Lumico
medigap solutions
Underwritten by
Elips Life Insurance Company

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

ARIZONA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 850, 851, 852, 85301-85320, 85322-85324, 85326-85327, 85329-85332, 85335, 85337-85340, 85342-85343, 85345, 85351, 85355, 85358, 85361-85363, 85372-85399, 864

	Preferred						Standard					
Issue Age	Plan A	Plan F	Plan G	HD Plan G	Plan N	Issue Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,990	2,411	2,010	789	1,499	65	2,211	2,678	2,233	877	1,666
66	1,990	2,411	2,010	789	1,499	66	2,211	2,678	2,233	877	1,666
67	1,990	2,411	2,010	789	1,499	67	2,211	2,678	2,233	877	1,666
68	1,990	2,411	2,010	789	1,499	68	2,211	2,678	2,233	877	1,666
69	1,990	2,411	2,010	789	1,532	69	2,211	2,678	2,233	877	1,700
70	2,031	2,463	2,053	805	1,565	70	2,257	2,736	2,281	895	1,739
71	2,075	2,514	2,096	823	1,598	71	2,307	2,795	2,330	915	1,775
72	2,129	2,580	2,152	845	1,638	72	2,366	2,866	2,392	938	1,820
73	2,185	2,648	2,208	866	1,682	73	2,428	2,942	2,453	963	1,870
74	2,242	2,717	2,267	890	1,728	74	2,491	3,019	2,518	988	1,919
75	2,301	2,787	2,325	913	1,771	75	2,557	3,098	2,583	1,013	1,968
76	2,360	2,860	2,387	937	1,817	76	2,622	3,177	2,651	1,041	2,018
77	2,433	2,949	2,458	966	1,873	77	2,704	3,277	2,732	1,072	2,081
78	2,509	3,039	2,534	994	1,931	78	2,788	3,377	2,816	1,104	2,145
79	2,585	3,131	2,613	1,025	1,990	79	2,871	3,479	2,901	1,137	2,210
80	2,664	3,228	2,693	1,057	2,051	80	2,960	3,586	2,991	1,174	2,278
81	2,745	3,327	2,774	1,089	2,113	81	3,050	3,696	3,082	1,211	2,348
82	2,830	3,427	2,858	1,122	2,178	82	3,143	3,809	3,176	1,246	2,419
83	2,930	3,547	2,957	1,160	2,254	83	3,255	3,940	3,287	1,290	2,505
84	3,033	3,673	3,060	1,200	2,333	84	3,370	4,081	3,400	1,334	2,592
85	3,140	3,802	3,170	1,244	2,415	85	3,489	4,224	3,522	1,381	2,683
86	3,249	3,935	3,279	1,287	2,501	86	3,612	4,372	3,644	1,431	2,779
87	3,364	4,073	3,395	1,333	2,589	87	3,738	4,526	3,772	1,480	2,875
88	3,482	4,216	3,515	1,378	2,679	88	3,870	4,684	3,905	1,532	2,977
89	3,603	4,363	3,637	1,427	2,775	89	4,003	4,847	4,042	1,587	3,084
90	3,730	4,515	3,765	1,477	2,872	90	4,144	5,018	4,183	1,642	3,190
91	3,861	4,674	3,897	1,529	2,973	91	4,288	5,194	4,329	1,699	3,303
92	3,995	4,838	4,032	1,582	3,075	92	4,439	5,374	4,479	1,759	3,417
93	4,134	5,007	4,173	1,638	3,182	93	4,593	5,563	4,636	1,820	3,538
94	4,278	5,181	4,319	1,693	3,296	94	4,754	5,756	4,798	1,882	3,660
95	4,427	5,363	4,468	1,754	3,409	95	4,919	5,959	4,964	1,949	3,788
96	4,580	5,550	4,624	1,814	3,527	96	5,089	6,165	5,136	2,015	3,920
97	4,745	5,749	4,789	1,880	3,655	97	5,272	6,389	5,321	2,089	4,062
98	4,937	5,979	4,981	1,955	3,801	98	5,483	6,642	5,534	2,171	4,223
99	5,133	6,218	5,180	2,034	3,953	99	5,702	6,909	5,756	2,258	4,392

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

Household Discount Factor .88

ELIPS LIFE INSURANCE COMPANY

ARIZONA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 850, 851, 852, 85301-85320, 85322-85324, 85326-85327, 85329-85332, 85335, 85337-85340, 85342-85343, 85345, 85351, 85355, 85358, 85361-85363, 85372-85399, 864

	Preferred				
Issue Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,743	2,112	1,761	691	1,314
66	1,743	2,112	1,761	691	1,314
67	1,743	2,112	1,761	691	1,314
68	1,743	2,112	1,761	691	1,314
69	1,743	2,112	1,761	691	1,342
70	1,779	2,158	1,799	705	1,371
71	1,818	2,203	1,837	721	1,400
72	1,865	2,261	1,886	740	1,435
73	1,914	2,320	1,935	758	1,474
74	1,965	2,381	1,986	779	1,514
75	2,016	2,442	2,037	800	1,552
76	2,068	2,506	2,092	821	1,592
77	2,132	2,584	2,154	847	1,641
78	2,198	2,663	2,221	871	1,692
79	2,265	2,743	2,289	898	1,744
80	2,334	2,828	2,360	926	1,797
81	2,405	2,915	2,430	954	1,851
82	2,480	3,003	2,504	983	1,908
83	2,568	3,108	2,591	1,017	1,975
84	2,658	3,218	2,681	1,052	2,044
85	2,751	3,331	2,778	1,090	2,116
86	2,847	3,448	2,873	1,128	2,192
87	2,947	3,569	2,975	1,168	2,268
88	3,051	3,694	3,080	1,207	2,347
89	3,157	3,823	3,187	1,251	2,432
90	3,268	3,956	3,299	1,294	2,516
91	3,383	4,095	3,414	1,340	2,605
92	3,500	4,239	3,533	1,386	2,694
93	3,622	4,387	3,656	1,435	2,788
94	3,748	4,540	3,784	1,484	2,888
95	3,879	4,699	3,915	1,537	2,987
96	4,013	4,863	4,051	1,589	3,091
97	4,158	5,037	4,196	1,647	3,202
98	4,325	5,239	4,364	1,713	3,331
99	4,497	5,448	4,538	1,782	3,463

	Standard				
Issue Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,937	2,347	1,956	768	1,459
66	1,937	2,347	1,956	768	1,459
67	1,937	2,347	1,956	768	1,459
68	1,937	2,347	1,956	768	1,459
69	1,937	2,347	1,956	768	1,490
70	1,978	2,397	1,998	784	1,524
71	2,021	2,449	2,041	802	1,555
72	2,073	2,511	2,096	822	1,595
73	2,127	2,578	2,149	844	1,638
74	2,183	2,645	2,206	866	1,681
75	2,240	2,714	2,264	888	1,725
76	2,297	2,784	2,323	912	1,768
77	2,369	2,871	2,394	939	1,823
78	2,443	2,959	2,467	967	1,879
79	2,515	3,048	2,542	996	1,937
80	2,593	3,142	2,621	1,029	1,996
81	2,672	3,238	2,701	1,061	2,057
82	2,754	3,337	2,783	1,092	2,119
83	2,852	3,452	2,880	1,130	2,195
84	2,953	3,576	2,979	1,169	2,271
85	3,057	3,701	3,086	1,210	2,350
86	3,164	3,831	3,193	1,254	2,435
87	3,275	3,965	3,305	1,297	2,519
88	3,391	4,104	3,421	1,342	2,609
89	3,507	4,247	3,541	1,390	2,702
90	3,631	4,397	3,665	1,438	2,795
91	3,757	4,551	3,793	1,489	2,894
92	3,889	4,709	3,924	1,541	2,994
93	4,024	4,874	4,062	1,595	3,100
94	4,166	5,044	4,204	1,649	3,207
95	4,310	5,221	4,349	1,708	3,319
96	4,459	5,402	4,501	1,766	3,434
97	4,619	5,598	4,662	1,830	3,559
98	4,805	5,819	4,849	1,902	3,700
99	4,996	6,054	5,043	1,979	3,848

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

Household Discount Factor .88

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ARIZONA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 850, 851, 852, 85301-85320, 85322-85324, 85326-85327, 85329-85332, 85335, 85337-85340, 85342-85343, 85345, 85351, 85355, 85358, 85361-85363, 85372-85399, 864

	Preferred				
Issue Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,776	2,153	1,795	704	1,339
66	1,776	2,153	1,795	704	1,339
67	1,776	2,153	1,795	704	1,339
68	1,776	2,153	1,795	704	1,339
69	1,776	2,153	1,795	704	1,367
70	1,813	2,199	1,833	720	1,397
71	1,853	2,246	1,872	735	1,426
72	1,901	2,303	1,922	754	1,464
73	1,951	2,365	1,971	773	1,502
74	2,002	2,426	2,024	794	1,542
75	2,054	2,490	2,076	815	1,581
76	2,108	2,553	2,130	836	1,622
77	2,172	2,634	2,195	862	1,673
78	2,240	2,714	2,263	887	1,724
79	2,308	2,796	2,332	915	1,776
80	2,378	2,882	2,403	943	1,831
81	2,451	2,971	2,477	972	1,886
82	2,526	3,060	2,552	1,002	1,944
83	2,616	3,166	2,641	1,036	2,012
84	2,708	3,280	2,733	1,072	2,083
85	2,803	3,394	2,830	1,110	2,156
86	2,901	3,513	2,928	1,150	2,232
87	3,003	3,637	3,031	1,190	2,311
88	3,109	3,764	3,138	1,230	2,393
89	3,217	3,895	3,247	1,275	2,477
90	3,330	4,032	3,362	1,318	2,564
91	3,447	4,173	3,480	1,365	2,654
92	3,567	4,319	3,600	1,412	2,746
93	3,691	4,469	3,726	1,463	2,842
94	3,820	4,626	3,856	1,513	2,942
95	3,953	4,788	3,989	1,566	3,044
96	4,090	4,955	4,128	1,620	3,150
97	4,237	5,134	4,275	1,678	3,263
98	4,407	5,338	4,447	1,745	3,393
99	4,583	5,551	4,626	1,815	3,529

	Standard				
Issue Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,973	2,391	1,993	783	1,487
66	1,973	2,391	1,993	783	1,487
67	1,973	2,391	1,993	783	1,487
68	1,973	2,391	1,993	783	1,487
69	1,973	2,391	1,993	783	1,518
70	2,016	2,443	2,037	799	1,552
71	2,059	2,496	2,080	817	1,584
72	2,113	2,559	2,136	837	1,626
73	2,169	2,628	2,190	859	1,669
74	2,224	2,695	2,248	883	1,713
75	2,282	2,766	2,307	906	1,757
76	2,342	2,837	2,367	929	1,802
77	2,414	2,926	2,439	957	1,858
78	2,489	3,015	2,514	986	1,916
79	2,564	3,106	2,590	1,016	1,973
80	2,643	3,202	2,671	1,048	2,034
81	2,722	3,300	2,752	1,080	2,096
82	2,807	3,401	2,836	1,112	2,160
83	2,906	3,518	2,934	1,152	2,235
84	3,010	3,644	3,037	1,191	2,315
85	3,115	3,771	3,144	1,234	2,396
86	3,225	3,903	3,254	1,277	2,481
87	3,337	4,040	3,367	1,322	2,568
88	3,455	4,183	3,487	1,368	2,658
89	3,574	4,328	3,608	1,416	2,752
90	3,700	4,481	3,736	1,465	2,849
91	3,829	4,638	3,865	1,517	2,949
92	3,962	4,799	3,998	1,569	3,051
93	4,101	4,966	4,140	1,624	3,158
94	4,244	5,140	4,285	1,681	3,268
95	4,392	5,320	4,432	1,740	3,382
96	4,544	5,505	4,586	1,800	3,500
97	4,708	5,704	4,751	1,865	3,626
98	4,896	5,931	4,941	1,939	3,770
99	5,092	6,169	5,139	2,017	3,921

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

Household Discount Factor .88

ELIPS LIFE INSURANCE COMPANY

ARIZONA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 850, 851, 852, 85301-85320, 85322-85324, 85326-85327, 85329-85332, 85335, 85337-85340, 85342-85343, 85345, 85351, 85355, 85358, 85361-85363, 85372-85399, 864

	Preferred				
Issue Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,556	1,886	1,573	617	1,173
66	1,556	1,886	1,573	617	1,173
67	1,556	1,886	1,573	617	1,173
68	1,556	1,886	1,573	617	1,173
69	1,556	1,886	1,573	617	1,197
70	1,589	1,926	1,606	631	1,224
71	1,624	1,968	1,640	644	1,250
72	1,666	2,018	1,684	661	1,283
73	1,710	2,072	1,727	677	1,316
74	1,754	2,126	1,773	696	1,351
75	1,800	2,181	1,819	714	1,385
76	1,847	2,237	1,866	732	1,421
77	1,903	2,307	1,924	755	1,466
78	1,963	2,378	1,983	777	1,511
79	2,022	2,450	2,043	802	1,556
80	2,083	2,525	2,106	827	1,604
81	2,148	2,603	2,170	852	1,652
82	2,213	2,681	2,236	878	1,704
83	2,292	2,774	2,314	908	1,763
84	2,373	2,873	2,395	939	1,825
85	2,456	2,974	2,480	972	1,889
86	2,542	3,078	2,566	1,007	1,956
87	2,631	3,186	2,656	1,043	2,025
88	2,724	3,298	2,750	1,078	2,096
89	2,818	3,413	2,845	1,117	2,171
90	2,918	3,532	2,945	1,155	2,247
91	3,020	3,656	3,049	1,196	2,325
92	3,126	3,784	3,154	1,237	2,406
93	3,234	3,916	3,265	1,282	2,490
94	3,347	4,053	3,378	1,326	2,577
95	3,463	4,196	3,495	1,372	2,667
96	3,583	4,341	3,617	1,419	2,760
97	3,712	4,498	3,746	1,471	2,859
98	3,862	4,677	3,896	1,529	2,973
99	4,015	4,864	4,053	1,590	3,092

	Standard				
Issue Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,729	2,095	1,747	686	1,303
66	1,729	2,095	1,747	686	1,303
67	1,729	2,095	1,747	686	1,303
68	1,729	2,095	1,747	686	1,303
69	1,729	2,095	1,747	686	1,330
70	1,766	2,140	1,784	700	1,360
71	1,804	2,187	1,822	716	1,388
72	1,851	2,242	1,871	733	1,424
73	1,900	2,302	1,919	752	1,462
74	1,948	2,361	1,970	773	1,501
75	1,999	2,423	2,021	794	1,540
76	2,052	2,486	2,074	814	1,579
77	2,115	2,564	2,137	839	1,628
78	2,181	2,642	2,203	864	1,678
79	2,246	2,722	2,270	890	1,729
80	2,316	2,805	2,340	918	1,782
81	2,385	2,891	2,411	946	1,836
82	2,459	2,980	2,485	974	1,892
83	2,546	3,082	2,571	1,009	1,959
84	2,637	3,193	2,661	1,044	2,028
85	2,729	3,304	2,755	1,081	2,099
86	2,826	3,420	2,851	1,119	2,174
87	2,924	3,540	2,951	1,158	2,250
88	3,027	3,665	3,055	1,198	2,329
89	3,132	3,792	3,161	1,241	2,412
90	3,242	3,926	3,273	1,284	2,496
91	3,355	4,063	3,387	1,329	2,583
92	3,472	4,205	3,503	1,375	2,673
93	3,593	4,352	3,627	1,423	2,767
94	3,718	4,503	3,754	1,473	2,864
95	3,848	4,661	3,883	1,525	2,963
96	3,981	4,824	4,018	1,577	3,067
97	4,125	4,998	4,163	1,634	3,177
98	4,290	5,196	4,330	1,699	3,304
99	4,462	5,405	4,503	1,767	3,435

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 same state where your policy was issued.

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) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*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) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*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) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*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) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*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) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*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