



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%	✓	✓	✓	✓	✓
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					

¹Plans 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.

²Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

³Plan 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
WEST VIRGINIA Standard Plans MALE Rates - ANNUAL
 FOR USE IN ZIP CODES: ALL OF STATE

Attained Age	Preferred				Attained Age	Standard			
	Plan A	Plan F	Plan G	Plan N		Plan A	Plan F	Plan G	Plan N
65	1,355	1,807	1,382	1,154	65	1,507	2,007	1,537	1,282
66	1,355	1,807	1,382	1,154	66	1,507	2,007	1,537	1,282
67	1,355	1,807	1,382	1,154	67	1,507	2,007	1,537	1,282
68	1,396	1,861	1,423	1,187	68	1,550	2,069	1,581	1,319
69	1,438	1,916	1,465	1,223	69	1,597	2,131	1,629	1,359
70	1,481	1,974	1,511	1,260	70	1,646	2,195	1,678	1,399
71	1,525	2,034	1,555	1,299	71	1,696	2,260	1,728	1,441
72	1,571	2,095	1,603	1,336	72	1,747	2,328	1,780	1,486
73	1,619	2,158	1,649	1,376	73	1,797	2,399	1,832	1,530
74	1,666	2,222	1,699	1,417	74	1,850	2,468	1,888	1,575
75	1,716	2,288	1,750	1,460	75	1,907	2,544	1,945	1,622
76	1,767	2,358	1,803	1,504	76	1,964	2,619	2,003	1,672
77	1,821	2,428	1,857	1,550	77	2,023	2,698	2,064	1,722
78	1,875	2,500	1,913	1,597	78	2,083	2,780	2,126	1,774
79	1,932	2,576	1,970	1,643	79	2,147	2,862	2,189	1,826
80	1,989	2,653	2,029	1,693	80	2,211	2,948	2,254	1,882
81	2,049	2,733	2,089	1,744	81	2,279	3,037	2,322	1,937
82	2,111	2,815	2,153	1,795	82	2,346	3,128	2,391	1,995
83	2,174	2,900	2,218	1,850	83	2,416	3,222	2,464	2,055
84	2,239	2,987	2,283	1,906	84	2,487	3,319	2,537	2,117
85	2,306	3,076	2,352	1,963	85	2,562	3,419	2,613	2,181
86	2,376	3,169	2,423	2,021	86	2,640	3,521	2,693	2,246
87	2,447	3,263	2,495	2,082	87	2,719	3,627	2,772	2,313
88	2,521	3,361	2,571	2,144	88	2,801	3,734	2,856	2,383
89	2,597	3,462	2,648	2,208	89	2,887	3,847	2,943	2,454
90	2,673	3,566	2,728	2,276	90	2,971	3,962	3,030	2,528
91	2,755	3,674	2,809	2,344	91	3,061	4,082	3,120	2,604
92	2,838	3,783	2,893	2,414	92	3,154	4,203	3,214	2,682
93	2,922	3,897	2,980	2,487	93	3,247	4,331	3,310	2,763
94	3,010	4,014	3,069	2,561	94	3,345	4,460	3,410	2,846
95	3,101	4,133	3,161	2,637	95	3,445	4,593	3,513	2,931
96	3,194	4,258	3,255	2,717	96	3,549	4,731	3,618	3,019
97	3,289	4,386	3,354	2,798	97	3,654	4,873	3,727	3,109
98	3,387	4,518	3,454	2,883	98	3,764	5,019	3,838	3,202
99	3,489	4,653	3,558	2,969	99	3,877	5,170	3,953	3,299

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

LUMICO LIFE INSURANCE COMPANY
WEST VIRGINIA Standard Plans FEMALE Rates - ANNUAL
 FOR USE IN ZIP CODES: ALL OF STATE

Attained Age	Preferred				Attained Age	Standard			
	Plan A	Plan F	Plan G	Plan N		Plan A	Plan F	Plan G	Plan N
65	1,179	1,572	1,203	1,003	65	1,311	1,746	1,337	1,115
66	1,179	1,572	1,203	1,003	66	1,311	1,746	1,337	1,115
67	1,179	1,572	1,203	1,003	67	1,311	1,746	1,337	1,115
68	1,215	1,619	1,238	1,033	68	1,349	1,800	1,376	1,147
69	1,251	1,667	1,275	1,064	69	1,390	1,853	1,417	1,183
70	1,288	1,718	1,314	1,096	70	1,432	1,909	1,460	1,218
71	1,327	1,769	1,353	1,129	71	1,475	1,966	1,503	1,254
72	1,367	1,823	1,394	1,163	72	1,520	2,026	1,549	1,292
73	1,408	1,877	1,435	1,198	73	1,564	2,086	1,594	1,331
74	1,449	1,933	1,478	1,233	74	1,610	2,147	1,643	1,370
75	1,494	1,991	1,523	1,270	75	1,659	2,213	1,691	1,411
76	1,538	2,051	1,568	1,309	76	1,709	2,279	1,742	1,454
77	1,584	2,113	1,616	1,348	77	1,761	2,347	1,795	1,498
78	1,632	2,176	1,664	1,389	78	1,813	2,418	1,849	1,543
79	1,681	2,241	1,714	1,430	79	1,868	2,490	1,905	1,589
80	1,730	2,308	1,765	1,473	80	1,923	2,565	1,961	1,637
81	1,783	2,378	1,818	1,517	81	1,982	2,642	2,020	1,685
82	1,836	2,449	1,873	1,562	82	2,041	2,721	2,081	1,736
83	1,892	2,522	1,929	1,610	83	2,102	2,803	2,144	1,788
84	1,948	2,598	1,987	1,658	84	2,164	2,887	2,207	1,842
85	2,006	2,676	2,046	1,707	85	2,229	2,974	2,273	1,897
86	2,067	2,757	2,108	1,759	86	2,297	3,062	2,343	1,954
87	2,129	2,839	2,171	1,811	87	2,365	3,155	2,412	2,013
88	2,193	2,924	2,237	1,866	88	2,437	3,248	2,485	2,073
89	2,259	3,012	2,304	1,922	89	2,511	3,347	2,560	2,135
90	2,326	3,102	2,373	1,979	90	2,585	3,447	2,637	2,199
91	2,397	3,196	2,443	2,039	91	2,663	3,551	2,715	2,266
92	2,469	3,292	2,517	2,100	92	2,744	3,657	2,797	2,333
93	2,543	3,390	2,592	2,163	93	2,825	3,767	2,880	2,404
94	2,618	3,492	2,670	2,228	94	2,910	3,880	2,967	2,476
95	2,697	3,596	2,750	2,295	95	2,997	3,996	3,056	2,550
96	2,778	3,704	2,832	2,364	96	3,088	4,116	3,147	2,627
97	2,862	3,816	2,918	2,434	97	3,180	4,239	3,242	2,704
98	2,947	3,930	3,005	2,508	98	3,275	4,366	3,340	2,786
99	3,036	4,048	3,095	2,583	99	3,373	4,498	3,439	2,870

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

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
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days</p>	<p>All but \$1408 All but \$352 a day All but \$704 a day \$0 \$0</p>	<p>\$0 \$352 a day \$704 a day 100% of Medicare eligible expenses \$0</p>	<p>\$1408 (Part A deductible) \$0 \$0 \$0** All costs</p>
<p>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 21st thru 100th day 101st day and after</p>	<p>All approved amounts All but \$176 a day \$0</p>	<p>\$0 \$0 \$0</p>	<p>\$0 Up to \$176 a day All costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$0 100%</p>	<p>3 pints \$0</p>	<p>\$0 \$0</p>
<p>HOSPICE CARE You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.</p>	<p>All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care</p>	<p>Medicare copayment/coinsurance</p>	<p>\$0</p>

****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
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days</p>	<p>All but \$1408 All but \$352 a day All but \$704 a day \$0 \$0</p>	<p>\$1408 (Part A deductible) \$352 a day \$704 a day 100% of Medicare eligible expenses \$0</p>	<p>\$0 \$0 \$0 \$0** All costs</p>
<p>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 21st thru 100th day 101st day and after</p>	<p>All approved amounts All but \$176 a day \$0</p>	<p>\$0 Up to \$176 a day \$0</p>	<p>\$0 \$0 All costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$0 100%</p>	<p>3 pints \$0</p>	<p>\$0 \$0</p>
<p>HOSPICE CARE You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.</p>	<p>All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care</p>	<p>Medicare copayment/coinsurance</p>	<p>\$0</p>

****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
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days</p>	<p>All but \$1408 All but \$352 a day All but \$704 a day \$0 \$0</p>	<p>\$1408 (Part A deductible) \$352 a day \$704 a day 100% of Medicare eligible expenses \$0</p>	<p>\$0 \$0 \$0 \$0** All costs</p>
<p>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 21st thru 100th day 101st day and after</p>	<p>All approved amounts All but \$176 a day \$0</p>	<p>\$0 Up to \$176 a day \$0</p>	<p>\$0 \$0 All costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$0 100%</p>	<p>3 pints \$0</p>	<p>\$0 \$0</p>
<p>HOSPICE CARE You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.</p>	<p>All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care</p>	<p>Medicare copayment/coinsurance</p>	<p>\$0</p>

****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* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$198 (Part B deductible) \$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 \$0 20%	\$0 \$198 (Part B deductible) \$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
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days</p>	<p>All but \$1408 All but \$352 a day All but \$704 a day \$0 \$0</p>	<p>\$1408 (Part A deductible) \$352 a day \$704 a day 100% of Medicare eligible expenses \$0</p>	<p>\$0 \$0 \$0 \$0** All costs</p>
<p>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 21st thru 100th day 101st day and after</p>	<p>All approved amounts All but \$176 a day \$0</p>	<p>\$0 Up to \$176 a day \$0</p>	<p>\$0 \$0 All costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$0 100%</p>	<p>3 pints \$0</p>	<p>\$0 \$0</p>
<p>HOSPICE CARE You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.</p>	<p>All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care</p>	<p>Medicare copayment/coinsurance</p>	<p>\$0</p>

****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
<p>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,</p> <p>First \$198 of Medicare Approved Amounts*</p> <p>Remainder of Medicare Approved Amounts</p>	<p>\$0</p> <p>Generally 80%</p>	<p>\$0</p> <p>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.</p>	<p>\$198 (Part B deductible)</p> <p>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.</p>
<p>PART B EXCESS CHARGES (Above Medicare Approved Amounts)</p>	<p>\$0</p>	<p>\$0</p>	<p>All costs</p>
<p>BLOOD</p> <p>First 3 pints</p> <p>Next \$198 of Medicare Approved Amounts*</p> <p>Remainder of Medicare Approved Amounts</p>	<p>\$0</p> <p>\$0</p> <p>80%</p>	<p>All costs</p> <p>\$0</p> <p>20%</p>	<p>\$0</p> <p>\$198 (Part B deductible)</p> <p>\$0</p>
<p>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</p>	<p>100%</p>	<p>\$0</p>	<p>\$0</p>

(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 \$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.