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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

NEVADA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 889-891

	Preferred					Standard			
Attained Age	Plan A	Plan F	Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	Plan N
65	1,893	2,356	1,930	1,472	65	2,104	2,617	2,146	1,635
66	1,893	2,356	1,930	1,472	66	2,104	2,617	2,146	1,635
67	1,893	2,356	1,930	1,472	67	2,104	2,617	2,146	1,635
68	1,950	2,426	1,988	1,515	68	2,164	2,698	2,208	1,682
69	2,009	2,499	2,047	1,560	69	2,231	2,778	2,275	1,735
70	2,068	2,574	2,110	1,607	70	2,299	2,862	2,344	1,786
71	2,130	2,652	2,172	1,657	71	2,368	2,947	2,414	1,839
72	2,195	2,732	2,238	1,705	72	2,439	3,036	2,486	1,896
73	2,261	2,814	2,303	1,756	73	2,510	3,128	2,559	1,952
74	2,326	2,898	2,373	1,808	74	2,584	3,218	2,637	2,009
75	2,397	2,984	2,444	1,863	75	2,663	3,317	2,716	2,070
76	2,468	3,074	2,518	1,920	76	2,743	3,415	2,797	2,133
77	2,544	3,166	2,593	1,977	77	2,826	3,518	2,882	2,197
78	2,619	3,261	2,672	2,038	78	2,909	3,625	2,970	2,264
79	2,698	3,359	2,752	2,097	79	2,998	3,732	3,057	2,330
80	2,778	3,459	2,834	2,160	80	3,087	3,844	3,148	2,401
81	2,862	3,563	2,918	2,225	81	3,182	3,961	3,243	2,472
82	2,948	3,670	3,007	2,291	82	3,276	4,078	3,340	2,546
83	3,036	3,781	3,098	2,361	83	3,374	4,202	3,441	2,622
84	3,127	3,895	3,189	2,432	84	3,474	4,328	3,543	2,701
85	3,220	4,011	3,285	2,504	85	3,578	4,458	3,649	2,783
86	3,318	4,132	3,383	2,579	86	3,687	4,591	3,761	2,866
87	3,418	4,255	3,485	2,657	87	3,797	4,729	3,871	2,952
88	3,521	4,383	3,590	2,736	88	3,912	4,869	3,989	3,040
89	3,627	4,514	3,698	2,818	89	4,031	5,017	4,110	3,132
90	3,734	4,650	3,809	2,904	90	4,149	5,166	4,232	3,225
91	3,847	4,791	3,923	2,991	91	4,275	5,322	4,358	3,323
92	3,963	4,933	4,040	3,081	92	4,404	5,481	4,489	3,422
93	4,081	5,081	4,161	3,173	93	4,534	5,647	4,623	3,526
94	4,204	5,235	4,287	3,268	94	4,672	5,816	4,762	3,632
95	4,330	5,390	4,415	3,365	95	4,811	5,990	4,906	3,740
96	4,460	5,553	4,546	3,467	96	4,957	6,169	5,052	3,853
97	4,593	5,720	4,684	3,570	97	5,104	6,354	5,205	3,967
98	4,731	5,891	4,824	3,678	98	5,256	6,544	5,360	4,086
99	4,873	6,068	4,969	3,788	99	5,415	6,742	5,521	4,209

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

Household Discount Factor .93

LUMICO LIFE INSURANCE COMPANY

NEVADA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 889-891

	Preferred					Standard			
Attained Age	Plan A	Plan F	Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	Plan N
65	1,630	2,030	1,663	1,268	65	1,812	2,254	1,849	1,409
66	1,630	2,030	1,663	1,268	66	1,812	2,254	1,849	1,409
67	1,630	2,030	1,663	1,268	67	1,812	2,254	1,849	1,409
68	1,680	2,090	1,712	1,305	68	1,864	2,323	1,902	1,449
69	1,730	2,152	1,763	1,344	69	1,922	2,393	1,959	1,494
70	1,781	2,217	1,817	1,384	70	1,980	2,465	2,019	1,538
71	1,834	2,284	1,871	1,427	71	2,040	2,538	2,079	1,584
72	1,890	2,353	1,928	1,469	72	2,101	2,615	2,141	1,633
73	1,948	2,424	1,984	1,513	73	2,162	2,694	2,204	1,681
74	2,003	2,496	2,044	1,558	74	2,226	2,772	2,271	1,731
75	2,065	2,570	2,105	1,605	75	2,294	2,857	2,339	1,783
76	2,126	2,648	2,169	1,653	76	2,363	2,942	2,409	1,837
77	2,191	2,727	2,234	1,703	77	2,434	3,030	2,482	1,892
78	2,256	2,808	2,301	1,755	78	2,506	3,122	2,558	1,950
79	2,324	2,893	2,370	1,806	79	2,582	3,214	2,633	2,007
80	2,392	2,980	2,441	1,860	80	2,659	3,311	2,711	2,068
81	2,465	3,069	2,513	1,917	81	2,741	3,411	2,793	2,129
82	2,539	3,161	2,590	1,973	82	2,822	3,513	2,876	2,193
83	2,615	3,257	2,668	2,033	83	2,906	3,619	2,964	2,258
84	2,693	3,355	2,746	2,095	84	2,992	3,728	3,052	2,327
85	2,774	3,455	2,830	2,157	85	3,082	3,840	3,143	2,397
86	2,858	3,559	2,914	2,222	86	3,176	3,954	3,239	2,469
87	2,944	3,665	3,001	2,288	87	3,271	4,073	3,334	2,542
88	3,033	3,775	3,092	2,357	88	3,369	4,194	3,436	2,619
89	3,124	3,888	3,185	2,427	89	3,472	4,321	3,540	2,697
90	3,216	4,005	3,281	2,501	90	3,574	4,450	3,645	2,778
91	3,314	4,126	3,379	2,576	91	3,682	4,584	3,753	2,862
92	3,414	4,249	3,480	2,653	92	3,794	4,721	3,866	2,948
93	3,515	4,377	3,584	2,733	93	3,905	4,864	3,982	3,037
94	3,621	4,509	3,692	2,815	94	4,024	5,009	4,102	3,128
95	3,730	4,642	3,803	2,898	95	4,144	5,159	4,225	3,221
96	3,842	4,783	3,916	2,986	96	4,270	5,314	4,352	3,318
97	3,956	4,927	4,034	3,075	97	4,396	5,473	4,483	3,417
98	4,075	5,074	4,155	3,168	98	4,527	5,637	4,617	3,519
99	4,197	5,226	4,280	3,263	99	4,664	5,807	4,755	3,626

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

Household Discount Factor .93

LUMICO LIFE INSURANCE COMPANY

NEVADA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 889-891

	Preferred					Standard			
Attained Age	Plan A	Plan F	Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	Plan N
65	1,646	2,050	1,680	1,280	65	1,831	2,277	1,867	1,422
66	1,646	2,050	1,680	1,280	66	1,831	2,277	1,867	1,422
67	1,646	2,050	1,680	1,280	67	1,831	2,277	1,867	1,422
68	1,696	2,111	1,729	1,318	68	1,884	2,347	1,921	1,464
69	1,748	2,174	1,781	1,358	69	1,941	2,417	1,979	1,509
70	1,799	2,240	1,835	1,398	70	2,000	2,489	2,039	1,554
71	1,853	2,307	1,890	1,441	71	2,060	2,563	2,099	1,601
72	1,909	2,377	1,947	1,484	72	2,122	2,641	2,163	1,649
73	1,967	2,448	2,004	1,528	73	2,184	2,721	2,226	1,698
74	2,024	2,521	2,065	1,574	74	2,249	2,800	2,294	1,748
75	2,086	2,596	2,127	1,621	75	2,317	2,885	2,362	1,800
76	2,148	2,674	2,190	1,670	76	2,386	2,972	2,433	1,855
77	2,213	2,755	2,257	1,720	77	2,459	3,061	2,507	1,912
78	2,279	2,837	2,325	1,772	78	2,531	3,154	2,583	1,969
79	2,347	2,922	2,394	1,824	79	2,609	3,247	2,660	2,027
80	2,417	3,010	2,465	1,879	80	2,686	3,344	2,738	2,089
81	2,491	3,100	2,539	1,936	81	2,769	3,446	2,821	2,150
82	2,565	3,193	2,616	1,993	82	2,850	3,548	2,906	2,215
83	2,642	3,289	2,695	2,054	83	2,936	3,655	2,994	2,282
84	2,720	3,388	2,775	2,115	84	3,022	3,765	3,083	2,350
85	2,802	3,489	2,858	2,178	85	3,113	3,878	3,175	2,421
86	2,886	3,595	2,944	2,244	86	3,208	3,994	3,272	2,493
87	2,974	3,702	3,031	2,311	87	3,303	4,114	3,368	2,568
88	3,063	3,813	3,124	2,381	88	3,403	4,236	3,471	2,645
89	3,155	3,928	3,217	2,452	89	3,507	4,365	3,575	2,724
90	3,249	4,046	3,314	2,526	90	3,610	4,495	3,682	2,806
91	3,347	4,168	3,412	2,602	91	3,719	4,631	3,791	2,892
92	3,448	4,292	3,515	2,680	92	3,832	4,769	3,906	2,977
93	3,551	4,421	3,620	2,760	93	3,945	4,913	4,022	3,067
94	3,657	4,554	3,729	2,843	94	4,065	5,059	4,143	3,160
95	3,767	4,690	3,841	2,928	95	4,185	5,211	4,268	3,254
96	3,880	4,831	3,956	3,016	96	4,312	5,368	4,395	3,351
97	3,997	4,976	4,075	3,106	97	4,441	5,528	4,528	3,451
98	4,116	5,125	4,197	3,200	98	4,574	5,694	4,664	3,555
99	4,240	5,279	4,323	3,296	99	4,711	5,865	4,803	3,662

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

Household Discount Factor .93

LUMICO LIFE INSURANCE COMPANY

NEVADA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 889-891

	Preferred					Standard			
Attained Age	Plan A	Plan F	Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	Plan N
65	1,418	1,765	1,447	1,103	65	1,577	1,961	1,608	1,225
66	1,418	1,765	1,447	1,103	66	1,577	1,961	1,608	1,225
67	1,418	1,765	1,447	1,103	67	1,577	1,961	1,608	1,225
68	1,461	1,818	1,490	1,135	68	1,622	2,021	1,655	1,261
69	1,505	1,873	1,534	1,170	69	1,672	2,082	1,704	1,300
70	1,549	1,929	1,581	1,204	70	1,722	2,144	1,756	1,338
71	1,596	1,987	1,627	1,241	71	1,774	2,208	1,808	1,379
72	1,644	2,047	1,677	1,278	72	1,828	2,275	1,863	1,420
73	1,694	2,109	1,726	1,316	73	1,881	2,343	1,918	1,463
74	1,743	2,171	1,778	1,356	74	1,937	2,412	1,976	1,506
75	1,797	2,236	1,832	1,396	75	1,996	2,485	2,035	1,551
76	1,850	2,303	1,886	1,439	76	2,056	2,559	2,096	1,598
77	1,906	2,373	1,944	1,481	77	2,118	2,636	2,160	1,647
78	1,963	2,444	2,002	1,526	78	2,180	2,716	2,225	1,696
79	2,022	2,517	2,062	1,571	79	2,247	2,797	2,291	1,746
80	2,082	2,592	2,123	1,619	80	2,313	2,880	2,359	1,799
81	2,145	2,670	2,187	1,667	81	2,385	2,968	2,430	1,852
82	2,209	2,751	2,253	1,717	82	2,455	3,056	2,503	1,907
83	2,275	2,833	2,321	1,769	83	2,529	3,148	2,578	1,965
84	2,343	2,918	2,390	1,822	84	2,603	3,243	2,655	2,024
85	2,413	3,005	2,461	1,876	85	2,681	3,341	2,735	2,085
86	2,486	3,096	2,536	1,933	86	2,763	3,440	2,818	2,148
87	2,562	3,188	2,611	1,991	87	2,845	3,544	2,901	2,212
88	2,638	3,284	2,690	2,051	88	2,931	3,649	2,990	2,278
89	2,718	3,383	2,771	2,112	89	3,021	3,759	3,079	2,346
90	2,798	3,485	2,854	2,175	90	3,109	3,872	3,172	2,417
91	2,883	3,590	2,939	2,241	91	3,203	3,988	3,265	2,491
92	2,970	3,697	3,027	2,308	92	3,301	4,108	3,364	2,564
93	3,059	3,808	3,118	2,377	93	3,398	4,231	3,464	2,642
94	3,150	3,922	3,212	2,449	94	3,501	4,358	3,569	2,721
95	3,245	4,039	3,308	2,522	95	3,605	4,489	3,676	2,802
96	3,342	4,161	3,407	2,598	96	3,714	4,623	3,786	2,887
97	3,442	4,286	3,510	2,675	97	3,825	4,761	3,900	2,972
98	3,545	4,414	3,615	2,756	98	3,939	4,904	4,017	3,062
99	3,652	4,547	3,723	2,839	99	4,058	5,052	4,137	3,154

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* 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.