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 2021[2]						$6220[2]	$3110[2]					

[1]Plans F and G also have a high deductible option which requires first paying a plan deductible of $2370 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

NEBRASKA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 680, 681, 683, 685

	Preferred						Standard				
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,443	1,762	1,457	583	1,119	65	1,603	1,958	1,619	649	1,242
66	1,443	1,762	1,457	583	1,119	66	1,603	1,958	1,619	649	1,242
67	1,443	1,762	1,457	583	1,119	67	1,603	1,958	1,619	649	1,242
68	1,443	1,762	1,457	583	1,152	68	1,603	1,958	1,619	649	1,280
69	1,486	1,816	1,502	600	1,187	69	1,651	2,018	1,669	668	1,318
70	1,531	1,870	1,547	619	1,222	70	1,701	2,079	1,718	687	1,359
71	1,577	1,926	1,593	638	1,259	71	1,751	2,141	1,771	708	1,399
72	1,632	1,994	1,649	659	1,303	72	1,813	2,216	1,832	732	1,447
73	1,688	2,063	1,707	683	1,348	73	1,876	2,294	1,896	758	1,498
74	1,748	2,135	1,766	707	1,396	74	1,943	2,373	1,963	785	1,551
75	1,809	2,210	1,827	731	1,445	75	2,009	2,456	2,031	813	1,605
76	1,873	2,288	1,892	757	1,495	76	2,080	2,542	2,102	842	1,660
77	1,947	2,379	1,967	787	1,554	77	2,163	2,644	2,187	876	1,727
78	2,025	2,474	2,046	818	1,617	78	2,251	2,749	2,273	908	1,796
79	2,106	2,573	2,128	852	1,681	79	2,340	2,858	2,364	946	1,868
80	2,190	2,676	2,213	886	1,749	80	2,434	2,974	2,459	983	1,943
81	2,278	2,783	2,301	921	1,818	81	2,531	3,091	2,557	1,023	2,021
82	2,370	2,893	2,394	958	1,891	82	2,633	3,215	2,658	1,063	2,101
83	2,465	3,009	2,488	996	1,967	83	2,740	3,344	2,765	1,105	2,185
84	2,565	3,130	2,587	1,035	2,046	84	2,850	3,478	2,875	1,149	2,273
85	2,668	3,255	2,691	1,076	2,127	85	2,963	3,618	2,991	1,196	2,365
86	2,773	3,386	2,800	1,121	2,213	86	3,081	3,763	3,110	1,244	2,460
87	2,885	3,522	2,912	1,164	2,303	87	3,205	3,913	3,236	1,294	2,559
88	2,999	3,662	3,027	1,211	2,395	88	3,333	4,070	3,364	1,345	2,660
89	3,119	3,808	3,149	1,260	2,491	89	3,465	4,232	3,498	1,399	2,768
90	3,243	3,960	3,274	1,310	2,591	90	3,605	4,401	3,639	1,455	2,879
91	3,373	4,120	3,405	1,363	2,694	91	3,749	4,577	3,783	1,514	2,995
92	3,508	4,285	3,542	1,416	2,803	92	3,899	4,761	3,935	1,573	3,113
93	3,649	4,456	3,682	1,474	2,915	93	4,055	4,951	4,093	1,638	3,239
94	3,795	4,635	3,830	1,532	3,031	94	4,217	5,149	4,256	1,703	3,367
95	3,946	4,820	3,983	1,593	3,152	95	4,385	5,355	4,425	1,771	3,502
96	4,105	5,014	4,142	1,657	3,278	96	4,560	5,571	4,602	1,842	3,642
97	4,268	5,214	4,307	1,723	3,410	97	4,742	5,794	4,785	1,915	3,788
98	4,439	5,423	4,479	1,791	3,546	98	4,932	6,023	4,976	1,990	3,940
99	4,616	5,639	4,659	1,863	3,687	99	5,128	6,265	5,176	2,070	4,096

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

Household Discount Factor .88

ELIPS LIFE INSURANCE COMPANY

NEBRASKA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 680, 681, 683, 685

	Preferred						Standard				
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,317	1,608	1,330	532	1,021	65	1,463	1,787	1,478	592	1,134
66	1,317	1,608	1,330	532	1,021	66	1,463	1,787	1,478	592	1,134
67	1,317	1,608	1,330	532	1,021	67	1,463	1,787	1,478	592	1,134
68	1,317	1,608	1,330	532	1,051	68	1,463	1,787	1,478	592	1,168
69	1,356	1,657	1,371	548	1,083	69	1,507	1,841	1,523	610	1,203
70	1,397	1,707	1,412	565	1,115	70	1,552	1,897	1,568	627	1,240
71	1,439	1,758	1,454	582	1,149	71	1,598	1,954	1,616	646	1,277
72	1,489	1,820	1,505	602	1,189	72	1,654	2,022	1,672	668	1,321
73	1,541	1,883	1,558	623	1,230	73	1,712	2,093	1,731	692	1,367
74	1,595	1,949	1,612	645	1,274	74	1,773	2,166	1,792	716	1,416
75	1,651	2,017	1,668	667	1,319	75	1,833	2,241	1,854	742	1,465
76	1,709	2,088	1,727	691	1,364	76	1,898	2,320	1,919	768	1,515
77	1,777	2,171	1,795	718	1,418	77	1,974	2,413	1,996	799	1,576
78	1,848	2,258	1,867	746	1,476	78	2,054	2,509	2,075	829	1,639
79	1,922	2,348	1,942	777	1,534	79	2,136	2,609	2,157	863	1,705
80	1,998	2,442	2,020	808	1,596	80	2,221	2,714	2,244	897	1,773
81	2,079	2,540	2,100	840	1,659	81	2,310	2,821	2,334	933	1,844
82	2,163	2,640	2,185	874	1,726	82	2,403	2,934	2,426	970	1,918
83	2,249	2,746	2,271	909	1,795	83	2,500	3,052	2,523	1,009	1,994
84	2,341	2,857	2,361	945	1,867	84	2,601	3,174	2,624	1,049	2,075
85	2,435	2,970	2,456	982	1,941	85	2,704	3,302	2,730	1,091	2,158
86	2,530	3,090	2,555	1,023	2,020	86	2,812	3,434	2,838	1,136	2,245
87	2,633	3,214	2,657	1,062	2,102	87	2,925	3,571	2,953	1,181	2,335
88	2,737	3,342	2,763	1,105	2,186	88	3,042	3,714	3,070	1,228	2,428
89	2,846	3,475	2,874	1,150	2,273	89	3,162	3,862	3,192	1,277	2,526
90	2,960	3,614	2,988	1,196	2,365	90	3,290	4,017	3,321	1,328	2,627
91	3,079	3,760	3,108	1,244	2,459	91	3,422	4,177	3,453	1,382	2,734
92	3,202	3,910	3,233	1,293	2,558	92	3,558	4,345	3,591	1,435	2,841
93	3,330	4,066	3,361	1,345	2,660	93	3,701	4,519	3,736	1,495	2,956
94	3,463	4,230	3,495	1,398	2,766	94	3,848	4,699	3,884	1,554	3,073
95	3,601	4,399	3,635	1,454	2,876	95	4,002	4,887	4,038	1,616	3,196
96	3,746	4,576	3,780	1,512	2,992	96	4,161	5,084	4,200	1,681	3,324
97	3,895	4,758	3,931	1,573	3,112	97	4,328	5,288	4,367	1,747	3,457
98	4,051	4,949	4,088	1,635	3,236	98	4,501	5,497	4,541	1,816	3,596
99	4,213	5,147	4,252	1,700	3,365	99	4,680	5,718	4,724	1,889	3,738

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

Household Discount Factor .88

ELIPS LIFE INSURANCE COMPANY

NEBRASKA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 680, 681, 683, 685

	Preferred						Standard				
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,289	1,574	1,302	521	998	65	1,432	1,749	1,445	579	1,109
66	1,289	1,574	1,302	521	998	66	1,432	1,749	1,445	579	1,109
67	1,289	1,574	1,302	521	998	67	1,432	1,749	1,445	579	1,109
68	1,289	1,574	1,302	521	1,029	68	1,432	1,749	1,445	579	1,143
69	1,327	1,621	1,341	536	1,059	69	1,474	1,801	1,489	596	1,177
70	1,367	1,670	1,381	552	1,091	70	1,518	1,855	1,534	614	1,212
71	1,407	1,720	1,422	569	1,124	71	1,564	1,912	1,581	632	1,248
72	1,456	1,780	1,472	588	1,163	72	1,618	1,979	1,636	654	1,293
73	1,508	1,843	1,523	609	1,204	73	1,675	2,048	1,693	677	1,338
74	1,560	1,907	1,577	631	1,246	74	1,733	2,119	1,752	701	1,385
75	1,615	1,973	1,633	653	1,290	75	1,794	2,193	1,814	725	1,433
76	1,672	2,042	1,689	676	1,335	76	1,857	2,269	1,877	751	1,483
77	1,739	2,125	1,757	703	1,388	77	1,931	2,361	1,952	782	1,543
78	1,808	2,209	1,826	730	1,444	78	2,009	2,454	2,030	812	1,604
79	1,880	2,297	1,899	760	1,502	79	2,089	2,552	2,110	844	1,668
80	1,955	2,390	1,977	790	1,561	80	2,172	2,655	2,196	878	1,735
81	2,034	2,484	2,055	822	1,623	81	2,260	2,760	2,282	914	1,804
82	2,116	2,584	2,136	855	1,688	82	2,350	2,871	2,373	950	1,876
83	2,201	2,687	2,222	889	1,756	83	2,445	2,986	2,469	987	1,951
84	2,290	2,794	2,310	924	1,827	84	2,544	3,105	2,567	1,026	2,029
85	2,381	2,907	2,403	961	1,899	85	2,645	3,230	2,671	1,068	2,112
86	2,476	3,023	2,499	1,000	1,976	86	2,751	3,360	2,777	1,111	2,196
87	2,576	3,145	2,600	1,039	2,056	87	2,861	3,494	2,889	1,155	2,285
88	2,678	3,269	2,704	1,080	2,138	88	2,977	3,634	3,003	1,201	2,375
89	2,785	3,400	2,812	1,125	2,224	89	3,094	3,778	3,124	1,249	2,471
90	2,896	3,537	2,924	1,169	2,313	90	3,219	3,930	3,250	1,299	2,571
91	3,013	3,678	3,041	1,216	2,406	91	3,348	4,087	3,378	1,351	2,674
92	3,132	3,825	3,162	1,264	2,502	92	3,480	4,251	3,513	1,405	2,780
93	3,258	3,979	3,289	1,315	2,602	93	3,620	4,420	3,654	1,462	2,891
94	3,388	4,138	3,420	1,368	2,707	94	3,765	4,597	3,800	1,520	3,007
95	3,524	4,303	3,556	1,422	2,814	95	3,915	4,782	3,951	1,581	3,127
96	3,664	4,476	3,698	1,479	2,926	96	4,072	4,974	4,109	1,644	3,252
97	3,810	4,656	3,845	1,539	3,044	97	4,234	5,173	4,272	1,710	3,383
98	3,963	4,841	3,999	1,600	3,166	98	4,403	5,379	4,443	1,778	3,517
99	4,122	5,035	4,160	1,663	3,292	99	4,579	5,594	4,622	1,849	3,659

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

Household Discount Factor .88

ELIPS LIFE INSURANCE COMPANY

NEBRASKA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 680, 681, 683, 685

	Preferred						Standard				
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,176	1,436	1,188	476	911	65	1,307	1,596	1,319	528	1,012
66	1,176	1,436	1,188	476	911	66	1,307	1,596	1,319	528	1,012
67	1,176	1,436	1,188	476	911	67	1,307	1,596	1,319	528	1,012
68	1,176	1,436	1,188	476	939	68	1,307	1,596	1,319	528	1,043
69	1,211	1,480	1,224	489	966	69	1,345	1,644	1,359	544	1,074
70	1,247	1,524	1,261	504	995	70	1,386	1,693	1,400	560	1,106
71	1,284	1,570	1,298	519	1,026	71	1,427	1,745	1,443	577	1,139
72	1,329	1,624	1,343	537	1,061	72	1,477	1,806	1,493	597	1,180
73	1,376	1,682	1,390	556	1,099	73	1,528	1,869	1,545	618	1,221
74	1,424	1,740	1,439	576	1,137	74	1,582	1,934	1,599	640	1,264
75	1,474	1,801	1,490	596	1,177	75	1,637	2,001	1,655	662	1,308
76	1,526	1,864	1,542	617	1,218	76	1,695	2,071	1,713	685	1,354
77	1,587	1,939	1,604	642	1,267	77	1,763	2,154	1,781	713	1,408
78	1,650	2,016	1,667	666	1,318	78	1,833	2,240	1,853	741	1,464
79	1,716	2,096	1,733	694	1,371	79	1,906	2,329	1,926	770	1,522
80	1,784	2,181	1,804	721	1,425	80	1,982	2,423	2,004	801	1,583
81	1,857	2,267	1,875	750	1,481	81	2,062	2,519	2,083	834	1,646
82	1,931	2,358	1,950	780	1,541	82	2,145	2,620	2,166	867	1,712
83	2,009	2,452	2,028	811	1,603	83	2,232	2,725	2,253	901	1,780
84	2,090	2,550	2,108	843	1,668	84	2,322	2,834	2,342	936	1,852
85	2,173	2,653	2,193	877	1,733	85	2,414	2,948	2,437	975	1,927
86	2,260	2,759	2,280	913	1,803	86	2,511	3,066	2,534	1,014	2,004
87	2,351	2,870	2,373	948	1,876	87	2,611	3,188	2,637	1,054	2,085
88	2,444	2,984	2,468	986	1,951	88	2,717	3,316	2,741	1,096	2,168
89	2,542	3,103	2,566	1,026	2,029	89	2,824	3,448	2,851	1,140	2,255
90	2,643	3,228	2,669	1,067	2,111	90	2,938	3,587	2,966	1,185	2,346
91	2,750	3,357	2,775	1,110	2,196	91	3,055	3,730	3,083	1,233	2,440
92	2,859	3,491	2,886	1,153	2,283	92	3,176	3,879	3,206	1,282	2,537
93	2,973	3,631	3,001	1,200	2,374	93	3,304	4,034	3,335	1,334	2,639
94	3,092	3,776	3,121	1,248	2,470	94	3,436	4,195	3,468	1,387	2,744
95	3,216	3,927	3,245	1,298	2,568	95	3,573	4,364	3,606	1,443	2,854
96	3,344	4,085	3,375	1,350	2,671	96	3,716	4,539	3,750	1,500	2,968
97	3,477	4,249	3,509	1,404	2,778	97	3,864	4,721	3,899	1,560	3,087
98	3,617	4,418	3,650	1,460	2,890	98	4,019	4,909	4,055	1,622	3,210
99	3,762	4,595	3,797	1,518	3,004	99	4,179	5,105	4,218	1,687	3,339

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.

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 $1484	$0	$1484 (Part A deductible)
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after:			
□ While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	$0	Up to $185.50 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 CALENDR YEAR

*Once you have been billed $203 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 $203 of Medicare Approved Amounts*	$0	$0	$203 (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 $203 of Medicare Approved Amounts*	$0	$0	$203 (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 $203 of Medicare Approved Amounts*	$0	$0	$203 (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 $1484	$1484 (Part A deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after:			
□ While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $185.50 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 $203 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 $203 of Medicare Approved Amounts*	$0	$203 (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 $203 of Medicare Approved Amounts*	$0	$203 (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 $203 of Medicare Approved Amounts*	$0	$203 (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 $1484	$1484 (Part A deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after:			
□ While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $185.50 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 $203 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 $203 of Medicare Approved Amounts*	$0	$0	$203 (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 $203 of Medicare Approved Amounts*	$0	$0	$203 (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 $203 of Medicare Approved Amounts*	$0	$0	$203 (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 $2370 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses exceed $2370. 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 $2370 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2370 DEDUCTIBLE** YOU PAY
HOSPITALIZATION* - Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but $1484	$1484 (Part A deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after:			
□ While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $185.50 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 $2370 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2370 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 $203 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 $2370 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses exceed $2370. 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 $2370 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2370 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 $203 of Medicare Approved Amounts*	$0	$0	$203 (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 $203 of Medicare Approved Amounts*	$0	$0	$203 (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 $2370 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2370 DEDUCTIBLE** YOU PAY
HOME HEALTH CARE – Medicare Approved Services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment:			
□ First $203 of Medicare Approved Amounts*	$0	$0	$203 (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 $2370 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2370 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 $1484	$1484 (Part A deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after:			
□ While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $185.50 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 $203 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 $203 of Medicare Approved Amounts*	$0	$0	$203 (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 $203 of Medicare Approved Amounts*	$0	$0	$203 (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 $203 of Medicare Approved Amounts*	$0	$0	$203 (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