Lumico
medigap solutions
Underwritten by
Elips Life Insurance Company

Elips Life Insurance Company
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OUTLINE OF MEDICARE SUPPLEMENT COVERAGE

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

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

This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available in your state. Every Company must make Plan "A" and either Plan C or F available for those eligible for Medicare prior to January 1, 2020 and either Plan D or G available for those eligible for Medicare on or after January 1 2020. 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

KENTUCKY Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 402, 410, 415-418

	Preferred				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	1,847	2,242	1,866	756	1,437
65	1,644	1,996	1,661	672	1,255
66	1,644	1,996	1,661	672	1,255
67	1,644	1,996	1,661	672	1,255
68	1,644	1,996	1,661	672	1,293
69	1,694	2,056	1,711	693	1,331
70	1,746	2,117	1,764	715	1,371
71	1,797	2,182	1,815	736	1,413
72	1,861	2,258	1,880	760	1,463
73	1,926	2,336	1,945	788	1,513
74	1,993	2,418	2,013	815	1,567
75	2,062	2,502	2,083	844	1,621
76	2,134	2,591	2,156	873	1,678
77	2,219	2,694	2,242	908	1,745
78	2,309	2,802	2,332	943	1,814
79	2,400	2,914	2,424	983	1,886
80	2,498	3,030	2,523	1,022	1,961
81	2,597	3,151	2,623	1,062	2,040
82	2,700	3,276	2,728	1,104	2,122
83	2,808	3,408	2,837	1,149	2,207
84	2,920	3,544	2,950	1,194	2,297
85	3,037	3,686	3,068	1,242	2,387
86	3,158	3,834	3,191	1,293	2,484
87	3,285	3,987	3,319	1,343	2,584
88	3,416	4,146	3,451	1,397	2,688
89	3,553	4,313	3,589	1,454	2,796
90	3,695	4,484	3,732	1,512	2,909
91	3,843	4,665	3,881	1,572	3,024
92	3,996	4,852	4,037	1,634	3,144
93	4,156	5,045	4,198	1,701	3,270
94	4,322	5,248	4,366	1,767	3,402
95	4,494	5,458	4,539	1,838	3,537
96	4,674	5,677	4,720	1,912	3,679
97	4,860	5,904	4,909	1,987	3,826
98	5,054	6,140	5,105	2,067	3,979
99	5,258	6,385	5,310	2,150	4,138

	Standard				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	2,053	2,492	2,074	840	1,596
65	1,827	2,218	1,845	749	1,394
66	1,827	2,218	1,845	749	1,394
67	1,827	2,218	1,845	749	1,394
68	1,827	2,218	1,845	749	1,436
69	1,882	2,285	1,902	771	1,480
70	1,939	2,352	1,958	792	1,524
71	1,999	2,423	2,019	816	1,570
72	2,067	2,508	2,087	845	1,623
73	2,140	2,597	2,162	875	1,681
74	2,215	2,687	2,237	905	1,741
75	2,291	2,779	2,314	937	1,801
76	2,372	2,879	2,396	971	1,864
77	2,468	2,994	2,493	1,010	1,939
78	2,565	3,113	2,591	1,048	2,017
79	2,668	3,237	2,694	1,091	2,097
80	2,776	3,367	2,803	1,134	2,180
81	2,886	3,501	2,915	1,181	2,267
82	3,000	3,640	3,030	1,227	2,358
83	3,120	3,786	3,151	1,275	2,452
84	3,243	3,939	3,276	1,327	2,551
85	3,376	4,096	3,410	1,380	2,653
86	3,508	4,261	3,544	1,436	2,759
87	3,651	4,430	3,688	1,493	2,872
88	3,796	4,608	3,834	1,552	2,987
89	3,947	4,792	3,987	1,614	3,105
90	4,105	4,983	4,147	1,679	3,230
91	4,270	5,183	4,313	1,747	3,362
92	4,440	5,391	4,484	1,815	3,493
93	4,619	5,605	4,665	1,889	3,635
94	4,803	5,831	4,851	1,964	3,780
95	4,994	6,065	5,044	2,044	3,931
96	5,193	6,308	5,246	2,125	4,087
97	5,400	6,561	5,454	2,210	4,252
98	5,616	6,821	5,672	2,297	4,422
99	5,842	7,094	5,900	2,389	4,597

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

Household Discount Factor .88

ELIPS LIFE INSURANCE COMPANY

KENTUCKY Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 402, 410, 415-418

	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	1,746	2,119	1,763	714	1,357	0-64	1,940	2,354	1,959	794	1,508
65	1,553	1,886	1,569	635	1,186	65	1,727	2,096	1,744	707	1,317
66	1,553	1,886	1,569	635	1,186	66	1,727	2,096	1,744	707	1,317
67	1,553	1,886	1,569	635	1,186	67	1,727	2,096	1,744	707	1,317
68	1,553	1,886	1,569	635	1,221	68	1,727	2,096	1,744	707	1,357
69	1,601	1,943	1,617	655	1,258	69	1,779	2,159	1,797	729	1,398
70	1,650	2,001	1,667	675	1,296	70	1,832	2,223	1,850	749	1,441
71	1,698	2,062	1,715	695	1,335	71	1,889	2,290	1,908	771	1,484
72	1,758	2,133	1,777	719	1,383	72	1,953	2,370	1,973	799	1,534
73	1,820	2,207	1,838	744	1,429	73	2,022	2,454	2,043	827	1,589
74	1,883	2,285	1,902	770	1,481	74	2,093	2,539	2,114	855	1,645
75	1,949	2,365	1,968	798	1,532	75	2,165	2,626	2,187	885	1,702
76	2,017	2,448	2,037	825	1,585	76	2,241	2,720	2,264	918	1,761
77	2,097	2,546	2,119	858	1,649	77	2,332	2,829	2,356	954	1,832
78	2,182	2,648	2,204	891	1,714	78	2,423	2,941	2,448	990	1,906
79	2,268	2,753	2,291	929	1,782	79	2,521	3,059	2,546	1,031	1,981
80	2,360	2,863	2,384	966	1,853	80	2,623	3,181	2,649	1,071	2,060
81	2,454	2,978	2,479	1,003	1,928	81	2,727	3,308	2,754	1,116	2,142
82	2,552	3,095	2,578	1,043	2,006	82	2,835	3,440	2,863	1,159	2,228
83	2,653	3,220	2,681	1,086	2,086	83	2,948	3,578	2,978	1,205	2,317
84	2,759	3,349	2,787	1,128	2,170	84	3,065	3,722	3,095	1,254	2,411
85	2,870	3,483	2,899	1,174	2,256	85	3,191	3,870	3,222	1,304	2,507
86	2,984	3,623	3,015	1,221	2,347	86	3,315	4,027	3,349	1,357	2,607
87	3,104	3,767	3,136	1,269	2,442	87	3,450	4,186	3,485	1,411	2,714
88	3,228	3,918	3,261	1,320	2,540	88	3,587	4,354	3,623	1,466	2,822
89	3,357	4,075	3,391	1,374	2,642	89	3,730	4,529	3,767	1,525	2,935
90	3,492	4,237	3,527	1,428	2,749	90	3,879	4,709	3,919	1,586	3,052
91	3,631	4,409	3,668	1,485	2,858	91	4,035	4,898	4,075	1,651	3,177
92	3,776	4,585	3,815	1,544	2,971	92	4,195	5,094	4,237	1,715	3,300
93	3,927	4,768	3,967	1,607	3,090	93	4,364	5,297	4,409	1,785	3,435
94	4,084	4,959	4,125	1,670	3,215	94	4,539	5,510	4,584	1,855	3,572
95	4,246	5,157	4,290	1,736	3,343	95	4,719	5,731	4,767	1,931	3,714
96	4,416	5,365	4,461	1,807	3,476	96	4,907	5,961	4,957	2,008	3,862
97	4,592	5,579	4,639	1,878	3,615	97	5,103	6,200	5,154	2,088	4,018
98	4,776	5,802	4,824	1,953	3,760	98	5,307	6,446	5,360	2,170	4,178
99	4,968	6,033	5,018	2,031	3,910	99	5,520	6,704	5,575	2,257	4,344

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

Household Discount Factor .88

ELIPS LIFE INSURANCE COMPANY

KENTUCKY Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 402, 410, 415-418

	Preferred				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	1,650	2,002	1,666	654	1,283
65	1,469	1,782	1,483	583	1,121
66	1,469	1,782	1,483	583	1,121
67	1,469	1,782	1,483	583	1,121
68	1,469	1,782	1,483	583	1,155
69	1,513	1,836	1,529	599	1,189
70	1,558	1,891	1,573	618	1,224
71	1,604	1,947	1,621	636	1,262
72	1,662	2,016	1,679	659	1,306
73	1,719	2,086	1,736	682	1,351
74	1,781	2,158	1,799	705	1,399
75	1,842	2,234	1,861	731	1,447
76	1,906	2,313	1,926	756	1,499
77	1,982	2,405	2,002	786	1,557
78	2,061	2,501	2,081	818	1,620
79	2,144	2,601	2,165	851	1,686
80	2,230	2,705	2,253	885	1,752
81	2,319	2,813	2,343	921	1,821
82	2,411	2,927	2,435	957	1,895
83	2,507	3,043	2,532	995	1,971
84	2,607	3,164	2,633	1,034	2,050
85	2,711	3,291	2,739	1,076	2,132
86	2,820	3,424	2,849	1,120	2,218
87	2,934	3,560	2,964	1,163	2,306
88	3,050	3,703	3,081	1,209	2,399
89	3,171	3,851	3,204	1,258	2,496
90	3,298	4,005	3,332	1,309	2,597
91	3,432	4,165	3,466	1,361	2,700
92	3,568	4,332	3,604	1,415	2,808
93	3,711	4,505	3,748	1,472	2,919
94	3,858	4,686	3,897	1,532	3,037
95	4,012	4,873	4,053	1,592	3,158
96	4,173	5,068	4,214	1,656	3,284
97	4,339	5,272	4,384	1,722	3,416
98	4,512	5,482	4,557	1,791	3,554
99	4,694	5,701	4,742	1,862	3,695

	Standard				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	1,832	2,224	1,851	750	1,425
65	1,631	1,980	1,647	667	1,244
66	1,631	1,980	1,647	667	1,244
67	1,631	1,980	1,647	667	1,244
68	1,631	1,980	1,647	667	1,283
69	1,680	2,039	1,697	687	1,321
70	1,730	2,101	1,748	707	1,361
71	1,784	2,164	1,802	730	1,401
72	1,845	2,240	1,864	755	1,450
73	1,911	2,318	1,930	780	1,502
74	1,976	2,399	1,996	809	1,554
75	2,047	2,483	2,067	836	1,608
76	2,117	2,571	2,139	866	1,663
77	2,203	2,673	2,225	902	1,732
78	2,290	2,778	2,313	936	1,800
79	2,381	2,890	2,405	974	1,872
80	2,477	3,006	2,502	1,012	1,947
81	2,575	3,126	2,602	1,055	2,025
82	2,677	3,250	2,705	1,096	2,106
83	2,785	3,381	2,813	1,138	2,188
84	2,898	3,517	2,927	1,184	2,277
85	3,013	3,658	3,043	1,231	2,370
86	3,133	3,804	3,164	1,282	2,464
87	3,260	3,957	3,292	1,333	2,564
88	3,390	4,114	3,424	1,386	2,666
89	3,524	4,279	3,560	1,441	2,773
90	3,665	4,449	3,703	1,499	2,884
91	3,813	4,628	3,851	1,560	3,001
92	3,965	4,814	4,005	1,621	3,120
93	4,123	5,006	4,165	1,687	3,246
94	4,288	5,206	4,331	1,753	3,374
95	4,458	5,415	4,503	1,823	3,509
96	4,635	5,633	4,682	1,896	3,649
97	4,820	5,857	4,869	1,973	3,795
98	5,014	6,091	5,065	2,051	3,947
99	5,214	6,334	5,267	2,133	4,105

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

Household Discount Factor .88

ELIPS LIFE INSURANCE COMPANY

KENTUCKY Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 402, 410, 415-418

	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	1,559	1,892	1,575	618	1,212	0-64	1,732	2,102	1,749	708	1,347
65	1,388	1,684	1,402	551	1,059	65	1,541	1,871	1,557	631	1,176
66	1,388	1,684	1,402	551	1,059	66	1,541	1,871	1,557	631	1,176
67	1,388	1,684	1,402	551	1,059	67	1,541	1,871	1,557	631	1,176
68	1,388	1,684	1,402	551	1,091	68	1,541	1,871	1,557	631	1,213
69	1,430	1,735	1,445	566	1,124	69	1,587	1,927	1,603	650	1,248
70	1,472	1,787	1,486	584	1,157	70	1,635	1,985	1,652	669	1,286
71	1,516	1,840	1,532	601	1,192	71	1,686	2,045	1,703	690	1,324
72	1,570	1,905	1,586	623	1,234	72	1,744	2,116	1,762	713	1,370
73	1,625	1,971	1,641	644	1,277	73	1,806	2,190	1,824	738	1,419
74	1,683	2,039	1,700	666	1,322	74	1,867	2,267	1,886	764	1,468
75	1,740	2,111	1,758	691	1,367	75	1,934	2,346	1,953	790	1,520
76	1,801	2,186	1,820	714	1,416	76	2,001	2,429	2,021	819	1,572
77	1,873	2,273	1,892	743	1,472	77	2,081	2,525	2,103	852	1,636
78	1,948	2,363	1,967	773	1,531	78	2,164	2,625	2,186	884	1,701
79	2,026	2,457	2,046	804	1,593	79	2,250	2,731	2,273	920	1,769
80	2,107	2,556	2,129	837	1,655	80	2,341	2,840	2,365	957	1,840
81	2,191	2,658	2,214	870	1,721	81	2,434	2,954	2,459	997	1,913
82	2,278	2,766	2,301	904	1,791	82	2,530	3,072	2,556	1,036	1,990
83	2,369	2,876	2,393	940	1,862	83	2,632	3,195	2,658	1,076	2,068
84	2,463	2,990	2,488	977	1,937	84	2,738	3,323	2,766	1,119	2,151
85	2,562	3,110	2,588	1,017	2,015	85	2,847	3,457	2,876	1,164	2,239
86	2,665	3,236	2,692	1,058	2,096	86	2,961	3,595	2,990	1,211	2,328
87	2,772	3,364	2,801	1,099	2,179	87	3,081	3,739	3,111	1,259	2,423
88	2,882	3,499	2,912	1,142	2,267	88	3,203	3,887	3,236	1,309	2,520
89	2,997	3,639	3,027	1,189	2,358	89	3,330	4,044	3,364	1,362	2,621
90	3,117	3,784	3,149	1,237	2,454	90	3,464	4,205	3,499	1,416	2,725
91	3,243	3,936	3,276	1,286	2,552	91	3,603	4,373	3,639	1,474	2,836
92	3,372	4,094	3,406	1,337	2,653	92	3,747	4,549	3,784	1,532	2,948
93	3,507	4,257	3,542	1,391	2,759	93	3,896	4,730	3,936	1,594	3,067
94	3,646	4,428	3,682	1,447	2,870	94	4,052	4,919	4,092	1,656	3,188
95	3,791	4,605	3,830	1,504	2,985	95	4,212	5,117	4,256	1,723	3,316
96	3,943	4,789	3,982	1,565	3,104	96	4,380	5,323	4,424	1,792	3,448
97	4,100	4,982	4,142	1,627	3,228	97	4,555	5,535	4,601	1,864	3,586
98	4,263	5,180	4,307	1,692	3,358	98	4,738	5,756	4,786	1,938	3,730
99	4,436	5,387	4,481	1,760	3,492	99	4,927	5,986	4,977	2,016	3,879

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.

There is a one-time $25 policy fee.

Household Discount: You are eligible for a household premium discount if 1) you are currently married and residing with your spouse or 2) you have been residing with a person for at least the last 12 months. If you qualify for this discount it will remain in effect for the life of 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 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