Lumico
medigap solutions
Underwritten by
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. 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[1]	K	L	M	N	C	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

OHIO Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 436, 440-445

	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	1,541	1,774	1,558	625	1,206	65	1,712	1,970	1,732	693	1,341
66	1,541	1,774	1,558	625	1,206	66	1,712	1,970	1,732	693	1,341
67	1,541	1,774	1,558	625	1,206	67	1,712	1,970	1,732	693	1,341
68	1,541	1,774	1,558	625	1,243	68	1,712	1,970	1,732	693	1,381
69	1,588	1,826	1,605	644	1,280	69	1,763	2,030	1,783	714	1,422
70	1,636	1,881	1,653	662	1,319	70	1,816	2,091	1,837	735	1,464
71	1,685	1,938	1,702	682	1,358	71	1,871	2,154	1,892	757	1,508
72	1,735	1,996	1,754	702	1,399	72	1,927	2,218	1,948	779	1,554
73	1,787	2,056	1,806	723	1,441	73	1,984	2,285	2,007	803	1,601
74	1,843	2,120	1,864	745	1,487	74	2,046	2,356	2,070	828	1,651
75	1,904	2,190	1,925	770	1,536	75	2,113	2,434	2,138	855	1,705
76	1,969	2,265	1,990	797	1,589	76	2,186	2,517	2,211	885	1,763
77	2,039	2,346	2,062	825	1,646	77	2,264	2,607	2,291	916	1,826
78	2,115	2,432	2,138	855	1,707	78	2,348	2,704	2,376	950	1,894
79	2,197	2,526	2,219	888	1,773	79	2,438	2,808	2,468	986	1,967
80	2,285	2,627	2,308	923	1,844	80	2,535	2,920	2,566	1,026	2,045
81	2,376	2,732	2,401	961	1,918	81	2,637	3,037	2,669	1,067	2,127
82	2,471	2,841	2,497	999	1,995	82	2,742	3,159	2,775	1,109	2,212
83	2,569	2,954	2,596	1,039	2,074	83	2,852	3,285	2,886	1,154	2,301
84	2,672	3,072	2,700	1,081	2,157	84	2,967	3,416	3,002	1,199	2,394
85	2,779	3,195	2,808	1,124	2,244	85	3,085	3,553	3,123	1,247	2,490
86	2,890	3,323	2,920	1,169	2,334	86	3,208	3,695	3,248	1,298	2,589
87	3,006	3,456	3,037	1,216	2,428	87	3,337	3,842	3,378	1,349	2,693
88	3,126	3,594	3,159	1,265	2,525	88	3,470	3,996	3,512	1,403	2,801
89	3,251	3,738	3,285	1,315	2,625	89	3,609	4,156	3,653	1,459	2,913
90	3,381	3,888	3,416	1,368	2,731	90	3,753	4,322	3,799	1,517	3,030
91	3,517	4,044	3,553	1,423	2,840	91	3,903	4,495	3,951	1,578	3,152
92	3,657	4,205	3,695	1,480	2,953	92	4,059	4,675	4,109	1,642	3,278
93	3,804	4,373	3,842	1,540	3,071	93	4,221	4,863	4,273	1,707	3,409
94	3,956	4,549	3,996	1,602	3,194	94	4,390	5,057	4,444	1,775	3,546
95	4,114	4,731	4,156	1,666	3,322	95	4,565	5,259	4,622	1,846	3,688
96	4,279	4,921	4,322	1,733	3,455	96	4,748	5,470	4,806	1,920	3,835
97	4,279	4,921	4,322	1,733	3,455	97	4,748	5,470	4,806	1,920	3,835
98	4,279	4,921	4,322	1,733	3,455	98	4,748	5,470	4,806	1,920	3,835
99	4,279	4,921	4,322	1,733	3,455	99	4,748	5,470	4,806	1,920	3,835

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

Household Discount Factor .93

ELIPS LIFE INSURANCE COMPANY

OHIO Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 450-454

	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	1,462	1,683	1,479	593	1,144	65	1,624	1,869	1,643	657	1,272
66	1,462	1,683	1,479	593	1,144	66	1,624	1,869	1,643	657	1,272
67	1,462	1,683	1,479	593	1,144	67	1,624	1,869	1,643	657	1,272
68	1,462	1,683	1,479	593	1,179	68	1,624	1,869	1,643	657	1,310
69	1,506	1,733	1,523	611	1,214	69	1,673	1,926	1,692	677	1,349
70	1,552	1,785	1,568	628	1,251	70	1,723	1,984	1,743	697	1,389
71	1,598	1,838	1,615	647	1,289	71	1,775	2,044	1,795	718	1,431
72	1,646	1,894	1,664	666	1,328	72	1,828	2,105	1,848	739	1,474
73	1,695	1,950	1,714	686	1,368	73	1,883	2,168	1,904	761	1,518
74	1,748	2,011	1,768	707	1,411	74	1,941	2,236	1,964	786	1,566
75	1,806	2,078	1,826	730	1,457	75	2,005	2,309	2,028	811	1,617
76	1,868	2,149	1,888	756	1,507	76	2,073	2,388	2,098	839	1,673
77	1,935	2,226	1,956	783	1,562	77	2,148	2,473	2,173	869	1,733
78	2,007	2,308	2,028	811	1,619	78	2,228	2,565	2,254	901	1,797
79	2,085	2,396	2,106	842	1,682	79	2,313	2,664	2,341	936	1,866
80	2,168	2,492	2,190	876	1,749	80	2,405	2,771	2,434	973	1,940
81	2,254	2,592	2,278	911	1,819	81	2,502	2,882	2,532	1,012	2,018
82	2,344	2,695	2,369	948	1,893	82	2,602	2,997	2,633	1,052	2,099
83	2,438	2,803	2,463	986	1,968	83	2,706	3,117	2,738	1,094	2,183
84	2,535	2,915	2,562	1,026	2,047	84	2,815	3,241	2,848	1,138	2,271
85	2,636	3,031	2,664	1,067	2,129	85	2,927	3,371	2,963	1,183	2,362
86	2,742	3,152	2,771	1,109	2,214	86	3,044	3,505	3,081	1,231	2,456
87	2,852	3,279	2,882	1,153	2,303	87	3,166	3,645	3,205	1,280	2,555
88	2,966	3,410	2,997	1,200	2,395	88	3,292	3,791	3,332	1,331	2,657
89	3,085	3,546	3,117	1,248	2,491	89	3,424	3,943	3,465	1,384	2,764
90	3,208	3,689	3,241	1,298	2,591	90	3,561	4,100	3,604	1,440	2,875
91	3,337	3,836	3,371	1,350	2,694	91	3,703	4,265	3,748	1,497	2,990
92	3,470	3,989	3,505	1,404	2,802	92	3,851	4,436	3,898	1,557	3,110
93	3,609	4,149	3,645	1,461	2,914	93	4,005	4,613	4,054	1,619	3,235
94	3,753	4,316	3,791	1,520	3,030	94	4,165	4,797	4,216	1,684	3,364
95	3,903	4,489	3,943	1,581	3,151	95	4,331	4,989	4,385	1,752	3,499
96	4,059	4,669	4,100	1,644	3,278	96	4,504	5,189	4,560	1,822	3,639
97	4,059	4,669	4,100	1,644	3,278	97	4,504	5,189	4,560	1,822	3,639
98	4,059	4,669	4,100	1,644	3,278	98	4,504	5,189	4,560	1,822	3,639
99	4,059	4,669	4,100	1,644	3,278	99	4,504	5,189	4,560	1,822	3,639

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

Household Discount Factor .93

ELIPS LIFE INSURANCE COMPANY

OHIO Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 436, 440-445, 450-454

	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	1,383	1,592	1,399	561	1,083	65	1,536	1,768	1,554	622	1,203
66	1,383	1,592	1,399	561	1,083	66	1,536	1,768	1,554	622	1,203
67	1,383	1,592	1,399	561	1,083	67	1,536	1,768	1,554	622	1,203
68	1,383	1,592	1,399	561	1,115	68	1,536	1,768	1,554	622	1,239
69	1,425	1,639	1,441	578	1,149	69	1,582	1,822	1,600	641	1,276
70	1,468	1,688	1,484	594	1,183	70	1,630	1,876	1,649	659	1,314
71	1,512	1,739	1,528	612	1,219	71	1,679	1,933	1,698	679	1,353
72	1,557	1,791	1,574	630	1,256	72	1,729	1,991	1,748	699	1,394
73	1,603	1,845	1,621	649	1,294	73	1,781	2,051	1,801	720	1,436
74	1,654	1,903	1,673	669	1,335	74	1,836	2,115	1,857	743	1,482
75	1,708	1,966	1,727	691	1,379	75	1,896	2,184	1,918	768	1,530
76	1,767	2,033	1,786	715	1,426	76	1,961	2,259	1,985	794	1,582
77	1,830	2,105	1,850	740	1,477	77	2,032	2,339	2,056	822	1,639
78	1,898	2,183	1,918	768	1,532	78	2,107	2,427	2,133	853	1,700
79	1,972	2,267	1,992	797	1,591	79	2,188	2,520	2,214	885	1,765
80	2,051	2,357	2,072	828	1,655	80	2,275	2,621	2,303	921	1,835
81	2,133	2,452	2,155	862	1,721	81	2,367	2,726	2,395	958	1,909
82	2,218	2,549	2,241	897	1,790	82	2,461	2,835	2,491	995	1,986
83	2,306	2,651	2,330	932	1,862	83	2,560	2,948	2,590	1,035	2,065
84	2,398	2,757	2,423	970	1,936	84	2,663	3,066	2,694	1,076	2,148
85	2,494	2,868	2,520	1,009	2,014	85	2,769	3,189	2,802	1,119	2,234
86	2,594	2,982	2,621	1,049	2,095	86	2,879	3,316	2,915	1,164	2,324
87	2,697	3,102	2,726	1,091	2,179	87	2,995	3,448	3,031	1,211	2,417
88	2,806	3,226	2,835	1,135	2,266	88	3,114	3,586	3,152	1,259	2,514
89	2,918	3,355	2,948	1,180	2,356	89	3,239	3,730	3,278	1,309	2,615
90	3,035	3,489	3,066	1,227	2,451	90	3,368	3,879	3,409	1,362	2,720
91	3,156	3,629	3,189	1,277	2,548	91	3,503	4,034	3,546	1,416	2,829
92	3,282	3,774	3,316	1,328	2,650	92	3,642	4,196	3,688	1,473	2,942
93	3,414	3,925	3,448	1,382	2,756	93	3,788	4,364	3,835	1,532	3,060
94	3,550	4,082	3,586	1,437	2,867	94	3,940	4,538	3,988	1,593	3,183
95	3,692	4,246	3,730	1,495	2,981	95	4,097	4,720	4,148	1,657	3,310
96	3,840	4,416	3,879	1,555	3,101	96	4,261	4,909	4,313	1,723	3,442
97	3,840	4,416	3,879	1,555	3,101	97	4,261	4,909	4,313	1,723	3,442
98	3,840	4,416	3,879	1,555	3,101	98	4,261	4,909	4,313	1,723	3,442
99	3,840	4,416	3,879	1,555	3,101	99	4,261	4,909	4,313	1,723	3,442

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

Household Discount Factor .93

ELIPS LIFE INSURANCE COMPANY

OHIO Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 436, 440-445

	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	1,377	1,583	1,390	556	1,078	65	1,529	1,761	1,546	618	1,195
66	1,377	1,583	1,390	556	1,078	66	1,529	1,761	1,546	618	1,195
67	1,377	1,583	1,390	556	1,078	67	1,529	1,761	1,546	618	1,195
68	1,377	1,583	1,390	556	1,110	68	1,529	1,761	1,546	618	1,231
69	1,418	1,631	1,432	572	1,143	69	1,575	1,814	1,592	636	1,268
70	1,460	1,680	1,475	590	1,177	70	1,622	1,867	1,640	655	1,307
71	1,503	1,730	1,520	607	1,212	71	1,671	1,923	1,689	675	1,347
72	1,549	1,782	1,565	626	1,248	72	1,721	1,981	1,740	695	1,388
73	1,596	1,836	1,612	645	1,286	73	1,773	2,040	1,792	716	1,430
74	1,646	1,893	1,663	665	1,327	74	1,829	2,105	1,849	738	1,474
75	1,700	1,955	1,718	687	1,370	75	1,888	2,174	1,909	763	1,522
76	1,759	2,022	1,776	710	1,417	76	1,953	2,249	1,975	789	1,575
77	1,822	2,094	1,839	736	1,467	77	2,023	2,329	2,045	817	1,631
78	1,890	2,172	1,907	763	1,522	78	2,098	2,416	2,121	847	1,692
79	1,962	2,256	1,981	792	1,581	79	2,179	2,510	2,203	880	1,757
80	2,040	2,346	2,060	824	1,644	80	2,265	2,610	2,291	915	1,828
81	2,122	2,439	2,142	856	1,709	81	2,355	2,714	2,382	951	1,900
82	2,208	2,537	2,228	890	1,777	82	2,450	2,823	2,477	990	1,976
83	2,296	2,638	2,317	925	1,849	83	2,548	2,937	2,576	1,030	2,056
84	2,387	2,744	2,409	963	1,922	84	2,650	3,054	2,679	1,071	2,138
85	2,483	2,854	2,505	1,002	2,000	85	2,757	3,175	2,787	1,114	2,223
86	2,582	2,968	2,606	1,041	2,079	86	2,867	3,303	2,898	1,158	2,312
87	2,685	3,086	2,710	1,083	2,162	87	2,981	3,435	3,014	1,205	2,404
88	2,793	3,210	2,819	1,127	2,249	88	3,101	3,572	3,134	1,253	2,500
89	2,904	3,339	2,931	1,172	2,339	89	3,225	3,715	3,260	1,303	2,600
90	3,020	3,473	3,048	1,219	2,432	90	3,353	3,863	3,389	1,356	2,704
91	3,140	3,612	3,170	1,268	2,530	91	3,488	4,018	3,525	1,410	2,812
92	3,265	3,756	3,296	1,319	2,630	92	3,627	4,178	3,667	1,466	2,924
93	3,397	3,905	3,428	1,371	2,735	93	3,772	4,345	3,813	1,525	3,041
94	3,532	4,062	3,565	1,426	2,845	94	3,923	4,520	3,965	1,585	3,163
95	3,674	4,225	3,708	1,484	2,959	95	4,080	4,701	4,124	1,649	3,289
96	3,821	4,393	3,856	1,543	3,077	96	4,242	4,889	4,289	1,714	3,420
97	3,821	4,393	3,856	1,543	3,077	97	4,242	4,889	4,289	1,714	3,420
98	3,821	4,393	3,856	1,543	3,077	98	4,242	4,889	4,289	1,714	3,420
99	3,821	4,393	3,856	1,543	3,077	99	4,242	4,889	4,289	1,714	3,420

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

Household Discount Factor .93

ELIPS LIFE INSURANCE COMPANY

OHIO Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 450-454

	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	1,306	1,502	1,319	527	1,022	65	1,451	1,671	1,466	586	1,133
66	1,306	1,502	1,319	527	1,022	66	1,451	1,671	1,466	586	1,133
67	1,306	1,502	1,319	527	1,022	67	1,451	1,671	1,466	586	1,133
68	1,306	1,502	1,319	527	1,053	68	1,451	1,671	1,466	586	1,168
69	1,345	1,547	1,359	543	1,084	69	1,494	1,721	1,511	604	1,203
70	1,385	1,594	1,400	559	1,117	70	1,538	1,772	1,556	622	1,240
71	1,426	1,642	1,442	576	1,150	71	1,585	1,825	1,603	640	1,278
72	1,470	1,691	1,485	594	1,184	72	1,633	1,879	1,651	659	1,316
73	1,514	1,742	1,530	612	1,220	73	1,682	1,936	1,701	679	1,356
74	1,562	1,796	1,577	630	1,259	74	1,735	1,997	1,754	700	1,399
75	1,613	1,855	1,629	652	1,300	75	1,792	2,062	1,812	724	1,444
76	1,668	1,918	1,685	674	1,344	76	1,853	2,133	1,874	748	1,494
77	1,728	1,987	1,745	698	1,392	77	1,919	2,210	1,940	775	1,547
78	1,793	2,060	1,809	724	1,444	78	1,990	2,292	2,012	804	1,605
79	1,861	2,140	1,879	751	1,500	79	2,067	2,381	2,090	835	1,667
80	1,936	2,226	1,955	781	1,560	80	2,149	2,476	2,173	868	1,734
81	2,014	2,314	2,032	813	1,622	81	2,234	2,575	2,260	902	1,803
82	2,095	2,406	2,113	845	1,686	82	2,324	2,678	2,350	939	1,875
83	2,178	2,503	2,198	878	1,754	83	2,418	2,786	2,444	977	1,950
84	2,264	2,603	2,285	914	1,824	84	2,514	2,897	2,542	1,016	2,028
85	2,355	2,707	2,377	950	1,897	85	2,615	3,013	2,644	1,057	2,109
86	2,450	2,816	2,472	988	1,972	86	2,720	3,134	2,749	1,099	2,193
87	2,547	2,928	2,571	1,028	2,051	87	2,828	3,259	2,859	1,143	2,281
88	2,650	3,046	2,674	1,069	2,133	88	2,942	3,389	2,974	1,189	2,372
89	2,755	3,168	2,781	1,112	2,219	89	3,059	3,524	3,092	1,237	2,466
90	2,865	3,294	2,892	1,157	2,308	90	3,181	3,665	3,216	1,286	2,565
91	2,979	3,427	3,007	1,203	2,400	91	3,309	3,812	3,344	1,338	2,667
92	3,098	3,563	3,127	1,251	2,495	92	3,441	3,964	3,479	1,391	2,774
93	3,222	3,705	3,252	1,301	2,595	93	3,579	4,123	3,617	1,446	2,885
94	3,351	3,854	3,382	1,353	2,700	94	3,722	4,288	3,762	1,504	3,000
95	3,485	4,008	3,518	1,407	2,807	95	3,871	4,460	3,913	1,564	3,120
96	3,625	4,168	3,659	1,464	2,919	96	4,025	4,639	4,069	1,626	3,245
97	3,625	4,168	3,659	1,464	2,919	97	4,025	4,639	4,069	1,626	3,245
98	3,625	4,168	3,659	1,464	2,919	98	4,025	4,639	4,069	1,626	3,245
99	3,625	4,168	3,659	1,464	2,919	99	4,025	4,639	4,069	1,626	3,245

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

Household Discount Factor .93

ELIPS LIFE INSURANCE COMPANY

OHIO Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 436, 440-445, 450-454

	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	1,236	1,421	1,247	499	967	65	1,372	1,580	1,387	554	1,072
66	1,236	1,421	1,247	499	967	66	1,372	1,580	1,387	554	1,072
67	1,236	1,421	1,247	499	967	67	1,372	1,580	1,387	554	1,072
68	1,236	1,421	1,247	499	996	68	1,372	1,580	1,387	554	1,105
69	1,273	1,464	1,285	513	1,026	69	1,413	1,628	1,429	571	1,138
70	1,310	1,508	1,324	529	1,056	70	1,455	1,676	1,472	588	1,173
71	1,349	1,553	1,364	545	1,088	71	1,499	1,726	1,516	606	1,209
72	1,390	1,599	1,405	562	1,120	72	1,545	1,778	1,561	624	1,245
73	1,432	1,647	1,447	579	1,154	73	1,591	1,831	1,609	643	1,283
74	1,477	1,699	1,492	596	1,191	74	1,641	1,889	1,659	663	1,323
75	1,526	1,755	1,541	616	1,230	75	1,695	1,951	1,714	685	1,366
76	1,578	1,814	1,594	637	1,272	76	1,752	2,018	1,772	708	1,413
77	1,635	1,880	1,651	660	1,317	77	1,815	2,091	1,835	733	1,464
78	1,696	1,949	1,712	685	1,366	78	1,883	2,168	1,904	760	1,518
79	1,761	2,024	1,778	711	1,419	79	1,955	2,252	1,977	790	1,577
80	1,831	2,105	1,849	739	1,475	80	2,033	2,343	2,056	821	1,640
81	1,905	2,189	1,923	769	1,534	81	2,114	2,436	2,138	854	1,705
82	1,981	2,276	1,999	799	1,595	82	2,199	2,534	2,223	888	1,773
83	2,060	2,368	2,079	831	1,659	83	2,287	2,636	2,312	924	1,845
84	2,142	2,462	2,162	864	1,725	84	2,378	2,741	2,405	961	1,918
85	2,228	2,561	2,248	899	1,794	85	2,474	2,850	2,501	1,000	1,995
86	2,317	2,664	2,338	935	1,866	86	2,573	2,964	2,601	1,040	2,075
87	2,410	2,770	2,432	972	1,940	87	2,675	3,083	2,705	1,082	2,158
88	2,506	2,881	2,529	1,011	2,018	88	2,783	3,206	2,813	1,125	2,244
89	2,606	2,997	2,630	1,052	2,099	89	2,894	3,334	2,925	1,170	2,333
90	2,710	3,116	2,735	1,094	2,183	90	3,009	3,467	3,042	1,217	2,427
91	2,818	3,241	2,844	1,138	2,270	91	3,130	3,606	3,164	1,265	2,523
92	2,931	3,371	2,958	1,183	2,360	92	3,255	3,750	3,291	1,316	2,624
93	3,048	3,505	3,077	1,231	2,455	93	3,385	3,900	3,422	1,368	2,729
94	3,170	3,646	3,199	1,280	2,554	94	3,521	4,056	3,558	1,423	2,838
95	3,297	3,792	3,327	1,331	2,655	95	3,661	4,219	3,701	1,479	2,952
96	3,429	3,943	3,461	1,385	2,762	96	3,807	4,388	3,849	1,538	3,069
97	3,429	3,943	3,461	1,385	2,762	97	3,807	4,388	3,849	1,538	3,069
98	3,429	3,943	3,461	1,385	2,762	98	3,807	4,388	3,849	1,538	3,069
99	3,429	3,943	3,461	1,385	2,762	99	3,807	4,388	3,849	1,538	3,069

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

Household Discount Factor .93

PREMIUM INFORMATION

We, Elips Life Insurance Company can only raise your premium if we raise the premium for all policies like yours in this State. Premiums are based on your attained age and will change on your policy anniversary date.

PREFERRED AND STANDARD PREMIUMS

Preferred and Standard premiums are shown on the premium charts. You are eligible for Preferred premiums if:

1. You apply for your Medicare Supplement insurance policy during the 6-month open enrollment period that begins on your Part B date.

2. You apply for your Medicare Supplement insurance policy during your eligible guaranteed issue period, or

3. Your answer is “no” to the question on the application that asks, “Within the past twelve (12) months, have you used any tobacco or nicotine products, including cigarettes, cigars, pipe, vapes, chewing tobacco, nicotine gum/patches, eCigarettes?”

HOUSEHOLD DISCOUNT

You are eligible for a household discount if, for the past year, you have resided with one other Medicare-eligible adult who owns or who will be issued a Medicare Supplement policy from us. If you live with another adult who is your legal spouse, we will waive the one (1) year requirement. We may request additional documentation to determine eligibility.

Your policy's household premium discount will be terminated if the other Medicare Supplement policyholder chooses to terminate his or her Medicare Supplement policy or he or she no longer resides with you.

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.

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 & 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.

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 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%	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

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

PLAN G

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

SERVICES	MEDICARE PAYS	PLAN PAYS	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.

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

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