Lumico medigap solutions
Underwritten by
Elips Life Insurance Company

Elips Life Insurance Company
State of Domicile: Missouri
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 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.

Effective 08-01-2023

ELIPS LIFE INSURANCE COMPANY

Policy Fee $25

UTAH Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL OF STATE

	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	1,577	1,909	1,593	618	1,214	65	1,752	2,123	1,769	689	1,347
66	1,577	1,909	1,593	618	1,214	66	1,752	2,123	1,769	689	1,347
67	1,577	1,909	1,593	618	1,214	67	1,752	2,123	1,769	689	1,347
68	1,577	1,909	1,593	618	1,214	68	1,752	2,123	1,769	689	1,347
69	1,577	1,909	1,593	618	1,250	69	1,752	2,123	1,769	689	1,387
70	1,624	1,966	1,641	636	1,288	70	1,805	2,187	1,823	710	1,428
71	1,673	2,026	1,690	655	1,327	71	1,859	2,253	1,877	731	1,471
72	1,732	2,097	1,749	678	1,374	72	1,924	2,332	1,943	757	1,523
73	1,793	2,171	1,810	702	1,421	73	1,991	2,413	2,011	784	1,576
74	1,855	2,246	1,874	727	1,471	74	2,061	2,497	2,081	811	1,631
75	1,920	2,325	1,940	753	1,523	75	2,133	2,585	2,153	839	1,688
76	1,986	2,407	2,008	779	1,576	76	2,208	2,676	2,229	869	1,748
77	2,055	2,491	2,078	806	1,631	77	2,285	2,770	2,307	899	1,810
78	2,128	2,579	2,150	834	1,688	78	2,365	2,867	2,387	930	1,873
79	2,202	2,668	2,226	863	1,748	79	2,448	2,968	2,471	963	1,939
80	2,279	2,761	2,304	893	1,810	80	2,533	3,072	2,558	996	2,007
81	2,360	2,858	2,384	925	1,873	81	2,622	3,179	2,647	1,031	2,078
82	2,442	2,957	2,468	957	1,939	82	2,714	3,290	2,739	1,066	2,150
83	2,528	3,061	2,555	991	2,007	83	2,809	3,405	2,835	1,104	2,226
84	2,616	3,168	2,644	1,025	2,078	84	2,907	3,524	2,934	1,143	2,304
85	2,707	3,279	2,736	1,061	2,150	85	3,008	3,647	3,037	1,183	2,385
86	2,788	3,378	2,819	1,092	2,215	86	3,098	3,756	3,128	1,219	2,456
87	2,872	3,480	2,903	1,125	2,281	87	3,191	3,869	3,222	1,256	2,530
88	2,958	3,584	2,990	1,158	2,349	88	3,286	3,985	3,319	1,294	2,606
89	3,047	3,692	3,080	1,193	2,420	89	3,386	4,105	3,418	1,333	2,683
90	3,138	3,802	3,173	1,229	2,492	90	3,487	4,228	3,520	1,373	2,763
91	3,233	3,915	3,268	1,265	2,567	91	3,592	4,355	3,626	1,414	2,847
92	3,330	4,033	3,366	1,303	2,643	92	3,700	4,485	3,735	1,456	2,932
93	3,430	4,154	3,467	1,342	2,722	93	3,811	4,620	3,848	1,499	3,020
94	3,533	4,279	3,571	1,382	2,805	94	3,926	4,758	3,964	1,545	3,111
95	3,638	4,408	3,677	1,423	2,889	95	4,044	4,901	4,083	1,591	3,204
96	3,730	4,518	3,770	1,459	2,961	96	4,145	5,023	4,185	1,631	3,284
97	3,823	4,630	3,865	1,496	3,035	97	4,249	5,148	4,290	1,672	3,366
98	3,919	4,746	3,962	1,534	3,111	98	4,355	5,277	4,397	1,714	3,450
99	4,017	4,865	4,061	1,572	3,189	99	4,464	5,409	4,507	1,758	3,537

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

Effective 08-01-2023

ELIPS LIFE INSURANCE COMPANY

Policy Fee $25

UTAH Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL OF STATE

	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	1,408	1,706	1,423	553	1,083	65	1,563	1,895	1,580	613	1,203
66	1,408	1,706	1,423	553	1,083	66	1,563	1,895	1,580	613	1,203
67	1,408	1,706	1,423	553	1,083	67	1,563	1,895	1,580	613	1,203
68	1,408	1,706	1,423	553	1,083	68	1,563	1,895	1,580	613	1,203
69	1,408	1,706	1,423	553	1,115	69	1,563	1,895	1,580	613	1,238
70	1,450	1,757	1,465	569	1,149	70	1,610	1,952	1,628	632	1,275
71	1,494	1,810	1,508	586	1,183	71	1,658	2,011	1,677	651	1,313
72	1,546	1,873	1,561	607	1,224	72	1,716	2,081	1,736	674	1,358
73	1,601	1,939	1,615	628	1,268	73	1,776	2,153	1,797	698	1,406
74	1,657	2,007	1,672	650	1,312	74	1,838	2,229	1,859	723	1,456
75	1,715	2,078	1,731	673	1,357	75	1,903	2,307	1,924	747	1,507
76	1,775	2,150	1,791	697	1,405	76	1,970	2,388	1,991	773	1,560
77	1,837	2,226	1,854	721	1,454	77	2,039	2,471	2,061	800	1,614
78	1,902	2,304	1,918	746	1,505	78	2,110	2,558	2,133	829	1,670
79	1,969	2,385	1,985	772	1,558	79	2,184	2,648	2,208	858	1,728
80	2,038	2,468	2,054	799	1,612	80	2,260	2,741	2,285	888	1,789
81	2,109	2,555	2,127	827	1,668	81	2,340	2,837	2,365	919	1,852
82	2,182	2,645	2,201	857	1,726	82	2,422	2,937	2,448	952	1,917
83	2,259	2,738	2,278	887	1,787	83	2,507	3,039	2,533	985	1,984
84	2,338	2,834	2,358	918	1,850	84	2,595	3,145	2,622	1,020	2,053
85	2,420	2,933	2,441	951	1,914	85	2,686	3,256	2,714	1,056	2,124
86	2,492	3,021	2,514	979	1,972	86	2,766	3,353	2,795	1,087	2,188
87	2,567	3,112	2,590	1,008	2,031	87	2,849	3,454	2,879	1,119	2,254
88	2,644	3,205	2,668	1,038	2,092	88	2,934	3,557	2,966	1,153	2,322
89	2,723	3,301	2,748	1,070	2,155	89	3,022	3,664	3,055	1,188	2,391
90	2,804	3,401	2,831	1,102	2,219	90	3,113	3,775	3,146	1,223	2,463
91	2,889	3,502	2,915	1,136	2,287	91	3,206	3,888	3,241	1,260	2,536
92	2,976	3,607	3,003	1,170	2,355	92	3,302	4,005	3,338	1,298	2,612
93	3,065	3,715	3,094	1,205	2,425	93	3,401	4,125	3,438	1,337	2,690
94	3,157	3,827	3,186	1,241	2,497	94	3,504	4,249	3,542	1,377	2,771
95	3,252	3,941	3,282	1,277	2,572	95	3,608	4,376	3,647	1,418	2,854
96	3,333	4,040	3,364	1,310	2,636	96	3,699	4,485	3,739	1,454	2,926
97	3,417	4,140	3,449	1,342	2,702	97	3,791	4,598	3,832	1,490	2,999
98	3,503	4,244	3,535	1,376	2,769	98	3,886	4,713	3,928	1,527	3,074
99	3,591	4,350	3,623	1,410	2,838	99	3,983	4,830	4,026	1,565	3,151

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

PREMIUM INFORMATION

Elips Life Insurance Company may change your premium on any premium due date if a new table of rates is applicable to the policy. The change in the table of rates will apply to all covered persons in the same class. Class is defined as attained age, gender, underwriting class, state of issue, and your most recent zip code of residence in the state of issue. Premiums are based on your attained age and will change on your policy anniversary date.

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 CALENDR 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

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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

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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