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. 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 2022[2]						$6620[2]	$3310[2]					

[1]Plans F and G also have a high deductible option which requires first paying a plan deductible of $2490 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 10-26-2021

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	5,409	6,335	5,193	1,769	4,115
65	2,163	2,534	2,078	707	1,646
66	2,250	2,636	2,160	735	1,712
67	2,340	2,741	2,247	765	1,781
68	2,433	2,850	2,337	795	1,851
69	2,531	2,964	2,430	827	1,926
70	2,633	3,083	2,528	861	2,003
71	2,738	3,206	2,628	894	2,082
72	2,847	3,335	2,733	930	2,166
73	2,975	3,485	2,856	972	2,264
74	3,110	3,641	2,985	1,016	2,366
75	3,249	3,804	3,119	1,062	2,472
76	3,395	3,977	3,260	1,110	2,583
77	3,548	4,155	3,407	1,160	2,699
78	3,708	4,343	3,560	1,212	2,820
79	3,875	4,538	3,720	1,266	2,948
80	4,049	4,742	3,887	1,323	3,081
81	4,232	4,955	4,062	1,383	3,219
82	4,422	5,178	4,245	1,445	3,363
83	4,620	5,411	4,436	1,511	3,515
84	4,829	5,654	4,635	1,578	3,674
85	5,046	5,909	4,844	1,649	3,839
86	5,273	6,174	5,061	1,724	4,011
87	5,510	6,453	5,289	1,802	4,193
88	5,757	6,743	5,528	1,883	4,380
89	6,017	7,046	5,777	1,967	4,578
90	6,288	7,364	6,036	2,055	4,784
91	6,570	7,695	6,308	2,148	5,000
92	6,866	8,042	6,591	2,244	5,225
93	7,175	8,403	6,888	2,345	5,459
94	7,499	8,781	7,199	2,451	5,705
95	7,836	9,176	7,523	2,561	5,961
96	8,189	9,590	7,860	2,676	6,230
97	8,556	10,020	8,214	2,796	6,510
98	8,942	10,472	8,585	2,922	6,803
99	9,344	10,943	8,970	3,054	7,109

	Standard				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	6,011	7,040	5,772	1,965	4,572
65	2,405	2,816	2,309	786	1,829
66	2,501	2,928	2,402	818	1,902
67	2,600	3,045	2,498	851	1,979
68	2,705	3,167	2,597	885	2,058
69	2,813	3,294	2,702	920	2,139
70	2,925	3,426	2,810	957	2,226
71	3,042	3,563	2,922	995	2,315
72	3,164	3,705	3,038	1,035	2,408
73	3,306	3,872	3,176	1,082	2,516
74	3,455	4,046	3,318	1,130	2,628
75	3,611	4,229	3,467	1,181	2,747
76	3,773	4,419	3,623	1,233	2,870
77	3,942	4,617	3,786	1,289	3,000
78	4,119	4,826	3,957	1,347	3,135
79	4,305	5,042	4,134	1,409	3,276
80	4,499	5,270	4,320	1,472	3,423
81	4,701	5,507	4,515	1,538	3,578
82	4,913	5,754	4,718	1,607	3,738
83	5,135	6,014	4,931	1,679	3,906
84	5,366	6,284	5,153	1,755	4,082
85	5,607	6,566	5,384	1,833	4,266
86	5,859	6,861	5,627	1,916	4,458
87	6,123	7,170	5,880	2,003	4,658
88	6,398	7,493	6,144	2,093	4,868
89	6,686	7,830	6,420	2,187	5,087
90	6,987	8,183	6,710	2,285	5,316
91	7,301	8,552	7,011	2,388	5,555
92	7,629	8,936	7,328	2,495	5,805
93	7,973	9,338	7,658	2,607	6,066
94	8,331	9,758	8,001	2,724	6,339
95	8,706	10,197	8,361	2,847	6,624
96	9,099	10,656	8,738	2,976	6,923
97	9,507	11,136	9,131	3,110	7,233
98	9,936	11,637	9,542	3,249	7,559
99	10,383	12,161	9,971	3,396	7,899

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				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	4,508	5,279	4,328	1,474	3,429
65	1,803	2,111	1,731	589	1,371
66	1,875	2,196	1,800	613	1,426
67	1,950	2,284	1,873	638	1,484
68	2,028	2,375	1,948	663	1,543
69	2,109	2,470	2,025	689	1,605
70	2,194	2,569	2,106	718	1,669
71	2,281	2,671	2,190	745	1,735
72	2,373	2,779	2,278	775	1,805
73	2,479	2,904	2,380	810	1,886
74	2,591	3,034	2,488	846	1,971
75	2,708	3,170	2,599	885	2,060
76	2,829	3,314	2,716	925	2,153
77	2,956	3,463	2,839	966	2,249
78	3,090	3,619	2,966	1,010	2,350
79	3,229	3,781	3,100	1,055	2,456
80	3,374	3,951	3,239	1,103	2,568
81	3,526	4,129	3,385	1,153	2,683
82	3,685	4,315	3,538	1,204	2,803
83	3,850	4,509	3,696	1,259	2,929
84	4,024	4,711	3,863	1,315	3,061
85	4,205	4,924	4,036	1,374	3,199
86	4,394	5,145	4,218	1,436	3,343
87	4,591	5,378	4,408	1,501	3,494
88	4,798	5,619	4,606	1,569	3,650
89	5,014	5,871	4,814	1,639	3,815
90	5,240	6,136	5,030	1,713	3,986
91	5,475	6,413	5,256	1,790	4,166
92	5,721	6,701	5,493	1,870	4,354
93	5,979	7,003	5,740	1,954	4,549
94	6,249	7,318	5,999	2,043	4,754
95	6,530	7,646	6,269	2,134	4,968
96	6,824	7,991	6,550	2,230	5,191
97	7,130	8,350	6,845	2,330	5,425
98	7,451	8,726	7,154	2,435	5,669
99	7,786	9,119	7,475	2,545	5,924

	Standard				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	5,009	5,866	4,810	1,638	3,810
65	2,004	2,346	1,924	655	1,524
66	2,084	2,440	2,001	681	1,585
67	2,166	2,538	2,081	709	1,649
68	2,254	2,639	2,164	738	1,715
69	2,344	2,745	2,251	766	1,783
70	2,438	2,855	2,341	798	1,855
71	2,535	2,969	2,435	829	1,929
72	2,636	3,088	2,531	863	2,006
73	2,755	3,226	2,646	901	2,096
74	2,879	3,371	2,765	941	2,190
75	3,009	3,524	2,889	984	2,289
76	3,144	3,683	3,019	1,028	2,391
77	3,285	3,848	3,155	1,074	2,500
78	3,433	4,021	3,298	1,123	2,613
79	3,588	4,201	3,445	1,174	2,730
80	3,749	4,391	3,600	1,226	2,853
81	3,918	4,589	3,763	1,281	2,981
82	4,094	4,795	3,931	1,339	3,115
83	4,279	5,011	4,109	1,399	3,255
84	4,471	5,236	4,294	1,463	3,401
85	4,673	5,471	4,486	1,528	3,555
86	4,883	5,718	4,689	1,596	3,715
87	5,103	5,975	4,900	1,669	3,881
88	5,331	6,244	5,120	1,744	4,056
89	5,571	6,525	5,350	1,823	4,239
90	5,823	6,819	5,591	1,904	4,430
91	6,084	7,126	5,843	1,990	4,629
92	6,358	7,446	6,106	2,079	4,838
93	6,644	7,781	6,381	2,173	5,055
94	6,943	8,131	6,668	2,270	5,283
95	7,255	8,498	6,968	2,373	5,520
96	7,583	8,880	7,281	2,480	5,769
97	7,923	9,280	7,609	2,591	6,028
98	8,280	9,698	7,951	2,708	6,299
99	8,653	10,134	8,309	2,830	6,583

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				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	4,147	4,856	3,981	1,356	3,154
65	1,658	1,942	1,593	542	1,262
66	1,725	2,021	1,656	564	1,312
67	1,794	2,101	1,723	587	1,365
68	1,865	2,185	1,792	610	1,419
69	1,940	2,272	1,863	634	1,477
70	2,018	2,363	1,938	660	1,535
71	2,099	2,458	2,015	685	1,596
72	2,183	2,556	2,095	713	1,661
73	2,280	2,671	2,190	745	1,735
74	2,384	2,791	2,289	779	1,814
75	2,491	2,916	2,391	814	1,895
76	2,602	3,049	2,499	851	1,980
77	2,720	3,186	2,612	889	2,069
78	2,843	3,329	2,729	929	2,162
79	2,970	3,479	2,852	971	2,260
80	3,104	3,635	2,980	1,014	2,362
81	3,244	3,798	3,114	1,060	2,468
82	3,390	3,970	3,255	1,107	2,578
83	3,542	4,148	3,401	1,158	2,694
84	3,702	4,334	3,554	1,210	2,816
85	3,869	4,530	3,713	1,264	2,943
86	4,042	4,733	3,880	1,321	3,075
87	4,224	4,947	4,055	1,381	3,214
88	4,414	5,169	4,238	1,443	3,358
89	4,613	5,402	4,429	1,508	3,510
90	4,821	5,645	4,628	1,576	3,667
91	5,037	5,900	4,836	1,647	3,833
92	5,264	6,165	5,053	1,720	4,005
93	5,500	6,442	5,281	1,797	4,185
94	5,749	6,732	5,519	1,879	4,373
95	6,008	7,035	5,767	1,963	4,570
96	6,278	7,352	6,026	2,052	4,776
97	6,560	7,682	6,297	2,144	4,991
98	6,855	8,028	6,581	2,240	5,215
99	7,163	8,389	6,877	2,341	5,450

	Standard				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	4,608	5,397	4,425	1,507	3,505
65	1,843	2,159	1,770	603	1,402
66	1,917	2,245	1,841	627	1,458
67	1,993	2,335	1,915	652	1,517
68	2,073	2,428	1,991	679	1,578
69	2,156	2,525	2,071	705	1,640
70	2,243	2,627	2,154	734	1,707
71	2,332	2,731	2,240	762	1,774
72	2,425	2,841	2,329	794	1,846
73	2,535	2,968	2,435	829	1,929
74	2,648	3,102	2,544	866	2,015
75	2,768	3,242	2,658	905	2,106
76	2,892	3,388	2,777	945	2,200
77	3,022	3,540	2,903	988	2,300
78	3,158	3,700	3,034	1,033	2,404
79	3,301	3,865	3,169	1,080	2,512
80	3,449	4,040	3,312	1,128	2,624
81	3,604	4,222	3,462	1,179	2,743
82	3,766	4,411	3,617	1,232	2,866
83	3,936	4,610	3,780	1,287	2,995
84	4,114	4,817	3,950	1,346	3,129
85	4,299	5,034	4,127	1,405	3,271
86	4,492	5,260	4,314	1,469	3,418
87	4,694	5,497	4,508	1,535	3,571
88	4,905	5,744	4,710	1,604	3,732
89	5,126	6,003	4,922	1,677	3,900
90	5,357	6,273	5,144	1,751	4,076
91	5,597	6,556	5,375	1,831	4,258
92	5,849	6,851	5,618	1,912	4,451
93	6,112	7,159	5,871	1,999	4,651
94	6,387	7,481	6,134	2,088	4,860
95	6,675	7,818	6,410	2,183	5,078
96	6,976	8,170	6,699	2,282	5,307
97	7,289	8,538	7,000	2,384	5,545
98	7,618	8,922	7,315	2,491	5,795
99	7,960	9,323	7,644	2,604	6,056

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, 1-800-434-0222, 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, (800) 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 $1556	$0	$1556 (Part A deductible)
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after:			
□ While using 60 lifetime reserve days	All but $778 a day	$778 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 $194.50 a day	$0	Up to $194.50 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 $233 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 $233 of Medicare Approved Amounts*	$0	$0	$233 (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 $233 of Medicare Approved Amounts*	$0	$0	$233 (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 $233 of Medicare Approved Amounts*	$0	$0	$233 (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 $1556	$1556 (Part A deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after:			
□ While using 60 lifetime reserve days	All but $778 a day	$778 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 $194.50 a day	Up to $194.50 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 $233 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 $233 of Medicare Approved Amounts*	$0	$233 (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 $233 of Medicare Approved Amounts*	$0	$233 (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 $233 of Medicare Approved Amounts*	$0	$233 (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 $1556	$1556 (Part A deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after:			
□ While using 60 lifetime reserve days	All but $778 a day	$778 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 $194.50 a day	Up to $194.50 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 $233 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 $233 of Medicare Approved Amounts*	$0	$0	$233 (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 $233 of Medicare Approved Amounts*	$0	$0	$233 (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 $233 of Medicare Approved Amounts*	$0	$0	$233 (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 $2490 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses exceed $2490. 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 $2490 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2490 DEDUCTIBLE** YOU PAY
HOSPITALIZATION* - Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but $1556	$1556 (Part A deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after:			
□ While using 60 lifetime reserve days	All but $778 a day	$778 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 $194.50 a day	Up to $194.50 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 $2490 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2490 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 $233 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 $2490 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses exceed $2490. 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 $2490 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2490 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 $233 of Medicare Approved Amounts*	$0	$0	$233 (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 $233 of Medicare Approved Amounts*	$0	$0	$233 (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 $2490 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2490 DEDUCTIBLE** YOU PAY
HOME HEALTH CARE – Medicare Approved Services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment:			
□ First $233 of Medicare Approved Amounts*	$0	$0	$233 (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 $2490 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2490 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 $1556	$1556 (Part A deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after:			
□ While using 60 lifetime reserve days	All but $778 a day	$778 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 $194.50 a day	Up to $194.50 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 $233 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 $233 of Medicare Approved Amounts*	$0	$0	$233 (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 $233 of Medicare Approved Amounts*	$0	$0	$233 (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 $233 of Medicare Approved Amounts*	$0	$0	$233 (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