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 2024[2]					$7060[2]	$3530[2]				

[1]Plans F and G also have a high deductible option which requires first paying a plan deductible of $2800 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. The annual OOP limits are determined in accordance with section 1882(w)(2) of the Social Security Act. That provision prescribed an OOP limit for 2006 of $4,000 for Plan K and $2,000 for Plan L, and directed that these amounts increase each subsequent year by an appropriate inflation adjustment specified by the Secretary of the United States Department of Health & Human Services. For 2020 the calculation of the OOP limits is based on estimates of the United States Per Capita Costs (USPCC) of the Medicare program developed by CMS as published with the announcement of Calendar Year (CY) 2018 and CY 2020 Medicare Advantage (MA) payment rates.

[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.

Effective 04-01-2024

Policy Fee $25

LUMICO LIFE INSURANCE COMPANY

OREGON Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 970-973

	Preferred					Standard			
Attained Age	**Plan A**	**Plan F**	**Plan G**	**Plan N**	**Attained Age**	**Plan A**	**Plan F**	**Plan G**	**Plan N**
0-64	2,779	3,703	2,809	2,193	0-64	3,088	4,115	3,123	2,437
65	2,779	3,703	2,809	2,193	65	3,088	4,115	3,123	2,437
66	2,779	3,703	2,809	2,193	66	3,088	4,115	3,123	2,437
67	2,779	3,703	2,809	2,193	67	3,088	4,115	3,123	2,437
68	2,779	3,703	2,809	2,193	68	3,088	4,115	3,123	2,437
69	2,779	3,703	2,809	2,193	69	3,088	4,115	3,123	2,437
70	2,888	3,851	2,922	2,281	70	3,210	4,281	3,247	2,535
71	3,004	4,006	3,038	2,372	71	3,339	4,452	3,378	2,637
72	3,126	4,167	3,161	2,468	72	3,474	4,630	3,512	2,741
73	3,251	4,334	3,287	2,566	73	3,611	4,815	3,653	2,851
74	3,382	4,508	3,420	2,670	74	3,757	5,008	3,800	2,964
75	3,517	4,688	3,557	2,776	75	3,905	5,208	3,950	3,084
76	3,656	4,875	3,697	2,887	76	4,062	5,416	4,107	3,207
77	3,802	5,070	3,846	3,003	77	4,225	5,632	4,272	3,336
78	3,957	5,274	4,001	3,122	78	4,394	5,858	4,443	3,469
79	4,113	5,484	4,159	3,247	79	4,568	6,092	4,622	3,607
80	4,278	5,703	4,326	3,376	80	4,753	6,336	4,806	3,752
81	4,448	5,931	4,499	3,511	81	4,941	6,589	4,999	3,902
82	4,626	6,169	4,680	3,654	82	5,141	6,853	5,198	4,058
83	4,813	6,416	4,867	3,798	83	5,347	7,128	5,407	4,221
84	5,006	6,673	5,062	3,952	84	5,559	7,413	5,624	4,389
85	5,205	6,939	5,265	4,108	85	5,783	7,709	5,847	4,564
86	5,411	7,216	5,473	4,273	86	6,014	8,018	6,082	4,747
87	5,630	7,506	5,693	4,445	87	6,255	8,338	6,325	4,938
88	5,856	7,806	5,922	4,622	88	6,503	8,671	6,577	5,134
89	6,089	8,119	6,159	4,807	89	6,763	9,018	6,840	5,340
90	6,332	8,443	6,404	4,999	90	7,033	9,379	7,115	5,554
91	6,585	8,780	6,661	5,199	91	7,317	9,754	7,398	5,775
92	6,849	9,132	6,926	5,407	92	7,609	10,145	7,696	6,006
93	7,124	9,497	7,204	5,623	93	7,913	10,550	8,003	6,247
94	7,407	9,876	7,491	5,848	94	8,231	10,973	8,323	6,497
95	7,703	10,271	7,790	6,081	95	8,559	11,413	8,656	6,759
96	8,012	10,681	8,102	6,324	96	8,902	11,870	9,004	7,028
97	8,332	11,108	8,425	6,578	97	9,259	12,344	9,364	7,309
98	8,664	11,552	8,763	6,839	98	9,628	12,837	9,737	7,602
99	9,010	12,014	9,112	7,113	99	10,014	13,350	10,127	7,906

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

Household Discount Factor .93

LUMICO LIFE INSURANCE COMPANY

OREGON Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 970-973

	Preferred					Standard			
Attained Age	Plan A	Plan F	Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	Plan N
0-64	2,677	3,568	2,707	2,113	0-64	2,975	3,965	3,009	2,348
65	2,677	3,568	2,707	2,113	65	2,975	3,965	3,009	2,348
66	2,677	3,568	2,707	2,113	66	2,975	3,965	3,009	2,348
67	2,677	3,568	2,707	2,113	67	2,975	3,965	3,009	2,348
68	2,677	3,568	2,707	2,113	68	2,975	3,965	3,009	2,348
69	2,677	3,568	2,707	2,113	69	2,975	3,965	3,009	2,348
70	2,783	3,711	2,815	2,198	70	3,093	4,124	3,129	2,443
71	2,894	3,860	2,927	2,285	71	3,217	4,290	3,254	2,541
72	3,012	4,015	3,045	2,378	72	3,347	4,461	3,384	2,641
73	3,132	4,176	3,167	2,472	73	3,479	4,639	3,520	2,747
74	3,258	4,344	3,295	2,573	74	3,620	4,825	3,661	2,856
75	3,388	4,517	3,427	2,675	75	3,763	5,017	3,806	2,971
76	3,523	4,697	3,562	2,782	76	3,914	5,218	3,957	3,090
77	3,663	4,885	3,706	2,893	77	4,071	5,427	4,116	3,214
78	3,812	5,082	3,855	3,008	78	4,234	5,644	4,281	3,342
79	3,963	5,284	4,008	3,129	79	4,401	5,869	4,453	3,476
80	4,122	5,495	4,168	3,253	80	4,579	6,105	4,631	3,615
81	4,286	5,714	4,335	3,383	81	4,761	6,349	4,817	3,760
82	4,457	5,944	4,509	3,520	82	4,953	6,603	5,009	3,910
83	4,637	6,181	4,689	3,659	83	5,152	6,868	5,210	4,067
84	4,823	6,429	4,877	3,808	84	5,356	7,143	5,419	4,229
85	5,015	6,686	5,072	3,958	85	5,572	7,428	5,634	4,398
86	5,214	6,952	5,274	4,118	86	5,795	7,726	5,860	4,574
87	5,425	7,232	5,485	4,283	87	6,026	8,034	6,095	4,757
88	5,642	7,521	5,705	4,453	88	6,266	8,354	6,337	4,947
89	5,867	7,823	5,934	4,631	89	6,516	8,689	6,590	5,145
90	6,101	8,135	6,170	4,817	90	6,777	9,036	6,855	5,351
91	6,345	8,460	6,418	5,010	91	7,050	9,398	7,128	5,564
92	6,599	8,799	6,673	5,210	92	7,331	9,774	7,415	5,787
93	6,864	9,150	6,941	5,418	93	7,624	10,165	7,711	6,019
94	7,137	9,516	7,217	5,635	94	7,930	10,572	8,019	6,260
95	7,422	9,896	7,506	5,859	95	8,247	10,996	8,340	6,512
96	7,720	10,291	7,806	6,093	96	8,577	11,437	8,675	6,772
97	8,028	10,703	8,118	6,338	97	8,921	11,893	9,022	7,042
98	8,348	11,131	8,443	6,590	98	9,276	12,369	9,382	7,324
99	8,681	11,575	8,780	6,853	99	9,648	12,863	9,758	7,617

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

Household Discount Factor .93

LUMICO LIFE INSURANCE COMPANY

OREGON Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 970-973

	Preferred					Standard			
Attained Age	Plan A	Plan F	Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	Plan N
0-64	2,502	3,336	2,532	1,975	0-64	2,755	3,673	2,787	2,175
65	2,502	3,336	2,532	1,975	65	2,755	3,673	2,787	2,175
66	2,502	3,336	2,532	1,975	66	2,755	3,673	2,787	2,175
67	2,502	3,336	2,532	1,975	67	2,755	3,673	2,787	2,175
68	2,502	3,336	2,532	1,975	68	2,755	3,673	2,787	2,175
69	2,502	3,336	2,532	1,975	69	2,755	3,673	2,787	2,175
70	2,611	3,480	2,640	2,062	70	2,864	3,819	2,897	2,262
71	2,721	3,626	2,751	2,146	71	2,978	3,972	3,012	2,352
72	2,830	3,772	2,861	2,233	72	3,098	4,130	3,133	2,447
73	2,933	3,912	2,968	2,316	73	3,223	4,296	3,259	2,543
74	3,034	4,045	3,068	2,395	74	3,352	4,467	3,388	2,645
75	3,131	4,173	3,165	2,472	75	3,485	4,645	3,524	2,751
76	3,223	4,298	3,259	2,545	76	3,624	4,832	3,665	2,861
77	3,317	4,422	3,354	2,618	77	3,770	5,025	3,812	2,976
78	3,407	4,542	3,446	2,689	78	3,920	5,227	3,964	3,095
79	3,489	4,652	3,528	2,755	79	4,077	5,435	4,123	3,219
80	3,566	4,755	3,607	2,816	80	4,240	5,652	4,288	3,346
81	3,637	4,849	3,679	2,872	81	4,407	5,877	4,459	3,480
82	3,710	4,946	3,751	2,928	82	4,585	6,113	4,638	3,619
83	3,783	5,044	3,826	2,988	83	4,768	6,358	4,822	3,765
84	3,860	5,145	3,902	3,047	84	4,961	6,613	5,015	3,915
85	3,937	5,248	3,981	3,107	85	5,158	6,877	5,216	4,071
86	4,015	5,353	4,061	3,170	86	5,364	7,151	5,425	4,235
87	4,096	5,461	4,141	3,234	87	5,579	7,437	5,640	4,404
88	4,178	5,570	4,226	3,297	88	5,802	7,735	5,867	4,580
89	4,261	5,682	4,310	3,365	89	6,034	8,044	6,102	4,762
90	4,347	5,795	4,396	3,432	90	6,274	8,366	6,346	4,953
91	4,433	5,911	4,485	3,500	91	6,525	8,701	6,601	5,151
92	4,523	6,029	4,573	3,571	92	6,787	9,048	6,864	5,357
93	4,613	6,149	4,664	3,642	93	7,059	9,411	7,139	5,573
94	4,703	6,272	4,758	3,713	94	7,340	9,786	7,423	5,794
95	4,798	6,396	4,853	3,786	95	7,632	10,177	7,720	6,025
96	4,894	6,525	4,949	3,863	96	7,939	10,585	8,029	6,268
97	4,993	6,656	5,050	3,940	97	8,257	11,007	8,349	6,518
98	5,092	6,789	5,150	4,019	98	8,585	11,447	8,682	6,778
99	5,193	6,924	5,252	4,100	99	8,928	11,904	9,030	7,049

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

Household Discount Factor .93

LUMICO LIFE INSURANCE COMPANY

OREGON Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 970-973

	Preferred					Standard			
Attained Age	Plan A	Plan F	Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	Plan N
0-64	2,411	3,215	2,439	1,903	0-64	2,654	3,539	2,685	2,096
65	2,411	3,215	2,439	1,903	65	2,654	3,539	2,685	2,096
66	2,411	3,215	2,439	1,903	66	2,654	3,539	2,685	2,096
67	2,411	3,215	2,439	1,903	67	2,654	3,539	2,685	2,096
68	2,411	3,215	2,439	1,903	68	2,654	3,539	2,685	2,096
69	2,411	3,215	2,439	1,903	69	2,654	3,539	2,685	2,096
70	2,516	3,353	2,544	1,986	70	2,760	3,680	2,792	2,179
71	2,621	3,494	2,650	2,068	71	2,869	3,827	2,902	2,266
72	2,727	3,634	2,757	2,151	72	2,985	3,980	3,018	2,357
73	2,826	3,769	2,860	2,231	73	3,105	4,139	3,140	2,450
74	2,923	3,897	2,956	2,307	74	3,229	4,304	3,264	2,548
75	3,016	4,021	3,049	2,381	75	3,357	4,476	3,396	2,650
76	3,105	4,141	3,140	2,452	76	3,492	4,656	3,531	2,756
77	3,196	4,261	3,231	2,522	77	3,632	4,842	3,673	2,867
78	3,283	4,377	3,320	2,591	78	3,777	5,036	3,820	2,982
79	3,362	4,482	3,400	2,654	79	3,928	5,237	3,973	3,101
80	3,436	4,581	3,475	2,713	80	4,085	5,445	4,131	3,224
81	3,504	4,672	3,545	2,767	81	4,246	5,662	4,296	3,353
82	3,574	4,765	3,615	2,821	82	4,418	5,890	4,468	3,487
83	3,645	4,860	3,686	2,879	83	4,594	6,126	4,646	3,628
84	3,719	4,958	3,760	2,936	84	4,780	6,372	4,832	3,773
85	3,794	5,057	3,835	2,994	85	4,970	6,626	5,026	3,923
86	3,868	5,158	3,913	3,055	86	5,168	6,890	5,227	4,080
87	3,947	5,261	3,990	3,116	87	5,375	7,165	5,434	4,244
88	4,025	5,367	4,071	3,177	88	5,590	7,453	5,653	4,412
89	4,106	5,474	4,153	3,242	89	5,813	7,750	5,880	4,589
90	4,188	5,584	4,236	3,307	90	6,045	8,061	6,114	4,772
91	4,271	5,696	4,321	3,372	91	6,287	8,383	6,360	4,963
92	4,358	5,809	4,406	3,441	92	6,539	8,718	6,613	5,162
93	4,445	5,925	4,494	3,509	93	6,802	9,067	6,879	5,369
94	4,532	6,043	4,584	3,578	94	7,072	9,429	7,152	5,583
95	4,623	6,163	4,676	3,648	95	7,354	9,805	7,438	5,805
96	4,716	6,287	4,768	3,722	96	7,649	10,198	7,736	6,039
97	4,811	6,413	4,865	3,797	97	7,955	10,606	8,044	6,280
98	4,906	6,541	4,962	3,873	98	8,271	11,029	8,366	6,530
99	5,003	6,671	5,061	3,951	99	8,602	11,470	8,701	6,792

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 this State. The change in premium 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.

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.

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 $1632	$0	$1632 (Part A deductible)
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	$0	Up to $204 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 $240 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 $240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 Generally 80%	 $0 Generally 20%	 $240 (Part B deductible) $0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD First 3 pints Next $240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 $0 80%	 All costs $0 20%	 $0 $240 (Part B deductible) $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 — Durable medical equipment First $240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 $240 (Part B deductible) $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 $1632	$1632 (Part A deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 $240 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 $240 of Medicare Approved Amounts*	$0	$240 (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 $240 of Medicare Approved amounts*	$0	$240 (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 $240 of Medicare Approved Amounts*	$0	$240 (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 $1632	$1632 (Part A deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 $240 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 $240 of Medicare Approved Amounts*	$0	$0	$240 (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 $240 of Medicare Approved Amounts*	$0	$0	$240 (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 $240 of Medicare Approved Amounts*	$0	$0	$240 (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 $1632	$1632 (Part A deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 $240 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 $240 of Medicare Approved Amounts*	$0	$0	$240 (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 $240 of Medicare Approved Amounts*	$0	$0	$240 (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 $240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 $240 (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.