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.

Effective 09-01-2023

ELIPS LIFE INSURANCE COMPANY

Policy Fee $25

CALIFORNIA Standard Plans UNISEX Rates - ANNUAL

FOR USE IN ZIP CODES: 900-918, 922, 925-929

	Preferred				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	5,788	6,778	5,557	1,892	4,403
65	2,314	2,711	2,223	756	1,761
66	2,408	2,820	2,311	786	1,831
67	2,504	2,932	2,404	819	1,905
68	2,603	3,050	2,501	851	1,981
69	2,708	3,171	2,600	884	2,061
70	2,817	3,298	2,704	921	2,143
71	2,929	3,430	2,812	957	2,228
72	3,046	3,568	2,924	995	2,318
73	3,183	3,728	3,056	1,040	2,422
74	3,327	3,895	3,194	1,087	2,531
75	3,476	4,070	3,337	1,136	2,645
76	3,632	4,255	3,488	1,188	2,764
77	3,796	4,446	3,645	1,241	2,887
78	3,968	4,646	3,809	1,297	3,017
79	4,146	4,855	3,980	1,355	3,154
80	4,332	5,073	4,159	1,416	3,297
81	4,528	5,301	4,346	1,480	3,444
82	4,732	5,540	4,542	1,546	3,598
83	4,943	5,789	4,746	1,616	3,761
84	5,166	6,049	4,959	1,688	3,931
85	5,399	6,322	5,183	1,764	4,107
86	5,642	6,606	5,415	1,844	4,292
87	5,895	6,905	5,659	1,928	4,486
88	6,160	7,214	5,914	2,014	4,687
89	6,438	7,539	6,181	2,104	4,898
90	6,728	7,879	6,459	2,199	5,118
91	7,030	8,234	6,749	2,298	5,349
92	7,346	8,604	7,052	2,401	5,590
93	7,677	8,991	7,370	2,509	5,841
94	8,023	9,396	7,702	2,623	6,104
95	8,385	9,818	8,049	2,740	6,378
96	8,762	10,261	8,410	2,863	6,666
97	9,155	10,721	8,789	2,992	6,966
98	9,567	11,205	9,185	3,127	7,279
99	9,998	11,708	9,598	3,268	7,606

	Standard				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	6,431	7,532	6,176	2,103	4,892
65	2,573	3,013	2,470	841	1,956
66	2,676	3,133	2,570	875	2,035
67	2,781	3,258	2,672	910	2,117
68	2,894	3,388	2,778	947	2,202
69	3,009	3,525	2,891	984	2,289
70	3,130	3,666	3,006	1,024	2,382
71	3,255	3,812	3,127	1,064	2,477
72	3,385	3,964	3,250	1,107	2,576
73	3,537	4,143	3,398	1,157	2,692
74	3,696	4,329	3,550	1,209	2,812
75	3,863	4,524	3,709	1,263	2,939
76	4,037	4,728	3,876	1,319	3,070
77	4,218	4,940	4,051	1,379	3,210
78	4,407	5,163	4,234	1,441	3,354
79	4,606	5,394	4,423	1,507	3,505
80	4,813	5,638	4,622	1,575	3,663
81	5,030	5,892	4,831	1,645	3,828
82	5,256	6,157	5,048	1,719	4,000
83	5,494	6,434	5,276	1,796	4,179
84	5,741	6,723	5,513	1,878	4,367
85	5,999	7,025	5,760	1,961	4,565
86	6,269	7,341	6,020	2,050	4,770
87	6,552	7,672	6,292	2,143	4,984
88	6,845	8,017	6,574	2,239	5,208
89	7,153	8,378	6,869	2,340	5,443
90	7,476	8,755	7,179	2,444	5,688
91	7,812	9,150	7,502	2,555	5,943
92	8,163	9,561	7,840	2,669	6,211
93	8,531	9,991	8,194	2,789	6,491
94	8,914	10,441	8,561	2,915	6,783
95	9,315	10,911	8,946	3,046	7,088
96	9,736	11,402	9,349	3,184	7,407
97	10,172	11,916	9,770	3,327	7,739
98	10,632	12,452	10,209	3,476	8,088
99	11,110	13,012	10,668	3,634	8,452

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

ELIPS LIFE INSURANCE COMPANY

CALIFORNIA Standard Plans UNISEX Rates - ANNUAL

FOR USE IN ZIP CODES: 919-921, 923-924, 930-953

	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	4,823	5,648	4,630	1,577	3,669	0-64	5,359	6,277	5,147	1,752	4,077
65	1,929	2,259	1,852	630	1,467	65	2,144	2,510	2,058	701	1,630
66	2,006	2,350	1,926	655	1,526	66	2,230	2,611	2,141	729	1,696
67	2,087	2,444	2,004	682	1,588	67	2,318	2,715	2,227	758	1,764
68	2,169	2,541	2,084	709	1,650	68	2,412	2,823	2,315	789	1,835
69	2,256	2,643	2,167	737	1,717	69	2,508	2,937	2,409	820	1,907
70	2,347	2,749	2,254	768	1,786	70	2,608	3,055	2,505	853	1,985
71	2,441	2,858	2,343	797	1,856	71	2,712	3,177	2,605	887	2,064
72	2,539	2,973	2,437	829	1,931	72	2,821	3,304	2,708	923	2,147
73	2,652	3,107	2,547	867	2,018	73	2,948	3,452	2,831	964	2,243
74	2,773	3,246	2,662	905	2,109	74	3,080	3,607	2,959	1,007	2,343
75	2,897	3,392	2,781	947	2,204	75	3,219	3,770	3,091	1,053	2,449
76	3,027	3,546	2,906	990	2,303	76	3,364	3,940	3,230	1,099	2,559
77	3,163	3,705	3,037	1,034	2,406	77	3,515	4,117	3,376	1,149	2,675
78	3,306	3,872	3,174	1,081	2,515	78	3,673	4,303	3,528	1,201	2,795
79	3,455	4,046	3,317	1,129	2,628	79	3,839	4,495	3,686	1,256	2,921
80	3,610	4,228	3,465	1,180	2,747	80	4,011	4,699	3,852	1,312	3,052
81	3,773	4,418	3,622	1,233	2,870	81	4,192	4,910	4,026	1,371	3,190
82	3,943	4,617	3,785	1,288	2,999	82	4,380	5,131	4,206	1,432	3,333
83	4,120	4,824	3,955	1,347	3,134	83	4,578	5,362	4,396	1,497	3,483
84	4,305	5,041	4,133	1,407	3,276	84	4,784	5,603	4,594	1,565	3,639
85	4,499	5,268	4,319	1,470	3,423	85	5,000	5,854	4,800	1,634	3,804
86	4,701	5,505	4,513	1,537	3,576	86	5,224	6,118	5,017	1,708	3,975
87	4,913	5,754	4,716	1,606	3,738	87	5,460	6,393	5,243	1,786	4,153
88	5,133	6,012	4,929	1,679	3,906	88	5,704	6,681	5,478	1,866	4,340
89	5,365	6,282	5,151	1,753	4,082	89	5,961	6,982	5,725	1,950	4,535
90	5,607	6,566	5,382	1,832	4,265	90	6,230	7,296	5,983	2,037	4,740
91	5,858	6,861	5,624	1,915	4,458	91	6,510	7,625	6,251	2,129	4,953
92	6,122	7,170	5,877	2,001	4,659	92	6,803	7,967	6,534	2,224	5,176
93	6,397	7,493	6,142	2,091	4,867	93	7,109	8,326	6,828	2,325	5,409
94	6,686	7,830	6,419	2,185	5,087	94	7,428	8,700	7,134	2,429	5,652
95	6,987	8,181	6,708	2,283	5,315	95	7,763	9,092	7,455	2,539	5,906
96	7,301	8,551	7,009	2,386	5,555	96	8,113	9,502	7,791	2,654	6,173
97	7,629	8,935	7,324	2,493	5,805	97	8,477	9,930	8,141	2,773	6,449
98	7,973	9,337	7,655	2,605	6,066	98	8,860	10,376	8,508	2,897	6,740
99	8,331	9,757	7,998	2,723	6,338	99	9,258	10,843	8,890	3,028	7,043

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

Household Discount Factor .88

ELIPS LIFE INSURANCE COMPANY

CALIFORNIA Standard Plans UNISEX Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 900-953

	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	4,437	5,196	4,260	1,451	3,375	0-64	4,931	5,775	4,735	1,612	3,751
65	1,774	2,078	1,704	580	1,350	65	1,972	2,310	1,894	645	1,500
66	1,846	2,162	1,772	603	1,404	66	2,051	2,402	1,970	671	1,560
67	1,920	2,248	1,843	628	1,461	67	2,132	2,498	2,049	698	1,623
68	1,996	2,338	1,917	652	1,518	68	2,219	2,598	2,130	726	1,688
69	2,076	2,431	1,993	678	1,580	69	2,307	2,702	2,216	754	1,755
70	2,160	2,529	2,073	706	1,643	70	2,399	2,810	2,305	785	1,826
71	2,246	2,630	2,156	733	1,708	71	2,495	2,922	2,397	816	1,899
72	2,335	2,735	2,242	763	1,777	72	2,595	3,039	2,492	849	1,975
73	2,440	2,858	2,343	797	1,857	73	2,712	3,176	2,605	887	2,064
74	2,551	2,986	2,449	833	1,940	74	2,834	3,319	2,722	927	2,156
75	2,665	3,121	2,558	871	2,028	75	2,962	3,469	2,844	968	2,253
76	2,785	3,262	2,674	911	2,119	76	3,095	3,625	2,972	1,011	2,354
77	2,910	3,408	2,794	951	2,214	77	3,234	3,787	3,106	1,057	2,461
78	3,042	3,562	2,920	994	2,313	78	3,379	3,959	3,246	1,105	2,572
79	3,178	3,722	3,052	1,039	2,418	79	3,532	4,136	3,391	1,155	2,687
80	3,321	3,890	3,188	1,085	2,527	80	3,690	4,323	3,544	1,207	2,808
81	3,471	4,064	3,332	1,135	2,641	81	3,856	4,517	3,704	1,261	2,935
82	3,628	4,248	3,482	1,185	2,759	82	4,030	4,720	3,870	1,318	3,066
83	3,790	4,438	3,639	1,239	2,883	83	4,212	4,933	4,045	1,377	3,204
84	3,961	4,638	3,802	1,294	3,013	84	4,401	5,155	4,227	1,440	3,348
85	4,139	4,847	3,973	1,352	3,149	85	4,600	5,386	4,416	1,504	3,500
86	4,325	5,065	4,152	1,414	3,290	86	4,806	5,628	4,616	1,571	3,657
87	4,520	5,294	4,339	1,478	3,439	87	5,023	5,882	4,824	1,643	3,821
88	4,723	5,531	4,534	1,544	3,593	88	5,248	6,146	5,040	1,717	3,993
89	4,936	5,780	4,739	1,613	3,755	89	5,484	6,423	5,267	1,794	4,173
90	5,158	6,041	4,952	1,686	3,924	90	5,732	6,712	5,504	1,874	4,361
91	5,390	6,312	5,174	1,762	4,101	91	5,989	7,015	5,751	1,959	4,557
92	5,632	6,597	5,407	1,841	4,286	92	6,258	7,330	6,011	2,046	4,762
93	5,885	6,893	5,650	1,923	4,478	93	6,540	7,660	6,282	2,139	4,976
94	6,151	7,203	5,905	2,011	4,680	94	6,834	8,004	6,563	2,235	5,200
95	6,428	7,527	6,171	2,100	4,890	95	7,142	8,365	6,859	2,335	5,434
96	6,717	7,867	6,448	2,195	5,110	96	7,464	8,741	7,168	2,441	5,679
97	7,019	8,220	6,738	2,294	5,340	97	7,799	9,135	7,490	2,551	5,933
98	7,335	8,590	7,042	2,397	5,580	98	8,151	9,546	7,827	2,665	6,200
99	7,665	8,976	7,358	2,505	5,831	99	8,518	9,976	8,179	2,786	6,480

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. For additional information concerning policy benefits, contact the Health Insurance Counseling and Advocacy Program (HICAP) or your agent. Call the HICAP toll-free telephone number, 1-816-434-0222, for a referral to your local HICAP office. HICAP is a service provided free of charge by the State of California. You may also contact the Consumer Affairs department of the California Department of Insurance after first contacting your agent or the insurance company for resolution of any problems. Elips Life Insurance Company's toll-free customer service telephone number is shown on the face page of your policy. You can contact the Consumer Affairs department at California Department of Insurance, Consumer Service Division, 300 South Spring Street, South Tower, Los Angeles, CA 90013, (816) 927-HELP (4357).

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