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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.

[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

GEORGIA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 300-303, 311, 399

	Preferred					Standard			
Issue Age	Plan A	Plan F	Plan G	Plan N	Issue Age	Plan A	Plan F	Plan G	Plan N
0-64	18,190	21,688	18,111	13,503	0-64	20,208	24,094	20,131	14,988
65	1,819	2,169	1,811	1,350	65	2,021	2,409	2,013	1,499
66	1,819	2,169	1,811	1,350	66	2,021	2,409	2,013	1,499
67	1,819	2,169	1,811	1,350	67	2,021	2,409	2,013	1,499
68	1,819	2,223	1,811	1,382	68	2,021	2,471	2,013	1,536
69	1,865	2,278	1,856	1,419	69	2,071	2,533	2,062	1,576
70	1,911	2,335	1,904	1,453	70	2,124	2,595	2,114	1,613
71	1,958	2,393	1,949	1,489	71	2,176	2,659	2,167	1,654
72	2,009	2,452	1,999	1,527	72	2,230	2,726	2,221	1,695
73	2,054	2,511	2,046	1,563	73	2,283	2,791	2,273	1,736
74	2,103	2,571	2,095	1,599	74	2,336	2,856	2,327	1,775
75	2,153	2,632	2,144	1,637	75	2,393	2,925	2,382	1,818
76	2,203	2,694	2,195	1,677	76	2,449	2,994	2,437	1,862
77	2,256	2,758	2,246	1,716	77	2,508	3,065	2,497	1,907
78	2,308	2,822	2,300	1,757	78	2,565	3,136	2,555	1,951
79	2,363	2,889	2,353	1,796	79	2,626	3,208	2,614	1,994
80	2,417	2,956	2,407	1,837	80	2,685	3,284	2,675	2,044
81	2,475	3,024	2,464	1,880	81	2,752	3,360	2,737	2,089
82	2,532	3,094	2,521	1,923	82	2,813	3,438	2,801	2,138
83	2,601	3,179	2,590	1,977	83	2,890	3,532	2,877	2,196
84	2,669	3,264	2,658	2,030	84	2,966	3,627	2,955	2,256
85	2,742	3,353	2,731	2,085	85	3,047	3,726	3,035	2,317
86	2,817	3,444	2,805	2,142	86	3,131	3,826	3,119	2,380
87	2,893	3,538	2,881	2,200	87	3,215	3,930	3,202	2,445
88	2,972	3,632	2,960	2,259	88	3,302	4,035	3,289	2,510
89	3,052	3,731	3,041	2,319	89	3,393	4,146	3,378	2,578
90	3,136	3,832	3,122	2,383	90	3,482	4,258	3,470	2,647
91	3,221	3,935	3,206	2,449	91	3,579	4,373	3,561	2,721
92	3,308	4,042	3,293	2,515	92	3,675	4,490	3,660	2,794
93	3,398	4,152	3,382	2,582	93	3,775	4,614	3,758	2,869
94	3,489	4,263	3,473	2,653	94	3,877	4,737	3,859	2,947
95	3,581	4,379	3,567	2,723	95	3,981	4,866	3,964	3,026
96	3,680	4,496	3,663	2,797	96	4,090	4,997	4,071	3,109
97	3,778	4,618	3,763	2,872	97	4,198	5,130	4,181	3,191
98	3,882	4,743	3,864	2,950	98	4,312	5,269	4,294	3,278
99	3,985	4,871	3,967	3,031	99	4,428	5,411	4,409	3,367

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

Household Discount Factor .93

LUMICO LIFE INSURANCE COMPANY

GEORGIA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 300-303, 311, 399

	Preferred					Standard			
Issue Age	Plan A	Plan F	Plan G	Plan N	Issue Age	Plan A	Plan F	Plan G	Plan N
0-64	16,490	19,661	16,419	12,241	0-64	18,320	21,842	18,249	13,587
65	1,649	1,966	1,642	1,224	65	1,832	2,184	1,825	1,359
66	1,649	1,966	1,642	1,224	66	1,832	2,184	1,825	1,359
67	1,649	1,966	1,642	1,224	67	1,832	2,184	1,825	1,359
68	1,649	2,016	1,642	1,253	68	1,832	2,240	1,825	1,393
69	1,690	2,065	1,682	1,286	69	1,878	2,296	1,870	1,428
70	1,733	2,117	1,726	1,317	70	1,926	2,353	1,916	1,462
71	1,775	2,169	1,767	1,350	71	1,973	2,411	1,964	1,499
72	1,821	2,223	1,812	1,384	72	2,022	2,471	2,013	1,537
73	1,862	2,277	1,854	1,417	73	2,070	2,530	2,060	1,574
74	1,907	2,330	1,899	1,450	74	2,118	2,589	2,109	1,610
75	1,951	2,386	1,944	1,484	75	2,169	2,652	2,159	1,648
76	1,997	2,442	1,989	1,520	76	2,220	2,714	2,210	1,688
77	2,045	2,500	2,036	1,555	77	2,274	2,778	2,264	1,729
78	2,092	2,558	2,085	1,593	78	2,325	2,843	2,316	1,768
79	2,142	2,619	2,133	1,628	79	2,381	2,908	2,370	1,808
80	2,191	2,679	2,182	1,666	80	2,434	2,977	2,425	1,853
81	2,244	2,742	2,233	1,704	81	2,495	3,046	2,481	1,893
82	2,295	2,805	2,286	1,743	82	2,550	3,117	2,540	1,938
83	2,357	2,881	2,348	1,793	83	2,620	3,202	2,608	1,991
84	2,420	2,959	2,410	1,840	84	2,689	3,288	2,679	2,045
85	2,486	3,039	2,475	1,890	85	2,762	3,378	2,751	2,101
86	2,554	3,122	2,543	1,942	86	2,838	3,468	2,827	2,158
87	2,623	3,207	2,612	1,994	87	2,914	3,563	2,902	2,217
88	2,694	3,293	2,683	2,048	88	2,993	3,658	2,982	2,276
89	2,767	3,382	2,756	2,103	89	3,076	3,758	3,063	2,337
90	2,843	3,473	2,831	2,161	90	3,156	3,860	3,145	2,400
91	2,920	3,567	2,907	2,220	91	3,244	3,964	3,228	2,467
92	2,999	3,665	2,985	2,280	92	3,331	4,071	3,318	2,532
93	3,080	3,764	3,066	2,341	93	3,422	4,183	3,407	2,601
94	3,163	3,865	3,149	2,405	94	3,514	4,294	3,498	2,672
95	3,247	3,970	3,234	2,469	95	3,609	4,411	3,593	2,744
96	3,336	4,076	3,321	2,535	96	3,707	4,530	3,690	2,818
97	3,425	4,187	3,411	2,603	97	3,806	4,651	3,790	2,893
98	3,519	4,300	3,503	2,674	98	3,909	4,777	3,893	2,971
99	3,613	4,416	3,596	2,747	99	4,014	4,906	3,997	3,053

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

Household Discount Factor .93

LUMICO LIFE INSURANCE COMPANY

GEORGIA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 300-303, 311, 399

	Preferred					Standard			
Issue Age	Plan A	Plan F	Plan G	Plan N	Issue Age	Plan A	Plan F	Plan G	Plan N
0-64	16,245	19,365	16,177	12,050	0-64	18,055	21,510	17,967	13,396
65	1,625	1,937	1,618	1,205	65	1,805	2,151	1,797	1,340
66	1,625	1,937	1,618	1,205	66	1,805	2,151	1,797	1,340
67	1,625	1,937	1,618	1,205	67	1,805	2,151	1,797	1,340
68	1,625	1,985	1,618	1,235	68	1,805	2,206	1,797	1,371
69	1,665	2,035	1,657	1,266	69	1,850	2,261	1,841	1,406
70	1,707	2,085	1,699	1,296	70	1,895	2,317	1,888	1,440
71	1,748	2,137	1,740	1,329	71	1,943	2,374	1,935	1,476
72	1,792	2,190	1,785	1,362	72	1,991	2,434	1,983	1,514
73	1,835	2,242	1,826	1,395	73	2,039	2,492	2,029	1,550
74	1,877	2,296	1,870	1,427	74	2,087	2,550	2,078	1,585
75	1,922	2,350	1,915	1,461	75	2,137	2,611	2,127	1,623
76	1,968	2,406	1,959	1,497	76	2,187	2,672	2,178	1,662
77	2,015	2,463	2,007	1,532	77	2,240	2,736	2,229	1,702
78	2,061	2,520	2,054	1,568	78	2,290	2,800	2,281	1,743
79	2,111	2,579	2,102	1,605	79	2,345	2,864	2,335	1,782
80	2,157	2,639	2,149	1,642	80	2,399	2,932	2,388	1,825
81	2,209	2,700	2,199	1,679	81	2,455	3,001	2,443	1,865
82	2,260	2,763	2,252	1,718	82	2,512	3,069	2,501	1,909
83	2,322	2,837	2,312	1,765	83	2,581	3,154	2,568	1,960
84	2,384	2,914	2,375	1,813	84	2,650	3,238	2,638	2,014
85	2,449	2,994	2,438	1,862	85	2,720	3,327	2,710	2,068
86	2,516	3,074	2,506	1,912	86	2,795	3,416	2,783	2,125
87	2,583	3,158	2,572	1,965	87	2,870	3,509	2,858	2,184
88	2,653	3,244	2,643	2,017	88	2,948	3,603	2,936	2,241
89	2,726	3,331	2,715	2,071	89	3,030	3,701	3,017	2,302
90	2,800	3,421	2,788	2,128	90	3,110	3,802	3,098	2,363
91	2,876	3,514	2,862	2,187	91	3,195	3,905	3,180	2,429
92	2,954	3,609	2,940	2,244	92	3,281	4,009	3,267	2,494
93	3,034	3,706	3,019	2,305	93	3,370	4,118	3,354	2,562
94	3,115	3,807	3,101	2,368	94	3,461	4,230	3,444	2,632
95	3,199	3,910	3,185	2,431	95	3,554	4,345	3,539	2,703
96	3,286	4,015	3,270	2,498	96	3,652	4,461	3,634	2,775
97	3,373	4,123	3,359	2,565	97	3,749	4,582	3,733	2,849
98	3,466	4,234	3,450	2,634	98	3,851	4,705	3,834	2,927
99	3,558	4,348	3,543	2,706	99	3,954	4,832	3,936	3,006

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

Household Discount Factor .93

LUMICO LIFE INSURANCE COMPANY

GEORGIA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 300-303, 311, 399

	Preferred					Standard			
Issue Age	Plan A	Plan F	Plan G	Plan N	Issue Age	Plan A	Plan F	Plan G	Plan N
0-64	14,727	17,555	14,665	10,924	0-64	16,367	19,500	16,288	12,144
65	1,473	1,756	1,466	1,092	65	1,637	1,950	1,629	1,214
66	1,473	1,756	1,466	1,092	66	1,637	1,950	1,629	1,214
67	1,473	1,756	1,466	1,092	67	1,637	1,950	1,629	1,214
68	1,473	1,800	1,466	1,120	68	1,637	1,999	1,629	1,243
69	1,510	1,845	1,502	1,148	69	1,677	2,050	1,669	1,274
70	1,547	1,890	1,541	1,175	70	1,718	2,100	1,712	1,305
71	1,584	1,937	1,578	1,205	71	1,762	2,152	1,754	1,338
72	1,624	1,985	1,618	1,235	72	1,805	2,207	1,798	1,372
73	1,664	2,033	1,655	1,265	73	1,849	2,259	1,839	1,405
74	1,701	2,081	1,695	1,294	74	1,892	2,312	1,884	1,437
75	1,743	2,130	1,736	1,325	75	1,937	2,367	1,928	1,471
76	1,784	2,181	1,776	1,357	76	1,983	2,423	1,974	1,507
77	1,826	2,233	1,819	1,389	77	2,031	2,481	2,021	1,543
78	1,869	2,284	1,862	1,422	78	2,076	2,539	2,068	1,581
79	1,913	2,338	1,906	1,455	79	2,125	2,597	2,117	1,615
80	1,956	2,393	1,948	1,489	80	2,174	2,658	2,165	1,654
81	2,003	2,447	1,994	1,522	81	2,226	2,720	2,215	1,691
82	2,048	2,504	2,042	1,557	82	2,277	2,783	2,267	1,731
83	2,105	2,572	2,096	1,600	83	2,340	2,859	2,328	1,777
84	2,161	2,642	2,153	1,643	84	2,402	2,935	2,391	1,826
85	2,220	2,714	2,211	1,688	85	2,466	3,016	2,457	1,875
86	2,280	2,787	2,272	1,734	86	2,534	3,096	2,523	1,926
87	2,342	2,863	2,332	1,781	87	2,602	3,181	2,591	1,980
88	2,405	2,941	2,396	1,828	88	2,672	3,266	2,662	2,032
89	2,471	3,020	2,461	1,878	89	2,747	3,355	2,735	2,087
90	2,538	3,102	2,528	1,929	90	2,819	3,447	2,809	2,142
91	2,607	3,186	2,594	1,982	91	2,896	3,540	2,883	2,202
92	2,678	3,271	2,665	2,035	92	2,974	3,635	2,961	2,261
93	2,750	3,360	2,737	2,090	93	3,055	3,733	3,041	2,322
94	2,824	3,451	2,811	2,147	94	3,137	3,834	3,123	2,386
95	2,900	3,544	2,887	2,204	95	3,222	3,939	3,209	2,450
96	2,979	3,640	2,965	2,264	96	3,310	4,044	3,295	2,516
97	3,058	3,738	3,045	2,325	97	3,398	4,154	3,384	2,583
98	3,142	3,839	3,128	2,388	98	3,491	4,265	3,476	2,654
99	3,225	3,942	3,212	2,453	99	3,585	4,380	3,568	2,725

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

Household Discount Factor .93

PREMIUM INFORMATION

We, Lumico Life Insurance Company, can only raise your premium if we raise the premium for all policies like yours in the same state where your policy was issued.

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. 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 $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.