Lumico
medigap solutions
Underwritten by
Elips Life Insurance Company

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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 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.

ELIPS LIFE INSURANCE COMPANY

VIRGINIA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 220-225, 232-237

	Preferred				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	1,627	N/A	N/A	N/A	N/A
65	1,627	2,027	1,643	665	1,241
66	1,627	2,027	1,643	665	1,241
67	1,627	2,027	1,643	665	1,241
68	1,627	2,027	1,643	665	1,278
69	1,676	2,089	1,692	687	1,317
70	1,727	2,150	1,745	707	1,356
71	1,779	2,215	1,796	728	1,398
72	1,840	2,293	1,859	753	1,447
73	1,904	2,371	1,924	780	1,496
74	1,972	2,455	1,991	806	1,550
75	2,040	2,541	2,061	836	1,604
76	2,112	2,631	2,132	865	1,659
77	2,196	2,736	2,219	898	1,726
78	2,284	2,846	2,307	933	1,794
79	2,376	2,959	2,399	972	1,865
80	2,472	3,078	2,496	1,011	1,940
81	2,570	3,200	2,596	1,051	2,019
82	2,672	3,328	2,699	1,093	2,100
83	2,779	3,461	2,807	1,137	2,183
84	2,888	3,600	2,918	1,182	2,271
85	3,005	3,744	3,035	1,229	2,361
86	3,125	3,895	3,156	1,279	2,457
87	3,251	4,049	3,284	1,329	2,556
88	3,381	4,211	3,415	1,382	2,659
89	3,517	4,379	3,552	1,438	2,764
90	3,657	4,554	3,694	1,495	2,876
91	3,802	4,738	3,840	1,555	2,990
92	3,955	4,928	3,994	1,617	3,111
93	4,112	5,124	4,154	1,683	3,235
94	4,277	5,329	4,320	1,748	3,364
95	4,446	5,543	4,491	1,818	3,499
96	4,624	5,765	4,670	1,892	3,639
97	4,808	5,995	4,857	1,967	3,784
98	5,003	6,235	5,053	2,045	3,937
99	5,204	6,485	5,255	2,127	4,092

	Standard				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	1,808	N/A	N/A	N/A	N/A
65	1,808	2,251	1,827	740	1,379
66	1,808	2,251	1,827	740	1,379
67	1,808	2,251	1,827	740	1,379
68	1,808	2,251	1,827	740	1,421
69	1,863	2,322	1,882	763	1,464
70	1,919	2,389	1,939	784	1,508
71	1,978	2,462	1,998	808	1,553
72	2,044	2,547	2,065	837	1,606
73	2,119	2,638	2,139	866	1,663
74	2,192	2,728	2,214	896	1,723
75	2,268	2,822	2,292	927	1,782
76	2,348	2,923	2,370	961	1,844
77	2,442	3,040	2,466	999	1,917
78	2,539	3,161	2,565	1,037	1,995
79	2,640	3,287	2,667	1,080	2,074
80	2,746	3,419	2,774	1,122	2,156
81	2,855	3,555	2,884	1,168	2,243
82	2,968	3,697	2,998	1,214	2,332
83	3,087	3,846	3,118	1,261	2,424
84	3,209	4,000	3,241	1,313	2,523
85	3,340	4,160	3,373	1,365	2,624
86	3,472	4,328	3,507	1,421	2,729
87	3,612	4,500	3,648	1,477	2,840
88	3,755	4,680	3,793	1,536	2,952
89	3,905	4,868	3,945	1,597	3,071
90	4,064	5,061	4,105	1,661	3,195
91	4,225	5,265	4,268	1,728	3,324
92	4,394	5,475	4,437	1,796	3,455
93	4,568	5,694	4,614	1,869	3,595
94	4,751	5,921	4,799	1,943	3,739
95	4,941	6,158	4,991	2,022	3,886
96	5,137	6,406	5,190	2,102	4,042
97	5,345	6,663	5,397	2,186	4,206
98	5,556	6,927	5,612	2,272	4,374
99	5,779	7,205	5,837	2,363	4,547

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

Household Discount Factor .88

ELIPS LIFE INSURANCE COMPANY

VIRGINIA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 220-225, 232-237

	Preferred				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	1,380	N/A	N/A	N/A	N/A
65	1,380	1,720	1,394	564	1,053
66	1,380	1,720	1,394	564	1,053
67	1,380	1,720	1,394	564	1,053
68	1,380	1,720	1,394	564	1,084
69	1,421	1,772	1,435	582	1,117
70	1,465	1,824	1,480	599	1,150
71	1,509	1,879	1,524	618	1,186
72	1,561	1,945	1,577	638	1,227
73	1,615	2,011	1,632	661	1,269
74	1,673	2,082	1,689	684	1,315
75	1,730	2,156	1,748	709	1,360
76	1,792	2,232	1,809	733	1,407
77	1,863	2,321	1,882	762	1,464
78	1,937	2,414	1,957	791	1,522
79	2,015	2,510	2,035	825	1,582
80	2,097	2,611	2,118	858	1,645
81	2,180	2,714	2,202	891	1,713
82	2,267	2,822	2,290	927	1,781
83	2,357	2,936	2,381	964	1,852
84	2,450	3,053	2,475	1,002	1,927
85	2,549	3,176	2,575	1,042	2,003
86	2,651	3,304	2,677	1,085	2,084
87	2,758	3,434	2,785	1,128	2,168
88	2,868	3,572	2,897	1,172	2,255
89	2,983	3,715	3,012	1,220	2,345
90	3,102	3,863	3,133	1,268	2,440
91	3,225	4,019	3,258	1,319	2,537
92	3,354	4,180	3,388	1,372	2,639
93	3,487	4,346	3,524	1,428	2,744
94	3,628	4,520	3,664	1,483	2,854
95	3,772	4,702	3,810	1,542	2,968
96	3,923	4,890	3,962	1,605	3,087
97	4,078	5,085	4,120	1,668	3,210
98	4,244	5,289	4,286	1,735	3,339
99	4,414	5,501	4,457	1,804	3,471

	Standard				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	1,533	N/A	N/A	N/A	N/A
65	1,533	1,910	1,549	628	1,169
66	1,533	1,910	1,549	628	1,169
67	1,533	1,910	1,549	628	1,169
68	1,533	1,910	1,549	628	1,206
69	1,580	1,969	1,596	647	1,242
70	1,627	2,026	1,644	665	1,279
71	1,678	2,088	1,695	685	1,318
72	1,734	2,160	1,752	710	1,362
73	1,797	2,237	1,815	734	1,411
74	1,859	2,314	1,878	760	1,461
75	1,924	2,394	1,944	787	1,511
76	1,991	2,480	2,010	815	1,564
77	2,071	2,578	2,092	847	1,626
78	2,154	2,681	2,176	880	1,692
79	2,239	2,788	2,262	916	1,759
80	2,329	2,900	2,353	952	1,829
81	2,422	3,015	2,446	991	1,903
82	2,518	3,136	2,543	1,030	1,978
83	2,618	3,262	2,645	1,070	2,056
84	2,722	3,392	2,749	1,113	2,140
85	2,833	3,528	2,861	1,158	2,226
86	2,945	3,671	2,974	1,206	2,315
87	3,064	3,817	3,094	1,253	2,409
88	3,185	3,970	3,218	1,302	2,504
89	3,313	4,129	3,346	1,355	2,605
90	3,448	4,293	3,482	1,409	2,710
91	3,583	4,466	3,620	1,466	2,820
92	3,727	4,644	3,764	1,524	2,931
93	3,875	4,830	3,914	1,586	3,050
94	4,030	5,023	4,071	1,648	3,171
95	4,191	5,223	4,233	1,715	3,297
96	4,358	5,434	4,402	1,783	3,429
97	4,533	5,652	4,578	1,854	3,567
98	4,713	5,876	4,760	1,928	3,710
99	4,902	6,111	4,951	2,005	3,857

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

Household Discount Factor .88

ELIPS LIFE INSURANCE COMPANY

VIRGINIA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 220-225, 232-237

	Preferred				
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
0-64	1,452	N/A	N/A	N/A	N/A
65	1,452	1,810	1,466	594	1,109
66	1,452	1,810	1,466	594	1,109
67	1,452	1,810	1,466	594	1,109
68	1,452	1,810	1,466	594	1,142
69	1,496	1,865	1,512	612	1,175
70	1,541	1,920	1,556	631	1,211
71	1,588	1,977	1,604	648	1,248
72	1,644	2,047	1,661	672	1,290
73	1,700	2,119	1,718	696	1,336
74	1,763	2,192	1,780	720	1,383
75	1,823	2,269	1,841	746	1,431
76	1,887	2,350	1,905	771	1,482
77	1,961	2,443	1,981	803	1,540
78	2,040	2,540	2,061	834	1,602
79	2,122	2,641	2,144	868	1,668
80	2,208	2,747	2,230	903	1,733
81	2,295	2,857	2,318	939	1,801
82	2,386	2,971	2,410	977	1,876
83	2,480	3,090	2,505	1,015	1,949
84	2,580	3,213	2,605	1,054	2,027
85	2,682	3,342	2,709	1,098	2,109
86	2,791	3,476	2,819	1,141	2,193
87	2,904	3,614	2,933	1,187	2,281
88	3,020	3,759	3,050	1,233	2,373
89	3,139	3,910	3,171	1,284	2,470
90	3,265	4,067	3,297	1,335	2,568
91	3,396	4,229	3,429	1,389	2,671
92	3,530	4,399	3,566	1,444	2,778
93	3,671	4,574	3,708	1,502	2,888
94	3,817	4,758	3,855	1,562	3,005
95	3,970	4,948	4,011	1,624	3,124
96	4,129	5,148	4,171	1,689	3,248
97	4,294	5,355	4,338	1,756	3,379
98	4,464	5,566	4,510	1,827	3,516
99	4,646	5,789	4,692	1,900	3,655

	Standard				
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
0-64	1,614	N/A	N/A	N/A	N/A
65	1,614	2,009	1,631	661	1,231
66	1,614	2,009	1,631	661	1,231
67	1,614	2,009	1,631	661	1,231
68	1,614	2,009	1,631	661	1,269
69	1,662	2,071	1,679	680	1,307
70	1,712	2,132	1,729	700	1,346
71	1,766	2,197	1,783	722	1,385
72	1,827	2,275	1,845	747	1,435
73	1,892	2,354	1,911	773	1,484
74	1,956	2,436	1,976	800	1,538
75	2,025	2,522	2,045	827	1,590
76	2,096	2,611	2,117	857	1,646
77	2,180	2,715	2,202	893	1,711
78	2,267	2,821	2,290	926	1,781
79	2,358	2,936	2,381	963	1,850
80	2,452	3,053	2,476	1,001	1,925
81	2,549	3,175	2,574	1,044	2,003
82	2,650	3,301	2,677	1,084	2,082
83	2,756	3,433	2,784	1,127	2,165
84	2,866	3,572	2,895	1,172	2,252
85	2,980	3,715	3,011	1,219	2,344
86	3,099	3,864	3,132	1,269	2,438
87	3,226	4,019	3,258	1,318	2,535
88	3,354	4,178	3,388	1,371	2,638
89	3,488	4,344	3,522	1,426	2,743
90	3,629	4,518	3,665	1,483	2,853
91	3,772	4,700	3,810	1,543	2,968
92	3,923	4,889	3,963	1,604	3,086
93	4,080	5,084	4,122	1,669	3,209
94	4,244	5,288	4,286	1,735	3,338
95	4,411	5,500	4,455	1,804	3,471
96	4,588	5,720	4,633	1,876	3,610
97	4,771	5,947	4,818	1,952	3,754
98	4,960	6,185	5,011	2,029	3,905
99	5,160	6,432	5,212	2,110	4,060

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

Household Discount Factor .88

ELIPS LIFE INSURANCE COMPANY

VIRGINIA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 220-225, 232-237

	Preferred				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	1,231	N/A	N/A	N/A	N/A
65	1,231	1,535	1,244	504	941
66	1,231	1,535	1,244	504	941
67	1,231	1,535	1,244	504	941
68	1,231	1,535	1,244	504	969
69	1,269	1,582	1,283	519	997
70	1,307	1,628	1,320	535	1,027
71	1,347	1,677	1,360	550	1,058
72	1,395	1,737	1,409	570	1,094
73	1,442	1,797	1,457	590	1,133
74	1,495	1,859	1,510	611	1,173
75	1,547	1,925	1,562	633	1,214
76	1,601	1,993	1,616	654	1,257
77	1,663	2,072	1,681	681	1,306
78	1,730	2,155	1,748	708	1,359
79	1,800	2,240	1,818	736	1,415
80	1,872	2,330	1,891	766	1,470
81	1,947	2,423	1,967	796	1,528
82	2,024	2,520	2,044	828	1,591
83	2,103	2,621	2,125	861	1,653
84	2,189	2,726	2,210	894	1,720
85	2,275	2,835	2,298	931	1,789
86	2,367	2,949	2,391	968	1,860
87	2,463	3,066	2,488	1,007	1,935
88	2,561	3,188	2,587	1,046	2,013
89	2,663	3,316	2,689	1,089	2,095
90	2,769	3,449	2,797	1,132	2,178
91	2,880	3,587	2,909	1,178	2,266
92	2,994	3,732	3,025	1,225	2,356
93	3,114	3,880	3,145	1,274	2,450
94	3,238	4,036	3,270	1,325	2,549
95	3,368	4,197	3,402	1,378	2,650
96	3,503	4,366	3,538	1,433	2,755
97	3,642	4,542	3,679	1,490	2,866
98	3,787	4,722	3,826	1,549	2,982
99	3,941	4,911	3,980	1,611	3,100

	Standard				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	1,369	N/A	N/A	N/A	N/A
65	1,369	1,704	1,383	561	1,044
66	1,369	1,704	1,383	561	1,044
67	1,369	1,704	1,383	561	1,044
68	1,369	1,704	1,383	561	1,076
69	1,410	1,757	1,424	577	1,109
70	1,453	1,809	1,467	594	1,142
71	1,498	1,864	1,512	613	1,175
72	1,549	1,929	1,565	634	1,217
73	1,605	1,997	1,621	656	1,259
74	1,659	2,066	1,676	678	1,304
75	1,718	2,139	1,735	701	1,349
76	1,777	2,214	1,796	727	1,397
77	1,849	2,303	1,868	757	1,452
78	1,923	2,393	1,943	786	1,511
79	2,000	2,490	2,020	817	1,569
80	2,080	2,590	2,100	849	1,633
81	2,162	2,693	2,183	885	1,699
82	2,248	2,800	2,271	920	1,766
83	2,338	2,912	2,362	956	1,836
84	2,431	3,030	2,456	994	1,910
85	2,528	3,151	2,554	1,034	1,988
86	2,629	3,278	2,656	1,076	2,068
87	2,736	3,409	2,764	1,118	2,150
88	2,845	3,544	2,874	1,163	2,237
89	2,958	3,685	2,988	1,209	2,327
90	3,078	3,832	3,108	1,258	2,420
91	3,200	3,986	3,232	1,309	2,518
92	3,328	4,147	3,361	1,360	2,617
93	3,461	4,312	3,496	1,416	2,722
94	3,600	4,485	3,636	1,472	2,831
95	3,741	4,665	3,779	1,530	2,944
96	3,891	4,852	3,930	1,591	3,062
97	4,047	5,045	4,087	1,656	3,184
98	4,208	5,246	4,250	1,721	3,313
99	4,377	5,456	4,421	1,790	3,444

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

Household Discount Factor .88

PREMIUM INFORMATION

We, Elips Life Insurance Company, can only raise your premium if we raise the premium for all policies like yours in the Commonwealth. 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. In addition, the premium may change on any premium due date if a new table of rates is applicable to the policy.

Premiums for other Medicare supplement policies that are issue age or community rated do not increase due to changes in your age.

While the cost of this policy at the covered individual's present age may be lower than the cost of a Medicare supplement policy that is based on issue age or community rated, it is important to compare the potential cost of these policies over the life of 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 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, 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 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 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. 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. 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

PLAN A

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
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

(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