Lumico
insurance made clear

LUMICO LIFE INSURANCE COMPANY
Outline of Medicare Supplement Coverage with $20 and $50 Copayment

THE COMMISSIONER OF COMMERCE OF THE STATE OF MINNESOTA HAS ESTABLISHED TWO CATEGORIES OF MEDICARE SUPPLEMENTS AND MINIMUMS FOR EACH, WITH THE EXTENDED BASIC MEDICARE SUPPLEMENT BEING THE MOST COMPREHENSIVE AND BASIC MEDICARE SUPPLEMENT BEING THE LEAST COMPREHENSIVE.

Every company must make the Extended Basic and Basic Plans available in the Minnesota. Only applicants that are first eligible for Medicare before January 1, 2020 may purchase Plans that cover the Part B Deductible. The chart below shows the plans available from Lumico Life Insurance Company.

BASIC PLAN	EXTENDED BASIC PLAN (Non-Newly Eligible)[1]	EXTENDED BASIC PLAN (Newly Eligible)[2]	HIGH DEDUCTIBLE PLAN[4]	$20 AND $50 COPAYMENT PLAN
Hospitalization: Part A Coinsurance	Hospitalization: Part A Coinsurance	Hospitalization: Part A Coinsurance	Hospitalization: Part A Coinsurance	Hospitalization: Part A Coinsurance
Medical Expenses: Part B Coinsurance	Medical Expenses: Part B Coinsurance	Medical Expenses: Part B Coinsurance	Medical Expenses: Part B Coinsurance	Medical Expenses: Part B Coinsurance except up to $20 copayment for office visit, and up to $50 copayment for ER
Blood: First three pints of blood each year	Blood: First three pints of blood each year	Blood: First three pints of blood each year	Blood: First three pints of blood each year	Blood: First three pints of blood each year
Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
Medicare Part A Deductible[3]	Medicare Part A Deductible	Medicare Part A Deductible	Medicare Part A Deductible	Medicare Part A Deductible
Medicare Part B Deductible[3] (Only available to Non-Newly Eligible)	Medicare Part B Deductible			
Medicare Part B Excess (100%)[3]	Medicare Part B Excess (100%)	Medicare Part B Excess (100%)		
Preventive Medical Care[3]	Preventive Medical Care	Preventive Medical Care		
Foreign Travel Emergency	Foreign Travel Care	Foreign Travel Care	Foreign Travel Emergency	Foreign Travel Emergency

[1]Non-Newly Eligible means applicants who turn age 65 before January 1, 2020 or first become eligible due to age, disability or end-stage renal disease before January 1, 2020.

[2]Newly Eligible means applicants who turn age 65 on or after January 1, 2020 or first become eligible due to age, disability or end-stage renal disease on or after January 1, 2020.

[3]This is an optional rider.

[4]This plan will pay coverage upon payment of the annual deductible. For 2024 the deductible amount is $2800. This amount will be adjusted annual to reflect the changes in Medicare.

LUMICO LIFE INSURANCE COMPANY

MINNESOTA Standard Plans UNISEX Rates - ANNUAL

FOR USE IN ZIP CODES: 550-555

	Non-Tobacco User										Tobacco User								
Age	Basic Plan	Rider A (Part A Ded)	Rider B (Part B Excess)	Rider C (Part B Ded)	Rider D (Prev Care)	High Deductible Plan	Copayment Plan	Extended Basic Plan (1)	Extended Basic Plan (2)	Age	Basic Plan	Rider A (Part A Ded)	Rider B (Part B Excess)	Rider C (Part B Ded)	Rider D (Prev Care)	High Deductible Plan	Copayment Plan	Extended Basic Plan (1)	Extended Basic Plan (2)
ALL	2,101.59	364.35	29.77	225.86	72.63	976.37	2,064.68	2,958.89	3,183.99	ALL	2,354.02	408.41	33.34	225.86	80.97	1,093.06	2,312.34	3,343.48	3,565.74

Extended Basic (1) is for those first eligible for Medicare Supplement after 1/1/20 (does not include the Part B Deductible Benefit)
Extended Basic (2) is for those first eligible for Medicare Supplement prior to 1/1/20 (includes the Part B Deductible Benefit)

**Rider C is not subject to area rating (NOTE: Rider C is not available to those newly eligible for Medicare after 1/1/2020).

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

LUMICO LIFE INSURANCE COMPANY

MINNESOTA Standard Plans UNISEX Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 550-555

	Non-Tobacco User										Tobacco User								
Age	Basic Plan	Rider A (Part A Ded)	Rider B (Part B Excess)	Rider C (Part B Ded)	Rider D (Prev Care)	High Deductible Plan	Copayment Plan	Extended Basic Plan (1)	Extended Basic Plan (2)	Age	Basic Plan	Rider A (Part A Ded)	Rider B (Part B Excess)	Rider C (Part B Ded)	Rider D (Prev Care)	High Deductible Plan	Copayment Plan	Extended Basic Plan (1)	Extended Basic Plan (2)
ALL	1,901.43	329.65	26.93	225.86	65.71	883.39	1,868.04	2,677.09	2,880.75	ALL	2,129.82	369.51	30.16	225.86	73.25	988.96	2,092.12	3,025.06	3,226.14

Extended Basic (1) is for those first eligible for Medicare Supplement after 1/1/20 (does not include the Part B Deductible Benefit)
Extended Basic (2) is for those first eligible for Medicare Supplement prior to 1/1/20 (includes the Part B Deductible Benefit)

**Rider C is not subject to area rating (NOTE: Rider C is not available to those newly eligible for Medicare after 1/1/2020).

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

PREMIUM INFORMATION

Lumico Life Insurance Company may change your premium if a new table of rates is applicable to the policy. We will give you 30 days advance written notice required by your state prior to any premium change. Any change in the table of rates must be approved by the Minnesota Department of Commerce.

These policies provide an anticipated loss ratio of 65%. This means that, on the average, you may expect that $65.00 of every $100.00 in premium will be returned as benefits to you over the life of the contract.

RENEWABILITY

This policy is guaranteed renewable as long as premiums are paid when due, subject to the grace period. You have the right to renew the policy, for consecutive terms, by payment of the required premium before the end of each grace period. This policy cannot be cancelled or nonrenewed on the grounds of the deterioration of your health for any reason other than the nonpayment of premium or material misrepresentation.

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 your insurance company. Additionally, it does not give all the details of Medicare coverage. Contact your local Social Security office or consult the Medicare handbook for more details

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to our Medicare Supplement Administrative Office at 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 within 10 days.

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.

COMPLETE ANSWERS ARE VERY IMPORTANT

The language in this section does not apply during open enrollment and guaranteed issue period.

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. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. **If you apply during the open enrollment or are eligible for guarantee issue, you do not need to provide your medical and health history.**

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

THESE POLICIES DO NOT COVER ALL MEDICAL EXPENSES BEYOND THOSE COVERED BY MEDICARE. THESE POLICIES DO NOT COVER ALL SKILLED NURSING HOME CARE EXPENSES AND DO NOT COVER CUSTODIAL OR RESIDENTIAL NURSING CARE. READ YOUR POLICY CAREFULLY TO DETERMINE WHICH NURSING HOME FACILITIES AND EXPENSES ARE COVERED BY YOUR POLICY.

Please refer to your policy for details.

$20 AND $50 COPAYMENT PLAN

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 through 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 through 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 physician'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 "Basic 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.

$20 AND $50 COPAYMENT PLAN

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

$20 AND $50 COPAYMENT PLAN

MEDICARE 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 EMERGENCY **Not Covered By Medicare**			
The Usual and Customary Charge for Hospital and medical expenses and supplies incurred as a result of a medical emergency during travel outside the United States.	$0	80% of covered charges	20%

ADDITIONAL BENEFITS

Diagnostic Procedures for Cancer: We will provide coverage for routine screening procedures for cancer and the office or facility visit, mammograms, including breast tomosynthesis for insureds who are at risk for breast cancer, surveillance tests for ovarian cancer for women who are at risk of ovarian cancer, pap smears and colorectal screening tests for men and women, when ordered by a Physician in accordance with the standard practice of medicine.

Diabetes Benefit: We will pay 80% of the expenses for: (1) all Physician prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes not otherwise covered under Part D of the Medicare program (regardless if You are enrolled in Part D); and (2) diabetes outpatient self-management training and education, including medical nutrition therapy, that is provided by a certified, registered, or licensed health care professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association. Coverage includes gestational, type I, or type II diabetes.

Routine Prostate Cancer Screening: We will pay the expense incurred for prostate cancer screening for men 40 years of age or older who are symptomatic or in a high risk category and for all men 50 years of age or older. The screening procedures will consist at a minimum of a prostate-specific antigen blood test and a digital rectal examination.

Alcoholism, Chemical Dependency or Drug Addiction Benefit: We will pay the Usual and Customary Charge for the treatment of alcoholism and chemical dependency on the same basis as any other medical condition when treatment is provided for: (a) Outpatient alcoholism and chemical dependency services that must not place a greater financial burden on You, or be more restrictive than those requirements and limitations for outpatient medical services; and (b) Inpatient hospital and residential alcoholism and chemical dependency services that must not place a greater financial burden on You, or be more restrictive than those requirements and limitations for inpatient hospital medical services. Benefits are not payable for that portion of expense paid by Medicare or paid under any other part of this Policy.

Scalp Hair Prostheses Benefit: We will pay the expenses incurred for any scalp hair prostheses worn for hair loss suffered as a result of alopecia areata. This benefit is limited to one prosthesis per Calendar Year.

Temporomandibular Joint Disorder and Craniomandibular Disorder Benefit: Coverage for the Usual and Customary Charge for the surgical and nonsurgical treatment of temporomandibular joint disorder and craniomandibular disorder on the same basis as that for treatment to any other joint in the body. Such treatment must be administered or prescribed by a Physician or dentist.

Reconstructive Surgery Benefit: We will pay benefits for reconstructive surgery when such service is incidental to or follows surgery resulting from Injury, Sickness or other diseases of the involved part. The coverage limitations on reconstructive surgery do not apply to reconstructive breast surgery following mastectomies. In these cases, coverage for reconstructive surgery must be provided if the mastectomy is Medically Necessary as determined by the attending Physician. Reconstructive surgery benefits include all stages of reconstruction of the breast on which the mastectomy was performed, surgery of the other breast to produce a symmetrical appearance and prosthesis and physical complications at all stages of the mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician. Benefits are not payable for that portion of expense for which benefits were paid by Medicare or under any other part of this Policy.

Outpatient Medical and Surgical Services Benefit: We will pay the Usual and Customary Charge for surgical center services for health care treatment or service rendered by a freestanding Ambulatory Surgical Center. Coverage for health care treatment or surgery on an outpatient basis at a facility equipped to perform these services, whether or not the facility is part of a Hospital, is provided on the same basis as that which would be covered in a Hospital. Benefits are not payable for that portion of expense for which benefits were paid by Medicare or under any other part of this Policy.

Lyme Disease Benefit: We will pay the expenses incurred for the treatment of diagnosed Lyme disease as any other medical service.

Immunization Benefits: We will pay 100% of the cost of immunizations not otherwise covered under Part D of the Medicare program.

Ventilator-Dependent Benefit: We will provide coverage for up to 120 hours of services provided by a private duty nurse or personal care assistant to You if You are a ventilator-dependent person and are in a Hospital. The personal care assistant or private duty nurse will perform only the services of communicator or interpreter for You during a transition period of up to 120 hours to assure adequate training of the hospital staff to communicate with You and to understand Your unique comfort, safety, and personal care needs.

Phenylketonuria Treatment Benefit: We will provide coverage for special dietary treatment for phenylketonuria when recommended by a Physician.

Mental Health Benefit: We will pay 100% of the cost sharing of Medicare Eligible Expenses for inpatient hospital and outpatient mental health covered services that are intended to treat or ameliorate an emotional, behavioral, or psychiatric condition if they are Medically Necessary.

Court-Ordered Mental Health Services: We will pay the Usual and Customary Charge for mental health services ordered by a court of competent jurisdiction under a court order that is issued on the basis of a behavioral care evaluation performed by a licensed psychiatrist or a doctoral level licensed psychologist, which includes a diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment. You may be required to send Us a copy of the court order and the behavioral care evaluation.