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.

Effective 09-01-2023

ELIPS LIFE INSURANCE COMPANY

Policy Fee $25

LOUISIANA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 700-704, 707-708

	Preferred				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	7,311	8,564	7,380	2,867	5,491
65	1,881	2,206	1,901	737	1,414
66	1,881	2,206	1,901	737	1,414
67	1,881	2,206	1,901	737	1,414
68	1,881	2,206	1,901	737	1,414
69	1,881	2,206	1,901	737	1,457
70	1,938	2,273	1,958	761	1,499
71	1,995	2,341	2,017	784	1,545
72	2,065	2,422	2,087	811	1,600
73	2,136	2,507	2,160	838	1,654
74	2,212	2,595	2,236	868	1,714
75	2,291	2,685	2,313	899	1,773
76	2,370	2,779	2,396	930	1,835
77	2,465	2,891	2,490	967	1,909
78	2,563	3,006	2,590	1,005	1,985
79	2,666	3,125	2,694	1,046	2,064
80	2,772	3,252	2,801	1,089	2,146
81	2,884	3,381	2,913	1,131	2,232
82	3,001	3,516	3,029	1,177	2,322
83	3,121	3,656	3,150	1,224	2,415
84	3,247	3,802	3,275	1,272	2,512
85	3,376	3,955	3,407	1,322	2,611
86	3,511	4,113	3,544	1,377	2,717
87	3,652	4,278	3,686	1,431	2,827
88	3,797	4,448	3,832	1,488	2,941
89	3,948	4,627	3,985	1,549	3,058
90	4,106	4,811	4,145	1,611	3,181
91	4,271	5,006	4,311	1,675	3,309
92	4,440	5,206	4,484	1,741	3,441
93	4,619	5,413	4,663	1,812	3,579
94	4,804	5,631	4,849	1,883	3,721
95	4,995	5,857	5,042	1,958	3,869
96	5,196	6,091	5,242	2,037	4,024
97	5,402	6,334	5,453	2,118	4,187
98	5,620	6,588	5,671	2,202	4,354
99	5,844	6,852	5,897	2,291	4,528

	Standard				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	8,114	9,517	8,200	3,187	6,101
65	2,090	2,451	2,112	821	1,572
66	2,090	2,451	2,112	821	1,572
67	2,090	2,451	2,112	821	1,572
68	2,090	2,451	2,112	821	1,572
69	2,090	2,451	2,112	821	1,618
70	2,154	2,525	2,175	845	1,669
71	2,218	2,601	2,241	869	1,718
72	2,295	2,692	2,319	900	1,777
73	2,374	2,786	2,401	931	1,839
74	2,458	2,883	2,485	965	1,905
75	2,543	2,983	2,571	998	1,971
76	2,633	3,088	2,660	1,034	2,038
77	2,738	3,213	2,768	1,076	2,122
78	2,848	3,339	2,877	1,116	2,206
79	2,962	3,472	2,992	1,162	2,294
80	3,081	3,613	3,113	1,208	2,384
81	3,203	3,756	3,236	1,258	2,481
82	3,332	3,906	3,366	1,307	2,580
83	3,468	4,063	3,500	1,357	2,682
84	3,608	4,226	3,640	1,413	2,791
85	3,751	4,395	3,787	1,470	2,903
86	3,900	4,572	3,936	1,529	3,020
87	4,059	4,753	4,097	1,590	3,141
88	4,220	4,944	4,258	1,653	3,267
89	4,387	5,141	4,428	1,719	3,398
90	4,564	5,347	4,607	1,789	3,535
91	4,746	5,562	4,789	1,861	3,677
92	4,935	5,784	4,982	1,933	3,822
93	5,133	6,015	5,181	2,013	3,977
94	5,338	6,256	5,387	2,092	4,134
95	5,551	6,506	5,602	2,176	4,301
96	5,772	6,768	5,825	2,264	4,471
97	6,002	7,039	6,058	2,353	4,652
98	6,243	7,318	6,300	2,446	4,838
99	6,492	7,612	6,553	2,544	5,030

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

ELIPS LIFE INSURANCE COMPANY

LOUISIANA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 700-704, 707-708

	Preferred				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	6,301	7,381	6,360	2,471	4,732
65	1,621	1,901	1,638	636	1,219
66	1,621	1,901	1,638	636	1,219
67	1,621	1,901	1,638	636	1,219
68	1,621	1,901	1,638	636	1,219
69	1,621	1,901	1,638	636	1,255
70	1,670	1,959	1,687	656	1,292
71	1,720	2,017	1,738	676	1,331
72	1,779	2,087	1,799	699	1,379
73	1,841	2,160	1,862	722	1,426
74	1,906	2,236	1,927	748	1,477
75	1,974	2,314	1,994	775	1,528
76	2,043	2,395	2,065	801	1,582
77	2,124	2,492	2,146	834	1,645
78	2,209	2,590	2,232	866	1,711
79	2,297	2,693	2,321	902	1,779
80	2,389	2,802	2,414	938	1,850
81	2,485	2,913	2,511	975	1,923
82	2,586	3,030	2,610	1,014	2,001
83	2,689	3,151	2,715	1,055	2,081
84	2,798	3,277	2,822	1,096	2,165
85	2,910	3,408	2,936	1,140	2,250
86	3,025	3,545	3,054	1,186	2,342
87	3,147	3,687	3,177	1,233	2,436
88	3,272	3,834	3,303	1,282	2,534
89	3,402	3,987	3,435	1,334	2,636
90	3,539	4,146	3,572	1,388	2,741
91	3,681	4,314	3,715	1,444	2,852
92	3,827	4,487	3,864	1,500	2,965
93	3,980	4,665	4,018	1,562	3,084
94	4,140	4,852	4,179	1,623	3,207
95	4,305	5,047	4,345	1,687	3,335
96	4,478	5,249	4,518	1,755	3,468
97	4,655	5,459	4,699	1,825	3,608
98	4,844	5,678	4,887	1,898	3,752
99	5,036	5,905	5,082	1,974	3,902

	Standard				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	6,993	8,201	7,066	2,747	5,258
65	1,801	2,112	1,820	708	1,355
66	1,801	2,112	1,820	708	1,355
67	1,801	2,112	1,820	708	1,355
68	1,801	2,112	1,820	708	1,355
69	1,801	2,112	1,820	708	1,395
70	1,856	2,176	1,874	728	1,438
71	1,911	2,242	1,932	749	1,480
72	1,978	2,320	1,998	776	1,531
73	2,046	2,401	2,069	802	1,585
74	2,119	2,485	2,141	831	1,642
75	2,192	2,571	2,216	860	1,698
76	2,269	2,661	2,293	892	1,756
77	2,359	2,769	2,386	927	1,829
78	2,454	2,878	2,480	962	1,901
79	2,553	2,992	2,578	1,002	1,977
80	2,655	3,114	2,683	1,041	2,055
81	2,761	3,237	2,789	1,084	2,138
82	2,872	3,366	2,900	1,126	2,224
83	2,989	3,501	3,016	1,170	2,312
84	3,109	3,642	3,137	1,218	2,405
85	3,233	3,788	3,264	1,267	2,502
86	3,361	3,940	3,392	1,318	2,602
87	3,498	4,096	3,531	1,370	2,707
88	3,636	4,261	3,670	1,425	2,816
89	3,781	4,431	3,816	1,481	2,928
90	3,933	4,608	3,970	1,542	3,046
91	4,090	4,793	4,127	1,604	3,169
92	4,253	4,984	4,293	1,666	3,293
93	4,424	5,184	4,465	1,735	3,427
94	4,600	5,391	4,643	1,803	3,563
95	4,784	5,607	4,827	1,875	3,706
96	4,974	5,832	5,020	1,951	3,853
97	5,173	6,066	5,221	2,028	4,009
98	5,380	6,307	5,429	2,108	4,169
99	5,594	6,560	5,647	2,193	4,335

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

Household Discount Factor .88

ELIPS LIFE INSURANCE COMPANY

LOUISIANA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 700-704, 707-708

	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
0-64	6,524	7,649	6,587	2,562	4,903	0-64	7,247	8,495	7,322	2,846	5,450
65	1,679	1,970	1,697	659	1,263	65	1,866	2,189	1,885	732	1,404
66	1,679	1,970	1,697	659	1,263	66	1,866	2,189	1,885	732	1,404
67	1,679	1,970	1,697	659	1,263	67	1,866	2,189	1,885	732	1,404
68	1,679	1,970	1,697	659	1,263	68	1,866	2,189	1,885	732	1,404
69	1,679	1,970	1,697	659	1,301	69	1,866	2,189	1,885	732	1,445
70	1,729	2,028	1,748	679	1,339	70	1,922	2,254	1,942	754	1,489
71	1,781	2,089	1,801	699	1,379	71	1,979	2,322	2,001	777	1,533
72	1,844	2,162	1,864	723	1,428	72	2,049	2,403	2,070	803	1,587
73	1,909	2,238	1,929	749	1,477	73	2,120	2,487	2,143	832	1,643
74	1,975	2,317	1,997	776	1,530	74	2,195	2,575	2,219	861	1,701
75	2,045	2,398	2,066	802	1,583	75	2,271	2,664	2,296	891	1,759
76	2,116	2,482	2,139	830	1,639	76	2,351	2,757	2,376	923	1,821
77	2,200	2,581	2,224	864	1,705	77	2,445	2,869	2,472	961	1,895
78	2,289	2,684	2,312	898	1,772	78	2,543	2,982	2,570	997	1,970
79	2,380	2,790	2,405	934	1,843	79	2,645	3,100	2,671	1,037	2,048
80	2,476	2,903	2,502	971	1,917	80	2,751	3,226	2,779	1,078	2,130
81	2,575	3,019	2,601	1,010	1,993	81	2,861	3,354	2,891	1,124	2,215
82	2,679	3,139	2,704	1,051	2,073	82	2,976	3,487	3,005	1,168	2,303
83	2,787	3,265	2,812	1,093	2,156	83	3,095	3,628	3,125	1,213	2,396
84	2,899	3,395	2,925	1,135	2,243	84	3,221	3,773	3,250	1,262	2,491
85	3,014	3,532	3,042	1,180	2,332	85	3,348	3,924	3,380	1,312	2,592
86	3,134	3,673	3,163	1,230	2,427	86	3,483	4,081	3,515	1,366	2,697
87	3,260	3,819	3,291	1,277	2,524	87	3,622	4,245	3,657	1,419	2,804
88	3,391	3,972	3,423	1,329	2,626	88	3,767	4,414	3,802	1,476	2,916
89	3,525	4,131	3,558	1,382	2,732	89	3,918	4,591	3,955	1,536	3,034
90	3,666	4,297	3,701	1,437	2,840	90	4,075	4,774	4,113	1,596	3,156
91	3,814	4,468	3,850	1,494	2,954	91	4,238	4,966	4,277	1,661	3,283
92	3,965	4,648	4,003	1,554	3,071	92	4,406	5,164	4,448	1,727	3,412
93	4,124	4,833	4,162	1,617	3,195	93	4,583	5,370	4,627	1,796	3,550
94	4,289	5,027	4,329	1,682	3,323	94	4,765	5,585	4,810	1,868	3,692
95	4,460	5,229	4,502	1,749	3,455	95	4,956	5,809	5,002	1,942	3,840
96	4,639	5,438	4,681	1,818	3,593	96	5,153	6,043	5,201	2,021	3,993
97	4,823	5,656	4,867	1,891	3,738	97	5,360	6,285	5,409	2,101	4,153
98	5,018	5,882	5,063	1,966	3,887	98	5,574	6,535	5,626	2,184	4,319
99	5,217	6,116	5,266	2,044	4,042	99	5,797	6,796	5,850	2,272	4,492

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

Household Discount Factor .88

ELIPS LIFE INSURANCE COMPANY

LOUISIANA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 700-704, 707-708

	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
0-64	5,622	6,592	5,677	2,208	4,225	0-64	6,246	7,321	6,310	2,453	4,697
65	1,447	1,697	1,463	568	1,089	65	1,608	1,886	1,624	631	1,210
66	1,447	1,697	1,463	568	1,089	66	1,608	1,886	1,624	631	1,210
67	1,447	1,697	1,463	568	1,089	67	1,608	1,886	1,624	631	1,210
68	1,447	1,697	1,463	568	1,089	68	1,608	1,886	1,624	631	1,210
69	1,447	1,697	1,463	568	1,121	69	1,608	1,886	1,624	631	1,245
70	1,490	1,748	1,506	585	1,154	70	1,657	1,943	1,674	650	1,283
71	1,535	1,800	1,552	602	1,189	71	1,706	2,001	1,724	670	1,321
72	1,589	1,864	1,606	623	1,231	72	1,765	2,071	1,784	692	1,368
73	1,645	1,929	1,662	646	1,273	73	1,827	2,143	1,847	717	1,416
74	1,702	1,996	1,721	669	1,319	74	1,892	2,219	1,912	742	1,466
75	1,762	2,066	1,780	691	1,365	75	1,957	2,296	1,979	768	1,516
76	1,824	2,139	1,843	716	1,412	76	2,026	2,376	2,047	796	1,569
77	1,896	2,225	1,917	745	1,469	77	2,107	2,472	2,130	828	1,633
78	1,973	2,313	1,992	774	1,527	78	2,192	2,569	2,215	859	1,697
79	2,051	2,404	2,073	805	1,588	79	2,279	2,671	2,302	894	1,765
80	2,133	2,502	2,156	837	1,652	80	2,371	2,780	2,395	929	1,835
81	2,219	2,602	2,241	870	1,717	81	2,466	2,890	2,491	968	1,909
82	2,309	2,705	2,331	906	1,786	82	2,564	3,005	2,590	1,006	1,984
83	2,402	2,814	2,423	942	1,858	83	2,668	3,126	2,693	1,045	2,065
84	2,498	2,926	2,521	978	1,933	84	2,775	3,251	2,801	1,087	2,147
85	2,598	3,044	2,622	1,017	2,010	85	2,885	3,382	2,913	1,131	2,234
86	2,701	3,165	2,726	1,060	2,091	86	3,001	3,517	3,029	1,178	2,324
87	2,810	3,292	2,836	1,101	2,175	87	3,122	3,658	3,151	1,223	2,416
88	2,922	3,423	2,950	1,145	2,263	88	3,247	3,804	3,276	1,272	2,513
89	3,038	3,560	3,067	1,191	2,354	89	3,376	3,956	3,408	1,323	2,614
90	3,159	3,703	3,189	1,239	2,447	90	3,511	4,114	3,545	1,376	2,720
91	3,287	3,851	3,318	1,288	2,545	91	3,652	4,279	3,686	1,431	2,829
92	3,417	4,006	3,449	1,339	2,647	92	3,797	4,450	3,834	1,488	2,941
93	3,554	4,165	3,587	1,393	2,754	93	3,949	4,628	3,987	1,548	3,060
94	3,696	4,332	3,730	1,449	2,864	94	4,106	4,814	4,145	1,609	3,182
95	3,844	4,506	3,879	1,507	2,977	95	4,271	5,006	4,310	1,674	3,309
96	3,997	4,686	4,034	1,567	3,096	96	4,441	5,208	4,482	1,742	3,441
97	4,157	4,874	4,195	1,629	3,221	97	4,619	5,416	4,661	1,811	3,579
98	4,324	5,069	4,363	1,694	3,350	98	4,803	5,632	4,848	1,882	3,722
99	4,496	5,271	4,539	1,762	3,484	99	4,996	5,856	5,042	1,958	3,871

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 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