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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

SOUTH CAROLINA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 294, 295, 298, 299

	Preferred					Standard			
Attained Age	Plan A	Plan F	Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	Plan N
65	1,470	1,793	1,442	1,157	65	1,632	1,992	1,603	1,285
66	1,470	1,793	1,442	1,157	66	1,632	1,992	1,603	1,285
67	1,470	1,793	1,442	1,157	67	1,632	1,992	1,603	1,285
68	1,470	1,847	1,442	1,191	68	1,632	2,053	1,603	1,323
69	1,513	1,902	1,485	1,228	69	1,681	2,114	1,650	1,364
70	1,559	1,959	1,531	1,263	70	1,733	2,177	1,701	1,404
71	1,605	2,018	1,576	1,302	71	1,784	2,243	1,751	1,446
72	1,655	2,078	1,624	1,341	72	1,838	2,310	1,804	1,490
73	1,704	2,141	1,671	1,381	73	1,893	2,380	1,857	1,535
74	1,754	2,205	1,722	1,422	74	1,949	2,450	1,913	1,579
75	1,806	2,272	1,774	1,464	75	2,007	2,525	1,971	1,627
76	1,860	2,339	1,827	1,510	76	2,068	2,600	2,029	1,676
77	1,916	2,410	1,882	1,554	77	2,131	2,677	2,091	1,727
78	1,973	2,482	1,939	1,602	78	2,193	2,758	2,154	1,779
79	2,034	2,557	1,996	1,648	79	2,260	2,840	2,218	1,831
80	2,094	2,633	2,056	1,698	80	2,326	2,926	2,284	1,887
81	2,158	2,712	2,118	1,749	81	2,399	3,013	2,353	1,942
82	2,222	2,794	2,182	1,801	82	2,469	3,104	2,424	2,001
83	2,289	2,877	2,247	1,856	83	2,545	3,197	2,497	2,061
84	2,358	2,964	2,314	1,911	84	2,618	3,293	2,571	2,123
85	2,428	3,053	2,383	1,968	85	2,698	3,393	2,648	2,188
86	2,502	3,145	2,455	2,028	86	2,780	3,493	2,729	2,253
87	2,576	3,239	2,528	2,088	87	2,862	3,599	2,810	2,321
88	2,655	3,336	2,605	2,151	88	2,948	3,705	2,895	2,390
89	2,734	3,436	2,684	2,215	89	3,038	3,818	2,982	2,461
90	2,815	3,539	2,764	2,282	90	3,127	3,932	3,072	2,535
91	2,901	3,645	2,846	2,351	91	3,223	4,050	3,162	2,613
92	2,988	3,755	2,931	2,421	92	3,320	4,172	3,257	2,691
93	3,078	3,867	3,020	2,494	93	3,418	4,297	3,355	2,772
94	3,169	3,983	3,110	2,570	94	3,522	4,425	3,455	2,855
95	3,263	4,103	3,203	2,645	95	3,627	4,559	3,560	2,940
96	3,362	4,225	3,299	2,725	96	3,737	4,695	3,666	3,028
97	3,462	4,352	3,399	2,806	97	3,848	4,836	3,777	3,118
98	3,567	4,483	3,500	2,891	98	3,963	4,980	3,891	3,212
99	3,674	4,618	3,605	2,978	99	4,083	5,130	4,006	3,309

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

Household Discount Factor .93

LUMICO LIFE INSURANCE COMPANY

SOUTH CAROLINA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 294, 295, 298, 299

	Preferred					Standard			
Attained Age	Plan A	Plan F	Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	Plan N
65	1,358	1,656	1,332	1,069	65	1,508	1,840	1,481	1,187
66	1,358	1,656	1,332	1,069	66	1,508	1,840	1,481	1,187
67	1,358	1,656	1,332	1,069	67	1,508	1,840	1,481	1,187
68	1,358	1,706	1,332	1,100	68	1,508	1,896	1,481	1,222
69	1,398	1,757	1,372	1,134	69	1,553	1,953	1,524	1,260
70	1,440	1,810	1,414	1,167	70	1,601	2,011	1,571	1,297
71	1,483	1,864	1,456	1,203	71	1,648	2,072	1,618	1,336
72	1,528	1,920	1,500	1,239	72	1,698	2,134	1,667	1,377
73	1,574	1,978	1,544	1,276	73	1,749	2,198	1,715	1,418
74	1,620	2,037	1,591	1,314	74	1,800	2,264	1,767	1,459
75	1,669	2,099	1,639	1,353	75	1,854	2,332	1,820	1,503
76	1,718	2,161	1,687	1,395	76	1,911	2,402	1,874	1,549
77	1,770	2,226	1,738	1,436	77	1,969	2,473	1,932	1,596
78	1,823	2,293	1,791	1,480	78	2,026	2,548	1,990	1,644
79	1,879	2,362	1,844	1,523	79	2,088	2,624	2,049	1,691
80	1,934	2,433	1,899	1,569	80	2,149	2,703	2,110	1,743
81	1,994	2,505	1,957	1,616	81	2,216	2,784	2,174	1,794
82	2,053	2,581	2,016	1,664	82	2,281	2,868	2,239	1,848
83	2,115	2,658	2,076	1,714	83	2,351	2,954	2,307	1,904
84	2,178	2,738	2,137	1,765	84	2,419	3,042	2,375	1,961
85	2,243	2,820	2,202	1,818	85	2,492	3,134	2,446	2,021
86	2,311	2,905	2,268	1,873	86	2,568	3,227	2,521	2,081
87	2,380	2,992	2,336	1,929	87	2,643	3,324	2,596	2,144
88	2,452	3,082	2,406	1,987	88	2,723	3,423	2,675	2,208
89	2,526	3,174	2,479	2,046	89	2,806	3,527	2,755	2,274
90	2,600	3,269	2,553	2,108	90	2,889	3,633	2,838	2,342
91	2,680	3,367	2,629	2,172	91	2,977	3,742	2,921	2,414
92	2,760	3,469	2,708	2,237	92	3,067	3,854	3,009	2,486
93	2,843	3,572	2,790	2,304	93	3,157	3,970	3,100	2,561
94	2,927	3,679	2,873	2,374	94	3,253	4,088	3,192	2,638
95	3,015	3,790	2,959	2,444	95	3,351	4,212	3,289	2,716
96	3,105	3,904	3,048	2,518	96	3,452	4,337	3,386	2,797
97	3,198	4,021	3,140	2,593	97	3,555	4,467	3,489	2,880
98	3,295	4,141	3,234	2,671	98	3,661	4,601	3,594	2,967
99	3,394	4,266	3,330	2,752	99	3,771	4,739	3,701	3,057

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

Household Discount Factor .93

LUMICO LIFE INSURANCE COMPANY

SOUTH CAROLINA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 294, 295, 298, 299

	Preferred					Standard			
Attained Age	Plan A	Plan F	Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	Plan N
65	1,312	1,601	1,288	1,033	65	1,457	1,779	1,431	1,147
66	1,312	1,601	1,288	1,033	66	1,457	1,779	1,431	1,147
67	1,312	1,601	1,288	1,033	67	1,457	1,779	1,431	1,147
68	1,312	1,649	1,288	1,063	68	1,457	1,832	1,431	1,181
69	1,352	1,699	1,326	1,096	69	1,501	1,887	1,473	1,218
70	1,392	1,749	1,367	1,128	70	1,547	1,944	1,518	1,253
71	1,434	1,802	1,407	1,163	71	1,594	2,002	1,563	1,291
72	1,477	1,856	1,450	1,197	72	1,642	2,063	1,611	1,330
73	1,521	1,912	1,493	1,233	73	1,690	2,125	1,658	1,370
74	1,566	1,969	1,538	1,270	74	1,740	2,187	1,709	1,410
75	1,614	2,028	1,584	1,308	75	1,792	2,254	1,759	1,452
76	1,662	2,089	1,631	1,348	76	1,846	2,321	1,812	1,497
77	1,712	2,152	1,680	1,388	77	1,902	2,391	1,867	1,542
78	1,763	2,217	1,731	1,430	78	1,958	2,463	1,923	1,589
79	1,816	2,283	1,783	1,472	79	2,018	2,536	1,981	1,635
80	1,870	2,351	1,836	1,516	80	2,077	2,612	2,039	1,685
81	1,927	2,421	1,891	1,562	81	2,142	2,691	2,101	1,735
82	1,984	2,494	1,948	1,608	82	2,205	2,772	2,164	1,787
83	2,044	2,569	2,007	1,657	83	2,271	2,855	2,229	1,841
84	2,104	2,646	2,066	1,707	84	2,338	2,940	2,296	1,896
85	2,167	2,726	2,128	1,757	85	2,408	3,029	2,364	1,953
86	2,233	2,808	2,192	1,810	86	2,482	3,119	2,436	2,012
87	2,301	2,892	2,257	1,865	87	2,555	3,213	2,508	2,072
88	2,370	2,978	2,326	1,921	88	2,632	3,309	2,585	2,134
89	2,441	3,067	2,396	1,978	89	2,713	3,409	2,662	2,198
90	2,513	3,159	2,468	2,038	90	2,793	3,511	2,742	2,264
91	2,589	3,255	2,541	2,099	91	2,877	3,617	2,823	2,333
92	2,668	3,353	2,617	2,162	92	2,964	3,724	2,909	2,402
93	2,747	3,453	2,696	2,227	93	3,052	3,837	2,995	2,474
94	2,829	3,556	2,777	2,294	94	3,144	3,951	3,085	2,549
95	2,914	3,663	2,860	2,362	95	3,238	4,070	3,179	2,625
96	3,002	3,773	2,946	2,433	96	3,336	4,192	3,273	2,704
97	3,092	3,886	3,035	2,506	97	3,435	4,318	3,372	2,784
98	3,184	4,003	3,126	2,582	98	3,538	4,447	3,473	2,868
99	3,280	4,122	3,219	2,659	99	3,644	4,581	3,577	2,955

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

Household Discount Factor .93

LUMICO LIFE INSURANCE COMPANY

SOUTH CAROLINA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 294, 295, 298, 299

	Preferred					Standard			
Attained Age	Plan A	Plan F	Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	Plan N
65	1,212	1,479	1,190	954	65	1,346	1,643	1,322	1,060
66	1,212	1,479	1,190	954	66	1,346	1,643	1,322	1,060
67	1,212	1,479	1,190	954	67	1,346	1,643	1,322	1,060
68	1,212	1,524	1,190	982	68	1,346	1,693	1,322	1,091
69	1,249	1,569	1,225	1,012	69	1,387	1,744	1,361	1,125
70	1,286	1,616	1,262	1,042	70	1,429	1,796	1,403	1,158
71	1,324	1,665	1,300	1,074	71	1,472	1,850	1,444	1,193
72	1,364	1,715	1,339	1,106	72	1,517	1,906	1,488	1,229
73	1,405	1,767	1,379	1,139	73	1,561	1,963	1,532	1,266
74	1,446	1,819	1,420	1,173	74	1,607	2,021	1,578	1,303
75	1,491	1,873	1,463	1,208	75	1,656	2,082	1,625	1,342
76	1,535	1,929	1,507	1,245	76	1,705	2,144	1,674	1,383
77	1,581	1,988	1,552	1,282	77	1,757	2,209	1,725	1,425
78	1,629	2,048	1,599	1,321	78	1,809	2,275	1,777	1,468
79	1,677	2,109	1,647	1,360	79	1,864	2,343	1,830	1,511
80	1,727	2,172	1,696	1,401	80	1,919	2,413	1,884	1,557
81	1,780	2,237	1,747	1,443	81	1,979	2,486	1,941	1,603
82	1,833	2,304	1,800	1,486	82	2,037	2,560	1,999	1,651
83	1,888	2,374	1,854	1,531	83	2,098	2,637	2,059	1,700
84	1,944	2,444	1,909	1,577	84	2,160	2,716	2,121	1,751
85	2,002	2,518	1,966	1,624	85	2,225	2,798	2,184	1,804
86	2,063	2,594	2,025	1,672	86	2,293	2,881	2,251	1,858
87	2,125	2,672	2,085	1,722	87	2,361	2,968	2,317	1,914
88	2,189	2,751	2,149	1,774	88	2,432	3,057	2,388	1,971
89	2,255	2,833	2,213	1,827	89	2,506	3,149	2,459	2,030
90	2,322	2,919	2,280	1,882	90	2,580	3,243	2,533	2,091
91	2,392	3,007	2,347	1,939	91	2,658	3,341	2,608	2,155
92	2,464	3,097	2,418	1,997	92	2,738	3,441	2,687	2,219
93	2,538	3,189	2,491	2,057	93	2,819	3,544	2,767	2,286
94	2,613	3,285	2,565	2,119	94	2,905	3,650	2,850	2,355
95	2,692	3,384	2,642	2,182	95	2,991	3,760	2,936	2,425
96	2,773	3,485	2,721	2,248	96	3,082	3,872	3,024	2,498
97	2,856	3,590	2,803	2,315	97	3,173	3,989	3,115	2,572
98	2,941	3,698	2,888	2,385	98	3,268	4,108	3,209	2,650
99	3,030	3,808	2,974	2,457	99	3,367	4,232	3,304	2,730

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. You will be notified, in writing, at least thirty-one (31) days in advance if a new table of rates is applicable to the policy.

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 $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 — Durable medical equipment First $198 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $198 (Part B deductible) 20%	 $0 $0 $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

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.