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

SOUTH CAROLINA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 294, 295, 298, 299

	Preferred				
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,574	1,945	1,590	636	1,214
66	1,574	1,945	1,590	636	1,214
67	1,574	1,945	1,590	636	1,214
68	1,574	1,945	1,590	636	1,214
69	1,574	1,945	1,590	636	1,251
70	1,622	2,004	1,638	656	1,288
71	1,670	2,064	1,687	676	1,326
72	1,728	2,136	1,746	699	1,374
73	1,788	2,210	1,808	723	1,421
74	1,851	2,288	1,871	749	1,472
75	1,916	2,368	1,936	775	1,523
76	1,983	2,452	2,004	802	1,575
77	2,062	2,549	2,084	833	1,639
78	2,145	2,650	2,168	867	1,704
79	2,231	2,757	2,255	902	1,772
80	2,320	2,867	2,344	938	1,843
81	2,413	2,982	2,438	975	1,916
82	2,510	3,100	2,535	1,014	1,993
83	2,612	3,224	2,636	1,055	2,074
84	2,717	3,353	2,741	1,096	2,156
85	2,826	3,488	2,851	1,140	2,242
86	2,937	3,628	2,966	1,186	2,333
87	3,055	3,774	3,085	1,233	2,428
88	3,177	3,923	3,207	1,282	2,525
89	3,304	4,080	3,335	1,335	2,626
90	3,436	4,244	3,468	1,388	2,732
91	3,573	4,415	3,607	1,443	2,840
92	3,715	4,591	3,752	1,501	2,955
93	3,865	4,774	3,901	1,561	3,073
94	4,019	4,966	4,057	1,623	3,195
95	4,180	5,165	4,219	1,687	3,323
96	4,347	5,372	4,387	1,755	3,455
97	4,521	5,587	4,562	1,825	3,594
98	4,702	5,811	4,745	1,897	3,739
99	4,890	6,042	4,935	1,975	3,887

	Standard				
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,749	2,162	1,767	708	1,349
66	1,749	2,162	1,767	708	1,349
67	1,749	2,162	1,767	708	1,349
68	1,749	2,162	1,767	708	1,349
69	1,749	2,162	1,767	708	1,390
70	1,801	2,227	1,820	728	1,432
71	1,856	2,294	1,875	750	1,475
72	1,919	2,374	1,940	776	1,525
73	1,987	2,457	2,009	803	1,579
74	2,057	2,543	2,079	831	1,635
75	2,128	2,631	2,151	860	1,691
76	2,203	2,724	2,226	892	1,751
77	2,291	2,833	2,316	927	1,821
78	2,384	2,946	2,408	962	1,894
79	2,478	3,063	2,504	1,001	1,969
80	2,578	3,186	2,604	1,041	2,047
81	2,681	3,312	2,709	1,084	2,130
82	2,788	3,444	2,816	1,127	2,215
83	2,902	3,584	2,928	1,171	2,303
84	3,019	3,727	3,045	1,218	2,397
85	3,139	3,877	3,169	1,267	2,493
86	3,263	4,032	3,294	1,319	2,593
87	3,396	4,193	3,428	1,370	2,697
88	3,531	4,361	3,563	1,424	2,805
89	3,671	4,534	3,706	1,482	2,917
90	3,819	4,716	3,854	1,541	3,034
91	3,971	4,905	4,008	1,604	3,158
92	4,130	5,101	4,169	1,667	3,281
93	4,295	5,305	4,336	1,735	3,414
94	4,466	5,517	4,508	1,803	3,550
95	4,645	5,738	4,688	1,875	3,692
96	4,830	5,970	4,875	1,951	3,839
97	5,023	6,208	5,069	2,029	3,994
98	5,224	6,455	5,271	2,108	4,153
99	5,432	6,714	5,483	2,193	4,318

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

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

Household Discount Factor .88

ELIPS LIFE INSURANCE COMPANY

SOUTH CAROLINA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 294, 295, 298, 299

	Preferred				
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,454	1,797	1,469	588	1,121
66	1,454	1,797	1,469	588	1,121
67	1,454	1,797	1,469	588	1,121
68	1,454	1,797	1,469	588	1,121
69	1,454	1,797	1,469	588	1,156
70	1,498	1,852	1,513	606	1,190
71	1,543	1,907	1,558	624	1,225
72	1,596	1,973	1,613	646	1,269
73	1,652	2,041	1,670	668	1,313
74	1,710	2,114	1,728	692	1,360
75	1,770	2,187	1,788	716	1,407
76	1,832	2,265	1,852	740	1,455
77	1,905	2,355	1,925	770	1,515
78	1,982	2,448	2,002	801	1,575
79	2,061	2,547	2,083	833	1,637
80	2,143	2,649	2,165	867	1,703
81	2,229	2,755	2,252	900	1,770
82	2,319	2,864	2,342	937	1,841
83	2,413	2,978	2,435	975	1,916
84	2,510	3,098	2,532	1,012	1,992
85	2,610	3,223	2,634	1,053	2,072
86	2,713	3,352	2,740	1,096	2,155
87	2,822	3,486	2,850	1,139	2,243
88	2,935	3,624	2,963	1,185	2,332
89	3,052	3,769	3,081	1,233	2,426
90	3,175	3,920	3,204	1,282	2,524
91	3,301	4,079	3,333	1,333	2,624
92	3,432	4,241	3,466	1,386	2,730
93	3,571	4,410	3,603	1,442	2,839
94	3,712	4,588	3,748	1,499	2,952
95	3,861	4,771	3,898	1,558	3,070
96	4,016	4,963	4,053	1,621	3,192
97	4,177	5,161	4,215	1,686	3,320
98	4,344	5,368	4,384	1,753	3,454
99	4,517	5,582	4,559	1,824	3,591

	Standard				
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,615	1,997	1,633	654	1,247
66	1,615	1,997	1,633	654	1,247
67	1,615	1,997	1,633	654	1,247
68	1,615	1,997	1,633	654	1,247
69	1,615	1,997	1,633	654	1,284
70	1,664	2,057	1,682	672	1,323
71	1,714	2,119	1,732	693	1,363
72	1,773	2,194	1,793	717	1,409
73	1,835	2,270	1,856	741	1,458
74	1,901	2,349	1,921	768	1,510
75	1,966	2,431	1,987	794	1,562
76	2,035	2,517	2,056	824	1,617
77	2,116	2,617	2,140	857	1,683
78	2,202	2,721	2,224	889	1,750
79	2,290	2,829	2,313	925	1,819
80	2,381	2,944	2,406	961	1,891
81	2,477	3,060	2,502	1,001	1,968
82	2,576	3,182	2,601	1,041	2,046
83	2,681	3,311	2,705	1,082	2,128
84	2,789	3,443	2,813	1,125	2,214
85	2,900	3,581	2,927	1,170	2,303
86	3,015	3,725	3,043	1,218	2,396
87	3,137	3,873	3,167	1,266	2,491
88	3,262	4,028	3,292	1,316	2,591
89	3,392	4,189	3,423	1,369	2,695
90	3,528	4,357	3,561	1,424	2,803
91	3,669	4,531	3,702	1,482	2,917
92	3,815	4,712	3,851	1,540	3,031
93	3,968	4,901	4,006	1,603	3,154
94	4,126	5,096	4,165	1,665	3,280
95	4,291	5,301	4,331	1,732	3,411
96	4,462	5,515	4,504	1,803	3,546
97	4,640	5,735	4,683	1,874	3,690
98	4,826	5,963	4,869	1,947	3,837
99	5,018	6,202	5,065	2,026	3,989

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

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

Household Discount Factor .88

ELIPS LIFE INSURANCE COMPANY

SOUTH CAROLINA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 294, 295, 298, 299

	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	1,406	1,737	1,420	568	1,085	65	1,561	1,930	1,578	632	1,205
66	1,406	1,737	1,420	568	1,085	66	1,561	1,930	1,578	632	1,205
67	1,406	1,737	1,420	568	1,085	67	1,561	1,930	1,578	632	1,205
68	1,406	1,737	1,420	568	1,085	68	1,561	1,930	1,578	632	1,205
69	1,406	1,737	1,420	568	1,117	69	1,561	1,930	1,578	632	1,240
70	1,448	1,789	1,463	585	1,150	70	1,609	1,987	1,625	650	1,279
71	1,491	1,843	1,507	603	1,185	71	1,656	2,047	1,675	669	1,316
72	1,542	1,908	1,559	623	1,226	72	1,714	2,120	1,732	692	1,363
73	1,596	1,974	1,614	645	1,269	73	1,774	2,194	1,794	717	1,410
74	1,653	2,043	1,670	668	1,313	74	1,837	2,270	1,857	742	1,460
75	1,711	2,114	1,729	691	1,359	75	1,901	2,350	1,921	768	1,510
76	1,771	2,188	1,789	716	1,407	76	1,967	2,431	1,988	796	1,563
77	1,841	2,277	1,861	745	1,463	77	2,046	2,529	2,068	828	1,626
78	1,915	2,367	1,935	774	1,521	78	2,128	2,630	2,150	859	1,690
79	1,991	2,461	2,012	805	1,583	79	2,213	2,734	2,236	894	1,758
80	2,072	2,560	2,094	837	1,646	80	2,302	2,845	2,326	929	1,828
81	2,154	2,663	2,176	871	1,711	81	2,394	2,958	2,418	968	1,902
82	2,241	2,769	2,263	905	1,781	82	2,489	3,076	2,515	1,007	1,978
83	2,332	2,879	2,354	942	1,851	83	2,591	3,200	2,615	1,045	2,056
84	2,426	2,995	2,448	978	1,926	84	2,695	3,328	2,719	1,087	2,139
85	2,523	3,115	2,546	1,018	2,003	85	2,803	3,461	2,829	1,131	2,225
86	2,623	3,240	2,647	1,060	2,083	86	2,914	3,600	2,941	1,177	2,315
87	2,729	3,369	2,754	1,101	2,166	87	3,031	3,744	3,061	1,224	2,408
88	2,837	3,503	2,863	1,145	2,255	88	3,153	3,893	3,182	1,272	2,504
89	2,950	3,643	2,978	1,191	2,345	89	3,278	4,048	3,309	1,323	2,605
90	3,068	3,789	3,097	1,238	2,439	90	3,409	4,211	3,442	1,376	2,710
91	3,191	3,942	3,220	1,289	2,537	91	3,546	4,380	3,579	1,432	2,819
92	3,319	4,099	3,349	1,340	2,637	92	3,687	4,555	3,722	1,488	2,930
93	3,451	4,263	3,484	1,394	2,743	93	3,834	4,736	3,871	1,549	3,048
94	3,589	4,433	3,622	1,449	2,853	94	3,988	4,926	4,025	1,610	3,170
95	3,732	4,612	3,767	1,507	2,967	95	4,148	5,124	4,185	1,675	3,296
96	3,881	4,797	3,917	1,567	3,085	96	4,313	5,329	4,352	1,742	3,428
97	4,036	4,989	4,074	1,629	3,209	97	4,485	5,543	4,526	1,811	3,565
98	4,198	5,187	4,236	1,695	3,337	98	4,665	5,763	4,707	1,883	3,708
99	4,366	5,394	4,407	1,763	3,471	99	4,851	5,994	4,895	1,958	3,857

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

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

Household Discount Factor .88

ELIPS LIFE INSURANCE COMPANY

SOUTH CAROLINA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 294, 295, 298, 299

	Preferred				
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,299	1,605	1,312	525	1,002
66	1,299	1,605	1,312	525	1,002
67	1,299	1,605	1,312	525	1,002
68	1,299	1,605	1,312	525	1,002
69	1,299	1,605	1,312	525	1,032
70	1,337	1,652	1,352	541	1,062
71	1,377	1,703	1,392	557	1,095
72	1,425	1,762	1,440	575	1,133
73	1,475	1,823	1,491	596	1,172
74	1,527	1,887	1,543	617	1,213
75	1,581	1,953	1,597	639	1,256
76	1,636	2,022	1,653	661	1,300
77	1,701	2,103	1,719	689	1,352
78	1,769	2,186	1,787	715	1,406
79	1,839	2,273	1,859	744	1,463
80	1,914	2,365	1,934	773	1,521
81	1,990	2,460	2,011	805	1,581
82	2,071	2,558	2,091	836	1,645
83	2,154	2,659	2,174	870	1,710
84	2,241	2,766	2,261	903	1,779
85	2,330	2,878	2,352	940	1,851
86	2,423	2,993	2,445	979	1,924
87	2,521	3,113	2,544	1,017	2,001
88	2,621	3,236	2,645	1,058	2,083
89	2,726	3,365	2,751	1,100	2,166
90	2,834	3,501	2,861	1,144	2,253
91	2,948	3,641	2,975	1,191	2,344
92	3,066	3,787	3,094	1,237	2,436
93	3,188	3,938	3,218	1,287	2,534
94	3,315	4,096	3,346	1,338	2,636
95	3,448	4,260	3,480	1,392	2,741
96	3,585	4,431	3,619	1,447	2,850
97	3,729	4,608	3,763	1,505	2,965
98	3,878	4,792	3,913	1,565	3,083
99	4,033	4,983	4,071	1,629	3,206

	Standard				
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,442	1,783	1,457	584	1,113
66	1,442	1,783	1,457	584	1,113
67	1,442	1,783	1,457	584	1,113
68	1,442	1,783	1,457	584	1,113
69	1,442	1,783	1,457	584	1,146
70	1,486	1,836	1,501	601	1,181
71	1,530	1,891	1,547	618	1,216
72	1,584	1,959	1,600	640	1,259
73	1,639	2,027	1,657	662	1,303
74	1,697	2,097	1,715	685	1,348
75	1,756	2,170	1,774	710	1,395
76	1,817	2,246	1,836	735	1,444
77	1,890	2,336	1,911	765	1,502
78	1,966	2,430	1,986	793	1,561
79	2,044	2,526	2,066	826	1,625
80	2,127	2,628	2,149	859	1,689
81	2,211	2,733	2,234	894	1,757
82	2,300	2,842	2,323	930	1,827
83	2,393	2,956	2,416	966	1,900
84	2,489	3,075	2,512	1,004	1,976
85	2,589	3,198	2,613	1,045	2,055
86	2,692	3,326	2,717	1,088	2,139
87	2,800	3,459	2,827	1,131	2,224
88	2,913	3,596	2,939	1,175	2,313
89	3,028	3,740	3,057	1,222	2,407
90	3,149	3,890	3,180	1,271	2,503
91	3,275	4,046	3,306	1,323	2,604
92	3,406	4,208	3,438	1,375	2,707
93	3,542	4,376	3,576	1,431	2,816
94	3,684	4,551	3,719	1,487	2,928
95	3,832	4,733	3,866	1,547	3,045
96	3,984	4,923	4,020	1,609	3,167
97	4,143	5,120	4,181	1,673	3,294
98	4,309	5,324	4,348	1,740	3,425
99	4,481	5,537	4,522	1,809	3,563

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

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

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. You will be notified, in writing, at least thirty-one (31) days in advance if a new table of rates is applicable to the policy.

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 CALENDER 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