Lumico
medigap solutions
Underwritten by
Elips Life Insurance Company

Elips Life Insurance Company
Home: 1450 American Lane, Suite 1100,Schaumburg, IL 60173
Admin: P.O. Box 10875, Clearwater, FL 33757
Elipslife.lumico.com

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE

BENEFIT PLANS A, F, G, N AND HIGH DEDUCTIBLE PLAN G

Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020

This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available in your state. Only applicants' first eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

Note: A ✓ means 100% of the benefit is paid.

Benefits	Plans available to all applicants									Medicare first eligible before 2020 only		
	A	B	D	G	G[1]	K	L	M	N	C	F	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	
Medicare Part B coinsurance or copayment	✓	✓	✓	✓		50%	75%	✓	copays apply[3]	✓	✓	
Blood (first three pints)	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓	
Part A hospice care coinsurance or copayment	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓	
Skilled nursing facility coinsurance			✓	✓		50%	75%	✓	✓	✓	✓	
Medicare Part A deductible		✓	✓	✓		50%	75%	50%	✓	✓	✓	
Medicare Part B deductible										✓	✓	
Medicare Part B excess charges				✓							✓	
Foreign travel emergency (up to plan limits)			✓	✓				✓	✓	✓	✓	
Out-of-pocket limit in 2024[2]						$7060[2]	$3530[2]					

[1]Plans F and G also have a high deductible option which requires first paying a plan deductible of $2800 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

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

[3]Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that do not result in an inpatient admission.

ELIPS LIFE INSURANCE COMPANY

MISSISSIPPI Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 394, 395

	Preferred				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	6,304	7,770	6,366	2,547	4,879
65	1,623	2,001	1,639	656	1,257
66	1,623	2,001	1,639	656	1,257
67	1,623	2,001	1,639	656	1,257
68	1,623	2,001	1,639	656	1,257
69	1,623	2,001	1,639	656	1,294
70	1,672	2,062	1,690	676	1,332
71	1,722	2,123	1,740	696	1,372
72	1,781	2,197	1,800	720	1,421
73	1,843	2,274	1,863	745	1,470
74	1,909	2,354	1,929	771	1,523
75	1,976	2,436	1,996	799	1,576
76	2,045	2,522	2,066	826	1,631
77	2,126	2,622	2,148	859	1,696
78	2,212	2,726	2,234	893	1,763
79	2,299	2,835	2,323	929	1,833
80	2,391	2,950	2,416	967	1,908
81	2,488	3,067	2,513	1,005	1,983
82	2,588	3,189	2,613	1,045	2,062
83	2,691	3,316	2,717	1,087	2,146
84	2,800	3,449	2,825	1,130	2,232
85	2,912	3,588	2,938	1,175	2,321
86	3,027	3,732	3,056	1,223	2,414
87	3,150	3,881	3,179	1,271	2,512
88	3,274	4,036	3,306	1,322	2,612
89	3,406	4,198	3,438	1,376	2,717
90	3,542	4,365	3,575	1,430	2,826
91	3,683	4,541	3,717	1,488	2,939
92	3,830	4,723	3,867	1,546	3,056
93	3,983	4,910	4,020	1,609	3,179
94	4,143	5,108	4,182	1,673	3,307
95	4,308	5,313	4,348	1,740	3,438
96	4,481	5,526	4,521	1,810	3,576
97	4,660	5,746	4,702	1,881	3,720
98	4,847	5,976	4,891	1,957	3,868
99	5,040	6,215	5,086	2,035	4,022

	Standard				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	6,999	8,636	7,070	2,831	5,418
65	1,802	2,224	1,821	729	1,397
66	1,802	2,224	1,821	729	1,397
67	1,802	2,224	1,821	729	1,397
68	1,802	2,224	1,821	729	1,397
69	1,802	2,224	1,821	729	1,438
70	1,858	2,291	1,877	750	1,483
71	1,912	2,360	1,933	772	1,526
72	1,979	2,442	2,000	800	1,578
73	2,048	2,528	2,070	827	1,634
74	2,120	2,615	2,144	857	1,692
75	2,194	2,706	2,217	887	1,751
76	2,271	2,802	2,295	919	1,811
77	2,362	2,914	2,387	956	1,884
78	2,456	3,030	2,482	992	1,960
79	2,554	3,150	2,581	1,032	2,038
80	2,657	3,277	2,685	1,073	2,119
81	2,764	3,407	2,791	1,117	2,204
82	2,874	3,543	2,903	1,161	2,292
83	2,991	3,685	3,018	1,206	2,383
84	3,111	3,833	3,139	1,255	2,480
85	3,235	3,988	3,267	1,306	2,580
86	3,363	4,147	3,395	1,359	2,682
87	3,499	4,312	3,533	1,412	2,790
88	3,640	4,485	3,673	1,468	2,903
89	3,783	4,665	3,819	1,527	3,018
90	3,936	4,851	3,973	1,589	3,140
91	4,094	5,045	4,130	1,653	3,267
92	4,257	5,247	4,296	1,717	3,396
93	4,428	5,457	4,469	1,789	3,533
94	4,603	5,675	4,647	1,859	3,673
95	4,787	5,903	4,832	1,933	3,821
96	4,977	6,140	5,024	2,011	3,972
97	5,177	6,386	5,224	2,091	4,133
98	5,385	6,639	5,434	2,173	4,297
99	5,598	6,906	5,652	2,261	4,469

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

Household Discount Factor .88

ELIPS LIFE INSURANCE COMPANY

MISSISSIPPI Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 394, 395

	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	5,884	7,252	5,942	2,377	4,554	0-64	6,532	8,060	6,598	2,643	5,057
65	1,515	1,867	1,530	612	1,173	65	1,682	2,076	1,699	680	1,304
66	1,515	1,867	1,530	612	1,173	66	1,682	2,076	1,699	680	1,304
67	1,515	1,867	1,530	612	1,173	67	1,682	2,076	1,699	680	1,304
68	1,515	1,867	1,530	612	1,173	68	1,682	2,076	1,699	680	1,304
69	1,515	1,867	1,530	612	1,208	69	1,682	2,076	1,699	680	1,342
70	1,560	1,924	1,577	631	1,243	70	1,734	2,138	1,751	700	1,384
71	1,607	1,982	1,624	649	1,281	71	1,785	2,202	1,804	721	1,424
72	1,662	2,050	1,680	672	1,327	72	1,847	2,279	1,867	747	1,473
73	1,720	2,122	1,739	695	1,372	73	1,911	2,359	1,932	772	1,525
74	1,782	2,197	1,800	720	1,421	74	1,979	2,441	2,001	800	1,579
75	1,844	2,274	1,863	746	1,471	75	2,047	2,525	2,069	828	1,634
76	1,908	2,354	1,928	771	1,522	76	2,119	2,615	2,142	858	1,690
77	1,984	2,447	2,005	802	1,583	77	2,204	2,720	2,228	892	1,759
78	2,064	2,545	2,085	833	1,645	78	2,293	2,828	2,317	926	1,829
79	2,146	2,646	2,168	867	1,711	79	2,384	2,940	2,409	963	1,902
80	2,231	2,753	2,255	903	1,781	80	2,480	3,059	2,506	1,001	1,978
81	2,322	2,862	2,346	938	1,851	81	2,579	3,180	2,605	1,043	2,057
82	2,415	2,977	2,439	975	1,925	82	2,682	3,307	2,709	1,083	2,139
83	2,512	3,095	2,536	1,015	2,003	83	2,791	3,440	2,817	1,126	2,224
84	2,614	3,219	2,636	1,054	2,083	84	2,903	3,578	2,929	1,172	2,314
85	2,718	3,349	2,742	1,097	2,166	85	3,020	3,722	3,049	1,219	2,408
86	2,826	3,484	2,853	1,142	2,253	86	3,139	3,871	3,168	1,268	2,504
87	2,940	3,623	2,967	1,186	2,345	87	3,266	4,025	3,297	1,318	2,604
88	3,056	3,767	3,085	1,234	2,438	88	3,397	4,186	3,428	1,370	2,709
89	3,179	3,918	3,209	1,284	2,536	89	3,531	4,354	3,564	1,425	2,817
90	3,305	4,074	3,337	1,335	2,638	90	3,673	4,528	3,709	1,483	2,930
91	3,437	4,239	3,470	1,389	2,743	91	3,821	4,708	3,855	1,543	3,049
92	3,575	4,408	3,609	1,443	2,853	92	3,973	4,898	4,010	1,603	3,169
93	3,718	4,583	3,752	1,502	2,967	93	4,132	5,093	4,171	1,669	3,297
94	3,866	4,767	3,903	1,561	3,086	94	4,296	5,297	4,337	1,735	3,428
95	4,021	4,959	4,059	1,624	3,209	95	4,468	5,509	4,509	1,804	3,566
96	4,182	5,157	4,220	1,689	3,338	96	4,646	5,731	4,689	1,877	3,707
97	4,349	5,363	4,389	1,756	3,472	97	4,831	5,961	4,876	1,952	3,857
98	4,524	5,578	4,564	1,826	3,610	98	5,026	6,196	5,071	2,028	4,011
99	4,704	5,800	4,747	1,899	3,754	99	5,225	6,445	5,275	2,110	4,171

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

Household Discount Factor .88

ELIPS LIFE INSURANCE COMPANY

MISSISSIPPI Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 394, 395

	Preferred				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	5,627	6,940	5,685	2,275	4,354
65	1,448	1,787	1,464	585	1,122
66	1,448	1,787	1,464	585	1,122
67	1,448	1,787	1,464	585	1,122
68	1,448	1,787	1,464	585	1,122
69	1,448	1,787	1,464	585	1,155
70	1,491	1,840	1,508	603	1,190
71	1,537	1,895	1,553	621	1,225
72	1,590	1,962	1,607	642	1,269
73	1,646	2,031	1,664	666	1,313
74	1,704	2,102	1,722	689	1,359
75	1,763	2,175	1,782	712	1,407
76	1,825	2,251	1,844	738	1,456
77	1,898	2,341	1,918	768	1,514
78	1,974	2,435	1,994	797	1,575
79	2,052	2,531	2,075	829	1,637
80	2,135	2,633	2,158	863	1,703
81	2,220	2,739	2,244	897	1,771
82	2,311	2,848	2,333	934	1,842
83	2,403	2,961	2,425	971	1,915
84	2,500	3,080	2,522	1,008	1,992
85	2,600	3,204	2,623	1,048	2,072
86	2,703	3,332	2,729	1,092	2,156
87	2,811	3,465	2,838	1,135	2,242
88	2,924	3,604	2,952	1,180	2,333
89	3,041	3,747	3,070	1,228	2,426
90	3,162	3,897	3,192	1,277	2,523
91	3,289	4,054	3,320	1,328	2,624
92	3,420	4,216	3,453	1,380	2,729
93	3,557	4,384	3,591	1,437	2,838
94	3,698	4,561	3,733	1,494	2,953
95	3,847	4,743	3,882	1,554	3,070
96	4,000	4,933	4,037	1,615	3,192
97	4,160	5,131	4,198	1,680	3,320
98	4,327	5,336	4,366	1,746	3,454
99	4,500	5,549	4,542	1,816	3,592

	Standard				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	6,251	7,710	6,313	2,529	4,839
65	1,609	1,985	1,626	651	1,247
66	1,609	1,985	1,626	651	1,247
67	1,609	1,985	1,626	651	1,247
68	1,609	1,985	1,626	651	1,247
69	1,609	1,985	1,626	651	1,283
70	1,658	2,044	1,675	670	1,323
71	1,707	2,106	1,726	690	1,362
72	1,766	2,181	1,785	715	1,410
73	1,829	2,256	1,849	739	1,459
74	1,893	2,335	1,913	766	1,510
75	1,959	2,417	1,980	791	1,563
76	2,028	2,502	2,049	820	1,617
77	2,109	2,601	2,131	854	1,683
78	2,194	2,704	2,216	886	1,750
79	2,281	2,812	2,304	922	1,820
80	2,372	2,927	2,397	958	1,892
81	2,468	3,043	2,492	997	1,968
82	2,567	3,164	2,591	1,037	2,046
83	2,670	3,291	2,696	1,077	2,128
84	2,777	3,423	2,803	1,121	2,214
85	2,888	3,561	2,916	1,165	2,303
86	3,004	3,703	3,032	1,213	2,395
87	3,124	3,850	3,154	1,261	2,492
88	3,250	4,004	3,279	1,311	2,591
89	3,378	4,164	3,410	1,363	2,696
90	3,514	4,332	3,547	1,418	2,804
91	3,655	4,505	3,688	1,476	2,917
92	3,800	4,685	3,835	1,534	3,032
93	3,952	4,872	3,990	1,596	3,154
94	4,110	5,066	4,148	1,659	3,280
95	4,275	5,270	4,314	1,726	3,410
96	4,445	5,482	4,485	1,795	3,547
97	4,622	5,701	4,665	1,867	3,690
98	4,807	5,928	4,852	1,941	3,837
99	5,000	6,165	5,046	2,018	3,990

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

Household Discount Factor .88

ELIPS LIFE INSURANCE COMPANY

MISSISSIPPI Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 394, 395

	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
0-64	5,252	6,477	5,306	2,123	4,064	0-64	5,834	7,196	5,892	2,360	4,517
65	1,351	1,667	1,366	546	1,047	65	1,502	1,852	1,518	608	1,163
66	1,351	1,667	1,366	546	1,047	66	1,502	1,852	1,518	608	1,163
67	1,351	1,667	1,366	546	1,047	67	1,502	1,852	1,518	608	1,163
68	1,351	1,667	1,366	546	1,047	68	1,502	1,852	1,518	608	1,163
69	1,351	1,667	1,366	546	1,078	69	1,502	1,852	1,518	608	1,198
70	1,392	1,718	1,408	563	1,110	70	1,548	1,908	1,563	625	1,235
71	1,435	1,769	1,449	580	1,144	71	1,594	1,966	1,611	644	1,271
72	1,484	1,831	1,500	599	1,184	72	1,649	2,035	1,666	667	1,316
73	1,536	1,895	1,553	621	1,226	73	1,707	2,106	1,725	690	1,362
74	1,590	1,962	1,607	643	1,268	74	1,767	2,180	1,786	715	1,410
75	1,645	2,030	1,663	665	1,313	75	1,828	2,256	1,848	739	1,458
76	1,704	2,101	1,721	689	1,359	76	1,893	2,335	1,912	766	1,509
77	1,771	2,185	1,790	717	1,413	77	1,969	2,428	1,989	797	1,571
78	1,843	2,273	1,862	744	1,470	78	2,047	2,524	2,068	827	1,633
79	1,916	2,363	1,936	774	1,528	79	2,129	2,625	2,150	860	1,698
80	1,992	2,458	2,014	805	1,589	80	2,214	2,732	2,238	894	1,766
81	2,072	2,556	2,094	837	1,653	81	2,303	2,840	2,326	931	1,837
82	2,157	2,658	2,177	872	1,719	82	2,395	2,953	2,418	968	1,909
83	2,243	2,764	2,264	906	1,788	83	2,492	3,072	2,516	1,006	1,986
84	2,333	2,875	2,354	941	1,859	84	2,592	3,195	2,616	1,046	2,066
85	2,427	2,991	2,448	979	1,934	85	2,696	3,323	2,722	1,088	2,149
86	2,523	3,110	2,547	1,019	2,012	86	2,804	3,456	2,830	1,132	2,235
87	2,624	3,234	2,649	1,060	2,092	87	2,916	3,594	2,944	1,177	2,326
88	2,729	3,364	2,755	1,101	2,177	88	3,033	3,737	3,060	1,224	2,418
89	2,838	3,498	2,865	1,146	2,265	89	3,153	3,887	3,183	1,273	2,516
90	2,951	3,638	2,979	1,192	2,355	90	3,279	4,043	3,311	1,323	2,617
91	3,070	3,784	3,099	1,239	2,449	91	3,411	4,204	3,443	1,377	2,723
92	3,192	3,935	3,222	1,288	2,547	92	3,546	4,372	3,580	1,431	2,830
93	3,320	4,092	3,351	1,341	2,649	93	3,689	4,547	3,724	1,490	2,944
94	3,452	4,257	3,484	1,394	2,756	94	3,836	4,729	3,872	1,549	3,061
95	3,590	4,427	3,623	1,450	2,865	95	3,990	4,919	4,026	1,611	3,183
96	3,733	4,605	3,768	1,507	2,979	96	4,149	5,117	4,186	1,676	3,311
97	3,883	4,788	3,918	1,568	3,099	97	4,314	5,321	4,354	1,742	3,444
98	4,039	4,980	4,075	1,630	3,223	98	4,487	5,533	4,528	1,812	3,581
99	4,200	5,179	4,239	1,695	3,352	99	4,666	5,754	4,710	1,883	3,724

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) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

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

PLAN A

PARTS A & B

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

PLAN F

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

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

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

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

PLAN F

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

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

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

(continued)

PLAN F

PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN G

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

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

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

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

PLAN G

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

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

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

(continued)

PLAN G

PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

HIGH DEDUCTIBLE PLAN G

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

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

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

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

(continued)

HIGH DEDUCTIBLE PLAN G

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

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

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

(continued)

HIGH DEDUCTIBLE PLAN G

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

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

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

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

(continued)

HIGH DEDUCTIBLE PLAN G

PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN N

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

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

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

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

PLAN N

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

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

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

(continued)

PLAN N

PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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