

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					

¹Plans 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.

²Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

³Plan 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.

TENNESSEE Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 372, 375, 381

Attained Age	Preferred					Attained Age	Standard				
	HD						HD				
	Plan A	Plan F	Plan G	Plan G	Plan N		Plan A	Plan F	Plan G	Plan G	Plan N
0-64	6,483	7,616	6,548	2,496	4,758	0-64	7,201	8,460	7,275	2,778	5,287
65	1,621	1,904	1,637	624	1,189	65	1,800	2,115	1,819	695	1,322
66	1,621	1,904	1,637	624	1,189	66	1,800	2,115	1,819	695	1,322
67	1,621	1,904	1,637	624	1,189	67	1,800	2,115	1,819	695	1,322
68	1,621	1,904	1,637	624	1,226	68	1,800	2,115	1,819	695	1,363
69	1,669	1,960	1,687	643	1,263	69	1,855	2,179	1,874	715	1,403
70	1,719	2,020	1,738	663	1,300	70	1,910	2,244	1,930	735	1,446
71	1,771	2,081	1,790	682	1,339	71	1,967	2,312	1,989	757	1,489
72	1,833	2,153	1,852	706	1,387	72	2,036	2,393	2,058	784	1,540
73	1,896	2,228	1,917	731	1,434	73	2,107	2,477	2,130	811	1,594
74	1,963	2,306	1,984	756	1,485	74	2,182	2,563	2,205	840	1,651
75	2,032	2,386	2,052	783	1,538	75	2,256	2,651	2,281	870	1,708
76	2,103	2,471	2,125	810	1,591	76	2,336	2,745	2,361	901	1,767
77	2,187	2,570	2,210	842	1,655	77	2,429	2,856	2,456	937	1,839
78	2,274	2,672	2,298	875	1,721	78	2,528	2,968	2,553	972	1,912
79	2,366	2,778	2,390	912	1,789	79	2,628	3,088	2,655	1,012	1,989
80	2,460	2,891	2,486	948	1,861	80	2,734	3,211	2,762	1,052	2,067
81	2,559	3,005	2,585	986	1,935	81	2,842	3,338	2,873	1,095	2,151
82	2,662	3,125	2,689	1,025	2,013	82	2,957	3,471	2,986	1,138	2,236
83	2,768	3,250	2,795	1,066	2,093	83	3,077	3,612	3,105	1,183	2,325
84	2,881	3,381	2,906	1,108	2,177	84	3,201	3,757	3,229	1,230	2,419
85	2,996	3,516	3,023	1,152	2,264	85	3,328	3,908	3,360	1,280	2,517
86	3,114	3,657	3,144	1,199	2,356	86	3,460	4,064	3,493	1,332	2,617
87	3,240	3,802	3,271	1,246	2,451	87	3,600	4,225	3,635	1,385	2,723
88	3,369	3,955	3,400	1,296	2,549	88	3,744	4,395	3,778	1,440	2,832
89	3,503	4,113	3,537	1,348	2,651	89	3,892	4,571	3,929	1,497	2,946
90	3,643	4,278	3,678	1,402	2,757	90	4,049	4,753	4,087	1,558	3,064
91	3,789	4,450	3,825	1,458	2,867	91	4,211	4,944	4,249	1,621	3,187
92	3,940	4,627	3,979	1,516	2,982	92	4,379	5,142	4,419	1,683	3,313
93	4,099	4,812	4,136	1,578	3,102	93	4,555	5,347	4,598	1,753	3,447
94	4,262	5,005	4,301	1,639	3,226	94	4,736	5,561	4,780	1,822	3,584
95	4,432	5,206	4,474	1,705	3,355	95	4,925	5,783	4,970	1,895	3,727
96	4,610	5,414	4,652	1,774	3,489	96	5,122	6,016	5,169	1,971	3,876
97	4,794	5,631	4,838	1,844	3,629	97	5,326	6,258	5,375	2,049	4,031
98	4,986	5,857	5,031	1,917	3,774	98	5,539	6,505	5,589	2,130	4,194
99	5,185	6,090	5,233	1,994	3,925	99	5,760	6,766	5,813	2,216	4,360

During open enrollment and guarantee issue periods only the best rates apply. These rates will continue upon each renewal.

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

TENNESSEE Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 372, 375, 381

Attained Age	Preferred					Attained Age	Standard				
	Plan A	Plan F	Plan G	Plan G	Plan N		Plan A	Plan F	Plan G	Plan G	Plan N
0-64	6,234	7,323	6,296	2,400	4,575	0-64	6,924	8,134	6,995	2,671	5,084
65	1,558	1,831	1,574	600	1,144	65	1,731	2,034	1,749	668	1,271
66	1,558	1,831	1,574	600	1,144	66	1,731	2,034	1,749	668	1,271
67	1,558	1,831	1,574	600	1,144	67	1,731	2,034	1,749	668	1,271
68	1,558	1,831	1,574	600	1,179	68	1,731	2,034	1,749	668	1,310
69	1,605	1,885	1,622	618	1,215	69	1,783	2,095	1,802	688	1,349
70	1,653	1,942	1,671	637	1,250	70	1,837	2,158	1,855	707	1,391
71	1,703	2,001	1,721	656	1,288	71	1,891	2,223	1,912	728	1,432
72	1,762	2,070	1,781	678	1,333	72	1,958	2,301	1,979	754	1,481
73	1,823	2,143	1,843	703	1,379	73	2,026	2,382	2,048	780	1,533
74	1,888	2,218	1,908	727	1,428	74	2,098	2,464	2,120	808	1,588
75	1,953	2,295	1,973	753	1,479	75	2,169	2,549	2,194	836	1,642
76	2,022	2,376	2,043	779	1,530	76	2,246	2,639	2,270	866	1,699
77	2,102	2,471	2,125	810	1,591	77	2,336	2,746	2,362	901	1,768
78	2,187	2,569	2,209	842	1,655	78	2,431	2,854	2,455	935	1,838
79	2,275	2,671	2,298	877	1,720	79	2,527	2,969	2,553	973	1,912
80	2,365	2,779	2,391	912	1,789	80	2,629	3,088	2,655	1,011	1,988
81	2,461	2,890	2,485	948	1,860	81	2,733	3,210	2,762	1,053	2,068
82	2,560	3,005	2,585	986	1,936	82	2,843	3,338	2,871	1,094	2,150
83	2,662	3,125	2,688	1,025	2,013	83	2,959	3,473	2,986	1,137	2,236
84	2,770	3,251	2,794	1,065	2,094	84	3,078	3,612	3,105	1,183	2,326
85	2,881	3,381	2,907	1,108	2,177	85	3,200	3,758	3,230	1,231	2,420
86	2,995	3,516	3,024	1,153	2,265	86	3,327	3,907	3,358	1,280	2,516
87	3,116	3,656	3,145	1,198	2,356	87	3,462	4,063	3,495	1,331	2,618
88	3,239	3,803	3,269	1,247	2,451	88	3,600	4,226	3,633	1,384	2,723
89	3,368	3,955	3,401	1,296	2,549	89	3,742	4,395	3,778	1,439	2,832
90	3,503	4,113	3,536	1,348	2,651	90	3,893	4,571	3,930	1,498	2,946
91	3,643	4,279	3,678	1,402	2,757	91	4,049	4,753	4,086	1,558	3,064
92	3,789	4,449	3,826	1,458	2,867	92	4,210	4,944	4,249	1,619	3,185
93	3,941	4,627	3,977	1,517	2,983	93	4,380	5,141	4,421	1,685	3,315
94	4,098	4,813	4,136	1,576	3,102	94	4,554	5,347	4,596	1,752	3,446
95	4,262	5,006	4,302	1,640	3,226	95	4,735	5,561	4,779	1,822	3,584
96	4,433	5,206	4,473	1,706	3,355	96	4,925	5,785	4,970	1,895	3,727
97	4,610	5,414	4,652	1,773	3,490	97	5,121	6,017	5,168	1,971	3,876
98	4,794	5,631	4,838	1,843	3,628	98	5,326	6,255	5,374	2,048	4,032
99	4,986	5,856	5,031	1,918	3,774	99	5,539	6,506	5,590	2,131	4,192

During open enrollment and guarantee issue periods only the best rates apply. These rates will continue upon each renewal.

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

TENNESSEE Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 372, 375, 381

Attained Age	Preferred					Attained Age	Standard				
	Plan A	Plan F	Plan G	Plan G	Plan N		Plan A	Plan F	Plan G	Plan G	Plan N
0-64	5,789	6,801	5,849	2,231	4,251	0-64	6,432	7,552	6,493	2,478	4,723
65	1,447	1,700	1,462	558	1,063	65	1,608	1,888	1,623	620	1,181
66	1,447	1,700	1,462	558	1,063	66	1,608	1,888	1,623	620	1,181
67	1,447	1,700	1,462	558	1,063	67	1,608	1,888	1,623	620	1,181
68	1,447	1,700	1,462	558	1,095	68	1,608	1,888	1,623	620	1,217
69	1,490	1,751	1,506	573	1,128	69	1,656	1,945	1,673	638	1,252
70	1,535	1,803	1,551	591	1,161	70	1,705	2,004	1,723	657	1,291
71	1,580	1,857	1,598	609	1,196	71	1,756	2,064	1,776	677	1,328
72	1,636	1,922	1,653	629	1,238	72	1,817	2,137	1,837	700	1,376
73	1,694	1,990	1,711	652	1,281	73	1,881	2,211	1,902	724	1,424
74	1,753	2,059	1,771	676	1,326	74	1,947	2,288	1,968	751	1,474
75	1,814	2,131	1,834	699	1,372	75	2,015	2,368	2,037	776	1,525
76	1,878	2,205	1,897	723	1,421	76	2,086	2,451	2,108	804	1,578
77	1,953	2,295	1,974	753	1,477	77	2,169	2,549	2,192	837	1,641
78	2,030	2,385	2,051	782	1,537	78	2,256	2,650	2,280	869	1,707
79	2,111	2,480	2,133	814	1,597	79	2,346	2,756	2,370	903	1,775
80	2,196	2,580	2,220	846	1,661	80	2,440	2,868	2,467	939	1,845
81	2,285	2,683	2,308	880	1,727	81	2,538	2,981	2,564	978	1,920
82	2,376	2,791	2,399	915	1,797	82	2,640	3,100	2,665	1,016	1,996
83	2,472	2,902	2,495	951	1,869	83	2,746	3,225	2,773	1,056	2,076
84	2,572	3,019	2,595	989	1,945	84	2,858	3,354	2,883	1,098	2,160
85	2,675	3,139	2,699	1,029	2,022	85	2,971	3,489	3,000	1,143	2,247
86	2,781	3,265	2,807	1,070	2,103	86	3,090	3,628	3,119	1,189	2,337
87	2,893	3,396	2,920	1,112	2,187	87	3,214	3,773	3,245	1,236	2,431
88	3,008	3,531	3,037	1,156	2,275	88	3,343	3,924	3,374	1,285	2,528
89	3,128	3,672	3,158	1,204	2,367	89	3,475	4,081	3,509	1,337	2,630
90	3,253	3,820	3,284	1,251	2,462	90	3,615	4,245	3,650	1,390	2,735
91	3,384	3,972	3,415	1,302	2,561	91	3,760	4,414	3,795	1,446	2,845
92	3,518	4,131	3,552	1,353	2,662	92	3,909	4,591	3,946	1,504	2,958
93	3,659	4,296	3,694	1,408	2,769	93	4,066	4,774	4,105	1,564	3,077
94	3,805	4,469	3,841	1,464	2,881	94	4,228	4,965	4,268	1,627	3,200
95	3,958	4,648	3,994	1,522	2,995	95	4,397	5,165	4,438	1,692	3,327
96	4,115	4,835	4,153	1,583	3,114	96	4,573	5,372	4,615	1,759	3,460
97	4,279	5,027	4,319	1,647	3,240	97	4,756	5,586	4,799	1,830	3,599
98	4,452	5,229	4,492	1,712	3,369	98	4,946	5,809	4,991	1,903	3,744
99	4,630	5,437	4,673	1,780	3,503	99	5,144	6,041	5,191	1,979	3,893

During open enrollment and guarantee issue periods only the best rates apply. These rates will continue upon each renewal.

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

TENNESSEE Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 372, 375, 381

Attained Age	Preferred					Attained Age	Standard				
	Plan A	Plan F	Plan G	Plan G	Plan N		Plan A	Plan F	Plan G	Plan G	Plan N
0-64	5,566	6,539	5,624	2,145	4,087	0-64	6,185	7,262	6,243	2,383	4,541
65	1,392	1,635	1,406	536	1,022	65	1,546	1,815	1,561	596	1,135
66	1,392	1,635	1,406	536	1,022	66	1,546	1,815	1,561	596	1,135
67	1,392	1,635	1,406	536	1,022	67	1,546	1,815	1,561	596	1,135
68	1,392	1,635	1,406	536	1,053	68	1,546	1,815	1,561	596	1,170
69	1,433	1,683	1,448	551	1,084	69	1,592	1,871	1,609	614	1,204
70	1,476	1,734	1,492	568	1,116	70	1,640	1,927	1,656	632	1,241
71	1,520	1,786	1,536	585	1,150	71	1,689	1,985	1,708	651	1,277
72	1,573	1,848	1,590	605	1,190	72	1,748	2,054	1,766	673	1,323
73	1,629	1,913	1,645	626	1,232	73	1,809	2,126	1,829	696	1,370
74	1,685	1,980	1,703	650	1,275	74	1,872	2,200	1,892	722	1,417
75	1,744	2,049	1,763	672	1,320	75	1,938	2,277	1,959	746	1,466
76	1,805	2,121	1,824	695	1,366	76	2,006	2,356	2,027	773	1,517
77	1,878	2,207	1,898	724	1,420	77	2,086	2,451	2,108	805	1,578
78	1,952	2,294	1,972	752	1,478	78	2,169	2,548	2,193	835	1,641
79	2,030	2,385	2,051	782	1,536	79	2,256	2,650	2,279	868	1,707
80	2,111	2,481	2,135	813	1,597	80	2,346	2,757	2,372	903	1,774
81	2,197	2,580	2,219	846	1,661	81	2,441	2,866	2,465	940	1,847
82	2,285	2,684	2,307	880	1,728	82	2,539	2,981	2,563	977	1,920
83	2,377	2,790	2,399	915	1,797	83	2,641	3,101	2,666	1,015	1,996
84	2,473	2,903	2,495	951	1,870	84	2,748	3,225	2,772	1,056	2,077
85	2,572	3,018	2,595	989	1,944	85	2,857	3,354	2,884	1,099	2,160
86	2,674	3,140	2,699	1,029	2,022	86	2,971	3,489	2,999	1,144	2,247
87	2,782	3,265	2,808	1,070	2,103	87	3,090	3,628	3,120	1,188	2,337
88	2,892	3,395	2,920	1,112	2,188	88	3,215	3,773	3,244	1,236	2,431
89	3,008	3,531	3,037	1,158	2,276	89	3,342	3,924	3,374	1,286	2,529
90	3,128	3,673	3,158	1,203	2,367	90	3,476	4,081	3,510	1,337	2,630
91	3,254	3,819	3,284	1,252	2,462	91	3,615	4,244	3,649	1,391	2,736
92	3,383	3,972	3,415	1,301	2,560	92	3,759	4,414	3,794	1,446	2,844
93	3,519	4,131	3,552	1,354	2,663	93	3,910	4,590	3,947	1,504	2,958
94	3,659	4,297	3,693	1,408	2,770	94	4,066	4,774	4,104	1,565	3,077
95	3,806	4,469	3,840	1,464	2,880	95	4,228	4,966	4,267	1,627	3,199
96	3,957	4,649	3,994	1,522	2,995	96	4,397	5,165	4,437	1,692	3,327
97	4,115	4,834	4,153	1,584	3,115	97	4,573	5,371	4,614	1,760	3,461
98	4,281	5,028	4,319	1,646	3,239	98	4,756	5,585	4,799	1,830	3,600
99	4,452	5,228	4,493	1,712	3,369	99	4,946	5,809	4,991	1,903	3,743

During open enrollment and guarantee issue periods only the best rates apply. These rates will continue upon each renewal.

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
<u>HOSPITALIZATION*</u> - 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
<u>SKILLED NURSING FACILITY CARE*</u> - 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
21 st thru 100 th day	All but \$204 a day	\$0	Up to \$204 a day
101 st day and after	\$0	\$0	All costs
<u>BLOOD</u>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<u>HOSPICE CARE</u> - 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
<u>MEDICAL EXPENSES</u> - 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
<u>PART B EXCESS CHARGES</u> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<u>BLOOD</u>			
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
<u>CLINICAL LABORATORY SERVICES</u> - Tests for diagnostic services	100%	\$0	\$0

PLAN A

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<u>HOME HEALTH CARE</u> – 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
<u>HOSPITALIZATION*</u> - 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
<u>SKILLED NURSING FACILITY CARE*</u> - 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
21 st thru 100 th day	All but \$204 a day	Up to \$204 a day	\$0
101 st day and after	\$0	\$0	All costs
<u>BLOOD</u>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<u>HOSPICE CARE</u> - 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
<u>MEDICAL EXPENSES</u> - 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
<u>PART B EXCESS CHARGES</u> (Above Medicare Approved Amounts)	\$0	100%	\$0
<u>BLOOD</u>			
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
<u>CLINICAL LABORATORY SERVICES</u> - Tests for diagnostic services	100%	\$0	\$0

(continued)

PLAN F
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<u>HOME HEALTH CARE</u> – 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
<u>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</u> – 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
<u>HOSPITALIZATION*</u> - 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
<u>SKILLED NURSING FACILITY CARE*</u> - 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
21 st thru 100 th day	All but \$204 a day	Up to \$204 a day	\$0
101 st day and after	\$0	\$0	All costs
<u>BLOOD</u>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<u>HOSPICE CARE</u> - 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
<u>MEDICAL EXPENSES</u> - 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
<u>PART B EXCESS CHARGES</u> (Above Medicare Approved Amounts)	\$0	100%	\$0
<u>BLOOD</u>			
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
<u>CLINICAL LABORATORY SERVICES</u> - 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
<u>HOSPITALIZATION*</u> - 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
<u>SKILLED NURSING FACILITY CARE*</u> - 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
21 st thru 100 th day	All but \$204 a day	Up to \$204 a day	\$0
101 st day and after	\$0	\$0	All costs
<u>BLOOD</u>			
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
<u>MEDICAL EXPENSES</u> - 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
<u>PART B EXCESS CHARGES</u> (Above Medicare Approved Amounts)	\$0	100%	\$0
<u>BLOOD</u>			
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
<u>CLINICAL LABORATORY SERVICES</u> - 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
<u>HOSPITALIZATION*</u> - 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
<u>SKILLED NURSING FACILITY CARE*</u> - 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
21 st thru 100 th day	All but \$204 a day	Up to \$204 a day	\$0
101 st day and after	\$0	\$0	All costs
<u>BLOOD</u>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<u>HOSPICE CARE</u> - 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
<u>MEDICAL EXPENSES</u> - 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.
<u>PART B EXCESS CHARGES</u> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<u>BLOOD</u>			
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
<u>CLINICAL LABORATORY SERVICES</u> - Tests for diagnostic services	100%	\$0	\$0

(continued)

PLAN N
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<u>HOME HEALTH CARE</u> – 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
<u>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</u> – 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