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 2021[2]						$6220[2]	$3110[2]					

[1]Plans F and G also have a high deductible option which requires first paying a plan deductible of $2370 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.

[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.

Effective 09-01-2020

LUMICO LIFE INSURANCE COMPANY

Policy Fee $25

ILLINOIS Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 600-608

	Preferred					Standard			
Attained Age	Plan A	Plan F	Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	Plan N
0-64	4,331	5,442	4,355	3,596	0-64	4,813	6,045	4,840	3,994
65	1,604	1,946	1,612	1,286	65	1,782	2,162	1,791	1,429
66	1,604	1,946	1,612	1,286	66	1,782	2,162	1,791	1,429
67	1,604	1,946	1,612	1,286	67	1,782	2,162	1,791	1,429
68	1,604	2,014	1,612	1,331	68	1,782	2,238	1,791	1,478
69	1,659	2,085	1,668	1,378	69	1,843	2,317	1,855	1,531
70	1,717	2,157	1,727	1,426	70	1,908	2,397	1,920	1,584
71	1,778	2,234	1,788	1,476	71	1,975	2,482	1,987	1,640
72	1,840	2,312	1,850	1,527	72	2,044	2,568	2,055	1,697
73	1,904	2,393	1,915	1,581	73	2,116	2,658	2,128	1,756
74	1,971	2,477	1,982	1,636	74	2,189	2,751	2,202	1,818
75	2,039	2,563	2,050	1,694	75	2,266	2,847	2,279	1,882
76	2,111	2,653	2,123	1,752	76	2,346	2,947	2,359	1,948
77	2,184	2,745	2,197	1,815	77	2,428	3,050	2,441	2,016
78	2,261	2,842	2,273	1,878	78	2,513	3,157	2,527	2,086
79	2,341	2,941	2,353	1,943	79	2,601	3,267	2,615	2,159
80	2,422	3,044	2,436	2,011	80	2,692	3,381	2,708	2,235
81	2,508	3,151	2,521	2,082	81	2,787	3,500	2,802	2,313
82	2,595	3,261	2,609	2,155	82	2,884	3,623	2,901	2,394
83	2,686	3,375	2,700	2,230	83	2,985	3,749	3,001	2,478
84	2,779	3,493	2,795	2,308	84	3,090	3,880	3,106	2,564
85	2,864	3,597	2,878	2,377	85	3,182	3,997	3,199	2,641
86	2,950	3,705	2,965	2,449	86	3,278	4,117	3,295	2,721
87	3,038	3,817	3,054	2,522	87	3,375	4,240	3,395	2,802
88	3,129	3,931	3,146	2,597	88	3,477	4,367	3,497	2,886
89	3,222	4,049	3,240	2,675	89	3,581	4,498	3,601	2,972
90	3,320	4,170	3,338	2,755	90	3,688	4,633	3,710	3,062
91	3,419	4,295	3,437	2,838	91	3,799	4,773	3,821	3,154
92	3,522	4,425	3,540	2,924	92	3,913	4,916	3,935	3,249
93	3,626	4,558	3,646	3,012	93	4,030	5,063	4,053	3,346
94	3,736	4,695	3,756	3,101	94	4,152	5,215	4,175	3,446
95	3,847	4,836	3,869	3,195	95	4,277	5,371	4,300	3,549
96	3,964	4,980	3,985	3,291	96	4,404	5,533	4,429	3,656
97	4,082	5,130	4,104	3,390	97	4,537	5,699	4,562	3,766
98	4,205	5,284	4,228	3,492	98	4,673	5,869	4,699	3,878
99	4,331	5,442	4,355	3,596	99	4,813	6,045	4,840	3,994

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

Household Discount Factor .93

LUMICO LIFE INSURANCE COMPANY

ILLINOIS Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 600-608

	Preferred					Standard			
Attained Age	**Plan A**	**Plan F**	**Plan G**	**Plan N**	**Attained Age**	**Plan A**	**Plan F**	**Plan G**	**Plan N**
0-64	3,799	4,773	3,820	3,154	0-64	4,222	5,303	4,246	3,504
65	1,407	1,707	1,414	1,128	65	1,563	1,897	1,571	1,254
66	1,407	1,707	1,414	1,128	66	1,563	1,897	1,571	1,254
67	1,407	1,707	1,414	1,128	67	1,563	1,897	1,571	1,254
68	1,407	1,767	1,414	1,168	68	1,563	1,963	1,571	1,297
69	1,455	1,829	1,463	1,209	69	1,617	2,032	1,627	1,343
70	1,506	1,893	1,515	1,251	70	1,674	2,102	1,684	1,389
71	1,560	1,960	1,568	1,295	71	1,732	2,177	1,743	1,439
72	1,614	2,028	1,623	1,340	72	1,793	2,252	1,803	1,489
73	1,670	2,099	1,680	1,387	73	1,856	2,331	1,866	1,540
74	1,729	2,173	1,738	1,435	74	1,921	2,413	1,932	1,595
75	1,789	2,248	1,799	1,486	75	1,988	2,497	1,999	1,651
76	1,852	2,327	1,862	1,537	76	2,058	2,585	2,069	1,708
77	1,916	2,408	1,927	1,592	77	2,130	2,675	2,141	1,768
78	1,984	2,493	1,994	1,647	78	2,204	2,769	2,217	1,830
79	2,053	2,579	2,064	1,704	79	2,282	2,866	2,294	1,894
80	2,124	2,670	2,137	1,764	80	2,361	2,966	2,375	1,960
81	2,200	2,764	2,211	1,826	81	2,444	3,070	2,458	2,029
82	2,276	2,861	2,289	1,890	82	2,530	3,178	2,544	2,100
83	2,356	2,961	2,369	1,956	83	2,618	3,289	2,633	2,174
84	2,438	3,064	2,452	2,024	84	2,710	3,404	2,725	2,249
85	2,512	3,156	2,525	2,085	85	2,791	3,506	2,806	2,316
86	2,587	3,250	2,601	2,148	86	2,875	3,611	2,891	2,387
87	2,665	3,348	2,679	2,212	87	2,961	3,719	2,978	2,458
88	2,745	3,448	2,759	2,279	88	3,050	3,831	3,067	2,532
89	2,827	3,552	2,842	2,347	89	3,141	3,946	3,159	2,607
90	2,912	3,658	2,928	2,417	90	3,235	4,064	3,254	2,686
91	2,999	3,768	3,015	2,490	91	3,333	4,187	3,351	2,767
92	3,089	3,882	3,106	2,565	92	3,432	4,312	3,452	2,850
93	3,181	3,998	3,198	2,642	93	3,535	4,441	3,556	2,935
94	3,277	4,118	3,295	2,721	94	3,642	4,574	3,663	3,023
95	3,375	4,242	3,394	2,802	95	3,751	4,712	3,772	3,113
96	3,477	4,369	3,495	2,886	96	3,863	4,853	3,885	3,207
97	3,581	4,500	3,600	2,974	97	3,980	4,999	4,002	3,303
98	3,688	4,635	3,708	3,063	98	4,099	5,148	4,122	3,402
99	3,799	4,773	3,820	3,154	99	4,222	5,303	4,246	3,504

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

Household Discount Factor .93

LUMICO LIFE INSURANCE COMPANY

ILLINOIS Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 600-608

	Preferred					Standard			
Attained Age	Plan A	Plan F	Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	Plan N
0-64	3,811	4,790	3,832	3,165	0-64	4,235	5,320	4,259	3,516
65	1,410	1,713	1,418	1,131	65	1,568	1,903	1,576	1,257
66	1,410	1,713	1,418	1,131	66	1,568	1,903	1,576	1,257
67	1,410	1,713	1,418	1,131	67	1,568	1,903	1,576	1,257
68	1,410	1,773	1,418	1,172	68	1,568	1,969	1,576	1,301
69	1,460	1,835	1,468	1,213	69	1,623	2,038	1,632	1,347
70	1,511	1,899	1,520	1,254	70	1,679	2,110	1,689	1,395
71	1,564	1,966	1,572	1,299	71	1,739	2,183	1,748	1,442
72	1,619	2,035	1,628	1,344	72	1,799	2,259	1,809	1,494
73	1,676	2,105	1,684	1,391	73	1,862	2,338	1,872	1,545
74	1,734	2,179	1,744	1,440	74	1,927	2,421	1,938	1,599
75	1,794	2,256	1,805	1,490	75	1,995	2,506	2,005	1,655
76	1,857	2,335	1,867	1,543	76	2,064	2,593	2,076	1,714
77	1,923	2,416	1,933	1,597	77	2,136	2,684	2,149	1,774
78	1,990	2,501	2,001	1,652	78	2,211	2,778	2,223	1,836
79	2,059	2,588	2,071	1,711	79	2,289	2,875	2,302	1,900
80	2,131	2,678	2,144	1,770	80	2,369	2,976	2,383	1,967
81	2,206	2,773	2,218	1,831	81	2,452	3,080	2,466	2,035
82	2,283	2,869	2,296	1,896	82	2,538	3,188	2,552	2,107
83	2,364	2,970	2,376	1,962	83	2,626	3,299	2,642	2,180
84	2,446	3,074	2,460	2,031	84	2,719	3,415	2,734	2,256
85	2,519	3,166	2,533	2,092	85	2,801	3,517	2,816	2,325
86	2,595	3,261	2,609	2,155	86	2,884	3,623	2,901	2,394
87	2,673	3,359	2,688	2,219	87	2,971	3,731	2,988	2,466
88	2,753	3,460	2,769	2,286	88	3,059	3,844	3,077	2,540
89	2,836	3,563	2,851	2,354	89	3,152	3,959	3,169	2,615
90	2,921	3,670	2,937	2,425	90	3,246	4,077	3,264	2,694
91	3,009	3,781	3,025	2,498	91	3,344	4,200	3,362	2,775
92	3,099	3,894	3,116	2,572	92	3,443	4,326	3,463	2,858
93	3,192	4,010	3,209	2,650	93	3,547	4,456	3,567	2,945
94	3,288	4,132	3,305	2,729	94	3,653	4,589	3,674	3,032
95	3,386	4,255	3,405	2,812	95	3,763	4,726	3,784	3,123
96	3,487	4,383	3,507	2,896	96	3,876	4,869	3,898	3,218
97	3,592	4,514	3,611	2,983	97	3,993	5,014	4,015	3,313
98	3,700	4,650	3,720	3,073	98	4,113	5,165	4,135	3,413
99	3,811	4,790	3,832	3,165	99	4,235	5,320	4,259	3,516

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

Household Discount Factor .93

LUMICO LIFE INSURANCE COMPANY

ILLINOIS Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 600-608

	Preferred					Standard			
Attained Age	**Plan A**	**Plan F**	**Plan G**	**Plan N**	**Attained Age**	**Plan A**	**Plan F**	**Plan G**	**Plan N**
0-64	3,343	4,201	3,361	2,776	0-64	3,715	4,667	3,736	3,084
65	1,237	1,503	1,244	992	65	1,376	1,669	1,382	1,103
66	1,237	1,503	1,244	992	66	1,376	1,669	1,382	1,103
67	1,237	1,503	1,244	992	67	1,376	1,669	1,382	1,103
68	1,237	1,555	1,244	1,028	68	1,376	1,727	1,382	1,141
69	1,280	1,609	1,287	1,064	69	1,423	1,788	1,432	1,181
70	1,326	1,666	1,333	1,100	70	1,473	1,851	1,482	1,223
71	1,372	1,724	1,379	1,139	71	1,525	1,915	1,533	1,265
72	1,420	1,785	1,428	1,179	72	1,578	1,982	1,587	1,310
73	1,470	1,847	1,477	1,220	73	1,634	2,051	1,642	1,356
74	1,521	1,912	1,530	1,263	74	1,690	2,124	1,700	1,403
75	1,574	1,979	1,583	1,307	75	1,750	2,198	1,759	1,452
76	1,629	2,048	1,638	1,353	76	1,811	2,275	1,821	1,504
77	1,687	2,119	1,696	1,401	77	1,874	2,355	1,885	1,556
78	1,746	2,194	1,755	1,449	78	1,939	2,437	1,950	1,611
79	1,807	2,271	1,817	1,500	79	2,008	2,522	2,019	1,666
80	1,870	2,349	1,880	1,553	80	2,078	2,610	2,090	1,725
81	1,935	2,432	1,946	1,607	81	2,151	2,702	2,163	1,785
82	2,003	2,517	2,014	1,663	82	2,226	2,797	2,239	1,848
83	2,073	2,605	2,085	1,721	83	2,304	2,894	2,317	1,912
84	2,145	2,697	2,158	1,782	84	2,385	2,996	2,398	1,979
85	2,210	2,778	2,222	1,835	85	2,457	3,085	2,470	2,039
86	2,276	2,861	2,289	1,890	86	2,530	3,178	2,544	2,100
87	2,345	2,947	2,358	1,947	87	2,606	3,273	2,621	2,163
88	2,415	3,035	2,429	2,006	88	2,684	3,372	2,699	2,228
89	2,488	3,126	2,501	2,065	89	2,765	3,473	2,780	2,294
90	2,562	3,220	2,576	2,127	90	2,848	3,576	2,863	2,364
91	2,639	3,316	2,654	2,191	91	2,933	3,684	2,949	2,434
92	2,718	3,415	2,733	2,256	92	3,020	3,795	3,038	2,507
93	2,800	3,518	2,815	2,325	93	3,111	3,909	3,129	2,583
94	2,884	3,624	2,899	2,394	94	3,204	4,026	3,222	2,660
95	2,971	3,733	2,987	2,466	95	3,301	4,146	3,320	2,739
96	3,059	3,845	3,076	2,540	96	3,400	4,271	3,419	2,822
97	3,151	3,960	3,168	2,617	97	3,502	4,398	3,522	2,906
98	3,245	4,079	3,263	2,695	98	3,607	4,531	3,628	2,994
99	3,343	4,201	3,361	2,776	99	3,715	4,667	3,736	3,084

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

Household Discount Factor .93

PREMIUM INFORMATION

Lumico Life Insurance Company may change your premium on any premium due date if a new table of rates is applicable to the policy. The change in the table of rates 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. 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, less any claims paid.

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. Please refer to your policy for details.

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 $1484	$0	$1484 (Part A deductible)
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	$0	Up to $185.50 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 $203 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 $203 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 Generally 80%	 $0 Generally 20%	 $203 (Part B deductible) $0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD First 3 pints Next $203 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 $0 80%	 All costs $0 20%	 $0 $203 (Part B deductible) $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 — Durable medical equipment First $203 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 $203 (Part B deductible) $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 $1484	$1484 (Part A deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $185.50 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 $203 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 $203 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 Generally 80%	 $203 (Part B deductible) Generally 20%	 $0 $0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD First 3 pints Next $203 of Medicare Approved amounts* Remainder of Medicare Approved amounts	 $0 $0 80%	 All costs $203 (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 $203 of Medicare Approved Amounts*	$0	$203 (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 $1484	$1484 (Part A deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $185.50 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 $203 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 $203 of Medicare Approved Amounts*	$0	$0	$203 (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 $203 of Medicare Approved Amounts*	$0	$0	$203 (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 $203 of Medicare Approved Amounts*	$0	$0	$203 (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 $1484	$1484 (Part A deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $185.50 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 $203 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 $203 of Medicare Approved Amounts*	$0	$0	$203 (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 $203 of Medicare Approved Amounts*	$0	$0	$203 (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 $203 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 $203 (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.