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

GEORGIA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 300-303, 311, 399

	Preferred				
				HD Plan	
Issue Age	Plan A	Plan F	Plan G	G	Plan N
0-64	19,011	22,848	19,213	7,497	14,264
65	1,943	2,334	1,962	766	1,470
66	1,943	2,334	1,962	766	1,470
67	1,943	2,334	1,962	766	1,470
68	1,943	2,334	1,962	766	1,470
69	1,943	2,334	1,962	766	1,502
70	1,983	2,385	2,004	782	1,534
71	2,026	2,436	2,047	799	1,566
72	2,079	2,498	2,101	820	1,607
73	2,133	2,564	2,156	841	1,649
74	2,189	2,632	2,213	864	1,694
75	2,246	2,700	2,270	886	1,736
76	2,304	2,770	2,330	909	1,782
77	2,375	2,857	2,400	938	1,836
78	2,449	2,943	2,475	965	1,893
79	2,523	3,033	2,551	995	1,951
80	2,600	3,126	2,629	1,026	2,011
81	2,680	3,221	2,708	1,057	2,071
82	2,763	3,319	2,790	1,090	2,134
83	2,861	3,435	2,887	1,127	2,210
84	2,962	3,558	2,988	1,166	2,287
85	3,065	3,681	3,095	1,208	2,368
86	3,173	3,811	3,201	1,251	2,451
87	3,284	3,944	3,315	1,295	2,538
88	3,399	4,084	3,431	1,339	2,627
89	3,518	4,225	3,551	1,386	2,721
90	3,641	4,373	3,675	1,435	2,816
91	3,769	4,527	3,805	1,485	2,914
92	3,901	4,685	3,936	1,536	3,015
93	4,036	4,848	4,074	1,591	3,120
94	4,177	5,018	4,216	1,645	3,231
95	4,323	5,194	4,362	1,704	3,342
96	4,472	5,375	4,513	1,762	3,459
97	4,633	5,568	4,676	1,826	3,584
98	4,819	5,790	4,863	1,898	3,726
99	5,011	6,022	5,057	1,975	3,876

	Standard				
				HD Plan	
Issue Age	Plan A	Plan F	Plan G	G	Plan N
0-64	21,121	25,384	21,346	8,330	15,849
65	2,158	2,594	2,180	851	1,632
66	2,158	2,594	2,180	851	1,632
67	2,158	2,594	2,180	851	1,632
68	2,158	2,594	2,180	851	1,632
69	2,158	2,594	2,180	851	1,667
70	2,203	2,650	2,227	870	1,705
71	2,252	2,706	2,274	888	1,740
72	2,310	2,776	2,335	910	1,785
73	2,370	2,850	2,394	935	1,833
74	2,432	2,924	2,458	960	1,881
75	2,496	3,000	2,522	985	1,930
76	2,560	3,077	2,589	1,011	1,978
77	2,640	3,173	2,667	1,041	2,040
78	2,721	3,271	2,750	1,072	2,103
79	2,803	3,370	2,833	1,105	2,167
80	2,890	3,473	2,920	1,141	2,234
81	2,977	3,580	3,009	1,175	2,302
82	3,069	3,689	3,101	1,210	2,372
83	3,178	3,816	3,208	1,253	2,455
84	3,290	3,953	3,320	1,296	2,542
85	3,406	4,091	3,438	1,342	2,631
86	3,526	4,235	3,558	1,389	2,724
87	3,649	4,382	3,683	1,438	2,819
88	3,779	4,537	3,813	1,488	2,919
89	3,908	4,695	3,946	1,541	3,023
90	4,046	4,860	4,084	1,594	3,128
91	4,186	5,031	4,227	1,650	3,238
92	4,333	5,205	4,372	1,708	3,350
93	4,484	5,387	4,526	1,768	3,468
94	4,641	5,575	4,684	1,828	3,589
95	4,803	5,770	4,846	1,893	3,714
96	4,969	5,972	5,015	1,957	3,843
97	5,148	6,188	5,195	2,029	3,982
98	5,354	6,433	5,402	2,109	4,140
99	5,567	6,691	5,619	2,193	4,306

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

Household Discount Factor .88

ELIPS LIFE INSURANCE COMPANY

GEORGIA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 300-303, 311, 399

	Preferred				
				HD Plan	
Issue Age	Plan A	Plan F	Plan G	G	Plan N
0-64	17,234	20,713	17,417	6,796	12,931
65	1,761	2,116	1,778	694	1,333
66	1,761	2,116	1,778	694	1,333
67	1,761	2,116	1,778	694	1,333
68	1,761	2,116	1,778	694	1,333
69	1,761	2,116	1,778	694	1,361
70	1,798	2,162	1,817	709	1,391
71	1,836	2,208	1,856	725	1,420
72	1,885	2,265	1,905	744	1,457
73	1,934	2,325	1,954	762	1,494
74	1,985	2,386	2,006	783	1,535
75	2,036	2,448	2,058	803	1,574
76	2,089	2,511	2,112	824	1,615
77	2,153	2,590	2,176	851	1,664
78	2,220	2,668	2,243	875	1,716
79	2,288	2,749	2,312	902	1,768
80	2,357	2,834	2,383	930	1,823
81	2,429	2,920	2,455	959	1,877
82	2,505	3,009	2,529	988	1,935
83	2,594	3,114	2,617	1,021	2,003
84	2,685	3,225	2,709	1,057	2,073
85	2,779	3,337	2,805	1,095	2,147
86	2,876	3,455	2,902	1,134	2,222
87	2,977	3,576	3,005	1,174	2,301
88	3,082	3,702	3,111	1,213	2,382
89	3,189	3,830	3,219	1,256	2,467
90	3,301	3,964	3,332	1,300	2,553
91	3,417	4,104	3,449	1,347	2,642
92	3,536	4,247	3,568	1,393	2,733
93	3,659	4,395	3,693	1,442	2,829
94	3,786	4,549	3,822	1,491	2,929
95	3,919	4,708	3,954	1,545	3,030
96	4,054	4,873	4,092	1,597	3,136
97	4,200	5,047	4,239	1,655	3,249
98	4,369	5,249	4,409	1,721	3,378
99	4,543	5,459	4,585	1,790	3,513

	Standard				
				HD Plan	
Issue Age	Plan A	Plan F	Plan G	G	Plan N
0-64	19,147	23,012	19,351	7,551	14,368
65	1,957	2,351	1,976	772	1,480
66	1,957	2,351	1,976	772	1,480
67	1,957	2,351	1,976	772	1,480
68	1,957	2,351	1,976	772	1,480
69	1,957	2,351	1,976	772	1,511
70	1,997	2,403	2,019	789	1,546
71	2,041	2,453	2,062	805	1,577
72	2,094	2,516	2,117	825	1,618
73	2,149	2,583	2,170	847	1,661
74	2,205	2,651	2,228	870	1,705
75	2,263	2,719	2,286	892	1,749
76	2,321	2,790	2,347	917	1,793
77	2,393	2,876	2,418	944	1,849
78	2,467	2,965	2,493	972	1,907
79	2,541	3,055	2,568	1,002	1,964
80	2,620	3,148	2,647	1,034	2,025
81	2,699	3,245	2,728	1,066	2,087
82	2,782	3,344	2,811	1,097	2,150
83	2,881	3,459	2,909	1,136	2,225
84	2,983	3,583	3,010	1,175	2,304
85	3,088	3,708	3,117	1,217	2,385
86	3,197	3,839	3,226	1,260	2,470
87	3,308	3,973	3,338	1,304	2,556
88	3,425	4,113	3,457	1,349	2,646
89	3,543	4,256	3,577	1,397	2,740
90	3,668	4,406	3,703	1,445	2,836
91	3,795	4,561	3,832	1,496	2,935
92	3,928	4,719	3,964	1,548	3,037
93	4,065	4,884	4,103	1,603	3,144
94	4,208	5,054	4,246	1,657	3,253
95	4,354	5,231	4,394	1,716	3,367
96	4,504	5,414	4,546	1,775	3,484
97	4,666	5,610	4,709	1,840	3,610
98	4,853	5,832	4,897	1,912	3,754
99	5,047	6,065	5,094	1,988	3,904

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

Household Discount Factor .88

ELIPS LIFE INSURANCE COMPANY

GEORGIA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 300-303, 311, 399

	Preferred				
				HD Plan	
Issue Age	Plan A	Plan F	Plan G	G	Plan N
0-64	16,973	20,395	17,150	6,698	12,737
65	1,734	2,084	1,752	684	1,312
66	1,734	2,084	1,752	684	1,312
67	1,734	2,084	1,752	684	1,312
68	1,734	2,084	1,752	684	1,312
69	1,734	2,084	1,752	684	1,340
70	1,771	2,129	1,790	699	1,370
71	1,809	2,175	1,828	714	1,399
72	1,856	2,231	1,876	732	1,435
73	1,905	2,290	1,925	751	1,473
74	1,954	2,350	1,976	772	1,511
75	2,005	2,411	2,027	791	1,550
76	2,058	2,472	2,080	812	1,591
77	2,120	2,550	2,143	838	1,639
78	2,187	2,628	2,209	862	1,690
79	2,253	2,707	2,277	888	1,741
80	2,322	2,791	2,347	916	1,795
81	2,393	2,877	2,418	944	1,849
82	2,466	2,963	2,491	973	1,907
83	2,554	3,067	2,578	1,006	1,972
84	2,644	3,175	2,668	1,041	2,042
85	2,737	3,287	2,763	1,078	2,115
86	2,833	3,403	2,859	1,116	2,189
87	2,932	3,522	2,960	1,156	2,265
88	3,035	3,645	3,064	1,195	2,345
89	3,141	3,772	3,171	1,238	2,429
90	3,251	3,904	3,282	1,281	2,514
91	3,365	4,042	3,397	1,326	2,602
92	3,482	4,183	3,514	1,372	2,692
93	3,603	4,329	3,638	1,421	2,786
94	3,729	4,480	3,764	1,469	2,884
95	3,859	4,637	3,895	1,521	2,984
96	3,993	4,800	4,030	1,573	3,088
97	4,136	4,972	4,174	1,630	3,199
98	4,302	5,170	4,342	1,695	3,327
99	4,474	5,376	4,516	1,763	3,460

	Standard				
				HD Plan	
Issue Age	Plan A	Plan F	Plan G	G	Plan N
0-64	18,857	22,659	19,059	7,439	14,149
65	1,927	2,315	1,946	760	1,458
66	1,927	2,315	1,946	760	1,458
67	1,927	2,315	1,946	760	1,458
68	1,927	2,315	1,946	760	1,458
69	1,927	2,315	1,946	760	1,489
70	1,967	2,366	1,989	776	1,521
71	2,010	2,417	2,030	794	1,554
72	2,062	2,478	2,085	813	1,594
73	2,117	2,544	2,138	834	1,636
74	2,171	2,610	2,195	857	1,680
75	2,228	2,679	2,252	879	1,723
76	2,286	2,747	2,311	902	1,767
77	2,356	2,833	2,381	930	1,821
78	2,430	2,921	2,455	958	1,878
79	2,503	3,008	2,529	987	1,934
80	2,580	3,101	2,608	1,018	1,994
81	2,659	3,195	2,687	1,049	2,055
82	2,740	3,293	2,769	1,081	2,118
83	2,837	3,407	2,865	1,119	2,192
84	2,938	3,529	2,964	1,157	2,269
85	3,041	3,652	3,070	1,199	2,348
86	3,148	3,781	3,176	1,240	2,433
87	3,258	3,913	3,288	1,284	2,517
88	3,373	4,051	3,404	1,328	2,606
89	3,489	4,191	3,523	1,376	2,699
90	3,613	4,340	3,647	1,423	2,793
91	3,738	4,492	3,774	1,473	2,891
92	3,869	4,648	3,904	1,525	2,991
93	4,004	4,810	4,042	1,578	3,096
94	4,144	4,978	4,183	1,632	3,205
95	4,288	5,152	4,327	1,690	3,316
96	4,436	5,332	4,478	1,748	3,431
97	4,596	5,524	4,638	1,812	3,555
98	4,780	5,744	4,824	1,883	3,696
99	4,971	5,975	5,017	1,959	3,844

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

Household Discount Factor .88

ELIPS LIFE INSURANCE COMPANY

GEORGIA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 300-303, 311, 399

	Preferred				
				HD Plan	
Issue Age	Plan A	Plan F	Plan G	G	Plan N
0-64	15,386	18,489	15,548	6,072	11,547
65	1,572	1,890	1,588	620	1,189
66	1,572	1,890	1,588	620	1,189
67	1,572	1,890	1,588	620	1,189
68	1,572	1,890	1,588	620	1,189
69	1,572	1,890	1,588	620	1,214
70	1,605	1,930	1,622	633	1,242
71	1,640	1,972	1,657	647	1,268
72	1,683	2,022	1,701	664	1,300
73	1,727	2,076	1,745	681	1,335
74	1,772	2,130	1,791	700	1,370
75	1,818	2,186	1,837	717	1,405
76	1,865	2,241	1,886	736	1,442
77	1,922	2,312	1,943	759	1,486
78	1,982	2,382	2,003	781	1,532
79	2,043	2,454	2,064	805	1,578
80	2,105	2,530	2,127	831	1,628
81	2,169	2,608	2,192	856	1,676
82	2,236	2,686	2,259	882	1,728
83	2,315	2,780	2,337	912	1,788
84	2,397	2,879	2,419	944	1,851
85	2,481	2,980	2,505	977	1,917
86	2,568	3,085	2,592	1,012	1,984
87	2,658	3,193	2,683	1,048	2,053
88	2,752	3,304	2,778	1,083	2,126
89	2,847	3,420	2,874	1,122	2,202
90	2,947	3,539	2,975	1,161	2,279
91	3,050	3,665	3,079	1,202	2,359
92	3,157	3,792	3,186	1,244	2,440
93	3,266	3,924	3,298	1,288	2,525
94	3,380	4,061	3,413	1,332	2,615
95	3,498	4,204	3,531	1,379	2,705
96	3,620	4,351	3,653	1,426	2,799
97	3,750	4,507	3,784	1,478	2,900
98	3,900	4,687	3,936	1,536	3,016
99	4,056	4,874	4,094	1,598	3,137

	Standard				
				HD Plan	
Issue Age	Plan A	Plan F	Plan G	G	Plan N
0-64	17,095	20,542	17,277	6,744	12,826
65	1,747	2,099	1,764	689	1,321
66	1,747	2,099	1,764	689	1,321
67	1,747	2,099	1,764	689	1,321
68	1,747	2,099	1,764	689	1,321
69	1,747	2,099	1,764	689	1,350
70	1,784	2,145	1,803	704	1,379
71	1,822	2,191	1,841	719	1,408
72	1,870	2,247	1,890	737	1,445
73	1,919	2,307	1,938	756	1,483
74	1,968	2,366	1,990	777	1,523
75	2,020	2,428	2,041	797	1,562
76	2,073	2,490	2,095	818	1,601
77	2,136	2,569	2,159	843	1,651
78	2,203	2,648	2,225	868	1,702
79	2,269	2,727	2,293	895	1,754
80	2,339	2,811	2,364	923	1,808
81	2,410	2,897	2,436	951	1,863
82	2,484	2,986	2,510	980	1,920
83	2,572	3,088	2,597	1,014	1,987
84	2,664	3,199	2,687	1,049	2,057
85	2,757	3,311	2,783	1,087	2,129
86	2,854	3,427	2,880	1,124	2,206
87	2,954	3,547	2,981	1,164	2,282
88	3,058	3,672	3,086	1,204	2,363
89	3,163	3,799	3,193	1,247	2,447
90	3,275	3,934	3,306	1,290	2,532
91	3,389	4,072	3,421	1,335	2,621
92	3,507	4,213	3,539	1,382	2,711
93	3,630	4,361	3,664	1,431	2,806
94	3,756	4,513	3,792	1,480	2,905
95	3,887	4,671	3,923	1,532	3,006
96	4,022	4,833	4,059	1,585	3,111
97	4,167	5,008	4,204	1,642	3,223
98	4,333	5,208	4,373	1,707	3,351
99	4,506	5,416	4,548	1,776	3,485

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 issue age, gender, underwriting class, state of issue, and your most recent zip code of residence in the state of issue.

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