

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.

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, unless authorized by the insurance commissioner.

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 Everence representative 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 company may contact you in an attempt to sell you insurance.



A variety of Medicare supplement plans to meet your needs



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2025 Benefit structure

Services	Medicare pays	Plans that use issue-age rating								Plans that use attained-age rating	
		Plan A		Plan F ⁵		Plan G		Plan L		Plan N	
		We pay	You pay	We pay	You pay	We pay	You pay	We pay	You pay up to \$3,610 ²	We pay	You pay
Inpatient Hospitalization											
1-60 days	All costs after \$1,676 deductible per benefit period	Nothing	\$1,676	\$1,676	Nothing	\$1,676	Nothing	\$1,257	\$419	\$1,676	Nothing
61-90 days	All but \$419 per day	\$419 per day	Nothing	\$419 per day	Nothing	\$419 per day	Nothing	\$419 per day	Nothing	\$419 per day	Nothing
60 lifetime reserve days	All but \$838 per day	\$838 per day	Nothing	\$838 per day	Nothing	\$838 per day	Nothing	\$838 per day	Nothing	\$838 per day	Nothing
Additional 365 days	Nothing	100% of Medicare-eligible expenses	Nothing	100% of Medicare-eligible expenses	Nothing	100% of Medicare-eligible expenses	Nothing	100% of Medicare-eligible expenses	Nothing	100% of Medicare-eligible expenses	Nothing
Skilled Nursing Facility											
21-100 days¹	All but \$209.50 per day	Nothing	\$209.50 per day	\$209.50 per day	Nothing	\$209.50 per day	Nothing	\$157.13 per day	\$52.37 per day	\$209.50 per day	Nothing
Blood											
	All costs after first 3 pints	First 3 pints	Nothing	First 3 pints	Nothing	First 3 pints	Nothing	75% of first 3 pints	25% of first 3 pints	First 3 pints	Nothing
Hospice Care											
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	Nothing	Medicare copayment/coinsurance	Nothing	Medicare copayment/coinsurance	Nothing	75% of copayment/coinsurance	25% of copayment/coinsurance	Medicare copayment/coinsurance	Nothing
Medical Services											
Physician, outpatient supplies, physical and speech therapy diagnostic tests, durable medical equipment	After \$257 deductible, generally 80% of Medicare-approved amount ⁴	Generally 20% of Medicare-approved amount	\$257 deductible	\$257 deductible and generally 20% of Medicare-approved amount	Nothing	Generally 20% of Medicare-approved amount	\$257 deductible	Generally 15% of Medicare-approved amount. Exception: 20% for preventive care	\$257 deductible and generally 5% of Medicare-approved amount	Balance left after deductible and copays	\$257 deductible; up to \$20 per office visit; up to \$50 ³ per emergency room visit
Part B excess charges	Nothing	Nothing	All costs	100%	Nothing	100%	Nothing	Nothing	All costs	Nothing	All costs
Foreign travel	Nothing	Nothing	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	Nothing	All costs	80% of costs after \$250 annual deductible; \$50,000 lifetime benefit	\$250 annual deductible; 20% of costs. All costs after maximum benefit

¹Medicare 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.

²This is your annual out-of-pocket limit. All expenses in the "You pay" column accumulate toward this limit except excess charges, foreign travel, and additional preventive care not covered by Medicare

³The \$50 copay is waived if you are admitted to a hospital, and the emergency visit is covered as a Part A expense.

⁴Part B deductible means you pay for services covered by Part B up to the deductible amount. Then Medicare pays 80% of the cost (coinsurance) approved by Medicare for most Part B services.

⁵Effective January 1, 2020: Only applicants first eligible for Medicare before 2020 may purchase Plans C or F.