,010
72	2,328	3,103	2,399	1,881	72	2,587	3,448	2,665	2,089
73	2,421	3,228	2,495	1,956	73	2,689	3,586	2,772	2,173
74	2,518	3,357	2,595	2,035	74	2,798	3,730	2,883	2,260
75	2,619	3,492	2,699	2,116	75	2,908	3,878	2,998	2,351
76	2,723	3,631	2,806	2,201	76	3,025	4,033	3,117	2,444
77	2,832	3,776	2,918	2,289	77	3,146	4,195	3,242	2,543
78	2,947	3,928	3,036	2,380	78	3,273	4,362	3,371	2,644
79	3,063	4,084	3,156	2,475	79	3,402	4,537	3,507	2,750
80	3,186	4,247	3,283	2,574	80	3,540	4,719	3,647	2,860
81	3,313	4,417	3,414	2,676	81	3,680	4,907	3,794	2,974
82	3,445	4,594	3,551	2,785	82	3,829	5,104	3,945	3,093
83	3,584	4,778	3,693	2,895	83	3,982	5,308	4,103	3,218
84	3,728	4,970	3,841	3,012	84	4,140	5,521	4,268	3,345
85	3,877	5,168	3,995	3,131	85	4,307	5,742	4,437	3,479
86	4,030	5,374	4,154	3,257	86	4,479	5,972	4,616	3,618
87	4,193	5,590	4,320	3,388	87	4,658	6,210	4,800	3,764
88	4,361	5,813	4,494	3,523	88	4,843	6,457	4,991	3,913
89	4,535	6,047	4,674	3,664	89	5,037	6,716	5,190	4,070
90	4,716	6,288	4,860	3,811	90	5,238	6,985	5,399	4,233
91	4,904	6,539	5,055	3,963	91	5,449	7,264	5,614	4,402
92	5,101	6,801	5,256	4,122	92	5,666	7,555	5,840	4,578
93	5,305	7,073	5,466	4,286	93	5,893	7,857	6,073	4,761
94	5,516	7,355	5,684	4,458	94	6,130	8,172	6,316	4,952
95	5,737	7,649	5,912	4,635	95	6,374	8,500	6,569	5,152
96	5,967	7,955	6,148	4,820	96	6,630	8,840	6,833	5,357
97	6,205	8,273	6,394	5,014	97	6,895	9,193	7,106	5,571
98	6,453	8,603	6,650	5,213	98	7,170	9,561	7,389	5,794
99	6,710	8,947	6,915	5,422	99	7,458	9,943	7,685	6,026

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	1,843	2,457	1,900	1,489	0-64	2,048	2,730	2,110	1,654
65	1,843	2,457	1,900	1,489	65	2,048	2,730	2,110	1,654
66	1,843	2,457	1,900	1,489	66	2,048	2,730	2,110	1,654
67	1,843	2,457	1,900	1,489	67	2,048	2,730	2,110	1,654
68	1,917	2,556	1,976	1,549	68	2,129	2,839	2,195	1,721
69	1,994	2,657	2,054	1,610	69	2,216	2,953	2,283	1,790
70	2,072	2,764	2,136	1,675	70	2,303	3,072	2,374	1,862
71	2,156	2,875	2,221	1,742	71	2,396	3,195	2,470	1,937
72	2,243	2,990	2,311	1,812	72	2,493	3,323	2,568	2,013
73	2,333	3,110	2,404	1,884	73	2,591	3,455	2,671	2,094
74	2,426	3,235	2,501	1,961	74	2,696	3,594	2,778	2,177
75	2,523	3,364	2,600	2,039	75	2,802	3,737	2,888	2,265
76	2,624	3,498	2,703	2,121	76	2,915	3,886	3,003	2,355
77	2,728	3,638	2,812	2,205	77	3,032	4,042	3,123	2,450
78	2,839	3,784	2,925	2,293	78	3,153	4,203	3,248	2,548
79	2,952	3,935	3,041	2,385	79	3,278	4,371	3,379	2,649
80	3,070	4,092	3,163	2,480	80	3,410	4,547	3,514	2,755
81	3,192	4,256	3,289	2,579	81	3,546	4,728	3,655	2,866
82	3,319	4,426	3,422	2,683	82	3,689	4,918	3,801	2,980
83	3,453	4,604	3,558	2,789	83	3,837	5,115	3,954	3,100
84	3,592	4,788	3,701	2,902	84	3,989	5,319	4,112	3,223
85	3,735	4,979	3,849	3,017	85	4,149	5,532	4,275	3,352
86	3,883	5,178	4,002	3,138	86	4,316	5,754	4,447	3,486
87	4,040	5,386	4,162	3,264	87	4,488	5,983	4,625	3,626
88	4,202	5,601	4,330	3,394	88	4,667	6,222	4,809	3,770
89	4,370	5,826	4,503	3,530	89	4,853	6,471	5,001	3,922
90	4,544	6,059	4,682	3,671	90	5,047	6,730	5,202	4,079
91	4,725	6,300	4,870	3,818	91	5,250	6,999	5,409	4,241
92	4,915	6,553	5,064	3,971	92	5,460	7,279	5,627	4,411
93	5,112	6,814	5,267	4,129	93	5,678	7,570	5,852	4,588
94	5,315	7,087	5,477	4,295	94	5,906	7,874	6,085	4,771
95	5,527	7,370	5,696	4,466	95	6,142	8,189	6,329	4,964
96	5,749	7,664	5,924	4,644	96	6,388	8,517	6,583	5,161
97	5,978	7,971	6,160	4,831	97	6,644	8,858	6,846	5,368
98	6,217	8,289	6,407	5,023	98	6,908	9,212	7,120	5,583
99	6,465	8,620	6,663	5,224	99	7,186	9,580	7,405	5,806

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 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	1,708	2,277	1,760	1,381	0-64	1,897	2,530	1,955	1,533
65	1,708	2,277	1,760	1,381	65	1,897	2,530	1,955	1,533
66	1,708	2,277	1,760	1,381	66	1,897	2,530	1,955	1,533
67	1,708	2,277	1,760	1,381	67	1,897	2,530	1,955	1,533
68	1,785	2,379	1,839	1,442	68	1,973	2,630	2,033	1,593
69	1,863	2,485	1,921	1,505	69	2,052	2,736	2,115	1,658
70	1,945	2,592	2,004	1,571	70	2,133	2,844	2,199	1,724
71	2,026	2,701	2,087	1,636	71	2,218	2,958	2,286	1,793
72	2,108	2,809	2,171	1,702	72	2,307	3,076	2,377	1,865
73	2,184	2,913	2,252	1,765	73	2,400	3,199	2,473	1,938
74	2,260	3,012	2,328	1,825	74	2,496	3,327	2,571	2,016
75	2,331	3,108	2,402	1,884	75	2,595	3,460	2,675	2,097
76	2,400	3,201	2,473	1,940	76	2,699	3,599	2,781	2,180
77	2,470	3,293	2,545	1,995	77	2,808	3,742	2,893	2,268
78	2,538	3,383	2,615	2,050	78	2,919	3,893	3,008	2,359
79	2,598	3,464	2,678	2,100	79	3,036	4,048	3,129	2,453
80	2,656	3,541	2,737	2,147	80	3,158	4,209	3,254	2,550
81	2,709	3,611	2,792	2,189	81	3,282	4,377	3,384	2,653
82	2,763	3,683	2,847	2,232	82	3,415	4,553	3,519	2,758
83	2,817	3,757	2,903	2,277	83	3,551	4,735	3,660	2,870
84	2,875	3,832	2,961	2,323	84	3,695	4,925	3,806	2,984
85	2,932	3,909	3,021	2,368	85	3,842	5,121	3,958	3,103
86	2,990	3,987	3,082	2,417	86	3,995	5,326	4,117	3,228
87	3,051	4,067	3,143	2,465	87	4,155	5,539	4,280	3,357
88	3,111	4,148	3,207	2,513	88	4,321	5,761	4,452	3,491
89	3,174	4,231	3,271	2,565	89	4,493	5,991	4,631	3,630
90	3,237	4,316	3,336	2,616	90	4,672	6,230	4,815	3,775
91	3,301	4,402	3,403	2,667	91	4,859	6,480	5,009	3,926
92	3,369	4,490	3,470	2,722	92	5,054	6,739	5,209	4,083
93	3,436	4,580	3,539	2,776	93	5,257	7,009	5,418	4,248
94	3,503	4,671	3,611	2,830	94	5,467	7,288	5,633	4,416
95	3,573	4,764	3,682	2,886	95	5,684	7,579	5,858	4,593
96	3,645	4,859	3,756	2,945	96	5,912	7,883	6,093	4,777
97	3,718	4,957	3,832	3,004	97	6,149	8,198	6,336	4,968
98	3,792	5,056	3,908	3,064	98	6,393	8,525	6,589	5,166
99	3,867	5,157	3,986	3,125	99	6,649	8,866	6,852	5,373

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 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	1,646	2,194	1,695	1,330	0-64	1,828	2,437	1,883	1,477
65	1,646	2,194	1,695	1,330	65	1,828	2,437	1,883	1,477
66	1,646	2,194	1,695	1,330	66	1,828	2,437	1,883	1,477
67	1,646	2,194	1,695	1,330	67	1,828	2,437	1,883	1,477
68	1,720	2,293	1,772	1,390	68	1,901	2,534	1,958	1,535
69	1,795	2,394	1,851	1,450	69	1,977	2,636	2,038	1,598
70	1,874	2,497	1,930	1,514	70	2,055	2,741	2,119	1,661
71	1,952	2,602	2,011	1,576	71	2,137	2,850	2,202	1,728
72	2,031	2,707	2,092	1,640	72	2,223	2,964	2,290	1,797
73	2,105	2,807	2,170	1,701	73	2,313	3,082	2,383	1,868
74	2,177	2,902	2,243	1,759	74	2,405	3,206	2,477	1,942
75	2,246	2,995	2,314	1,815	75	2,500	3,333	2,577	2,020
76	2,313	3,084	2,383	1,869	76	2,600	3,467	2,680	2,101
77	2,380	3,173	2,452	1,923	77	2,705	3,606	2,787	2,186
78	2,445	3,259	2,520	1,975	78	2,813	3,751	2,899	2,273
79	2,503	3,338	2,580	2,023	79	2,925	3,900	3,015	2,364
80	2,559	3,412	2,637	2,068	80	3,042	4,055	3,135	2,457
81	2,610	3,480	2,690	2,109	81	3,162	4,217	3,260	2,556
82	2,662	3,549	2,743	2,150	82	3,290	4,386	3,391	2,658
83	2,714	3,620	2,797	2,194	83	3,421	4,562	3,526	2,765
84	2,770	3,692	2,853	2,238	84	3,560	4,745	3,667	2,876
85	2,825	3,766	2,910	2,282	85	3,701	4,935	3,814	2,990
86	2,881	3,841	2,969	2,328	86	3,849	5,132	3,967	3,110
87	2,939	3,918	3,028	2,375	87	4,003	5,336	4,124	3,235
88	2,998	3,997	3,090	2,422	88	4,163	5,550	4,290	3,363
89	3,058	4,077	3,151	2,471	89	4,329	5,772	4,462	3,498
90	3,119	4,159	3,215	2,521	90	4,502	6,003	4,640	3,637
91	3,181	4,242	3,279	2,570	91	4,682	6,243	4,826	3,783
92	3,246	4,326	3,344	2,622	92	4,870	6,493	5,019	3,934
93	3,310	4,413	3,410	2,675	93	5,065	6,753	5,220	4,093
94	3,375	4,500	3,479	2,727	94	5,267	7,022	5,427	4,255
95	3,443	4,590	3,548	2,781	95	5,477	7,303	5,645	4,425
96	3,512	4,682	3,619	2,837	96	5,697	7,595	5,871	4,603
97	3,583	4,776	3,692	2,894	97	5,925	7,898	6,104	4,787
98	3,654	4,871	3,765	2,952	98	6,160	8,214	6,348	4,978
99	3,726	4,968	3,840	3,011	99	6,406	8,542	6,602	5,177

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

Household Discount Factor: 0.93

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 $1408	$0	$1408 (Part A deductible)
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $704 a day	$704 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 $176 a day	$0	Up to $176 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 $198 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 $198 of Medicare Approved Amounts*	$0	$0	$198 (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 $198 of Medicare Approved Amounts*	$0	$0	$198 (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 $198 of Medicare Approved Amounts*	$0	$0	$198 (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 $1408	$1408 (Part A deductible)	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $704 a day	$704 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 $176 a day	Up to $176 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 $198 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 $198 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 Generally 80%	 $198 (Part B deductible) Generally 20%	 $0 $0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD First 3 pints Next $198 of Medicare Approved amounts* Remainder of Medicare Approved amounts	 $0 $0 80%	 All costs $198 (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 $198 of Medicare Approved Amounts*	$0	$198 (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 $1408	$1408 (Part A deductible)	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $704 a day	$704 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 $176 a day	Up to $176 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 $198 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 $198 of Medicare Approved Amounts*	$0	$0	$198 (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 $198 of Medicare Approved Amounts*	$0	$0	$198 (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 $198 of Medicare Approved Amounts*	$0	$0	$198 (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 $1408	$1408 (Part A deductible)	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $704 a day	$704 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 $176 a day	Up to $176 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 $198 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 $198 of Medicare Approved Amounts*	$0	$0	$198 (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	$0	All costs	$0
Next $198 of Medicare Approved Amounts*	$0	$0	$198 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$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 $198 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% $0 80%	$0 $0 20%	$0 $198 (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.