Lumico
insurance made clear

LUMICO LIFE INSURANCE COMPANY
Outline of Medicare Supplement Coverage
Benefit Plans A, F, G, and N
Benefit Chart of Medicare Supplement Plans Sold for Effective Dates on or After June 1, 2010

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state.

Basic Benefits:

- **Hospitalization – Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.**
- **Medical Expenses – Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or copayments.**
- **Blood – First three pints of blood each year.**
- **Hospice – Part A coinsurance**

A	B	C	D	F	F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance		Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				Part B Excess (100%)		Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket limit $5560 paid at 100% after limit reached	Out-of-pocket limit $2780 paid at 100% after limit reached		

***Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2300 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2300. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

LUMICO LIFE INSURANCE COMPANY

OREGON Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 970-972

	Preferred					Standard			
Attained Age	Plan A	Plan F	Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	Plan N
0-64	1,771	2,361	1,860	1,515	0-64	1,968	2,623	2,066	1,683
65	1,771	2,361	1,860	1,515	65	1,968	2,623	2,066	1,683
66	1,771	2,361	1,860	1,515	66	1,968	2,623	2,066	1,683
67	1,771	2,361	1,860	1,515	67	1,968	2,623	2,066	1,683
68	1,842	2,456	1,935	1,577	68	2,046	2,728	2,149	1,751
69	1,916	2,554	2,011	1,638	69	2,129	2,838	2,235	1,821
70	1,992	2,656	2,092	1,705	70	2,213	2,952	2,325	1,895
71	2,071	2,762	2,175	1,772	71	2,302	3,070	2,418	1,971
72	2,156	2,873	2,263	1,844	72	2,395	3,193	2,514	2,048
73	2,242	2,989	2,353	1,918	73	2,490	3,320	2,615	2,130
74	2,332	3,109	2,448	1,995	74	2,591	3,453	2,720	2,215
75	2,425	3,233	2,546	2,074	75	2,693	3,591	2,828	2,304
76	2,521	3,362	2,647	2,158	76	2,801	3,735	2,940	2,397
77	2,622	3,496	2,753	2,244	77	2,913	3,884	3,058	2,493
78	2,728	3,637	2,864	2,333	78	3,030	4,039	3,181	2,592
79	2,836	3,782	2,978	2,427	79	3,150	4,201	3,309	2,696
80	2,950	3,933	3,097	2,523	80	3,277	4,369	3,441	2,804
81	3,067	4,090	3,221	2,624	81	3,408	4,544	3,579	2,916
82	3,190	4,254	3,350	2,730	82	3,545	4,726	3,721	3,032
83	3,319	4,424	3,484	2,838	83	3,687	4,915	3,871	3,155
84	3,452	4,602	3,624	2,953	84	3,834	5,112	4,026	3,280
85	3,590	4,785	3,769	3,070	85	3,988	5,316	4,186	3,411
86	3,732	4,976	3,918	3,193	86	4,147	5,529	4,354	3,547
87	3,882	5,176	4,075	3,321	87	4,313	5,750	4,528	3,690
88	4,038	5,383	4,239	3,454	88	4,485	5,979	4,708	3,836
89	4,199	5,599	4,409	3,592	89	4,664	6,219	4,897	3,990
90	4,366	5,822	4,584	3,736	90	4,850	6,467	5,094	4,150
91	4,541	6,055	4,769	3,885	91	5,045	6,726	5,297	4,316
92	4,723	6,297	4,959	4,041	92	5,247	6,996	5,509	4,488
93	4,912	6,549	5,157	4,202	93	5,457	7,275	5,730	4,668
94	5,108	6,811	5,363	4,370	94	5,676	7,567	5,958	4,855
95	5,312	7,083	5,577	4,544	95	5,902	7,870	6,197	5,051
96	5,525	7,365	5,800	4,725	96	6,139	8,185	6,446	5,252
97	5,745	7,660	6,032	4,915	97	6,384	8,512	6,703	5,462
98	5,975	7,966	6,273	5,111	98	6,639	8,852	6,971	5,681
99	6,213	8,284	6,524	5,315	99	6,905	9,206	7,250	5,908

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

Household Discount Factor: 0.93

LUMICO LIFE INSURANCE COMPANY

OREGON Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 970-972

	Preferred					Standard			
Attained Age	Plan A	Plan F	Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	Plan N
0-64	1,706	2,275	1,792	1,459	0-64	1,896	2,528	1,990	1,622
65	1,706	2,275	1,792	1,459	65	1,896	2,528	1,990	1,622
66	1,706	2,275	1,792	1,459	66	1,896	2,528	1,990	1,622
67	1,706	2,275	1,792	1,459	67	1,896	2,528	1,990	1,622
68	1,775	2,366	1,864	1,519	68	1,972	2,629	2,071	1,687
69	1,846	2,461	1,938	1,579	69	2,051	2,734	2,154	1,755
70	1,919	2,559	2,015	1,642	70	2,133	2,844	2,240	1,825
71	1,996	2,662	2,096	1,708	71	2,218	2,958	2,330	1,899
72	2,077	2,769	2,180	1,777	72	2,308	3,076	2,423	1,974
73	2,160	2,880	2,267	1,848	73	2,399	3,199	2,520	2,053
74	2,247	2,995	2,359	1,922	74	2,496	3,327	2,621	2,134
75	2,337	3,115	2,453	1,999	75	2,595	3,460	2,725	2,220
76	2,429	3,239	2,550	2,079	76	2,699	3,598	2,833	2,309
77	2,526	3,369	2,653	2,162	77	2,807	3,742	2,947	2,402
78	2,629	3,504	2,760	2,248	78	2,920	3,892	3,064	2,498
79	2,733	3,644	2,869	2,338	79	3,035	4,047	3,188	2,597
80	2,843	3,789	2,984	2,431	80	3,158	4,210	3,315	2,701
81	2,955	3,940	3,103	2,528	81	3,283	4,378	3,448	2,809
82	3,074	4,099	3,228	2,631	82	3,416	4,553	3,586	2,922
83	3,198	4,263	3,357	2,735	83	3,553	4,736	3,730	3,039
84	3,326	4,434	3,491	2,845	84	3,694	4,925	3,879	3,160
85	3,459	4,610	3,631	2,958	85	3,842	5,122	4,033	3,286
86	3,595	4,794	3,775	3,077	86	3,996	5,327	4,195	3,418
87	3,741	4,987	3,927	3,200	87	4,156	5,540	4,363	3,555
88	3,890	5,186	4,085	3,328	88	4,321	5,761	4,536	3,696
89	4,046	5,394	4,248	3,461	89	4,493	5,992	4,718	3,845
90	4,207	5,610	4,417	3,599	90	4,673	6,231	4,908	3,999
91	4,375	5,834	4,595	3,744	91	4,861	6,481	5,103	4,158
92	4,551	6,067	4,778	3,893	92	5,055	6,740	5,308	4,324
93	4,733	6,310	4,969	4,049	93	5,258	7,010	5,520	4,498
94	4,921	6,562	5,167	4,211	94	5,469	7,291	5,741	4,678
95	5,118	6,824	5,374	4,378	95	5,687	7,583	5,971	4,866
96	5,323	7,097	5,588	4,553	96	5,915	7,886	6,211	5,060
97	5,536	7,380	5,811	4,736	97	6,151	8,201	6,459	5,263
98	5,757	7,675	6,044	4,924	98	6,397	8,529	6,717	5,473
99	5,986	7,982	6,286	5,121	99	6,653	8,870	6,985	5,692

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

Household Discount Factor: 0.93

LUMICO LIFE INSURANCE COMPANY

OREGON Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 970-972

	Preferred					Standard			
Attained Age	Plan A	Plan F	Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	Plan N
0-64	1,582	2,108	1,660	1,354	0-64	1,756	2,342	1,844	1,503
65	1,582	2,108	1,660	1,354	65	1,756	2,342	1,844	1,503
66	1,582	2,108	1,660	1,354	66	1,756	2,342	1,844	1,503
67	1,582	2,108	1,660	1,354	67	1,756	2,342	1,844	1,503
68	1,653	2,203	1,735	1,414	68	1,827	2,435	1,918	1,562
69	1,725	2,301	1,813	1,476	69	1,900	2,533	1,995	1,626
70	1,801	2,400	1,890	1,541	70	1,975	2,634	2,074	1,690
71	1,876	2,501	1,969	1,604	71	2,054	2,739	2,156	1,758
72	1,952	2,601	2,048	1,669	72	2,137	2,848	2,243	1,828
73	2,023	2,697	2,125	1,731	73	2,222	2,962	2,333	1,900
74	2,092	2,789	2,197	1,789	74	2,311	3,081	2,425	1,976
75	2,159	2,878	2,266	1,847	75	2,403	3,203	2,523	2,056
76	2,222	2,964	2,333	1,902	76	2,499	3,332	2,624	2,138
77	2,287	3,049	2,401	1,956	77	2,600	3,465	2,729	2,224
78	2,350	3,132	2,467	2,010	78	2,703	3,604	2,838	2,313
79	2,406	3,208	2,526	2,058	79	2,811	3,748	2,952	2,405
80	2,459	3,279	2,582	2,105	80	2,924	3,897	3,070	2,500
81	2,508	3,344	2,634	2,146	81	3,039	4,053	3,192	2,601
82	2,558	3,410	2,686	2,188	82	3,162	4,215	3,320	2,704
83	2,609	3,479	2,739	2,233	83	3,288	4,384	3,452	2,814
84	2,662	3,548	2,794	2,277	84	3,421	4,560	3,590	2,926
85	2,715	3,619	2,850	2,322	85	3,557	4,742	3,734	3,042
86	2,768	3,692	2,907	2,369	86	3,699	4,932	3,884	3,165
87	2,825	3,766	2,965	2,417	87	3,847	5,128	4,038	3,291
88	2,881	3,841	3,025	2,464	88	4,001	5,334	4,200	3,422
89	2,938	3,918	3,086	2,514	89	4,161	5,547	4,369	3,559
90	2,998	3,996	3,147	2,565	90	4,326	5,769	4,543	3,701
91	3,057	4,076	3,211	2,615	91	4,499	6,000	4,725	3,849
92	3,119	4,158	3,274	2,668	92	4,680	6,239	4,914	4,003
93	3,181	4,241	3,339	2,722	93	4,868	6,490	5,111	4,164
94	3,243	4,325	3,406	2,775	94	5,062	6,748	5,314	4,330
95	3,308	4,411	3,474	2,830	95	5,263	7,018	5,527	4,503
96	3,375	4,499	3,543	2,887	96	5,475	7,299	5,748	4,684
97	3,443	4,590	3,615	2,945	97	5,694	7,590	5,977	4,871
98	3,511	4,681	3,687	3,004	98	5,920	7,894	6,216	5,065
99	3,581	4,775	3,760	3,064	99	6,157	8,209	6,465	5,268

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

Household Discount Factor: 0.93

LUMICO LIFE INSURANCE COMPANY

OREGON Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 970-972

	Preferred					Standard			
Attained Age	Plan A	Plan F	Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	Plan N
0-64	1,524	2,031	1,599	1,304	0-64	1,692	2,257	1,777	1,448
65	1,524	2,031	1,599	1,304	65	1,692	2,257	1,777	1,448
66	1,524	2,031	1,599	1,304	66	1,692	2,257	1,777	1,448
67	1,524	2,031	1,599	1,304	67	1,692	2,257	1,777	1,448
68	1,592	2,123	1,672	1,362	68	1,761	2,347	1,848	1,505
69	1,662	2,217	1,746	1,422	69	1,830	2,441	1,922	1,566
70	1,735	2,312	1,821	1,484	70	1,903	2,538	1,999	1,629
71	1,808	2,409	1,897	1,545	71	1,979	2,639	2,078	1,694
72	1,880	2,506	1,974	1,608	72	2,059	2,744	2,161	1,762
73	1,949	2,599	2,047	1,667	73	2,141	2,854	2,248	1,831
74	2,016	2,687	2,116	1,724	74	2,227	2,968	2,337	1,904
75	2,080	2,773	2,183	1,780	75	2,315	3,086	2,431	1,981
76	2,141	2,855	2,248	1,832	76	2,408	3,210	2,528	2,060
77	2,204	2,938	2,313	1,885	77	2,505	3,339	2,629	2,143
78	2,264	3,018	2,377	1,936	78	2,605	3,473	2,735	2,229
79	2,318	3,091	2,434	1,983	79	2,709	3,611	2,844	2,317
80	2,369	3,159	2,488	2,028	80	2,817	3,755	2,958	2,409
81	2,416	3,222	2,538	2,068	81	2,928	3,905	3,076	2,506
82	2,465	3,286	2,588	2,108	82	3,047	4,062	3,199	2,606
83	2,513	3,352	2,639	2,151	83	3,168	4,224	3,326	2,711
84	2,565	3,419	2,692	2,194	84	3,296	4,394	3,459	2,819
85	2,616	3,487	2,746	2,237	85	3,427	4,569	3,598	2,931
86	2,667	3,557	2,801	2,283	86	3,564	4,752	3,742	3,049
87	2,721	3,628	2,857	2,328	87	3,707	4,941	3,891	3,171
88	2,776	3,701	2,915	2,374	88	3,855	5,139	4,047	3,297
89	2,831	3,775	2,973	2,423	89	4,009	5,345	4,209	3,429
90	2,888	3,851	3,033	2,471	90	4,168	5,558	4,377	3,566
91	2,945	3,928	3,094	2,520	91	4,335	5,781	4,553	3,709
92	3,005	4,006	3,155	2,571	92	4,509	6,012	4,735	3,857
93	3,065	4,086	3,217	2,622	93	4,690	6,253	4,924	4,012
94	3,125	4,167	3,282	2,674	94	4,877	6,502	5,120	4,172
95	3,188	4,250	3,347	2,726	95	5,071	6,762	5,325	4,338
96	3,252	4,335	3,414	2,782	96	5,275	7,032	5,538	4,513
97	3,317	4,422	3,483	2,837	97	5,486	7,313	5,759	4,693
98	3,383	4,511	3,552	2,894	98	5,704	7,606	5,989	4,880
99	3,450	4,600	3,623	2,952	99	5,932	7,909	6,229	5,076

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

Household Discount Factor: 0.93

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. This type of premium change can occur on any premium due date, but will only occur once in a 12 month period.

Premiums are based on your attained age and will change on your policy anniversary date.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and Lumico Life Insurance Company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to: Lumico Life Insurance Company, Medicare Supplement Administration, P.O. Box 10875, Clearwater, Florida 33757-8875. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments, 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 $1364	$0	$1364 (Part A deductible)
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	$0	Up to $170.50 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 $185 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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 $1364	$1364 (Part A deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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 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 F
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $185 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 $185 of Medicare Approved Amounts*	$0	$185 (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 $185 of Medicare Approved amounts*	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$185 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER SERVICES – 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 $1364	$1364 (Part A deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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 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 G
MEDICARE (PART B) – MEDICAL SERVICES-PER – CALENDAR YEAR

*Once you have been billed $185 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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 $1364	$1364 (Part A deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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 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 N
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $185 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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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	100%	$0	$0
— Durable medical equipment			
First $185 of Medicare Approved Amounts*	$0	$0	$185 (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.