Lumico
medigap solutions
Underwritten by
Elips Life Insurance Company

Elips Life Insurance Company
Home: 1450 American Lane, Suite 1100,Schaumburg, IL 60173
Admin: P.O. Box 10875, Clearwater, FL 33757
Elipslife.lumico.com

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE

BENEFIT PLANS A, F, G, N AND HIGH DEDUCTIBLE PLAN G

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.

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[1]	K	L	M	N	C	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.

ELIPS LIFE INSURANCE COMPANY

OHIO Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 436, 440-445

	Preferred						Standard				
				HD						HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
65	1,667	2,050	1,686	689	1,331	65	1,851	2,279	1,872	764	1,479
66	1,667	2,050	1,686	689	1,331	66	1,851	2,279	1,872	764	1,479
67	1,667	2,050	1,686	689	1,331	67	1,851	2,279	1,872	764	1,479
68	1,667	2,050	1,686	689	1,331	68	1,851	2,279	1,872	764	1,479
69	1,667	2,050	1,686	689	1,371	69	1,851	2,279	1,872	764	1,522
70	1,717	2,112	1,736	709	1,412	70	1,907	2,347	1,929	787	1,568
71	1,769	2,175	1,787	731	1,455	71	1,964	2,418	1,986	811	1,615
72	1,822	2,241	1,842	752	1,499	72	2,023	2,491	2,045	835	1,664
73	1,876	2,308	1,897	774	1,544	73	2,084	2,565	2,107	860	1,714
74	1,935	2,380	1,957	798	1,593	74	2,149	2,646	2,173	887	1,768
75	1,999	2,459	2,021	825	1,645	75	2,219	2,732	2,244	916	1,826
76	2,068	2,543	2,090	853	1,702	76	2,295	2,825	2,322	947	1,888
77	2,141	2,634	2,165	883	1,763	77	2,377	2,927	2,405	981	1,956
78	2,221	2,731	2,244	916	1,828	78	2,466	3,036	2,495	1,017	2,029
79	2,307	2,836	2,330	951	1,898	79	2,560	3,153	2,591	1,056	2,106
80	2,399	2,949	2,424	989	1,975	80	2,662	3,279	2,694	1,099	2,190
81	2,495	3,067	2,521	1,029	2,054	81	2,769	3,410	2,802	1,143	2,278
82	2,595	3,189	2,622	1,070	2,136	82	2,880	3,547	2,914	1,188	2,370
83	2,698	3,317	2,726	1,113	2,222	83	2,995	3,688	3,031	1,236	2,465
84	2,806	3,449	2,835	1,158	2,311	84	3,115	3,836	3,152	1,284	2,564
85	2,918	3,587	2,948	1,204	2,403	85	3,240	3,989	3,279	1,336	2,667
86	3,034	3,731	3,066	1,252	2,500	86	3,369	4,148	3,410	1,390	2,773
87	3,156	3,880	3,189	1,302	2,600	87	3,504	4,314	3,547	1,445	2,885
88	3,283	4,035	3,317	1,355	2,704	88	3,644	4,486	3,688	1,502	3,000
89	3,414	4,197	3,450	1,408	2,812	89	3,790	4,666	3,835	1,563	3,120
90	3,550	4,365	3,587	1,465	2,925	90	3,941	4,852	3,989	1,625	3,245
91	3,693	4,540	3,731	1,524	3,041	91	4,098	5,047	4,149	1,690	3,376
92	3,840	4,721	3,880	1,585	3,163	92	4,262	5,249	4,314	1,758	3,511
93	3,994	4,910	4,034	1,649	3,289	93	4,432	5,459	4,486	1,828	3,651
94	4,154	5,107	4,195	1,715	3,421	94	4,609	5,677	4,666	1,901	3,798
95	4,319	5,312	4,364	1,784	3,557	95	4,794	5,904	4,853	1,977	3,950
96	4,493	5,525	4,538	1,856	3,700	96	4,985	6,141	5,047	2,056	4,108
97	4,493	5,525	4,538	1,856	3,700	97	4,985	6,141	5,047	2,056	4,108
98	4,493	5,525	4,538	1,856	3,700	98	4,985	6,141	5,047	2,056	4,108
99	4,493	5,525	4,538	1,856	3,700	99	4,985	6,141	5,047	2,056	4,108

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

Household Discount Factor .93

ELIPS LIFE INSURANCE COMPANY

OHIO Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 450-454

	Preferred						Standard					
				HD						HD		
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
65	1,582	1,945	1,599	654	1,263	65	1,756	2,162	1,776	725	1,403
66	1,582	1,945	1,599	654	1,263	66	1,756	2,162	1,776	725	1,403
67	1,582	1,945	1,599	654	1,263	67	1,756	2,162	1,776	725	1,403
68	1,582	1,945	1,599	654	1,263	68	1,756	2,162	1,776	725	1,403
69	1,582	1,945	1,599	654	1,301	69	1,756	2,162	1,776	725	1,444
70	1,629	2,004	1,647	673	1,340	70	1,809	2,227	1,830	747	1,487
71	1,678	2,064	1,696	693	1,380	71	1,864	2,294	1,885	769	1,532
72	1,728	2,126	1,747	713	1,422	72	1,920	2,363	1,941	792	1,579
73	1,780	2,190	1,800	735	1,465	73	1,977	2,434	1,999	816	1,626
74	1,836	2,258	1,857	757	1,511	74	2,038	2,510	2,062	842	1,677
75	1,896	2,333	1,917	782	1,561	75	2,105	2,592	2,129	869	1,732
76	1,962	2,413	1,983	810	1,614	76	2,177	2,681	2,203	899	1,792
77	2,031	2,499	2,054	838	1,673	77	2,255	2,777	2,282	931	1,856
78	2,107	2,591	2,129	869	1,734	78	2,339	2,880	2,367	965	1,925
79	2,189	2,691	2,211	902	1,801	79	2,429	2,991	2,458	1,002	1,998
80	2,276	2,798	2,300	938	1,874	80	2,526	3,111	2,556	1,043	2,078
81	2,367	2,910	2,392	976	1,948	81	2,627	3,235	2,659	1,084	2,161
82	2,462	3,026	2,487	1,015	2,027	82	2,732	3,365	2,765	1,127	2,248
83	2,559	3,147	2,586	1,056	2,108	83	2,841	3,499	2,875	1,172	2,338
84	2,662	3,273	2,690	1,098	2,192	84	2,956	3,639	2,991	1,219	2,432
85	2,768	3,403	2,797	1,142	2,280	85	3,073	3,785	3,111	1,267	2,530
86	2,879	3,539	2,909	1,188	2,372	86	3,196	3,935	3,235	1,318	2,631
87	2,994	3,681	3,026	1,235	2,467	87	3,324	4,093	3,365	1,371	2,737
88	3,114	3,828	3,147	1,285	2,565	88	3,457	4,256	3,499	1,425	2,846
89	3,239	3,982	3,273	1,336	2,668	89	3,596	4,426	3,639	1,482	2,960
90	3,368	4,141	3,403	1,390	2,775	90	3,739	4,603	3,784	1,542	3,079
91	3,503	4,307	3,540	1,446	2,885	91	3,888	4,788	3,936	1,604	3,203
92	3,643	4,479	3,681	1,504	3,001	92	4,043	4,980	4,093	1,668	3,331
93	3,789	4,658	3,828	1,564	3,121	93	4,205	5,179	4,256	1,734	3,464
94	3,941	4,845	3,980	1,627	3,245	94	4,373	5,386	4,427	1,803	3,603
95	4,098	5,040	4,140	1,693	3,375	95	4,548	5,602	4,604	1,876	3,747
96	4,262	5,242	4,305	1,761	3,511	96	4,730	5,826	4,788	1,951	3,897
97	4,262	5,242	4,305	1,761	3,511	97	4,730	5,826	4,788	1,951	3,897
98	4,262	5,242	4,305	1,761	3,511	98	4,730	5,826	4,788	1,951	3,897
99	4,262	5,242	4,305	1,761	3,511	99	4,730	5,826	4,788	1,951	3,897

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

Household Discount Factor .93

ELIPS LIFE INSURANCE COMPANY

OHIO Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 436, 440-445, 450-454

	Preferred						Standard					
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,496	1,840	1,513	619	1,194	65	1,661	2,045	1,680	686	1,327
66	1,496	1,840	1,513	619	1,194	66	1,661	2,045	1,680	686	1,327
67	1,496	1,840	1,513	619	1,194	67	1,661	2,045	1,680	686	1,327
68	1,496	1,840	1,513	619	1,194	68	1,661	2,045	1,680	686	1,327
69	1,496	1,840	1,513	619	1,230	69	1,661	2,045	1,680	686	1,366
70	1,541	1,896	1,558	636	1,267	70	1,711	2,107	1,731	706	1,407
71	1,588	1,952	1,604	656	1,306	71	1,763	2,170	1,783	728	1,450
72	1,635	2,011	1,653	675	1,345	72	1,816	2,235	1,836	749	1,493
73	1,684	2,071	1,702	695	1,385	73	1,870	2,302	1,891	771	1,538
74	1,736	2,136	1,756	716	1,429	74	1,928	2,374	1,950	796	1,587
75	1,794	2,207	1,814	740	1,477	75	1,991	2,452	2,014	822	1,638
76	1,856	2,282	1,875	766	1,527	76	2,059	2,536	2,084	850	1,695
77	1,922	2,364	1,943	793	1,582	77	2,133	2,626	2,159	881	1,755
78	1,993	2,451	2,014	822	1,641	78	2,213	2,724	2,239	913	1,821
79	2,070	2,545	2,091	854	1,704	79	2,298	2,829	2,325	948	1,890
80	2,153	2,646	2,175	887	1,772	80	2,389	2,942	2,418	986	1,966
81	2,239	2,753	2,262	923	1,843	81	2,485	3,060	2,515	1,026	2,044
82	2,328	2,862	2,353	960	1,917	82	2,584	3,183	2,615	1,066	2,127
83	2,421	2,977	2,446	999	1,994	83	2,688	3,310	2,720	1,109	2,212
84	2,518	3,096	2,545	1,039	2,074	84	2,796	3,442	2,829	1,153	2,301
85	2,618	3,219	2,646	1,081	2,157	85	2,907	3,580	2,943	1,199	2,393
86	2,723	3,348	2,752	1,123	2,243	86	3,023	3,723	3,061	1,247	2,489
87	2,832	3,482	2,862	1,168	2,333	87	3,144	3,871	3,183	1,297	2,589
88	2,946	3,621	2,977	1,216	2,427	88	3,270	4,026	3,310	1,348	2,692
89	3,064	3,766	3,096	1,264	2,523	89	3,401	4,187	3,442	1,402	2,800
90	3,186	3,917	3,219	1,315	2,625	90	3,537	4,355	3,580	1,459	2,913
91	3,314	4,074	3,348	1,367	2,729	91	3,678	4,529	3,723	1,517	3,030
92	3,446	4,237	3,482	1,423	2,838	92	3,825	4,711	3,872	1,578	3,151
93	3,584	4,406	3,621	1,480	2,952	93	3,978	4,899	4,026	1,641	3,277
94	3,728	4,583	3,765	1,540	3,070	94	4,137	5,095	4,187	1,706	3,409
95	3,876	4,767	3,916	1,601	3,193	95	4,302	5,299	4,355	1,775	3,545
96	4,032	4,958	4,073	1,665	3,321	96	4,474	5,511	4,529	1,845	3,686
97	4,032	4,958	4,073	1,665	3,321	97	4,474	5,511	4,529	1,845	3,686
98	4,032	4,958	4,073	1,665	3,321	98	4,474	5,511	4,529	1,845	3,686
99	4,032	4,958	4,073	1,665	3,321	99	4,474	5,511	4,529	1,845	3,686

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

Household Discount Factor .93

ELIPS LIFE INSURANCE COMPANY

OHIO Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 436, 440-445

	Preferred						Standard					
				HD						HD		
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
65	1,489	1,831	1,504	613	1,189	65	1,654	2,036	1,672	682	1,318
66	1,489	1,831	1,504	613	1,189	66	1,654	2,036	1,672	682	1,318
67	1,489	1,831	1,504	613	1,189	67	1,654	2,036	1,672	682	1,318
68	1,489	1,831	1,504	613	1,189	68	1,654	2,036	1,672	682	1,318
69	1,489	1,831	1,504	613	1,224	69	1,654	2,036	1,672	682	1,358
70	1,533	1,886	1,549	632	1,261	70	1,703	2,096	1,722	702	1,400
71	1,579	1,943	1,596	650	1,298	71	1,754	2,159	1,774	723	1,442
72	1,627	2,001	1,644	670	1,337	72	1,807	2,224	1,827	744	1,486
73	1,676	2,061	1,693	690	1,377	73	1,861	2,291	1,882	767	1,531
74	1,728	2,125	1,746	712	1,421	74	1,920	2,363	1,941	791	1,579
75	1,785	2,195	1,803	736	1,467	75	1,983	2,441	2,005	817	1,630
76	1,846	2,270	1,865	761	1,517	76	2,050	2,525	2,074	845	1,687
77	1,913	2,351	1,931	788	1,571	77	2,124	2,615	2,147	875	1,747
78	1,984	2,438	2,002	817	1,630	78	2,203	2,713	2,227	907	1,812
79	2,060	2,533	2,080	848	1,693	79	2,287	2,818	2,313	942	1,882
80	2,143	2,634	2,163	882	1,761	80	2,378	2,931	2,405	980	1,957
81	2,228	2,739	2,249	917	1,831	81	2,473	3,047	2,501	1,019	2,035
82	2,318	2,848	2,339	954	1,903	82	2,572	3,170	2,601	1,060	2,116
83	2,410	2,962	2,432	991	1,980	83	2,676	3,297	2,705	1,103	2,202
84	2,506	3,080	2,529	1,031	2,059	84	2,783	3,428	2,813	1,147	2,289
85	2,607	3,204	2,630	1,073	2,141	85	2,894	3,565	2,926	1,193	2,381
86	2,711	3,332	2,736	1,115	2,227	86	3,010	3,708	3,043	1,241	2,476
87	2,819	3,465	2,845	1,160	2,316	87	3,130	3,857	3,165	1,291	2,575
88	2,932	3,604	2,959	1,207	2,408	88	3,256	4,010	3,291	1,342	2,678
89	3,049	3,749	3,077	1,256	2,505	89	3,386	4,171	3,423	1,396	2,784
90	3,171	3,899	3,200	1,306	2,605	90	3,521	4,337	3,559	1,452	2,896
91	3,297	4,055	3,328	1,358	2,709	91	3,662	4,511	3,701	1,510	3,011
92	3,429	4,217	3,461	1,412	2,817	92	3,808	4,691	3,850	1,570	3,131
93	3,566	4,385	3,600	1,469	2,930	93	3,961	4,879	4,004	1,633	3,257
94	3,709	4,561	3,743	1,527	3,047	94	4,119	5,074	4,163	1,698	3,387
95	3,857	4,743	3,893	1,589	3,169	95	4,284	5,278	4,330	1,766	3,522
96	4,012	4,932	4,049	1,653	3,296	96	4,455	5,489	4,504	1,836	3,663
97	4,012	4,932	4,049	1,653	3,296	97	4,455	5,489	4,504	1,836	3,663
98	4,012	4,932	4,049	1,653	3,296	98	4,455	5,489	4,504	1,836	3,663
99	4,012	4,932	4,049	1,653	3,296	99	4,455	5,489	4,504	1,836	3,663

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

Household Discount Factor .93

ELIPS LIFE INSURANCE COMPANY

OHIO Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 450-454

	Preferred						Standard				
				HD						HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
65	1,413	1,737	1,427	581	1,128	65	1,569	1,932	1,586	647	1,251
66	1,413	1,737	1,427	581	1,128	66	1,569	1,932	1,586	647	1,251
67	1,413	1,737	1,427	581	1,128	67	1,569	1,932	1,586	647	1,251
68	1,413	1,737	1,427	581	1,128	68	1,569	1,932	1,586	647	1,251
69	1,413	1,737	1,427	581	1,161	69	1,569	1,932	1,586	647	1,289
70	1,455	1,790	1,470	599	1,196	70	1,615	1,989	1,634	666	1,328
71	1,498	1,843	1,514	617	1,232	71	1,664	2,049	1,683	686	1,368
72	1,543	1,898	1,559	636	1,268	72	1,714	2,110	1,733	706	1,410
73	1,590	1,955	1,606	655	1,307	73	1,766	2,173	1,786	728	1,453
74	1,640	2,016	1,656	675	1,348	74	1,822	2,242	1,841	750	1,498
75	1,693	2,082	1,711	698	1,392	75	1,881	2,315	1,902	775	1,547
76	1,752	2,153	1,769	722	1,440	76	1,945	2,395	1,967	801	1,600
77	1,815	2,231	1,832	748	1,491	77	2,015	2,481	2,037	830	1,657
78	1,882	2,313	1,900	775	1,547	78	2,090	2,573	2,113	861	1,719
79	1,955	2,403	1,973	805	1,606	79	2,170	2,673	2,195	894	1,786
80	2,033	2,499	2,052	837	1,670	80	2,256	2,780	2,282	930	1,857
81	2,114	2,598	2,134	870	1,737	81	2,346	2,891	2,373	966	1,931
82	2,199	2,702	2,219	905	1,806	82	2,441	3,007	2,467	1,006	2,008
83	2,287	2,810	2,308	940	1,878	83	2,538	3,128	2,566	1,046	2,089
84	2,378	2,922	2,400	978	1,953	84	2,640	3,253	2,669	1,088	2,172
85	2,473	3,039	2,495	1,018	2,032	85	2,746	3,382	2,776	1,132	2,259
86	2,572	3,162	2,596	1,058	2,113	86	2,855	3,518	2,887	1,177	2,349
87	2,675	3,287	2,699	1,101	2,197	87	2,970	3,659	3,002	1,224	2,443
88	2,782	3,420	2,808	1,145	2,285	88	3,089	3,805	3,122	1,273	2,540
89	2,893	3,557	2,920	1,191	2,376	89	3,212	3,957	3,247	1,324	2,642
90	3,008	3,699	3,036	1,239	2,472	90	3,340	4,115	3,376	1,378	2,747
91	3,128	3,847	3,157	1,289	2,570	91	3,474	4,279	3,512	1,433	2,857
92	3,253	4,000	3,283	1,340	2,672	92	3,613	4,450	3,653	1,490	2,971
93	3,383	4,160	3,415	1,393	2,779	93	3,758	4,628	3,798	1,549	3,090
94	3,519	4,327	3,551	1,449	2,891	94	3,908	4,814	3,950	1,611	3,213
95	3,660	4,500	3,693	1,507	3,007	95	4,064	5,007	4,108	1,675	3,342
96	3,807	4,679	3,841	1,568	3,127	96	4,226	5,208	4,273	1,742	3,475
97	3,807	4,679	3,841	1,568	3,127	97	4,226	5,208	4,273	1,742	3,475
98	3,807	4,679	3,841	1,568	3,127	98	4,226	5,208	4,273	1,742	3,475
99	3,807	4,679	3,841	1,568	3,127	99	4,226	5,208	4,273	1,742	3,475

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

Household Discount Factor .93

ELIPS LIFE INSURANCE COMPANY

OHIO Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 436, 440-445, 450-454

	Preferred						Standard				
				HD						HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
65	1,336	1,643	1,349	550	1,067	65	1,484	1,827	1,501	612	1,183
66	1,336	1,643	1,349	550	1,067	66	1,484	1,827	1,501	612	1,183
67	1,336	1,643	1,349	550	1,067	67	1,484	1,827	1,501	612	1,183
68	1,336	1,643	1,349	550	1,067	68	1,484	1,827	1,501	612	1,183
69	1,336	1,643	1,349	550	1,099	69	1,484	1,827	1,501	612	1,219
70	1,376	1,693	1,390	567	1,131	70	1,528	1,881	1,546	630	1,256
71	1,417	1,743	1,432	584	1,165	71	1,574	1,938	1,592	649	1,294
72	1,460	1,795	1,475	602	1,200	72	1,622	1,996	1,639	668	1,334
73	1,504	1,850	1,519	620	1,236	73	1,670	2,056	1,689	688	1,374
74	1,551	1,907	1,567	639	1,275	74	1,723	2,121	1,742	710	1,417
75	1,602	1,970	1,618	660	1,317	75	1,779	2,190	1,799	733	1,463
76	1,657	2,037	1,674	683	1,362	76	1,840	2,266	1,861	758	1,514
77	1,717	2,110	1,733	707	1,410	77	1,906	2,347	1,927	785	1,568
78	1,781	2,188	1,797	733	1,463	78	1,977	2,434	1,999	814	1,626
79	1,849	2,273	1,867	761	1,519	79	2,053	2,529	2,076	846	1,689
80	1,923	2,364	1,942	792	1,580	80	2,134	2,630	2,159	879	1,757
81	2,000	2,458	2,019	823	1,643	81	2,219	2,735	2,245	914	1,826
82	2,080	2,556	2,099	856	1,708	82	2,309	2,845	2,334	951	1,899
83	2,163	2,658	2,183	890	1,777	83	2,401	2,959	2,428	990	1,976
84	2,249	2,764	2,270	926	1,848	84	2,497	3,077	2,525	1,029	2,055
85	2,340	2,875	2,360	963	1,922	85	2,597	3,199	2,626	1,071	2,137
86	2,433	2,991	2,455	1,001	1,998	86	2,701	3,328	2,731	1,113	2,222
87	2,530	3,110	2,553	1,041	2,078	87	2,809	3,461	2,840	1,158	2,311
88	2,632	3,235	2,656	1,083	2,161	88	2,922	3,599	2,954	1,204	2,403
89	2,736	3,364	2,762	1,127	2,248	89	3,038	3,743	3,072	1,253	2,499
90	2,846	3,499	2,872	1,172	2,338	90	3,160	3,893	3,194	1,303	2,599
91	2,959	3,639	2,987	1,219	2,431	91	3,287	4,048	3,322	1,355	2,702
92	3,077	3,784	3,106	1,267	2,528	92	3,418	4,210	3,455	1,409	2,810
93	3,201	3,935	3,230	1,318	2,629	93	3,554	4,378	3,593	1,465	2,923
94	3,328	4,093	3,359	1,371	2,735	94	3,697	4,554	3,736	1,524	3,040
95	3,462	4,257	3,494	1,426	2,844	95	3,844	4,737	3,886	1,584	3,161
96	3,601	4,427	3,634	1,483	2,958	96	3,998	4,926	4,042	1,647	3,287
97	3,601	4,427	3,634	1,483	2,958	97	3,998	4,926	4,042	1,647	3,287
98	3,601	4,427	3,634	1,483	2,958	98	3,998	4,926	4,042	1,647	3,287
99	3,601	4,427	3,634	1,483	2,958	99	3,998	4,926	4,042	1,647	3,287

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

Household Discount Factor .93

PREMIUM INFORMATION

We, Elips Life Insurance Company can only raise your premium if we raise the premium for all policies like yours in this State. Premiums are based on your attained age and will change on your policy anniversary date.

PREFERRED AND STANDARD PREMIUMS

Preferred and Standard premiums are shown on the premium charts. You are eligible for Preferred premiums if:

1. You apply for your Medicare Supplement insurance policy during the 6-month open enrollment period that begins on your Part B date.

2. You apply for your Medicare Supplement insurance policy during your eligible guaranteed issue period, or

3. Your answer is “no” to the question on the application that asks, “Within the past twelve (12) months, have you used any tobacco or nicotine products, including cigarettes, cigars, pipe, vapes, chewing tobacco, nicotine gum/patches, eCigarettes?”

HOUSEHOLD DISCOUNT

You are eligible for a household discount if, for the past year, you have resided with one other Medicare-eligible adult who owns or who will be issued a Medicare Supplement policy from us. If you live with another adult who is your legal spouse, we will waive the one (1) year requirement. We may request additional documentation to determine eligibility.

Your policy's household premium discount will be terminated if the other Medicare Supplement policyholder chooses to terminate his or her Medicare Supplement policy or he or she no longer resides with you.

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 Elips Life Insurance Company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to: Elips 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 Elips 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 & 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. Elips 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*	$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 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 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

PLAN G

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 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 (Unless Part B deductible has been met)
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 (Unless Part B deductible has been met)
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 (Unless Part B deductible has been met)
- 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

HIGH DEDUCTIBLE 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.

**This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $2800 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses exceed $2800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2800 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2800 DEDUCTIBLE** 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

(continued)

HIGH DEDUCTIBLE PLAN G

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2800 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2800 DEDUCTIBLE** YOU PAY
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.

(continued)

HIGH DEDUCTIBLE 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.

**This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $2800 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses exceed $2800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2800 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2800 DEDUCTIBLE** 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 (Unless Part B deductible has been met)
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 (Unless Part B deductible has been met)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - Tests for diagnostic services	100%	$0	$0

(continued)

HIGH DEDUCTIBLE PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2800 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2800 DEDUCTIBLE** 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 (Unless Part B deductible has been met)
- Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2800 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2800 DEDUCTIBLE** 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 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 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

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