Plan limitations and your rights

Medicare supplement plans from Everence do have some limitations of coverage. And, if you enroll, you will have certain rights as a covered person.

Benefits not covered

Unless specifically stated in your plan, Everence Medicare supplement plans do not cover or consider for payment any service or supply, or any portion of a service or supply, that is not a Medicare-eligible expense, nor will it duplicate any benefit paid by Medicare.

These are some of the policy exclusions:

1. Any expense a covered person incurs which Medicare does not consider to be a covered charge or approved charge unless such benefits are expressly provided for by this policy;
2. Services performed by you, a member of your immediate family, or a person who usually resides in your home for which no charge is normally made in the absence of insurance;
3. Custodial care;
4. Any loss covered by worker's compensation or employer's liability laws;
5. Home health care to the extent not covered by Medicare;
6. Expenses incurred while this policy is not in force, except as provided in the Part titled *Coverage Provisions* and the section *Benefits After Certificate Terminates*;
7. Hospital or skilled nursing facility confinement that begins while this policy is not in force;
8. That portion of any expense incurred which is paid for by Medicare; or
9. Loss or expense that is payable under any other Medicare supplement insurance policy or certificate.

Your coverage cannot be canceled

As with any Medicare supplement plan offered in your state, we will not cancel or refuse to renew your health plan certificate for any reason other than failure to make premium payment or because of fraudulent misrepresentation by the applicant.

One supplement plan is enough

If you are already enrolled in another Medicare plan other than original Medicare (such as another Medicare supplement plan or Medicare Advantage plan), you do not need two plans. If you wish to cancel a previously issued health policy, only you can do so. Talk to your licensed agent about how to cancel the other coverage.

This is a brief summary of the Medicare supplement plans available from Everence. The health plan certificate contains details about the plan's provisions, limitations, and variations. Medicare supplement insurance plans offered by **Everence Association Inc., a fraternal benefit society,** are not available in all states, and are not connected with or endorsed by the U.S. government or the federal Medicare program. This is a solicitation of insurance and an insurance agent or insurance company may contact you in an attempt to sell you insurance.

An outline of coverage is available upon request.

In Arizona, Plan A is 2125114, Plan F is 2125115, Plan G is 2125116, Plan N is 2125117.

Everence®

2190763 (Revised 11/25 - 2251341) AZ 2026



A variety of Medicare supplement plans to meet your needs

Everence Association Inc.,
a fraternal benefit society
1110 North Main Street
Goshen, IN 46527

Everence®

2026 Benefit structure

	Services	Medicare pays	Plan A		Plan F[3]		Plan G		Plan N	
			We pay	You pay	We pay	You pay	We pay	You pay	We pay	You pay
Part A	**Inpatient Hospitalization**									
	1-60 days	All costs after $1,736 deductible per benefit period	$0	$1,736	$1,736	$0	$1,736	$0	$1,736	$0
	61-90 days	All but $434 per day	$434 per day	$0	$434 per day	$0	$434 per day	$0	$434 per day	$0
	60 lifetime reserve days	All but $868 per day	$868 per day	$0	$868 per day	$0	$868 per day	$0	$868 per day	$0
	Additional 365 days	$0	100% of Medicare-eligible expenses	$0	100% of Medicare-eligible expenses	$0	100% of Medicare-eligible expenses	$0	100% of Medicare-eligible expenses	$0
	Skilled Nursing Facility									
	21-100 days[1]	All but $217 per day	$0	$217 per day	$217 per day	$0	$217 per day	$0	$217 per day	$0
	Blood									
		All costs after first 3 pints	First 3 pints	$0	First 3 pints	$0	First 3 pints	$0	First 3 pints	$0
	Hospice Care									
		All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0	Medicare copayment/ coinsurance	$0	Medicare copayment/ coinsurance	$0	Medicare copayment/ coinsurance	$0
Part B	**Medical Services**									
	Blood	All costs after first 3 pints	First 3 pints	$0	First 3 pints	$0	First 3 pints	$0	First 3 pints	$0
	Physician, outpatient supplies, physical and speech therapy diagnostic tests, durable medical equipment	After $283 deductible, generally 80% of Medicare-approved amount	Generally 20% of Medicare-approved amount	$283 deductible	$283 deductible and generally 20% of Medicare-approved amount	$0	Generally 20% of Medicare-approved amount	$283 deductible	Balance left after deductible and copays	$283 deductible; up to $20 per office visit; up to $50[2] per emergency room visit
	Part B excess charges	$0	$0	All costs	100%	$0	100%	$0	$0	All costs
	Foreign travel	$0	$0	All costs	80% of costs after $250 annual deductible; $50,000 lifetime benefit	$250 annual deductible; 20% of costs. All costs after maximum benefit	80% of costs after $250 annual deductible; $50,000 lifetime benefit	$250 annual deductible; 20% of costs. All costs after maximum benefit	80% of costs after $250 annual deductible; $50,000 lifetime benefit	$250 annual deductible; 20% of costs. All costs after maximum benefit

[1]Medicare covers all costs for days 1-20 after a three-day hospital stay, so the plans don't need to cover those first 20 days. You must meet Medicare's requirement, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.

[2]The $50 copay is waived if you are admitted to a hospital, and the emergency visit is covered as a Part A expense.

[3]Effective January 1, 2020: Only applicants first eligible for Medicare before 2020 may purchase Plan F.