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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 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.

LUMICO LIFE INSURANCE COMPANY

NEBRASKA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 680, 681, 683, 685

	Preferred					Standard			
Attained Age	Plan A	Plan F	Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	Plan N
65	1,415	1,753	1,429	1,101	65	1,571	1,948	1,588	1,222
66	1,415	1,753	1,429	1,101	66	1,571	1,948	1,588	1,222
67	1,415	1,753	1,429	1,101	67	1,571	1,948	1,588	1,222
68	1,415	1,806	1,429	1,133	68	1,571	2,007	1,588	1,258
69	1,457	1,859	1,470	1,168	69	1,619	2,068	1,634	1,297
70	1,501	1,916	1,516	1,202	70	1,668	2,129	1,684	1,335
71	1,545	1,973	1,561	1,239	71	1,717	2,193	1,735	1,375
72	1,592	2,032	1,609	1,276	72	1,769	2,258	1,787	1,418
73	1,640	2,093	1,656	1,314	73	1,822	2,326	1,839	1,460
74	1,688	2,156	1,706	1,353	74	1,876	2,395	1,895	1,502
75	1,739	2,221	1,758	1,393	75	1,932	2,468	1,952	1,547
76	1,791	2,287	1,809	1,436	76	1,990	2,542	2,010	1,594
77	1,845	2,357	1,863	1,478	77	2,051	2,618	2,071	1,643
78	1,900	2,427	1,920	1,523	78	2,111	2,696	2,133	1,692
79	1,958	2,500	1,978	1,568	79	2,176	2,777	2,197	1,742
80	2,016	2,575	2,037	1,615	80	2,240	2,860	2,263	1,795
81	2,078	2,652	2,098	1,663	81	2,309	2,946	2,331	1,848
82	2,139	2,732	2,162	1,713	82	2,377	3,035	2,401	1,903
83	2,204	2,813	2,226	1,765	83	2,449	3,126	2,473	1,961
84	2,269	2,898	2,292	1,818	84	2,521	3,219	2,547	2,019
85	2,337	2,984	2,360	1,872	85	2,597	3,318	2,623	2,081
86	2,408	3,075	2,433	1,929	86	2,675	3,415	2,703	2,143
87	2,480	3,167	2,505	1,986	87	2,755	3,518	2,783	2,208
88	2,555	3,262	2,580	2,046	88	2,838	3,623	2,867	2,273
89	2,632	3,359	2,659	2,107	89	2,924	3,733	2,954	2,341
90	2,709	3,460	2,737	2,171	90	3,010	3,845	3,043	2,411
91	2,792	3,564	2,819	2,236	91	3,102	3,959	3,132	2,485
92	2,876	3,671	2,903	2,303	92	3,196	4,078	3,227	2,559
93	2,962	3,780	2,992	2,372	93	3,291	4,202	3,324	2,637
94	3,050	3,894	3,080	2,444	94	3,390	4,327	3,422	2,716
95	3,142	4,011	3,173	2,516	95	3,491	4,458	3,526	2,796
96	3,236	4,131	3,268	2,592	96	3,597	4,590	3,631	2,880
97	3,332	4,255	3,367	2,669	97	3,703	4,727	3,741	2,966
98	3,434	4,383	3,467	2,750	98	3,814	4,870	3,854	3,055
99	3,536	4,515	3,571	2,833	99	3,929	5,015	3,968	3,148

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

Household Discount Factor .93

LUMICO LIFE INSURANCE COMPANY

NEBRASKA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 680, 681, 683, 685

	Preferred					Standard			
Attained Age	Plan A	Plan F	Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	Plan N
65	1,289	1,597	1,301	1,003	65	1,431	1,774	1,447	1,113
66	1,289	1,597	1,301	1,003	66	1,431	1,774	1,447	1,113
67	1,289	1,597	1,301	1,003	67	1,431	1,774	1,447	1,113
68	1,289	1,645	1,301	1,032	68	1,431	1,828	1,447	1,146
69	1,327	1,694	1,339	1,064	69	1,475	1,883	1,488	1,182
70	1,367	1,745	1,381	1,094	70	1,520	1,939	1,534	1,216
71	1,407	1,797	1,422	1,128	71	1,564	1,997	1,580	1,253
72	1,450	1,851	1,466	1,162	72	1,611	2,057	1,628	1,291
73	1,494	1,907	1,508	1,197	73	1,659	2,119	1,676	1,330
74	1,538	1,964	1,554	1,232	74	1,709	2,182	1,726	1,368
75	1,584	2,023	1,601	1,269	75	1,760	2,248	1,778	1,409
76	1,631	2,084	1,648	1,308	76	1,813	2,315	1,831	1,452
77	1,680	2,147	1,697	1,346	77	1,868	2,385	1,886	1,496
78	1,731	2,210	1,749	1,388	78	1,923	2,456	1,943	1,541
79	1,784	2,277	1,802	1,428	79	1,982	2,529	2,001	1,586
80	1,836	2,346	1,856	1,471	80	2,040	2,605	2,062	1,635
81	1,892	2,415	1,911	1,515	81	2,103	2,684	2,123	1,683
82	1,949	2,488	1,969	1,560	82	2,166	2,764	2,187	1,733
83	2,008	2,563	2,028	1,608	83	2,231	2,848	2,253	1,786
84	2,067	2,639	2,087	1,656	84	2,296	2,932	2,320	1,839
85	2,128	2,718	2,150	1,705	85	2,365	3,022	2,389	1,896
86	2,194	2,801	2,216	1,757	86	2,437	3,111	2,463	1,952
87	2,259	2,885	2,281	1,809	87	2,509	3,205	2,535	2,011
88	2,327	2,971	2,350	1,864	88	2,585	3,300	2,612	2,071
89	2,398	3,060	2,422	1,919	89	2,664	3,400	2,690	2,133
90	2,468	3,152	2,493	1,977	90	2,742	3,502	2,772	2,196
91	2,543	3,246	2,568	2,037	91	2,826	3,607	2,853	2,264
92	2,620	3,344	2,645	2,098	92	2,911	3,715	2,939	2,331
93	2,698	3,444	2,725	2,161	93	2,997	3,827	3,028	2,402
94	2,778	3,547	2,806	2,226	94	3,088	3,941	3,117	2,474
95	2,862	3,654	2,890	2,292	95	3,180	4,061	3,212	2,547
96	2,948	3,763	2,977	2,361	96	3,277	4,181	3,307	2,624
97	3,035	3,876	3,067	2,432	97	3,373	4,306	3,408	2,701
98	3,128	3,992	3,158	2,505	98	3,474	4,436	3,510	2,783
99	3,221	4,112	3,253	2,581	99	3,579	4,568	3,615	2,867

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

Household Discount Factor .93

LUMICO LIFE INSURANCE COMPANY

NEBRASKA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 680, 681, 683, 685

	Preferred					Standard			
Attained Age	Plan A	Plan F	Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	Plan N
65	1,263	1,565	1,276	982	65	1,403	1,739	1,417	1,091
66	1,263	1,565	1,276	982	66	1,403	1,739	1,417	1,091
67	1,263	1,565	1,276	982	67	1,403	1,739	1,417	1,091
68	1,263	1,612	1,276	1,011	68	1,403	1,791	1,417	1,123
69	1,301	1,661	1,314	1,042	69	1,446	1,845	1,459	1,158
70	1,340	1,711	1,353	1,073	70	1,489	1,900	1,504	1,192
71	1,381	1,762	1,394	1,106	71	1,534	1,958	1,549	1,228
72	1,421	1,814	1,436	1,139	72	1,580	2,017	1,596	1,265
73	1,464	1,869	1,479	1,173	73	1,627	2,077	1,642	1,303
74	1,507	1,925	1,523	1,208	74	1,675	2,139	1,692	1,341
75	1,554	1,983	1,569	1,244	75	1,726	2,203	1,742	1,382
76	1,599	2,042	1,616	1,282	76	1,778	2,269	1,795	1,424
77	1,647	2,103	1,665	1,320	77	1,831	2,337	1,849	1,467
78	1,697	2,166	1,715	1,360	78	1,885	2,407	1,905	1,511
79	1,749	2,231	1,766	1,400	79	1,942	2,480	1,962	1,555
80	1,800	2,299	1,819	1,442	80	1,999	2,554	2,020	1,603
81	1,855	2,368	1,873	1,485	81	2,062	2,631	2,081	1,650
82	1,910	2,439	1,930	1,530	82	2,123	2,709	2,143	1,699
83	1,967	2,512	1,988	1,576	83	2,187	2,791	2,209	1,751
84	2,026	2,587	2,047	1,623	84	2,251	2,874	2,274	1,803
85	2,086	2,665	2,108	1,672	85	2,319	2,962	2,342	1,858
86	2,150	2,745	2,172	1,722	86	2,388	3,049	2,413	1,913
87	2,214	2,827	2,236	1,773	87	2,460	3,142	2,485	1,971
88	2,280	2,912	2,304	1,827	88	2,534	3,235	2,560	2,030
89	2,350	2,999	2,374	1,881	89	2,611	3,333	2,637	2,090
90	2,419	3,089	2,445	1,938	90	2,688	3,433	2,717	2,153
91	2,493	3,181	2,517	1,997	91	2,770	3,536	2,796	2,219
92	2,567	3,277	2,593	2,056	92	2,853	3,641	2,882	2,285
93	2,644	3,376	2,671	2,118	93	2,938	3,751	2,967	2,354
94	2,724	3,477	2,750	2,182	94	3,027	3,863	3,056	2,425
95	2,805	3,581	2,833	2,247	95	3,117	3,980	3,149	2,497
96	2,890	3,689	2,918	2,315	96	3,211	4,098	3,242	2,572
97	2,976	3,800	3,006	2,383	97	3,306	4,221	3,340	2,648
98	3,066	3,914	3,097	2,455	98	3,406	4,348	3,441	2,728
99	3,157	4,031	3,188	2,530	99	3,509	4,478	3,543	2,810

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

Household Discount Factor .93

LUMICO LIFE INSURANCE COMPANY

NEBRASKA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 680, 681, 683, 685

	Preferred					Standard			
Attained Age	Plan A	Plan F	Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	Plan N
65	1,150	1,426	1,162	895	65	1,278	1,584	1,290	994
66	1,150	1,426	1,162	895	66	1,278	1,584	1,290	994
67	1,150	1,426	1,162	895	67	1,278	1,584	1,290	994
68	1,150	1,468	1,162	921	68	1,278	1,631	1,290	1,023
69	1,185	1,513	1,197	949	69	1,317	1,681	1,329	1,055
70	1,220	1,558	1,233	977	70	1,356	1,731	1,370	1,086
71	1,258	1,605	1,270	1,007	71	1,397	1,783	1,411	1,119
72	1,295	1,653	1,308	1,037	72	1,439	1,837	1,454	1,153
73	1,334	1,703	1,347	1,068	73	1,482	1,892	1,495	1,187
74	1,373	1,754	1,387	1,100	74	1,526	1,948	1,541	1,222
75	1,415	1,807	1,429	1,133	75	1,572	2,007	1,587	1,258
76	1,456	1,860	1,472	1,168	76	1,619	2,067	1,635	1,297
77	1,501	1,916	1,516	1,202	77	1,667	2,129	1,685	1,336
78	1,546	1,973	1,562	1,239	78	1,717	2,193	1,735	1,376
79	1,593	2,033	1,609	1,275	79	1,769	2,259	1,787	1,417
80	1,639	2,094	1,657	1,314	80	1,821	2,326	1,840	1,460
81	1,689	2,157	1,706	1,353	81	1,878	2,397	1,895	1,503
82	1,740	2,222	1,758	1,393	82	1,934	2,468	1,952	1,548
83	1,792	2,288	1,811	1,436	83	1,992	2,542	2,012	1,595
84	1,845	2,357	1,865	1,479	84	2,050	2,618	2,072	1,643
85	1,900	2,427	1,920	1,523	85	2,112	2,698	2,133	1,692
86	1,959	2,500	1,978	1,569	86	2,176	2,777	2,198	1,743
87	2,017	2,576	2,037	1,615	87	2,241	2,862	2,264	1,795
88	2,077	2,652	2,098	1,664	88	2,308	2,947	2,332	1,849
89	2,140	2,732	2,162	1,714	89	2,379	3,036	2,402	1,904
90	2,204	2,814	2,227	1,765	90	2,449	3,127	2,475	1,961
91	2,271	2,898	2,292	1,819	91	2,523	3,221	2,547	2,021
92	2,338	2,985	2,362	1,873	92	2,599	3,317	2,625	2,081
93	2,409	3,075	2,433	1,929	93	2,676	3,417	2,702	2,144
94	2,481	3,167	2,505	1,987	94	2,757	3,519	2,784	2,209
95	2,555	3,262	2,581	2,046	95	2,840	3,625	2,869	2,274
96	2,633	3,360	2,658	2,108	96	2,925	3,733	2,953	2,343
97	2,711	3,461	2,738	2,171	97	3,011	3,845	3,043	2,412
98	2,792	3,565	2,821	2,237	98	3,103	3,961	3,134	2,485
99	2,876	3,671	2,904	2,304	99	3,196	4,079	3,228	2,560

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*	$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	$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

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

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*	$0	$203 (Part B deductible)	$0
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	$203 (Part B deductible)	$0
Remainder of Medicare Approved amounts	80%	20%	$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.