Lumico
medigap solutions
Underwritten by
Elips Life Insurance Company

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OUTLINE OF MEDICARE SUPPLEMENT COVERAGE

BENEFIT PLANS A, B, 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. Every company must make Plans A, B and D or G available. 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.

ELIPS LIFE INSURANCE COMPANY

PENNSYLVANIA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 189-194

	Preferred					
					HD	
Attained Age	Plan A	Plan B	Plan F	Plan G	Plan G	Plan N
Under 65	1,877	1,905	2,207	1,912	750	1,451
65	1,877	1,905	2,207	1,912	750	1,451
66	1,877	1,905	2,207	1,912	750	1,451
67	1,877	1,905	2,207	1,912	750	1,451
68	1,877	1,905	2,273	1,912	750	1,495
69	1,877	1,905	2,341	1,912	750	1,540
70	1,934	1,963	2,411	1,979	773	1,585
71	1,991	2,021	2,484	2,048	797	1,635
72	2,052	2,082	2,570	2,120	821	1,691
73	2,123	2,155	2,660	2,194	848	1,750
74	2,196	2,230	2,754	2,271	879	1,812
75	2,274	2,307	2,849	2,350	909	1,875
76	2,353	2,388	2,949	2,432	942	1,940
77	2,436	2,472	3,067	2,530	974	2,018
78	2,533	2,570	3,191	2,632	1,012	2,098
79	2,634	2,673	3,317	2,736	1,052	2,183
80	2,740	2,782	3,451	2,846	1,097	2,269
81	2,849	2,892	3,587	2,960	1,140	2,360
82	2,964	3,008	3,732	3,078	1,185	2,456
83	3,083	3,130	3,881	3,201	1,232	2,553
84	3,207	3,255	4,036	3,329	1,282	2,656
85	3,337	3,386	4,197	3,463	1,332	2,762
86	3,471	3,523	4,366	3,601	1,385	2,873
87	3,607	3,661	4,540	3,745	1,442	2,988
88	3,753	3,810	4,722	3,894	1,498	3,107
89	3,902	3,961	4,910	4,051	1,559	3,233
90	4,058	4,118	5,107	4,213	1,622	3,363
91	4,220	4,283	5,312	4,380	1,686	3,499
92	4,389	4,454	5,523	4,556	1,753	3,638
93	4,564	4,632	5,745	4,738	1,823	3,783
94	4,748	4,819	5,975	4,929	1,898	3,934
95	4,937	5,010	6,214	5,126	1,971	4,091
96	5,134	5,210	6,464	5,331	2,050	4,255
97	5,340	5,420	6,721	5,544	2,133	4,426
98	5,553	5,636	6,989	5,765	2,217	4,603
99	5,775	5,863	7,270	5,995	2,306	4,786

	Standard					
					HD	
Attained Age	Plan A	Plan B	Plan F	Plan G	Plan G	Plan N
Under 65	2,085	2,116	2,452	2,125	835	1,611
65	2,085	2,116	2,452	2,125	835	1,611
66	2,085	2,116	2,452	2,125	835	1,611
67	2,085	2,116	2,452	2,125	835	1,611
68	2,085	2,116	2,526	2,125	835	1,660
69	2,085	2,116	2,602	2,125	835	1,710
70	2,148	2,180	2,679	2,199	860	1,761
71	2,212	2,246	2,760	2,277	884	1,814
72	2,278	2,313	2,856	2,356	910	1,877
73	2,358	2,393	2,956	2,439	943	1,943
74	2,440	2,476	3,059	2,525	976	2,011
75	2,527	2,565	3,166	2,613	1,010	2,081
76	2,613	2,652	3,278	2,704	1,045	2,155
77	2,705	2,746	3,409	2,811	1,083	2,239
78	2,814	2,857	3,544	2,924	1,127	2,330
79	2,928	2,972	3,685	3,042	1,169	2,424
80	3,044	3,090	3,835	3,164	1,217	2,519
81	3,166	3,213	3,987	3,290	1,265	2,620
82	3,292	3,342	4,147	3,421	1,317	2,726
83	3,425	3,476	4,312	3,558	1,368	2,834
84	3,564	3,618	4,485	3,700	1,422	2,948
85	3,708	3,764	4,665	3,848	1,480	3,066
86	3,855	3,913	4,852	4,003	1,539	3,189
87	4,008	4,068	5,045	4,162	1,602	3,317
88	4,170	4,233	5,247	4,330	1,665	3,451
89	4,336	4,402	5,455	4,502	1,731	3,590
90	4,508	4,575	5,676	4,682	1,800	3,735
91	4,690	4,761	5,903	4,870	1,873	3,883
92	4,878	4,951	6,139	5,064	1,949	4,037
93	5,072	5,148	6,384	5,266	2,025	4,198
94	5,276	5,355	6,640	5,478	2,108	4,368
95	5,486	5,568	6,905	5,696	2,190	4,543
96	5,704	5,790	7,184	5,924	2,280	4,722
97	5,932	6,021	7,471	6,161	2,370	4,912
98	6,169	6,262	7,768	6,408	2,465	5,111
99	6,416	6,512	8,079	6,664	2,562	5,314

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

Household Discount Factor .88

ELIPS LIFE INSURANCE COMPANY

PENNSYLVANIA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 150-154, 156

	Preferred					
					HD	
Attained Age	Plan A	Plan B	Plan F	Plan G	Plan G	Plan N
Under 65	1,709	1,735	2,009	1,741	683	1,321
65	1,709	1,735	2,009	1,741	683	1,321
66	1,709	1,735	2,009	1,741	683	1,321
67	1,709	1,735	2,009	1,741	683	1,321
68	1,709	1,735	2,069	1,741	683	1,362
69	1,709	1,735	2,131	1,741	683	1,402
70	1,760	1,787	2,195	1,802	704	1,443
71	1,813	1,840	2,262	1,864	726	1,488
72	1,868	1,896	2,340	1,930	747	1,540
73	1,932	1,962	2,422	1,997	772	1,593
74	2,000	2,030	2,507	2,068	800	1,649
75	2,070	2,101	2,594	2,140	827	1,707
76	2,142	2,174	2,685	2,214	857	1,767
77	2,218	2,251	2,793	2,303	887	1,837
78	2,306	2,340	2,905	2,396	922	1,911
79	2,399	2,434	3,020	2,491	958	1,987
80	2,495	2,533	3,142	2,591	998	2,065
81	2,594	2,633	3,266	2,695	1,038	2,148
82	2,699	2,739	3,398	2,802	1,078	2,236
83	2,807	2,850	3,533	2,915	1,121	2,324
84	2,919	2,963	3,675	3,030	1,167	2,418
85	3,038	3,083	3,821	3,152	1,212	2,514
86	3,160	3,207	3,975	3,278	1,261	2,616
87	3,284	3,333	4,133	3,410	1,313	2,721
88	3,417	3,468	4,299	3,545	1,364	2,829
89	3,553	3,606	4,470	3,688	1,419	2,944
90	3,694	3,749	4,649	3,836	1,477	3,062
91	3,842	3,899	4,836	3,988	1,535	3,185
92	3,996	4,055	5,029	4,148	1,596	3,312
93	4,155	4,218	5,230	4,314	1,659	3,444
94	4,322	4,387	5,440	4,487	1,728	3,582
95	4,494	4,562	5,657	4,667	1,795	3,725
96	4,674	4,743	5,885	4,853	1,866	3,874
97	4,862	4,935	6,120	5,047	1,942	4,030
98	5,056	5,131	6,364	5,248	2,018	4,191
99	5,258	5,338	6,619	5,458	2,099	4,358

	Standard					
					HD	
Attained Age	Plan A	Plan B	Plan F	Plan G	Plan G	Plan N
Under 65	1,898	1,926	2,233	1,935	760	1,466
65	1,898	1,926	2,233	1,935	760	1,466
66	1,898	1,926	2,233	1,935	760	1,466
67	1,898	1,926	2,233	1,935	760	1,466
68	1,898	1,926	2,300	1,935	760	1,512
69	1,898	1,926	2,369	1,935	760	1,557
70	1,956	1,985	2,439	2,002	783	1,603
71	2,014	2,045	2,513	2,073	805	1,652
72	2,074	2,106	2,600	2,145	829	1,709
73	2,147	2,179	2,691	2,220	858	1,769
74	2,222	2,255	2,785	2,298	888	1,831
75	2,301	2,335	2,883	2,379	919	1,895
76	2,379	2,414	2,984	2,462	952	1,962
77	2,463	2,500	3,104	2,560	986	2,039
78	2,562	2,601	3,227	2,662	1,026	2,122
79	2,666	2,706	3,355	2,769	1,064	2,207
80	2,772	2,813	3,492	2,880	1,108	2,294
81	2,883	2,926	3,630	2,995	1,151	2,385
82	2,998	3,043	3,776	3,115	1,199	2,481
83	3,118	3,165	3,926	3,239	1,246	2,580
84	3,245	3,294	4,083	3,368	1,295	2,684
85	3,376	3,427	4,247	3,504	1,347	2,791
86	3,510	3,562	4,418	3,644	1,401	2,904
87	3,649	3,704	4,593	3,789	1,459	3,020
88	3,797	3,854	4,778	3,942	1,516	3,142
89	3,948	4,008	4,967	4,099	1,576	3,268
90	4,104	4,165	5,168	4,263	1,639	3,400
91	4,270	4,335	5,374	4,433	1,705	3,536
92	4,441	4,508	5,589	4,610	1,774	3,676
93	4,618	4,687	5,812	4,795	1,844	3,822
94	4,803	4,875	6,045	4,987	1,919	3,977
95	4,995	5,069	6,287	5,186	1,994	4,136
96	5,194	5,272	6,540	5,394	2,076	4,299
97	5,401	5,481	6,802	5,610	2,158	4,473
98	5,617	5,701	7,072	5,834	2,244	4,653
99	5,841	5,929	7,355	6,067	2,333	4,839

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

Household Discount Factor .88

ELIPS LIFE INSURANCE COMPANY

PENNSYLVANIA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 150-154, 156, 189-194

	Preferred					
					HD	
Attained Age	Plan A	Plan B	Plan F	Plan G	Plan G	Plan N
Under 65	1,485	1,507	1,746	1,513	593	1,148
65	1,485	1,507	1,746	1,513	593	1,148
66	1,485	1,507	1,746	1,513	593	1,148
67	1,485	1,507	1,746	1,513	593	1,148
68	1,485	1,507	1,798	1,513	593	1,183
69	1,485	1,507	1,852	1,513	593	1,218
70	1,530	1,553	1,907	1,566	612	1,254
71	1,575	1,598	1,965	1,620	631	1,293
72	1,623	1,647	2,033	1,677	649	1,338
73	1,679	1,704	2,104	1,735	671	1,384
74	1,737	1,764	2,178	1,797	695	1,433
75	1,799	1,825	2,254	1,859	719	1,483
76	1,861	1,889	2,333	1,924	745	1,535
77	1,927	1,956	2,426	2,001	771	1,596
78	2,003	2,033	2,524	2,082	801	1,660
79	2,084	2,115	2,624	2,165	832	1,727
80	2,168	2,201	2,730	2,251	867	1,795
81	2,254	2,287	2,838	2,342	902	1,867
82	2,345	2,380	2,952	2,435	937	1,943
83	2,439	2,476	3,070	2,532	974	2,019
84	2,537	2,575	3,193	2,633	1,014	2,101
85	2,639	2,679	3,320	2,739	1,053	2,185
86	2,745	2,787	3,453	2,848	1,096	2,273
87	2,854	2,896	3,591	2,963	1,141	2,364
88	2,969	3,014	3,735	3,080	1,185	2,458
89	3,087	3,133	3,884	3,204	1,233	2,558
90	3,210	3,257	4,040	3,333	1,283	2,661
91	3,338	3,388	4,202	3,465	1,334	2,768
92	3,472	3,523	4,369	3,604	1,387	2,878
93	3,610	3,664	4,544	3,748	1,442	2,992
94	3,756	3,812	4,727	3,899	1,501	3,112
95	3,905	3,963	4,915	4,055	1,559	3,236
96	4,061	4,121	5,113	4,217	1,622	3,366
97	4,224	4,288	5,317	4,385	1,687	3,501
98	4,393	4,458	5,529	4,560	1,753	3,641
99	4,569	4,638	5,751	4,742	1,824	3,786

	Standard					
					HD	
Attained Age	Plan A	Plan B	Plan F	Plan G	Plan G	Plan N
Under 65	1,649	1,674	1,940	1,681	661	1,274
65	1,649	1,674	1,940	1,681	661	1,274
66	1,649	1,674	1,940	1,681	661	1,274
67	1,649	1,674	1,940	1,681	661	1,274
68	1,649	1,674	1,998	1,681	661	1,313
69	1,649	1,674	2,059	1,681	661	1,353
70	1,699	1,725	2,119	1,739	680	1,393
71	1,750	1,777	2,184	1,801	699	1,435
72	1,802	1,830	2,259	1,863	720	1,485
73	1,866	1,893	2,338	1,929	746	1,537
74	1,930	1,959	2,420	1,997	772	1,591
75	1,999	2,029	2,505	2,067	799	1,646
76	2,067	2,098	2,593	2,139	827	1,704
77	2,140	2,172	2,697	2,224	857	1,771
78	2,226	2,260	2,804	2,313	891	1,843
79	2,316	2,351	2,915	2,406	925	1,918
80	2,408	2,444	3,034	2,503	963	1,993
81	2,505	2,542	3,154	2,602	1,000	2,072
82	2,604	2,644	3,281	2,706	1,042	2,156
83	2,709	2,750	3,411	2,814	1,082	2,242
84	2,820	2,862	3,548	2,927	1,125	2,332
85	2,933	2,978	3,690	3,044	1,171	2,425
86	3,050	3,095	3,838	3,166	1,217	2,523
87	3,170	3,218	3,991	3,292	1,267	2,624
88	3,299	3,349	4,151	3,425	1,317	2,730
89	3,430	3,482	4,315	3,562	1,369	2,840
90	3,566	3,619	4,490	3,704	1,424	2,954
91	3,710	3,766	4,669	3,852	1,481	3,072
92	3,858	3,917	4,856	4,006	1,542	3,194
93	4,012	4,073	5,050	4,166	1,602	3,321
94	4,173	4,236	5,252	4,333	1,667	3,456
95	4,340	4,404	5,462	4,506	1,733	3,593
96	4,512	4,580	5,683	4,686	1,803	3,735
97	4,693	4,763	5,910	4,874	1,875	3,886
98	4,880	4,953	6,145	5,069	1,950	4,043
99	5,075	5,152	6,391	5,271	2,027	4,204

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

Household Discount Factor .88

ELIPS LIFE INSURANCE COMPANY

PENNSYLVANIA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 189-194

	Preferred					
					HD	
Attained Age	Plan A	Plan B	Plan F	Plan G	Plan G	Plan N
Under 65	1,676	1,702	1,970	1,709	670	1,294
65	1,676	1,702	1,970	1,709	670	1,294
66	1,676	1,702	1,970	1,709	670	1,294
67	1,676	1,702	1,970	1,709	670	1,294
68	1,676	1,702	2,029	1,709	670	1,335
69	1,676	1,702	2,090	1,709	670	1,374
70	1,726	1,751	2,152	1,767	689	1,415
71	1,778	1,805	2,218	1,829	710	1,458
72	1,830	1,857	2,294	1,893	731	1,509
73	1,895	1,923	2,374	1,960	758	1,561
74	1,962	1,991	2,458	2,029	784	1,617
75	2,030	2,061	2,543	2,100	812	1,672
76	2,101	2,133	2,633	2,173	840	1,731
77	2,175	2,207	2,739	2,259	869	1,801
78	2,262	2,295	2,848	2,350	905	1,873
79	2,352	2,387	2,961	2,444	940	1,948
80	2,446	2,482	3,081	2,542	978	2,025
81	2,543	2,581	3,203	2,644	1,018	2,105
82	2,647	2,687	3,331	2,750	1,058	2,191
83	2,752	2,794	3,464	2,860	1,100	2,278
84	2,864	2,906	3,603	2,973	1,144	2,369
85	2,979	3,023	3,748	3,093	1,188	2,464
86	3,098	3,145	3,898	3,216	1,237	2,563
87	3,221	3,270	4,052	3,345	1,287	2,667
88	3,351	3,402	4,216	3,479	1,338	2,772
89	3,484	3,536	4,383	3,618	1,391	2,885
90	3,623	3,678	4,560	3,763	1,447	3,002
91	3,768	3,824	4,742	3,913	1,505	3,122
92	3,920	3,978	4,931	4,070	1,565	3,245
93	4,075	4,137	5,130	4,233	1,627	3,375
94	4,238	4,301	5,335	4,402	1,693	3,511
95	4,407	4,473	5,548	4,579	1,761	3,652
96	4,584	4,652	5,771	4,761	1,831	3,796
97	4,766	4,837	6,001	4,951	1,904	3,949
98	4,957	5,030	6,240	5,150	1,980	4,107
99	5,156	5,234	6,490	5,356	2,059	4,271

	Standard					
					HD	
Attained Age	Plan A	Plan B	Plan F	Plan G	Plan G	Plan N
Under 65	1,863	1,891	2,190	1,896	745	1,439
65	1,863	1,891	2,190	1,896	745	1,439
66	1,863	1,891	2,190	1,896	745	1,439
67	1,863	1,891	2,190	1,896	745	1,439
68	1,863	1,891	2,255	1,896	745	1,482
69	1,863	1,891	2,324	1,896	745	1,526
70	1,918	1,946	2,393	1,963	767	1,572
71	1,975	2,005	2,466	2,031	789	1,620
72	2,034	2,065	2,550	2,102	814	1,676
73	2,105	2,137	2,640	2,176	842	1,735
74	2,179	2,211	2,732	2,253	871	1,797
75	2,255	2,289	2,827	2,332	902	1,859
76	2,334	2,369	2,928	2,413	932	1,924
77	2,416	2,452	3,044	2,510	967	2,001
78	2,513	2,550	3,165	2,609	1,006	2,081
79	2,613	2,652	3,291	2,714	1,044	2,164
80	2,718	2,758	3,424	2,822	1,086	2,250
81	2,826	2,869	3,560	2,936	1,129	2,340
82	2,940	2,984	3,704	3,053	1,177	2,435
83	3,058	3,103	3,851	3,174	1,223	2,531
84	3,181	3,229	4,005	3,302	1,270	2,633
85	3,310	3,359	4,166	3,434	1,321	2,738
86	3,441	3,493	4,334	3,571	1,374	2,848
87	3,579	3,633	4,505	3,714	1,430	2,963
88	3,723	3,779	4,686	3,863	1,487	3,081
89	3,873	3,930	4,872	4,017	1,546	3,205
90	4,025	4,086	5,069	4,178	1,607	3,335
91	4,188	4,250	5,272	4,346	1,672	3,468
92	4,355	4,421	5,482	4,518	1,740	3,606
93	4,528	4,596	5,702	4,699	1,808	3,749
94	4,710	4,781	5,930	4,888	1,882	3,901
95	4,898	4,971	6,167	5,084	1,955	4,056
96	5,093	5,170	6,416	5,286	2,034	4,218
97	5,297	5,376	6,671	5,498	2,116	4,389
98	5,509	5,592	6,937	5,718	2,201	4,564
99	5,729	5,814	7,215	5,947	2,288	4,746

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

Household Discount Factor .88

ELIPS LIFE INSURANCE COMPANY

PENNSYLVANIA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 150-154, 156

	Preferred					
					HD	
Attained Age	Plan A	Plan B	Plan F	Plan G	Plan G	Plan N
Under 65	1,526	1,549	1,793	1,556	610	1,179
65	1,526	1,549	1,793	1,556	610	1,179
66	1,526	1,549	1,793	1,556	610	1,179
67	1,526	1,549	1,793	1,556	610	1,179
68	1,526	1,549	1,847	1,556	610	1,215
69	1,526	1,549	1,903	1,556	610	1,251
70	1,571	1,595	1,959	1,609	628	1,288
71	1,619	1,643	2,019	1,665	647	1,327
72	1,667	1,691	2,089	1,724	666	1,374
73	1,725	1,751	2,162	1,785	690	1,421
74	1,786	1,813	2,237	1,847	714	1,473
75	1,848	1,876	2,316	1,912	739	1,523
76	1,913	1,942	2,397	1,979	765	1,576
77	1,980	2,009	2,494	2,057	791	1,640
78	2,059	2,090	2,593	2,140	824	1,706
79	2,141	2,173	2,696	2,225	856	1,774
80	2,227	2,259	2,805	2,314	891	1,843
81	2,316	2,350	2,916	2,407	927	1,917
82	2,410	2,446	3,033	2,503	964	1,995
83	2,506	2,544	3,154	2,603	1,002	2,074
84	2,607	2,646	3,281	2,707	1,041	2,157
85	2,712	2,752	3,412	2,816	1,082	2,244
86	2,821	2,863	3,549	2,928	1,126	2,334
87	2,933	2,977	3,689	3,045	1,172	2,428
88	3,051	3,098	3,838	3,167	1,218	2,524
89	3,172	3,220	3,991	3,294	1,266	2,627
90	3,299	3,349	4,152	3,426	1,318	2,733
91	3,431	3,482	4,318	3,562	1,370	2,843
92	3,569	3,622	4,490	3,705	1,425	2,955
93	3,710	3,766	4,670	3,854	1,481	3,073
94	3,859	3,916	4,857	4,008	1,541	3,196
95	4,013	4,072	5,051	4,169	1,603	3,325
96	4,174	4,236	5,255	4,335	1,667	3,456
97	4,340	4,404	5,463	4,508	1,734	3,595
98	4,513	4,580	5,682	4,688	1,803	3,739
99	4,695	4,765	5,908	4,876	1,875	3,888

	Standard					
					HD	
Attained Age	Plan A	Plan B	Plan F	Plan G	Plan G	Plan N
Under 65	1,696	1,721	1,993	1,726	678	1,310
65	1,696	1,721	1,993	1,726	678	1,310
66	1,696	1,721	1,993	1,726	678	1,310
67	1,696	1,721	1,993	1,726	678	1,310
68	1,696	1,721	2,053	1,726	678	1,349
69	1,696	1,721	2,115	1,726	678	1,390
70	1,746	1,771	2,179	1,787	698	1,431
71	1,798	1,825	2,245	1,850	719	1,475
72	1,852	1,880	2,322	1,914	741	1,526
73	1,917	1,946	2,403	1,981	766	1,580
74	1,984	2,013	2,488	2,051	793	1,636
75	2,053	2,084	2,574	2,123	821	1,692
76	2,125	2,157	2,666	2,197	849	1,752
77	2,200	2,233	2,772	2,285	880	1,821
78	2,288	2,322	2,882	2,375	916	1,895
79	2,379	2,414	2,996	2,471	951	1,970
80	2,474	2,511	3,117	2,569	989	2,048
81	2,573	2,612	3,242	2,673	1,028	2,130
82	2,677	2,717	3,372	2,779	1,071	2,217
83	2,784	2,826	3,506	2,890	1,113	2,305
84	2,896	2,940	3,647	3,006	1,156	2,397
85	3,013	3,059	3,793	3,127	1,203	2,492
86	3,133	3,181	3,945	3,251	1,251	2,593
87	3,259	3,307	4,102	3,382	1,302	2,697
88	3,389	3,440	4,266	3,517	1,353	2,805
89	3,526	3,578	4,436	3,658	1,407	2,918
90	3,665	3,720	4,615	3,804	1,463	3,037
91	3,813	3,870	4,799	3,956	1,522	3,157
92	3,965	4,025	4,991	4,114	1,584	3,283
93	4,122	4,185	5,191	4,279	1,646	3,414
94	4,288	4,353	5,399	4,451	1,713	3,551
95	4,459	4,526	5,614	4,629	1,780	3,693
96	4,637	4,707	5,841	4,813	1,852	3,841
97	4,823	4,895	6,073	5,006	1,926	3,996
98	5,015	5,091	6,316	5,206	2,004	4,155
99	5,216	5,294	6,568	5,414	2,083	4,321

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

Household Discount Factor .88

ELIPS LIFE INSURANCE COMPANY

PENNSYLVANIA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 150-154, 156, 189-194

	Preferred					
					HD	
Attained Age	Plan A	Plan B	Plan F	Plan G	Plan G	Plan N
Under 65	1,326	1,346	1,558	1,352	530	1,024
65	1,326	1,346	1,558	1,352	530	1,024
66	1,326	1,346	1,558	1,352	530	1,024
67	1,326	1,346	1,558	1,352	530	1,024
68	1,326	1,346	1,605	1,352	530	1,056
69	1,326	1,346	1,654	1,352	530	1,087
70	1,365	1,385	1,702	1,398	545	1,119
71	1,407	1,428	1,754	1,447	562	1,153
72	1,448	1,469	1,815	1,498	579	1,194
73	1,499	1,521	1,878	1,551	599	1,235
74	1,552	1,575	1,944	1,605	620	1,279
75	1,606	1,630	2,012	1,661	642	1,323
76	1,662	1,688	2,083	1,719	665	1,370
77	1,720	1,746	2,167	1,787	688	1,425
78	1,789	1,816	2,253	1,859	716	1,482
79	1,860	1,888	2,343	1,933	744	1,541
80	1,935	1,963	2,437	2,011	774	1,602
81	2,012	2,042	2,533	2,091	805	1,665
82	2,094	2,125	2,635	2,175	837	1,733
83	2,177	2,210	2,740	2,262	871	1,802
84	2,265	2,299	2,850	2,352	905	1,874
85	2,356	2,391	2,965	2,446	940	1,949
86	2,451	2,488	3,084	2,544	979	2,028
87	2,548	2,586	3,205	2,646	1,018	2,109
88	2,651	2,691	3,335	2,752	1,059	2,193
89	2,756	2,797	3,467	2,862	1,100	2,282
90	2,866	2,910	3,607	2,976	1,145	2,374
91	2,981	3,025	3,751	3,095	1,190	2,470
92	3,101	3,147	3,901	3,219	1,238	2,567
93	3,223	3,272	4,058	3,349	1,287	2,670
94	3,353	3,403	4,220	3,482	1,339	2,777
95	3,486	3,538	4,388	3,622	1,393	2,889
96	3,626	3,680	4,565	3,766	1,448	3,003
97	3,770	3,827	4,747	3,917	1,506	3,124
98	3,921	3,979	4,936	4,074	1,567	3,249
99	4,079	4,140	5,134	4,237	1,629	3,378

	Standard					
					HD	
Attained Age	Plan A	Plan B	Plan F	Plan G	Plan G	Plan N
Under 65	1,473	1,496	1,732	1,500	589	1,138
65	1,473	1,496	1,732	1,500	589	1,138
66	1,473	1,496	1,732	1,500	589	1,138
67	1,473	1,496	1,732	1,500	589	1,138
68	1,473	1,496	1,784	1,500	589	1,172
69	1,473	1,496	1,838	1,500	589	1,207
70	1,517	1,539	1,893	1,553	607	1,243
71	1,562	1,586	1,950	1,607	624	1,282
72	1,609	1,633	2,017	1,663	644	1,326
73	1,665	1,691	2,088	1,721	666	1,373
74	1,724	1,749	2,161	1,782	689	1,421
75	1,784	1,810	2,237	1,844	714	1,470
76	1,847	1,874	2,316	1,909	738	1,522
77	1,911	1,940	2,408	1,985	765	1,583
78	1,988	2,017	2,504	2,064	796	1,646
79	2,067	2,098	2,603	2,147	826	1,712
80	2,150	2,181	2,708	2,232	859	1,780
81	2,236	2,269	2,816	2,322	893	1,851
82	2,326	2,361	2,930	2,415	931	1,926
83	2,419	2,455	3,046	2,511	967	2,002
84	2,516	2,555	3,168	2,612	1,005	2,083
85	2,618	2,657	3,296	2,717	1,045	2,166
86	2,722	2,763	3,428	2,825	1,087	2,253
87	2,831	2,874	3,564	2,938	1,131	2,344
88	2,945	2,989	3,707	3,056	1,176	2,437
89	3,063	3,109	3,854	3,178	1,223	2,536
90	3,184	3,232	4,010	3,305	1,271	2,638
91	3,313	3,362	4,170	3,438	1,322	2,743
92	3,445	3,497	4,336	3,574	1,376	2,852
93	3,582	3,636	4,510	3,717	1,430	2,966
94	3,726	3,782	4,691	3,867	1,489	3,086
95	3,874	3,933	4,878	4,022	1,547	3,209
96	4,029	4,089	5,075	4,182	1,609	3,337
97	4,190	4,253	5,277	4,349	1,674	3,472
98	4,358	4,423	5,488	4,523	1,741	3,610
99	4,532	4,599	5,707	4,704	1,810	3,755

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.

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. NOTE: The policy fee is fully refundable if the policy is not issued, delivery of the policy is refused or the policy is returned with the policy's 30-day free look period.

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 $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 B

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	$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 B

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 B

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