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

ALABAMA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 350-352

	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	1,714	2,075	1,748	679	1,303	65	1,904	2,304	1,941	757	1,449
66	1,714	2,075	1,748	679	1,303	66	1,904	2,304	1,941	757	1,449
67	1,714	2,075	1,748	679	1,303	67	1,904	2,304	1,941	757	1,449
68	1,714	2,137	1,748	679	1,329	68	1,904	2,374	1,941	757	1,477
69	1,729	2,156	1,764	685	1,341	69	1,923	2,399	1,960	764	1,492
70	1,746	2,177	1,782	692	1,354	70	1,940	2,421	1,978	771	1,506
71	1,777	2,216	1,813	704	1,378	71	1,975	2,464	2,014	785	1,533
72	1,807	2,253	1,844	716	1,401	72	2,009	2,507	2,049	799	1,560
73	1,870	2,331	1,908	741	1,450	73	2,080	2,595	2,121	827	1,614
74	1,936	2,414	1,975	767	1,501	74	2,152	2,685	2,194	856	1,671
75	2,008	2,503	2,048	796	1,556	75	2,231	2,783	2,274	887	1,732
76	2,078	2,591	2,120	824	1,612	76	2,309	2,880	2,354	918	1,792
77	2,159	2,692	2,202	856	1,674	77	2,402	2,996	2,449	955	1,864
78	2,247	2,802	2,292	890	1,742	78	2,496	3,115	2,546	992	1,938
79	2,337	2,913	2,383	926	1,812	79	2,596	3,239	2,647	1,032	2,015
80	2,445	3,048	2,494	969	1,896	80	2,720	3,392	2,773	1,081	2,110
81	2,584	3,221	2,635	1,023	2,004	81	2,872	3,583	2,928	1,141	2,229
82	2,686	3,349	2,741	1,064	2,082	82	2,987	3,726	3,046	1,187	2,318
83	2,794	3,483	2,850	1,107	2,167	83	3,105	3,873	3,166	1,234	2,410
84	2,905	3,621	2,963	1,151	2,252	84	3,229	4,028	3,292	1,283	2,506
85	3,023	3,768	3,084	1,198	2,343	85	3,360	4,192	3,427	1,335	2,607
86	3,142	3,917	3,206	1,245	2,436	86	3,492	4,357	3,561	1,388	2,711
87	3,269	4,076	3,336	1,295	2,535	87	3,635	4,535	3,707	1,445	2,822
88	3,399	4,238	3,468	1,346	2,635	88	3,778	4,714	3,853	1,502	2,933
89	3,535	4,408	3,606	1,401	2,742	89	3,929	4,902	4,007	1,562	3,049
90	3,676	4,583	3,751	1,456	2,850	90	4,088	5,099	4,168	1,625	3,172
91	3,824	4,767	3,901	1,515	2,965	91	4,249	5,301	4,333	1,689	3,298
92	3,976	4,956	4,056	1,575	3,082	92	4,420	5,514	4,507	1,757	3,430
93	4,134	5,154	4,217	1,638	3,206	93	4,597	5,734	4,688	1,827	3,568
94	4,300	5,360	4,387	1,704	3,334	94	4,781	5,964	4,874	1,900	3,710
95	4,472	5,576	4,562	1,773	3,468	95	4,971	6,200	5,068	1,976	3,857
96	4,650	5,796	4,743	1,843	3,605	96	5,169	6,449	5,271	2,055	4,012
97	4,836	6,030	4,934	1,916	3,750	97	5,376	6,707	5,481	2,137	4,171
98	5,029	6,270	5,130	1,992	3,899	98	5,590	6,973	5,700	2,221	4,338
99	5,230	6,520	5,336	2,072	4,055	99	5,814	7,253	5,929	2,311	4,512

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

Household Discount Factor .88

ELIPS LIFE INSURANCE COMPANY

ALABAMA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 350-352

	Preferred						Standard				
				HD						HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
65	1,559	1,888	1,591	618	1,186	65	1,732	2,097	1,766	689	1,318
66	1,559	1,888	1,591	618	1,186	66	1,732	2,097	1,766	689	1,318
67	1,559	1,888	1,591	618	1,186	67	1,732	2,097	1,766	689	1,318
68	1,559	1,944	1,591	618	1,209	68	1,732	2,160	1,766	689	1,344
69	1,574	1,961	1,605	623	1,220	69	1,749	2,183	1,784	695	1,357
70	1,589	1,981	1,621	629	1,232	70	1,765	2,203	1,800	702	1,371
71	1,617	2,016	1,649	640	1,253	71	1,797	2,242	1,832	714	1,395
72	1,644	2,050	1,678	651	1,275	72	1,828	2,282	1,864	727	1,419
73	1,702	2,121	1,736	675	1,319	73	1,893	2,361	1,930	752	1,469
74	1,761	2,197	1,797	698	1,366	74	1,958	2,443	1,997	779	1,520
75	1,827	2,278	1,863	724	1,416	75	2,030	2,532	2,069	807	1,576
76	1,891	2,357	1,929	749	1,467	76	2,101	2,621	2,142	835	1,630
77	1,964	2,449	2,004	779	1,523	77	2,186	2,726	2,228	869	1,696
78	2,044	2,549	2,086	810	1,585	78	2,271	2,834	2,317	903	1,763
79	2,126	2,650	2,168	842	1,648	79	2,362	2,947	2,409	939	1,833
80	2,225	2,773	2,269	882	1,725	80	2,475	3,087	2,523	984	1,920
81	2,351	2,931	2,398	931	1,823	81	2,613	3,260	2,664	1,038	2,028
82	2,444	3,047	2,494	969	1,895	82	2,718	3,391	2,771	1,080	2,109
83	2,542	3,169	2,594	1,007	1,972	83	2,825	3,524	2,881	1,123	2,193
84	2,643	3,295	2,696	1,047	2,049	84	2,938	3,665	2,996	1,168	2,281
85	2,750	3,429	2,806	1,090	2,132	85	3,057	3,815	3,118	1,215	2,372
86	2,859	3,564	2,917	1,133	2,217	86	3,177	3,964	3,240	1,263	2,466
87	2,974	3,709	3,035	1,179	2,307	87	3,308	4,127	3,373	1,315	2,567
88	3,093	3,856	3,155	1,225	2,398	88	3,438	4,289	3,506	1,367	2,668
89	3,217	4,011	3,281	1,275	2,495	89	3,575	4,460	3,646	1,421	2,774
90	3,345	4,170	3,413	1,325	2,594	90	3,720	4,640	3,793	1,479	2,887
91	3,479	4,338	3,549	1,379	2,698	91	3,866	4,824	3,943	1,537	3,001
92	3,618	4,510	3,691	1,433	2,805	92	4,022	5,018	4,101	1,599	3,121
93	3,761	4,689	3,837	1,491	2,917	93	4,182	5,218	4,265	1,662	3,246
94	3,913	4,877	3,992	1,550	3,034	94	4,350	5,427	4,435	1,729	3,375
95	4,069	5,073	4,151	1,613	3,155	95	4,523	5,642	4,612	1,798	3,510
96	4,231	5,274	4,316	1,677	3,280	96	4,704	5,868	4,796	1,870	3,650
97	4,401	5,486	4,489	1,743	3,412	97	4,891	6,102	4,987	1,944	3,796
98	4,576	5,705	4,668	1,813	3,548	98	5,086	6,345	5,186	2,021	3,947
99	4,759	5,933	4,855	1,886	3,690	99	5,290	6,599	5,394	2,103	4,106

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

Household Discount Factor .88

ELIPS LIFE INSURANCE COMPANY

ALABAMA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 350-352

	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	1,501	1,816	1,530	595	1,140	65	1,667	2,017	1,699	660	1,268
66	1,501	1,816	1,530	595	1,140	66	1,667	2,017	1,699	660	1,268
67	1,501	1,816	1,530	595	1,140	67	1,667	2,017	1,699	660	1,268
68	1,501	1,871	1,530	595	1,164	68	1,667	2,079	1,699	660	1,293
69	1,515	1,890	1,545	601	1,175	69	1,683	2,099	1,716	666	1,305
70	1,528	1,907	1,558	606	1,185	70	1,698	2,118	1,732	673	1,318
71	1,556	1,941	1,586	616	1,207	71	1,728	2,156	1,763	685	1,341
72	1,583	1,975	1,614	627	1,228	72	1,759	2,194	1,794	697	1,364
73	1,638	2,045	1,671	649	1,271	73	1,822	2,271	1,857	722	1,413
74	1,695	2,115	1,728	672	1,315	74	1,885	2,351	1,921	747	1,462
75	1,757	2,192	1,793	696	1,363	75	1,954	2,436	1,992	774	1,515
76	1,819	2,270	1,855	720	1,412	76	2,021	2,521	2,060	800	1,567
77	1,891	2,360	1,929	749	1,467	77	2,102	2,623	2,143	833	1,631
78	1,968	2,455	2,007	779	1,526	78	2,187	2,727	2,229	866	1,696
79	2,046	2,552	2,086	810	1,587	79	2,272	2,834	2,317	900	1,763
80	2,142	2,672	2,184	849	1,662	80	2,380	2,968	2,426	942	1,846
81	2,262	2,823	2,308	897	1,756	81	2,514	3,136	2,563	996	1,950
82	2,353	2,935	2,399	932	1,825	82	2,615	3,261	2,666	1,036	2,028
83	2,445	3,051	2,494	969	1,898	83	2,718	3,391	2,772	1,077	2,109
84	2,543	3,172	2,594	1,008	1,974	84	2,827	3,525	2,882	1,120	2,193
85	2,646	3,301	2,698	1,049	2,052	85	2,942	3,669	2,999	1,166	2,282
86	2,752	3,433	2,806	1,090	2,136	86	3,058	3,814	3,118	1,211	2,372
87	2,862	3,570	2,918	1,133	2,220	87	3,182	3,969	3,245	1,261	2,469
88	2,976	3,713	3,035	1,179	2,309	88	3,309	4,127	3,373	1,311	2,566
89	3,096	3,862	3,157	1,227	2,402	89	3,441	4,291	3,508	1,363	2,670
90	3,220	4,017	3,283	1,275	2,499	90	3,579	4,463	3,649	1,417	2,776
91	3,349	4,177	3,414	1,326	2,597	91	3,721	4,641	3,794	1,474	2,887
92	3,481	4,343	3,550	1,380	2,701	92	3,869	4,826	3,945	1,533	3,001
93	3,621	4,517	3,692	1,434	2,809	93	4,025	5,019	4,103	1,594	3,122
94	3,765	4,698	3,839	1,492	2,922	94	4,184	5,218	4,266	1,657	3,246
95	3,916	4,885	3,994	1,552	3,038	95	4,352	5,428	4,437	1,724	3,377
96	4,073	5,080	4,154	1,614	3,159	96	4,524	5,643	4,613	1,792	3,510
97	4,235	5,282	4,318	1,677	3,284	97	4,705	5,870	4,797	1,864	3,651
98	4,403	5,493	4,491	1,745	3,417	98	4,894	6,104	4,989	1,938	3,796
99	4,580	5,714	4,671	1,815	3,553	99	5,090	6,349	5,189	2,016	3,948

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

Household Discount Factor .88

ELIPS LIFE INSURANCE COMPANY

ALABAMA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 350-352

	Preferred						Standard				
				HD						HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
65	1,366	1,652	1,392	541	1,037	65	1,517	1,835	1,546	601	1,153
66	1,366	1,652	1,392	541	1,037	66	1,517	1,835	1,546	601	1,153
67	1,366	1,652	1,392	541	1,037	67	1,517	1,835	1,546	601	1,153
68	1,366	1,703	1,392	541	1,059	68	1,517	1,892	1,546	601	1,177
69	1,379	1,720	1,406	546	1,070	69	1,531	1,910	1,561	606	1,188
70	1,391	1,735	1,418	551	1,079	70	1,545	1,927	1,576	612	1,199
71	1,416	1,766	1,443	561	1,098	71	1,573	1,961	1,604	623	1,220
72	1,440	1,797	1,469	571	1,117	72	1,601	1,997	1,632	634	1,241
73	1,491	1,860	1,520	591	1,156	73	1,657	2,066	1,690	657	1,286
74	1,542	1,924	1,573	611	1,197	74	1,715	2,139	1,748	680	1,330
75	1,599	1,995	1,631	633	1,240	75	1,778	2,217	1,813	704	1,379
76	1,655	2,065	1,688	655	1,285	76	1,839	2,294	1,875	728	1,426
77	1,721	2,147	1,755	682	1,335	77	1,913	2,387	1,950	758	1,484
78	1,791	2,234	1,826	709	1,389	78	1,990	2,482	2,028	788	1,543
79	1,861	2,322	1,898	737	1,444	79	2,067	2,579	2,108	819	1,604
80	1,949	2,431	1,988	773	1,512	80	2,165	2,701	2,208	857	1,680
81	2,058	2,568	2,100	816	1,598	81	2,288	2,853	2,332	906	1,775
82	2,141	2,670	2,183	848	1,660	82	2,380	2,967	2,426	942	1,845
83	2,225	2,776	2,269	882	1,727	83	2,473	3,086	2,522	980	1,919
84	2,314	2,887	2,360	917	1,796	84	2,572	3,208	2,622	1,019	1,996
85	2,408	3,004	2,455	954	1,867	85	2,677	3,338	2,729	1,061	2,077
86	2,504	3,124	2,553	992	1,943	86	2,783	3,470	2,837	1,102	2,158
87	2,604	3,248	2,655	1,031	2,020	87	2,896	3,612	2,952	1,147	2,246
88	2,708	3,378	2,761	1,073	2,101	88	3,011	3,755	3,069	1,193	2,335
89	2,817	3,514	2,872	1,116	2,186	89	3,131	3,905	3,192	1,240	2,429
90	2,930	3,655	2,988	1,160	2,274	90	3,256	4,061	3,320	1,290	2,526
91	3,047	3,801	3,107	1,207	2,363	91	3,386	4,223	3,452	1,341	2,627
92	3,167	3,952	3,230	1,255	2,457	92	3,521	4,391	3,590	1,395	2,731
93	3,295	4,110	3,359	1,305	2,556	93	3,662	4,567	3,733	1,450	2,841
94	3,426	4,274	3,494	1,357	2,658	94	3,807	4,748	3,881	1,508	2,953
95	3,563	4,445	3,634	1,412	2,764	95	3,960	4,939	4,037	1,569	3,072
96	3,706	4,623	3,779	1,469	2,874	96	4,117	5,135	4,198	1,630	3,194
97	3,853	4,807	3,929	1,526	2,989	97	4,281	5,341	4,365	1,696	3,322
98	4,007	4,998	4,086	1,588	3,109	98	4,453	5,554	4,540	1,763	3,454
99	4,167	5,199	4,250	1,651	3,233	99	4,632	5,777	4,722	1,834	3,593

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

Household Discount Factor .88

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 CALENDAR YEAR

*Once you have been billed $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $240 of Medicare Approved Amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare Approved Amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - Tests for diagnostic services	100%	$0	$0

PLAN A

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – Medicare Approved Services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment:			
- First $240 of Medicare Approved Amounts*	$0	$0	$240 (Part B deductible)
- Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN F

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

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* - Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but $1632	$1632 (Part A deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
- Once lifetime reserve days are used:			
• Additional 365 days	$0	100% of Medicare eligible expenses	$0**
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* - You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE - You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $240 of Medicare Approved Amounts*	$0	$240 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare Approved Amounts*	$0	$240 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - Tests for diagnostic services	100%	$0	$0

(continued)

PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – Medicare Approved Services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment:			
- First $240 of Medicare Approved Amounts*	$0	$240 (Part B deductible)	$0
- Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE – Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

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

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* - Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but $1632	$1632 (Part A deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
- Once lifetime reserve days are used:			
• Additional 365 days	$0	100% of Medicare eligible expenses	$0**
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* - You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE - You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $240 of Medicare Approved Amounts*	$0	$0	$240 (Unless Part B deductible has been met)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare Approved Amounts*	$0	$0	$240 (Unless Part B deductible has been met)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - Tests for diagnostic services	100%	$0	$0

(continued)

PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – Medicare Approved Services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment:			
- First $240 of Medicare Approved Amounts*	$0	$0	$240 (Unless Part B deductible has been met)
- Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE – Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

HIGH DEDUCTIBLE PLAN G

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

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

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

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2800 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2800 DEDUCTIBLE** YOU PAY
HOSPITALIZATION* - Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but $1632	$1632 (Part A deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
- Once lifetime reserve days are used:			
• Additional 365 days	$0	100% of Medicare eligible expenses	$0***
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* - You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

(continued)

HIGH DEDUCTIBLE PLAN G

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

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2800 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2800 DEDUCTIBLE** YOU PAY
HOSPICE CARE - You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

***NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

(continued)

HIGH DEDUCTIBLE PLAN G

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2800 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2800 DEDUCTIBLE** YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $240 of Medicare Approved Amounts*	$0	$0	$240 (Unless Part B deductible has been met)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare Approved Amounts*	$0	$0	$240 (Unless Part B deductible has been met)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - Tests for diagnostic services	100%	$0	$0

(continued)

HIGH DEDUCTIBLE PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2800 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2800 DEDUCTIBLE** YOU PAY
HOME HEALTH CARE – Medicare Approved Services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment:			
- First $240 of Medicare Approved Amounts*	$0	$0	$240 (Unless Part B deductible has been met)
- Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2800 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2800 DEDUCTIBLE** YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE – Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN N

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

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* - Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but $1632	$1632 (Part A deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
- Once lifetime reserve days are used:			
• Additional 365 days	$0	100% of Medicare eligible expenses	$0**
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* - You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE - You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $240 of Medicare Approved Amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare Approved Amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - Tests for diagnostic services	100%	$0	$0

(continued)

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – Medicare Approved Services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment:			
- First $240 of Medicare Approved Amounts*	$0	$0	$240 (Part B deductible)
- Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE – Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum