

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. Only applicants' **first** eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

In Colorado, it is a requirement that all plans offered by Lumico Life Insurance Company are available to under age 65 Medicare qualified individuals.

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					

¹Plans 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.

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.

COLORADO Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 800-802

Attained Age	Preferred				Attained Age	Standard			
	Plan A	Plan F	Plan G	Plan N		Plan A	Plan F	Plan G	Plan N
Under 65	2,777	3,590	2,792	2,263	Under 65	3,088	3,989	3,106	2,512
65	1,907	2,465	1,917	1,553	65	2,118	2,739	2,131	1,725
66	1,907	2,465	1,917	1,553	66	2,118	2,739	2,131	1,725
67	1,907	2,465	1,917	1,553	67	2,118	2,739	2,131	1,725
68	1,907	2,465	1,917	1,553	68	2,118	2,739	2,131	1,725
69	1,964	2,539	1,975	1,600	69	2,182	2,823	2,195	1,778
70	2,022	2,616	2,036	1,647	70	2,247	2,906	2,261	1,831
71	2,082	2,693	2,095	1,698	71	2,314	2,992	2,329	1,886
72	2,146	2,774	2,160	1,748	72	2,383	3,082	2,399	1,943
73	2,210	2,857	2,222	1,801	73	2,454	3,176	2,470	2,002
74	2,275	2,943	2,290	1,854	74	2,528	3,270	2,545	2,059
75	2,354	3,046	2,370	1,920	75	2,617	3,384	2,634	2,131
76	2,436	3,153	2,453	1,987	76	2,709	3,502	2,726	2,206
77	2,521	3,263	2,538	2,056	77	2,803	3,624	2,821	2,284
78	2,609	3,377	2,628	2,128	78	2,902	3,751	2,920	2,364
79	2,700	3,495	2,719	2,203	79	3,003	3,882	3,022	2,447
80	2,795	3,618	2,815	2,281	80	3,109	4,018	3,128	2,533
81	2,892	3,744	2,913	2,361	81	3,217	4,158	3,238	2,621
82	2,994	3,875	3,015	2,444	82	3,330	4,304	3,351	2,713
83	3,098	4,011	3,121	2,530	83	3,447	4,454	3,469	2,808
84	3,206	4,151	3,231	2,619	84	3,567	4,610	3,590	2,906
85	3,319	4,297	3,345	2,710	85	3,693	4,771	3,716	3,008
86	3,435	4,447	3,463	2,805	86	3,822	4,938	3,846	3,113
87	3,556	4,603	3,584	2,903	87	3,955	5,110	3,981	3,222
88	3,681	4,764	3,709	3,006	88	4,094	5,289	4,120	3,335
89	3,811	4,931	3,839	3,111	89	4,237	5,474	4,265	3,453
90	3,944	5,103	3,973	3,220	90	4,386	5,666	4,415	3,574
91	4,082	5,282	4,113	3,333	91	4,539	5,865	4,570	3,699
92	4,225	5,467	4,256	3,450	92	4,697	6,070	4,730	3,829
93	4,372	5,659	4,405	3,571	93	4,861	6,283	4,896	3,962
94	4,525	5,858	4,559	3,696	94	5,031	6,503	5,068	4,101
95	4,683	6,063	4,718	3,826	95	5,207	6,731	5,245	4,244
96	4,847	6,276	4,883	3,959	96	5,389	6,967	5,428	4,393
97	5,017	6,496	5,054	4,098	97	5,578	7,210	5,618	4,547
98	5,192	6,724	5,231	4,241	98	5,773	7,463	5,815	4,706
99	5,374	6,958	5,414	4,390	99	5,975	7,724	6,018	4,871

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

LUMICO LIFE INSURANCE COMPANY**COLORADO Standard Plans MALE Rates - ANNUAL**

FOR USE IN ZIP CODES: ALL EXCEPT 800-802

Attained Age	Preferred				Attained Age	Standard			
	Plan A	Plan F	Plan G	Plan N		Plan A	Plan F	Plan G	Plan N
Under 65	2,399	3,102	2,412	1,955	Under 65	2,668	3,446	2,683	2,171
65	1,647	2,130	1,656	1,342	65	1,830	2,367	1,841	1,490
66	1,647	2,130	1,656	1,342	66	1,830	2,367	1,841	1,490
67	1,647	2,130	1,656	1,342	67	1,830	2,367	1,841	1,490
68	1,647	2,130	1,656	1,342	68	1,830	2,367	1,841	1,490
69	1,697	2,194	1,706	1,382	69	1,885	2,439	1,896	1,536
70	1,747	2,260	1,759	1,423	70	1,942	2,511	1,953	1,582
71	1,799	2,327	1,810	1,467	71	1,999	2,585	2,012	1,629
72	1,854	2,397	1,866	1,510	72	2,059	2,663	2,073	1,679
73	1,909	2,469	1,920	1,556	73	2,121	2,744	2,134	1,729
74	1,966	2,543	1,979	1,602	74	2,184	2,825	2,199	1,779
75	2,034	2,632	2,048	1,659	75	2,261	2,924	2,276	1,841
76	2,105	2,724	2,119	1,716	76	2,340	3,026	2,355	1,906
77	2,178	2,819	2,193	1,776	77	2,422	3,132	2,438	1,973
78	2,254	2,918	2,270	1,839	78	2,507	3,241	2,523	2,042
79	2,333	3,020	2,350	1,904	79	2,595	3,354	2,611	2,114
80	2,415	3,126	2,432	1,971	80	2,686	3,471	2,702	2,188
81	2,499	3,235	2,517	2,040	81	2,780	3,593	2,797	2,265
82	2,586	3,348	2,605	2,112	82	2,877	3,719	2,896	2,344
83	2,676	3,465	2,697	2,186	83	2,978	3,848	2,997	2,426
84	2,770	3,587	2,792	2,263	84	3,082	3,983	3,102	2,511
85	2,867	3,713	2,890	2,341	85	3,190	4,122	3,210	2,599
86	2,968	3,842	2,992	2,424	86	3,302	4,266	3,323	2,690
87	3,073	3,977	3,097	2,509	87	3,417	4,415	3,439	2,784
88	3,181	4,116	3,205	2,597	88	3,537	4,570	3,560	2,882
89	3,292	4,260	3,317	2,688	89	3,661	4,730	3,685	2,983
90	3,408	4,409	3,433	2,782	90	3,790	4,895	3,815	3,088
91	3,527	4,564	3,553	2,879	91	3,922	5,067	3,949	3,196
92	3,650	4,724	3,677	2,981	92	4,059	5,245	4,087	3,308
93	3,778	4,889	3,806	3,085	93	4,200	5,429	4,230	3,423
94	3,910	5,061	3,939	3,194	94	4,347	5,618	4,379	3,543
95	4,047	5,239	4,076	3,306	95	4,499	5,815	4,532	3,667
96	4,188	5,423	4,219	3,421	96	4,656	6,019	4,690	3,795
97	4,335	5,612	4,366	3,541	97	4,820	6,229	4,854	3,928
98	4,486	5,809	4,519	3,665	98	4,988	6,448	5,024	4,066
99	4,643	6,012	4,678	3,793	99	5,162	6,674	5,199	4,208

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

COLORADO Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 800-802

Attained Age	Preferred				Attained Age	Standard			
	Plan A	Plan F	Plan G	Plan N		Plan A	Plan F	Plan G	Plan N
Under 65	2,479	3,205	2,496	2,019	Under 65	2,756	3,561	2,775	2,244
65	1,702	2,201	1,713	1,387	65	1,890	2,446	1,903	1,540
66	1,702	2,201	1,713	1,387	66	1,890	2,446	1,903	1,540
67	1,702	2,201	1,713	1,387	67	1,890	2,446	1,903	1,540
68	1,702	2,201	1,713	1,387	68	1,890	2,446	1,903	1,540
69	1,752	2,268	1,763	1,428	69	1,948	2,520	1,959	1,587
70	1,805	2,335	1,817	1,472	70	2,007	2,593	2,019	1,635
71	1,859	2,404	1,871	1,515	71	2,067	2,672	2,078	1,683
72	1,915	2,478	1,928	1,561	72	2,129	2,753	2,142	1,734
73	1,972	2,552	1,984	1,608	73	2,192	2,836	2,205	1,786
74	2,032	2,629	2,043	1,655	74	2,257	2,920	2,272	1,838
75	2,103	2,721	2,114	1,714	75	2,336	3,023	2,352	1,902
76	2,176	2,817	2,188	1,774	76	2,418	3,128	2,435	1,969
77	2,253	2,916	2,264	1,837	77	2,503	3,238	2,520	2,038
78	2,332	3,017	2,343	1,901	78	2,591	3,352	2,608	2,109
79	2,414	3,123	2,425	1,967	79	2,681	3,469	2,700	2,183
80	2,499	3,233	2,510	2,037	80	2,775	3,590	2,794	2,259
81	2,586	3,345	2,598	2,108	81	2,873	3,715	2,893	2,338
82	2,677	3,462	2,688	2,181	82	2,973	3,845	2,993	2,420
83	2,770	3,583	2,783	2,258	83	3,077	3,980	3,098	2,504
84	2,867	3,708	2,880	2,337	84	3,184	4,119	3,207	2,591
85	2,967	3,837	2,980	2,418	85	3,295	4,264	3,319	2,683
86	3,071	3,972	3,085	2,503	86	3,410	4,412	3,435	2,777
87	3,178	4,111	3,194	2,590	87	3,530	4,567	3,556	2,874
88	3,290	4,255	3,305	2,681	88	3,654	4,727	3,680	2,974
89	3,405	4,404	3,420	2,775	89	3,782	4,892	3,809	3,078
90	3,524	4,558	3,540	2,872	90	3,914	5,063	3,942	3,186
91	3,648	4,718	3,664	2,973	91	4,051	5,241	4,080	3,297
92	3,776	4,884	3,792	3,077	92	4,193	5,424	4,223	3,413
93	3,908	5,055	3,925	3,184	93	4,340	5,615	4,370	3,533
94	4,044	5,231	4,062	3,296	94	4,492	5,811	4,522	3,657
95	4,186	5,414	4,204	3,412	95	4,649	6,013	4,680	3,785
96	4,332	5,603	4,352	3,532	96	4,811	6,223	4,844	3,917
97	4,483	5,799	4,504	3,656	97	4,979	6,441	5,013	4,055
98	4,640	6,002	4,662	3,784	98	5,153	6,667	5,189	4,197
99	4,803	6,212	4,825	3,916	99	5,334	6,900	5,371	4,344

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

LUMICO LIFE INSURANCE COMPANY**COLORADO Standard Plans FEMALE Rates - ANNUAL**

FOR USE IN ZIP CODES: ALL EXCEPT 800-802

Attained Age	Preferred				Attained Age	Standard			
	Plan A	Plan F	Plan G	Plan N		Plan A	Plan F	Plan G	Plan N
Under 65	2,142	2,769	2,156	1,745	Under 65	2,381	3,076	2,398	1,939
65	1,471	1,902	1,480	1,198	65	1,633	2,113	1,644	1,330
66	1,471	1,902	1,480	1,198	66	1,633	2,113	1,644	1,330
67	1,471	1,902	1,480	1,198	67	1,633	2,113	1,644	1,330
68	1,471	1,902	1,480	1,198	68	1,633	2,113	1,644	1,330
69	1,514	1,960	1,523	1,234	69	1,683	2,177	1,693	1,371
70	1,560	2,017	1,570	1,271	70	1,734	2,241	1,744	1,413
71	1,607	2,077	1,617	1,309	71	1,786	2,309	1,796	1,454
72	1,655	2,141	1,666	1,349	72	1,840	2,379	1,850	1,499
73	1,704	2,205	1,714	1,389	73	1,894	2,451	1,905	1,543
74	1,755	2,272	1,765	1,430	74	1,950	2,523	1,963	1,588
75	1,817	2,351	1,827	1,481	75	2,018	2,612	2,032	1,643
76	1,880	2,434	1,891	1,533	76	2,089	2,703	2,104	1,701
77	1,946	2,519	1,956	1,587	77	2,163	2,798	2,178	1,761
78	2,015	2,607	2,025	1,642	78	2,238	2,896	2,253	1,822
79	2,086	2,698	2,095	1,700	79	2,316	2,997	2,333	1,886
80	2,159	2,793	2,169	1,760	80	2,398	3,102	2,414	1,952
81	2,235	2,890	2,245	1,821	81	2,482	3,210	2,499	2,020
82	2,313	2,991	2,323	1,885	82	2,568	3,322	2,586	2,091
83	2,393	3,096	2,404	1,951	83	2,658	3,439	2,677	2,164
84	2,477	3,204	2,488	2,019	84	2,751	3,559	2,771	2,239
85	2,564	3,315	2,575	2,090	85	2,847	3,684	2,868	2,318
86	2,654	3,432	2,666	2,163	86	2,947	3,812	2,968	2,399
87	2,746	3,552	2,759	2,238	87	3,050	3,946	3,072	2,483
88	2,842	3,677	2,855	2,317	88	3,157	4,084	3,179	2,570
89	2,942	3,805	2,955	2,398	89	3,267	4,227	3,291	2,659
90	3,045	3,938	3,059	2,482	90	3,381	4,374	3,406	2,752
91	3,152	4,077	3,166	2,569	91	3,500	4,528	3,525	2,849
92	3,262	4,219	3,276	2,658	92	3,623	4,687	3,648	2,949
93	3,376	4,367	3,391	2,751	93	3,750	4,851	3,776	3,052
94	3,494	4,520	3,510	2,848	94	3,881	5,020	3,907	3,160
95	3,617	4,678	3,633	2,948	95	4,016	5,196	4,044	3,270
96	3,743	4,841	3,760	3,051	96	4,157	5,377	4,185	3,384
97	3,874	5,011	3,892	3,158	97	4,302	5,565	4,332	3,503
98	4,009	5,186	4,028	3,269	98	4,452	5,760	4,484	3,626
99	4,150	5,367	4,169	3,383	99	4,608	5,962	4,641	3,753

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

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 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. Your premium can change if you move to another area within the state of Colorado; however, if you move out of Colorado, your premium will continue to be based on the most recent zip code of your residence in Colorado.

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 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1632 All but \$408 a day All but \$816 a day \$0 \$0	\$0 \$408 a day \$816 a day 100% of Medicare eligible expenses \$0	\$1632 (Part A deductible) \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$204 a day \$0	\$0 \$0 \$0	\$0 Up to \$204 a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1632 All but \$408 a day All but \$816 a day \$0 \$0	\$1632 (Part A deductible) \$408 a day \$816 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$204 a day \$0	\$0 Up to \$204 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$240 (Part B deductible) Generally 20%	 \$0 \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$240 of Medicare Approved amounts* Remainder of Medicare Approved amounts	\$0 \$0 80%	All costs \$240 (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 \$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 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1632 All but \$408 a day All but \$816 a day \$0 \$0	\$1632 (Part A deductible) \$408 a day \$816 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$204 a day \$0	\$0 Up to \$204 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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* 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	100%	\$0
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

(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 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1632 All but \$408 a day All but \$816 a day \$0 \$0	\$1632 (Part A deductible) \$408 a day \$816 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$204 a day \$0	\$0 Up to \$204 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$0 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.	 \$240 (Part B deductible) 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 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

(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 \$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.