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. Every Company must make Plan "A" and either Plan C or F available for those eligible for Medicare prior to January 1, 2020 and either Plan D or G available for those eligible for Medicare on or after January 1 2020. Only applicants' **first** eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

Note: A ✓ means 100% of the benefit is paid.

Benefits	Plans available to all applicants									Medicare first eligible before 2020 only		
	A	B	D	G	G[1]	K	L	M	N	C	F	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	
Medicare Part B coinsurance or copayment	✓	✓	✓	✓		50%	75%	✓	copays apply[3]	✓	✓	
Blood (first three pints)	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓	
Part A hospice care coinsurance or copayment	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓	
Skilled nursing facility coinsurance			✓	✓		50%	75%	✓	✓	✓	✓	
Medicare Part A deductible		✓	✓	✓		50%	75%	50%	✓	✓	✓	
Medicare Part B deductible										✓	✓	
Medicare Part B excess charges				✓							✓	
Foreign travel emergency (up to plan limits)			✓	✓				✓	✓	✓	✓	
Out-of-pocket limit in 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

KENTUCKY Standard Plans MALE Rates - ANNUAL

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

	Preferred				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
Under 65	5,978	7,257	6,040	NA	NA
65	1,494	1,815	1,510	622	1,162
66	1,494	1,815	1,510	622	1,162
67	1,494	1,815	1,510	622	1,162
68	1,494	1,815	1,510	622	1,197
69	1,540	1,869	1,555	642	1,233
70	1,587	1,925	1,603	662	1,270
71	1,634	1,984	1,650	681	1,308
72	1,692	2,052	1,709	704	1,355
73	1,751	2,123	1,768	729	1,401
74	1,812	2,199	1,830	754	1,451
75	1,875	2,275	1,893	782	1,501
76	1,940	2,355	1,960	809	1,553
77	2,018	2,449	2,038	840	1,615
78	2,099	2,547	2,120	873	1,680
79	2,182	2,649	2,204	910	1,746
80	2,270	2,754	2,293	946	1,816
81	2,361	2,865	2,385	983	1,889
82	2,455	2,978	2,480	1,022	1,965
83	2,553	3,098	2,579	1,064	2,044
84	2,654	3,222	2,681	1,105	2,127
85	2,761	3,351	2,789	1,150	2,211
86	2,871	3,486	2,900	1,197	2,300
87	2,987	3,624	3,017	1,244	2,393
88	3,105	3,769	3,137	1,294	2,488
89	3,230	3,921	3,262	1,346	2,589
90	3,359	4,077	3,393	1,400	2,693
91	3,493	4,241	3,528	1,455	2,800
92	3,633	4,411	3,670	1,513	2,911
93	3,778	4,587	3,816	1,575	3,028
94	3,929	4,771	3,969	1,636	3,150
95	4,085	4,962	4,127	1,701	3,275
96	4,249	5,161	4,291	1,770	3,406
97	4,418	5,367	4,462	1,840	3,543
98	4,594	5,582	4,641	1,914	3,684
99	4,780	5,804	4,828	1,990	3,831

	Standard				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
Under 65	6,645	8,065	6,712	NA	NA
65	1,661	2,017	1,678	693	1,291
66	1,661	2,017	1,678	693	1,291
67	1,661	2,017	1,678	693	1,291
68	1,661	2,017	1,678	693	1,330
69	1,711	2,078	1,729	714	1,370
70	1,763	2,139	1,780	734	1,412
71	1,817	2,203	1,836	755	1,454
72	1,879	2,280	1,898	783	1,503
73	1,946	2,361	1,965	810	1,557
74	2,013	2,443	2,034	838	1,612
75	2,083	2,527	2,104	868	1,668
76	2,156	2,617	2,178	899	1,725
77	2,243	2,722	2,266	935	1,795
78	2,332	2,830	2,355	970	1,867
79	2,425	2,943	2,449	1,010	1,941
80	2,523	3,061	2,548	1,050	2,019
81	2,624	3,183	2,650	1,093	2,099
82	2,727	3,309	2,754	1,136	2,183
83	2,836	3,442	2,865	1,180	2,270
84	2,948	3,581	2,978	1,228	2,362
85	3,069	3,723	3,100	1,277	2,457
86	3,189	3,874	3,222	1,330	2,555
87	3,319	4,028	3,353	1,382	2,660
88	3,451	4,189	3,486	1,437	2,765
89	3,588	4,357	3,624	1,494	2,875
90	3,732	4,530	3,770	1,554	2,991
91	3,881	4,712	3,921	1,618	3,113
92	4,036	4,901	4,077	1,681	3,234
93	4,199	5,096	4,241	1,749	3,366
94	4,367	5,301	4,410	1,818	3,500
95	4,540	5,513	4,586	1,892	3,640
96	4,721	5,734	4,769	1,967	3,784
97	4,909	5,964	4,958	2,046	3,937
98	5,106	6,201	5,157	2,127	4,094
99	5,310	6,450	5,364	2,212	4,256

Modal Factors: Semi Annual: 0.5000 Quarterly: 0.25000 Monthly: Divide by 1

Household Discount Factor .88

ELIPS LIFE INSURANCE COMPANY

KENTUCKY Standard Plans MALE Rates - ANNUAL

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

	Preferred				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
Under 65	5,649	6,858	5,707	NA	NA
65	1,412	1,715	1,427	588	1,098
66	1,412	1,715	1,427	588	1,098
67	1,412	1,715	1,427	588	1,098
68	1,412	1,715	1,427	588	1,131
69	1,455	1,766	1,470	607	1,165
70	1,500	1,819	1,515	625	1,200
71	1,544	1,875	1,559	644	1,236
72	1,599	1,939	1,615	665	1,280
73	1,654	2,006	1,671	689	1,324
74	1,712	2,078	1,729	713	1,371
75	1,772	2,150	1,789	739	1,418
76	1,833	2,226	1,852	764	1,468
77	1,907	2,314	1,926	794	1,526
78	1,984	2,407	2,003	825	1,587
79	2,062	2,503	2,083	860	1,650
80	2,145	2,603	2,167	894	1,716
81	2,231	2,707	2,254	929	1,785
82	2,320	2,814	2,343	966	1,857
83	2,412	2,927	2,437	1,005	1,931
84	2,508	3,045	2,534	1,044	2,010
85	2,609	3,166	2,636	1,087	2,089
86	2,713	3,294	2,741	1,131	2,173
87	2,822	3,425	2,851	1,175	2,261
88	2,934	3,562	2,964	1,223	2,351
89	3,052	3,705	3,083	1,272	2,446
90	3,174	3,852	3,206	1,323	2,545
91	3,301	4,008	3,334	1,375	2,646
92	3,433	4,168	3,468	1,430	2,751
93	3,570	4,334	3,606	1,488	2,861
94	3,713	4,508	3,750	1,546	2,977
95	3,860	4,689	3,900	1,608	3,095
96	4,015	4,877	4,055	1,673	3,219
97	4,175	5,072	4,217	1,739	3,348
98	4,341	5,275	4,386	1,809	3,481
99	4,517	5,485	4,562	1,881	3,620

	Standard				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
Under 65	6,279	7,621	6,343	NA	NA
65	1,570	1,906	1,585	655	1,220
66	1,570	1,906	1,585	655	1,220
67	1,570	1,906	1,585	655	1,220
68	1,570	1,906	1,585	655	1,257
69	1,617	1,963	1,634	675	1,295
70	1,666	2,021	1,682	693	1,334
71	1,717	2,082	1,735	714	1,374
72	1,776	2,155	1,793	740	1,420
73	1,839	2,231	1,857	765	1,471
74	1,902	2,308	1,922	792	1,523
75	1,968	2,388	1,988	820	1,576
76	2,037	2,473	2,058	850	1,630
77	2,120	2,572	2,141	884	1,696
78	2,203	2,674	2,226	917	1,764
79	2,292	2,781	2,314	955	1,834
80	2,384	2,892	2,408	992	1,908
81	2,479	3,008	2,504	1,033	1,984
82	2,577	3,127	2,603	1,073	2,063
83	2,680	3,253	2,707	1,115	2,145
84	2,786	3,384	2,814	1,161	2,232
85	2,900	3,518	2,929	1,207	2,322
86	3,014	3,661	3,045	1,257	2,414
87	3,136	3,806	3,168	1,306	2,513
88	3,261	3,958	3,294	1,358	2,613
89	3,391	4,117	3,425	1,412	2,717
90	3,527	4,281	3,563	1,469	2,826
91	3,668	4,453	3,705	1,529	2,942
92	3,814	4,631	3,852	1,588	3,056
93	3,968	4,815	4,008	1,653	3,181
94	4,126	5,009	4,167	1,718	3,307
95	4,290	5,210	4,333	1,788	3,439
96	4,461	5,419	4,506	1,859	3,576
97	4,639	5,636	4,685	1,933	3,720
98	4,825	5,860	4,873	2,010	3,869
99	5,018	6,095	5,069	2,090	4,022

Modal Factors: Semi Annual: 0.5000 Quarterly: 0.25000 Monthly: Divide by 1

Household Discount Factor .88

ELIPS LIFE INSURANCE COMPANY

KENTUCKY Standard Plans FEMALE Rates - ANNUAL

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

	Preferred				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
Under 65	5,341	6,479	5,392	NA	NA
65	1,335	1,620	1,348	540	1,038
66	1,335	1,620	1,348	540	1,038
67	1,335	1,620	1,348	540	1,038
68	1,335	1,620	1,348	540	1,069
69	1,376	1,669	1,390	555	1,101
70	1,416	1,719	1,430	572	1,134
71	1,458	1,770	1,474	589	1,168
72	1,511	1,832	1,526	610	1,209
73	1,563	1,897	1,578	631	1,251
74	1,619	1,962	1,635	653	1,295
75	1,674	2,031	1,692	677	1,340
76	1,733	2,103	1,751	700	1,388
77	1,802	2,187	1,820	728	1,442
78	1,874	2,274	1,892	758	1,500
79	1,949	2,364	1,969	788	1,561
80	2,027	2,459	2,048	820	1,622
81	2,108	2,557	2,130	852	1,686
82	2,192	2,661	2,214	886	1,755
83	2,279	2,766	2,302	921	1,825
84	2,370	2,877	2,394	957	1,898
85	2,464	2,992	2,490	996	1,974
86	2,564	3,113	2,590	1,037	2,054
87	2,667	3,236	2,694	1,077	2,135
88	2,773	3,366	2,801	1,119	2,221
89	2,883	3,501	2,912	1,165	2,311
90	2,999	3,641	3,029	1,212	2,405
91	3,120	3,787	3,151	1,260	2,500
92	3,244	3,938	3,277	1,310	2,600
93	3,374	4,095	3,407	1,363	2,703
94	3,508	4,260	3,543	1,418	2,812
95	3,647	4,430	3,684	1,474	2,924
96	3,793	4,607	3,831	1,534	3,041
97	3,945	4,793	3,985	1,595	3,163
98	4,102	4,983	4,143	1,658	3,291
99	4,267	5,183	4,311	1,724	3,422

	Standard				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
Under 65	5,930	7,198	5,993	NA	NA
65	1,482	1,800	1,498	618	1,152
66	1,482	1,800	1,498	618	1,152
67	1,482	1,800	1,498	618	1,152
68	1,482	1,800	1,498	618	1,188
69	1,527	1,854	1,542	637	1,223
70	1,573	1,910	1,589	655	1,260
71	1,622	1,967	1,638	676	1,297
72	1,678	2,036	1,695	699	1,343
73	1,737	2,107	1,755	723	1,391
74	1,796	2,181	1,815	749	1,439
75	1,861	2,257	1,879	774	1,489
76	1,925	2,337	1,945	802	1,540
77	2,002	2,430	2,023	835	1,603
78	2,082	2,526	2,103	867	1,667
79	2,165	2,627	2,187	901	1,733
80	2,252	2,733	2,275	937	1,803
81	2,341	2,842	2,365	977	1,875
82	2,434	2,955	2,459	1,015	1,950
83	2,532	3,074	2,557	1,054	2,026
84	2,635	3,197	2,661	1,097	2,108
85	2,739	3,326	2,766	1,140	2,194
86	2,848	3,459	2,877	1,187	2,281
87	2,964	3,597	2,993	1,234	2,374
88	3,081	3,740	3,113	1,283	2,469
89	3,204	3,890	3,236	1,334	2,568
90	3,332	4,045	3,366	1,388	2,671
91	3,466	4,207	3,501	1,444	2,778
92	3,605	4,376	3,641	1,501	2,889
93	3,749	4,551	3,787	1,562	3,005
94	3,898	4,733	3,937	1,623	3,124
95	4,053	4,922	4,094	1,688	3,249
96	4,214	5,121	4,256	1,756	3,379
97	4,382	5,325	4,426	1,827	3,514
98	4,558	5,537	4,604	1,899	3,655
99	4,740	5,758	4,788	1,975	3,801

Modal Factors: Semi Annual: 0.5000 Quarterly: 0.25000 Monthly: Divide by 1

Household Discount Factor .88

ELIPS LIFE INSURANCE COMPANY

KENTUCKY Standard Plans FEMALE Rates - ANNUAL

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

	Preferred				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
Under 65	5,047	6,122	5,095	NA	NA
65	1,262	1,531	1,274	510	981
66	1,262	1,531	1,274	510	981
67	1,262	1,531	1,274	510	981
68	1,262	1,531	1,274	510	1,010
69	1,300	1,577	1,313	524	1,040
70	1,338	1,624	1,351	541	1,071
71	1,378	1,673	1,393	556	1,104
72	1,428	1,731	1,442	577	1,142
73	1,477	1,792	1,491	596	1,182
74	1,530	1,854	1,545	617	1,224
75	1,582	1,919	1,599	640	1,266
76	1,638	1,987	1,654	661	1,311
77	1,703	2,066	1,720	688	1,363
78	1,771	2,149	1,788	716	1,417
79	1,842	2,234	1,860	745	1,475
80	1,916	2,324	1,935	775	1,533
81	1,992	2,416	2,013	805	1,593
82	2,071	2,514	2,092	837	1,658
83	2,154	2,614	2,175	870	1,724
84	2,239	2,718	2,262	904	1,793
85	2,329	2,827	2,353	941	1,865
86	2,423	2,942	2,447	980	1,941
87	2,520	3,058	2,546	1,018	2,018
88	2,620	3,181	2,647	1,058	2,099
89	2,724	3,308	2,752	1,101	2,184
90	2,834	3,440	2,862	1,145	2,272
91	2,948	3,578	2,978	1,191	2,363
92	3,065	3,721	3,096	1,238	2,457
93	3,188	3,870	3,220	1,288	2,554
94	3,315	4,025	3,348	1,340	2,657
95	3,446	4,186	3,481	1,393	2,763
96	3,584	4,354	3,620	1,449	2,874
97	3,728	4,529	3,766	1,507	2,989
98	3,876	4,709	3,915	1,567	3,110
99	4,032	4,898	4,074	1,629	3,233

	Standard				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
Under 65	5,603	6,802	5,663	NA	NA
65	1,401	1,701	1,415	584	1,089
66	1,401	1,701	1,415	584	1,089
67	1,401	1,701	1,415	584	1,089
68	1,401	1,701	1,415	584	1,123
69	1,443	1,752	1,457	602	1,156
70	1,486	1,805	1,502	619	1,191
71	1,533	1,859	1,548	639	1,226
72	1,585	1,924	1,602	660	1,269
73	1,642	1,991	1,658	683	1,314
74	1,697	2,061	1,715	708	1,360
75	1,758	2,133	1,776	731	1,407
76	1,819	2,208	1,838	758	1,455
77	1,892	2,296	1,912	789	1,515
78	1,967	2,387	1,987	819	1,575
79	2,046	2,482	2,066	852	1,638
80	2,128	2,582	2,150	886	1,704
81	2,212	2,685	2,235	923	1,772
82	2,300	2,792	2,324	959	1,843
83	2,393	2,905	2,416	996	1,915
84	2,490	3,021	2,514	1,036	1,992
85	2,588	3,143	2,614	1,077	2,073
86	2,691	3,268	2,718	1,122	2,156
87	2,801	3,399	2,828	1,166	2,243
88	2,912	3,534	2,942	1,212	2,333
89	3,027	3,676	3,058	1,261	2,427
90	3,149	3,822	3,181	1,311	2,524
91	3,275	3,976	3,308	1,365	2,625
92	3,406	4,135	3,440	1,418	2,730
93	3,542	4,300	3,578	1,476	2,840
94	3,683	4,472	3,720	1,534	2,952
95	3,830	4,651	3,869	1,595	3,070
96	3,982	4,839	4,022	1,659	3,193
97	4,141	5,032	4,183	1,726	3,321
98	4,307	5,232	4,351	1,794	3,454
99	4,479	5,441	4,525	1,866	3,592

Modal Factors: Semi Annual: 0.5000 Quarterly: 0.25000 Monthly: Divide by 1

Household Discount Factor .88

PREMIUM INFORMATION

Elips Life Insurance Company may change your premium on any premium due date if a new table of rates is applicable to the policy. The change in the table of rates will apply to all covered persons in the same class. Class is defined as attained age, gender, underwriting class, state of issue, and your most recent zip code of residence in the state of issue. Premiums are based on your attained age and will change on your policy anniversary date.

There is a one-time $25 policy fee.

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

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and Elips Life Insurance Company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to: Elips Life Insurance Company, Medicare Supplement Administration, P.O. Box 10875, Clearwater, Florida 33757-8875. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments, less any claims paid.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs. Neither Elips Life Insurance Company nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult Medicare and You for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. Elips Life Insurance Company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded. Please refer to your policy for details.

PLAN A

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* - Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but $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