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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 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.

[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

NEW MEXICO Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 871

	Preferred					Standard			
Attained Age	Plan A	Plan F	Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	Plan N
65	1,385	1,755	1,413	1,123	65	1,540	1,949	1,572	1,248
66	1,385	1,755	1,413	1,123	66	1,540	1,949	1,572	1,248
67	1,385	1,809	1,413	1,123	67	1,540	2,010	1,572	1,248
68	1,426	1,863	1,455	1,156	68	1,584	2,070	1,618	1,284
69	1,469	1,918	1,499	1,191	69	1,632	2,133	1,666	1,324
70	1,513	1,976	1,545	1,226	70	1,681	2,197	1,716	1,363
71	1,557	2,036	1,590	1,264	71	1,731	2,262	1,768	1,404
72	1,605	2,097	1,640	1,302	72	1,783	2,330	1,821	1,447
73	1,653	2,160	1,687	1,341	73	1,836	2,401	1,875	1,490
74	1,702	2,225	1,738	1,381	74	1,891	2,471	1,932	1,533
75	1,761	2,303	1,799	1,429	75	1,958	2,558	1,999	1,587
76	1,823	2,384	1,862	1,480	76	2,026	2,647	2,069	1,642
77	1,886	2,467	1,927	1,531	77	2,097	2,740	2,142	1,700
78	1,951	2,553	1,995	1,585	78	2,171	2,835	2,216	1,759
79	2,020	2,643	2,065	1,640	79	2,247	2,934	2,294	1,821
80	2,091	2,735	2,137	1,698	80	2,326	3,037	2,374	1,885
81	2,164	2,831	2,212	1,757	81	2,407	3,143	2,456	1,950
82	2,239	2,930	2,290	1,819	82	2,491	3,253	2,543	2,019
83	2,317	3,033	2,369	1,883	83	2,578	3,368	2,632	2,089
84	2,399	3,139	2,452	1,948	84	2,669	3,485	2,724	2,162
85	2,483	3,249	2,538	2,017	85	2,762	3,607	2,820	2,238
86	2,570	3,362	2,628	2,087	86	2,859	3,732	2,918	2,317
87	2,661	3,480	2,720	2,160	87	2,959	3,863	3,020	2,397
88	2,754	3,601	2,816	2,236	88	3,063	3,999	3,126	2,481
89	2,851	3,727	2,914	2,315	89	3,170	4,139	3,235	2,568
90	2,951	3,857	3,016	2,395	90	3,281	4,283	3,349	2,658
91	3,054	3,992	3,122	2,479	91	3,396	4,433	3,466	2,751
92	3,161	4,132	3,231	2,566	92	3,514	4,588	3,588	2,847
93	3,271	4,276	3,345	2,656	93	3,637	4,748	3,714	2,946
94	3,385	4,426	3,462	2,749	94	3,764	4,915	3,844	3,049
95	3,504	4,581	3,583	2,844	95	3,896	5,086	3,979	3,156
96	3,626	4,741	3,708	2,944	96	4,032	5,264	4,118	3,266
97	3,753	4,907	3,838	3,047	97	4,173	5,448	4,262	3,380
98	3,884	5,079	3,972	3,154	98	4,319	5,638	4,411	3,499
99	4,020	5,257	4,111	3,264	99	4,470	5,836	4,565	3,621

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

Household Discount Factor .93

LUMICO LIFE INSURANCE COMPANY

NEW MEXICO Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 871

	Preferred					Standard			
Attained Age	Plan A	Plan F	Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	Plan N
65	1,300	1,648	1,326	1,055	65	1,445	1,830	1,475	1,171
66	1,300	1,648	1,326	1,055	66	1,445	1,830	1,475	1,171
67	1,300	1,698	1,326	1,055	67	1,445	1,887	1,475	1,171
68	1,339	1,749	1,366	1,085	68	1,487	1,943	1,519	1,205
69	1,379	1,801	1,407	1,118	69	1,532	2,003	1,564	1,243
70	1,420	1,855	1,451	1,151	70	1,578	2,062	1,611	1,279
71	1,462	1,911	1,493	1,186	71	1,625	2,124	1,660	1,318
72	1,507	1,969	1,539	1,222	72	1,674	2,187	1,710	1,359
73	1,552	2,028	1,584	1,259	73	1,724	2,254	1,760	1,399
74	1,598	2,089	1,632	1,296	74	1,775	2,320	1,813	1,439
75	1,653	2,162	1,689	1,342	75	1,838	2,401	1,876	1,490
76	1,711	2,238	1,748	1,389	76	1,902	2,485	1,942	1,542
77	1,771	2,316	1,809	1,438	77	1,969	2,572	2,010	1,596
78	1,832	2,397	1,872	1,488	78	2,038	2,662	2,080	1,652
79	1,896	2,481	1,938	1,540	79	2,109	2,754	2,153	1,709
80	1,963	2,568	2,006	1,594	80	2,183	2,851	2,228	1,769
81	2,031	2,658	2,076	1,650	81	2,260	2,951	2,306	1,831
82	2,102	2,750	2,149	1,708	82	2,339	3,054	2,387	1,895
83	2,176	2,847	2,224	1,767	83	2,421	3,161	2,471	1,962
84	2,252	2,947	2,302	1,829	84	2,505	3,272	2,557	2,030
85	2,331	3,050	2,383	1,893	85	2,593	3,386	2,647	2,101
86	2,413	3,156	2,467	1,960	86	2,684	3,504	2,740	2,175
87	2,498	3,267	2,553	2,028	87	2,778	3,627	2,835	2,251
88	2,585	3,381	2,643	2,099	88	2,875	3,754	2,935	2,329
89	2,676	3,499	2,736	2,173	89	2,976	3,886	3,037	2,411
90	2,770	3,621	2,831	2,249	90	3,080	4,021	3,144	2,495
91	2,867	3,748	2,931	2,327	91	3,188	4,162	3,254	2,582
92	2,967	3,879	3,033	2,409	92	3,299	4,307	3,368	2,672
93	3,071	4,014	3,140	2,493	93	3,414	4,458	3,487	2,766
94	3,178	4,155	3,250	2,580	94	3,533	4,614	3,609	2,863
95	3,289	4,300	3,364	2,670	95	3,657	4,775	3,735	2,963
96	3,404	4,451	3,481	2,764	96	3,785	4,942	3,866	3,066
97	3,523	4,607	3,603	2,861	97	3,918	5,114	4,001	3,174
98	3,646	4,768	3,729	2,961	98	4,054	5,293	4,141	3,284
99	3,774	4,935	3,859	3,065	99	4,196	5,478	4,286	3,399

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

Household Discount Factor .93

LUMICO LIFE INSURANCE COMPANY

NEW MEXICO Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 871

	Preferred					Standard			
Attained Age	Plan A	Plan F	Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	Plan N
65	1,236	1,566	1,263	1,002	65	1,374	1,740	1,404	1,114
66	1,236	1,566	1,263	1,002	66	1,374	1,740	1,404	1,114
67	1,236	1,615	1,263	1,002	67	1,374	1,794	1,404	1,114
68	1,274	1,663	1,300	1,033	68	1,414	1,849	1,444	1,147
69	1,311	1,713	1,338	1,063	69	1,458	1,905	1,488	1,182
70	1,351	1,764	1,379	1,095	70	1,501	1,961	1,533	1,217
71	1,391	1,817	1,420	1,129	71	1,546	2,019	1,578	1,253
72	1,433	1,872	1,463	1,162	72	1,593	2,080	1,626	1,291
73	1,475	1,929	1,506	1,197	73	1,640	2,144	1,673	1,330
74	1,520	1,987	1,552	1,232	74	1,688	2,207	1,725	1,369
75	1,573	2,056	1,606	1,276	75	1,748	2,284	1,786	1,416
76	1,628	2,128	1,663	1,320	76	1,809	2,364	1,849	1,466
77	1,685	2,203	1,721	1,367	77	1,872	2,447	1,914	1,517
78	1,745	2,280	1,780	1,414	78	1,938	2,533	1,981	1,571
79	1,806	2,360	1,842	1,464	79	2,006	2,621	2,050	1,625
80	1,869	2,442	1,906	1,515	80	2,076	2,713	2,122	1,682
81	1,935	2,527	1,974	1,569	81	2,149	2,807	2,196	1,740
82	2,002	2,616	2,043	1,623	82	2,224	2,906	2,273	1,801
83	2,072	2,707	2,114	1,680	83	2,302	3,008	2,353	1,863
84	2,145	2,802	2,188	1,738	84	2,382	3,113	2,434	1,929
85	2,220	2,900	2,264	1,799	85	2,465	3,222	2,519	1,997
86	2,298	3,002	2,343	1,861	86	2,551	3,334	2,608	2,066
87	2,378	3,107	2,425	1,927	87	2,641	3,451	2,699	2,139
88	2,461	3,216	2,510	1,995	88	2,733	3,571	2,793	2,214
89	2,547	3,328	2,598	2,064	89	2,829	3,696	2,891	2,291
90	2,637	3,444	2,690	2,137	90	2,928	3,825	2,992	2,371
91	2,729	3,565	2,784	2,212	91	3,031	3,959	3,097	2,454
92	2,825	3,690	2,882	2,289	92	3,137	4,097	3,205	2,540
93	2,924	3,819	2,982	2,369	93	3,247	4,241	3,317	2,628
94	3,025	3,953	3,086	2,452	94	3,360	4,390	3,434	2,720
95	3,132	4,091	3,194	2,538	95	3,478	4,543	3,553	2,815
96	3,241	4,235	3,307	2,626	96	3,599	4,702	3,677	2,914
97	3,354	4,383	3,422	2,718	97	3,725	4,867	3,806	3,016
98	3,472	4,537	3,542	2,813	98	3,855	5,037	3,940	3,122
99	3,593	4,696	3,666	2,912	99	3,990	5,214	4,077	3,231

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

Household Discount Factor .93

LUMICO LIFE INSURANCE COMPANY

NEW MEXICO Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 871

	Preferred					Standard			
Attained Age	Plan A	Plan F	Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	Plan N
65	1,160	1,470	1,186	941	65	1,290	1,634	1,318	1,046
66	1,160	1,470	1,186	941	66	1,290	1,634	1,318	1,046
67	1,160	1,516	1,186	941	67	1,290	1,685	1,318	1,046
68	1,196	1,562	1,220	969	68	1,327	1,735	1,356	1,076
69	1,231	1,608	1,257	998	69	1,368	1,788	1,396	1,110
70	1,268	1,656	1,295	1,028	70	1,409	1,841	1,439	1,143
71	1,306	1,706	1,333	1,059	71	1,451	1,895	1,481	1,176
72	1,345	1,758	1,374	1,091	72	1,495	1,953	1,527	1,212
73	1,385	1,811	1,414	1,124	73	1,539	2,013	1,571	1,249
74	1,427	1,865	1,457	1,157	74	1,585	2,072	1,619	1,285
75	1,477	1,931	1,508	1,198	75	1,641	2,144	1,676	1,329
76	1,528	1,998	1,561	1,239	76	1,698	2,219	1,735	1,376
77	1,582	2,068	1,615	1,283	77	1,758	2,298	1,797	1,424
78	1,638	2,140	1,671	1,328	78	1,819	2,378	1,860	1,474
79	1,695	2,216	1,730	1,374	79	1,883	2,461	1,925	1,526
80	1,755	2,293	1,790	1,422	80	1,949	2,546	1,992	1,579
81	1,816	2,373	1,853	1,473	81	2,017	2,635	2,062	1,634
82	1,880	2,456	1,918	1,524	82	2,088	2,728	2,134	1,691
83	1,945	2,542	1,985	1,577	83	2,161	2,824	2,209	1,749
84	2,014	2,630	2,054	1,632	84	2,236	2,922	2,285	1,811
85	2,084	2,722	2,126	1,689	85	2,314	3,025	2,365	1,874
86	2,157	2,818	2,200	1,747	86	2,395	3,130	2,448	1,940
87	2,232	2,916	2,277	1,809	87	2,479	3,239	2,534	2,008
88	2,310	3,019	2,356	1,872	88	2,566	3,353	2,622	2,078
89	2,391	3,124	2,439	1,938	89	2,656	3,470	2,714	2,151
90	2,475	3,234	2,525	2,006	90	2,748	3,591	2,809	2,226
91	2,562	3,347	2,614	2,076	91	2,845	3,717	2,907	2,304
92	2,652	3,464	2,705	2,149	92	2,945	3,847	3,009	2,384
93	2,745	3,585	2,800	2,224	93	3,048	3,981	3,114	2,468
94	2,840	3,711	2,897	2,302	94	3,155	4,121	3,224	2,554
95	2,940	3,841	2,999	2,382	95	3,265	4,265	3,336	2,643
96	3,042	3,975	3,104	2,466	96	3,379	4,415	3,452	2,736
97	3,149	4,115	3,213	2,552	97	3,497	4,569	3,573	2,831
98	3,259	4,259	3,325	2,641	98	3,619	4,729	3,699	2,931
99	3,373	4,409	3,441	2,734	99	3,746	4,895	3,828	3,033

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 given at least sixty (60) days advance written notice 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 $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*	$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	$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

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

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* 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	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.