

## Avera Health Plans (AHP)

### Outline of Medicare Supplement Coverage - Cover Page 1 of 2

#### Benefit Chart of Medicare Supplement Plans Sold with Effective Dates on or after June 1, 2010

**Standard Plan A, B, C and F and Medicare SELECT Supplement Plans A, B, C, and F are Available.**

**Plans E, H, I, and J are no longer available for sale after June 1, 2010.**

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make Plan “A” available. Some plans may not be available in your state. **The plans in bold type listed below (A, B, C, and F) are also available as Medicare SELECT Plans. Medicare SELECT plans contain restrictions on your use of providers.**

**See Outlines of Coverage sections for details about ALL plans**

#### **BASIC BENEFITS for Plans A-N**

- **Hospitalization** – Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses** – Part B coinsurance (generally 20% of Medicare-approved expenses), or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.
- **Blood** – First three pints of blood each year.
- **Hospice** – Part A cost sharing.

<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>	<b>F</b>	F*	<b>G</b>
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance*		Basic, including 100% Part B coinsurance
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible
		Part B Deductible		Part B Deductible		
				Part B Excess (100%)		Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency

\***Plan F** also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plans F after the policyholder has paid a calendar year \$2,000 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed \$2,000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan’s separate foreign travel emergency deductible.

**The plans in bold type (A, B, C, & F) are also available as Medicare SELECT Plans. Medicare SELECT plans contain restrictions on your use of providers.**

## Avera Health Plans (AHP)

### Outline of Medicare Supplement Coverage - Cover Page 2 of 2

See **Outlines of Coverage** sections for details about all plans.

**Basic Benefits for Plans K and L include similar services as Plans A-G, but cost-sharing for the basic benefits is at different levels.**

K**	L**	M	N
Hospitalization and preventative care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventative care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER
50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
50% Part A deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Foreign Travel Emergency	Foreign Travel Emergency
Out-of-pocket annual limit \$4,620; benefits paid at 100% after limit reached	Out-of-pocket annual limit \$2,310; benefits paid at 100% after limit reached		

**\*\*Plans K and L provide for different cost-sharing for items and services than Plans A-G. Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called “Excess Charges”. You will be responsible for paying excess charges. The out-of-pocket annual limit will increase each year for inflation.**

**See Outlines of Coverage for details and exceptions.**

## PREMIUM INFORMATION

Avera Health Plans (AHP) can only raise your premium if we raise the premium for all policies like yours in this State. Premiums are based on the increasing age of the insured as well as the mode of the premium payment selected. Your premiums are based on your attained age in one year increments. Your premium rates will increase every year based on age. **Premium in the chart below is subject to change.**

### ANNUAL PREMIUM

**STANDARD PLAN SERVICE AREA: All counties in Iowa are included in the service area for the Standard Plan.**

**SELECT PLAN SERVICE AREA: Dickenson, Emmet, Lyon, O'Brien, Osceola, Plymouth, Sioux and Woodbury counties. (12/15/09)**

ATTAINED AGE	Standard Plan A		Select Plan A		Standard Plan B		Select Plan B		Standard Plan C		Select Plan C	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Under 65	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	882.00	819.00	839.00	779.00	1,152.00	1,069.00	866.00	804.00	1,329.00	1,234.00	1,036.00	961.00
66	905.00	840.00	860.00	798.00	1,182.00	1,097.00	888.00	825.00	1,363.00	1,265.00	1,062.00	986.00
67	928.00	861.00	881.00	818.00	1,211.00	1,124.00	910.00	845.00	1,397.00	1,297.00	1,089.00	1,011.00
68	963.00	894.00	915.00	850.00	1,258.00	1,168.00	946.00	878.00	1,449.00	1,345.00	1,131.00	1,050.00
69	991.00	920.00	941.00	873.00	1,294.00	1,201.00	971.00	901.00	1,489.00	1,382.00	1,163.00	1,080.00
70	1,150.00	1,067.00	1,091.00	1,013.00	1,502.00	1,394.00	1,127.00	1,046.00	1,728.00	1,604.00	1,350.00	1,253.00
71	1,240.00	1,151.00	1,179.00	1,094.00	1,622.00	1,505.00	1,216.00	1,129.00	1,866.00	1,732.00	1,457.00	1,352.00
72	1,314.00	1,219.00	1,248.00	1,158.00	1,716.00	1,593.00	1,287.00	1,195.00	1,976.00	1,834.00	1,542.00	1,432.00
73	1,376.00	1,277.00	1,307.00	1,213.00	1,798.00	1,669.00	1,348.00	1,251.00	2,070.00	1,922.00	1,615.00	1,499.00
74	1,443.00	1,340.00	1,372.00	1,274.00	1,886.00	1,751.00	1,414.00	1,312.00	2,170.00	2,015.00	1,693.00	1,571.00
75	1,518.00	1,409.00	1,443.00	1,340.00	1,984.00	1,842.00	1,488.00	1,381.00	2,283.00	2,119.00	1,781.00	1,653.00
76	1,563.00	1,451.00	1,486.00	1,379.00	2,043.00	1,896.00	1,532.00	1,422.00	2,352.00	2,183.00	1,835.00	1,703.00
77	1,625.00	1,508.00	1,545.00	1,434.00	2,122.00	1,970.00	1,592.00	1,477.00	2,445.00	2,270.00	1,905.00	1,768.00
78	1,675.00	1,555.00	1,593.00	1,478.00	2,189.00	2,032.00	1,641.00	1,523.00	2,521.00	2,340.00	1,964.00	1,823.00
79	1,725.00	1,601.00	1,640.00	1,522.00	2,254.00	2,092.00	1,689.00	1,568.00	2,595.00	2,409.00	2,020.00	1,875.00
80+	1,843.00	1,711.00	1,752.00	1,627.00	2,410.00	2,237.00	1,806.00	1,676.00	2,774.00	2,575.00	2,161.00	2,006.00

ATTAINED AGE	Standard Plan F		Select Plan F	
	Male	Female	Male	Female
Under 65	N/A	N/A	N/A	N/A
65	1,339.00	1,243.00	1,046.00	971.00
66	1,374.00	1,276.00	1,073.00	996.00
67	1,409.00	1,308.00	1,099.00	1,020.00
68	1,463.00	1,358.00	1,142.00	1,060.00
69	1,504.00	1,396.00	1,174.00	1,089.00
70	1,745.00	1,620.00	1,362.00	1,264.00
71	1,885.00	1,750.00	1,470.00	1,365.00
72	1,995.00	1,852.00	1,557.00	1,445.00
73	2,090.00	1,940.00	1,630.00	1,513.00
74	2,191.00	2,034.00	1,710.00	1,587.00
75	2,305.00	2,140.00	1,798.00	1,669.00
76	2,374.00	2,204.00	1,852.00	1,719.00
77	2,466.00	2,289.00	1,925.00	1,787.00
78	2,544.00	2,361.00	1,984.00	1,842.00
79	2,618.00	2,430.00	2,043.00	1,896.00
80+	2,800.00	2,599.00	2,184.00	2,027.00

(Rates – 06/01/10)

**Annual premium conversion formulas<sup>1</sup>:**

Semi-Annual X .5203, Quarterly X .2646, Monthly X .0900

Preauthorized Check Plan X .0855

<sup>1</sup> Semi-annual, quarterly and monthly premiums are rounded to the nearest dollar; PAC payments are rounded up to the nearest nickel.

AHP offers Medicare Supplement plans, which do not restrict your use of hospitals. You have the right to purchase this Standard Plan A, B, C, or F at anytime.

**OUTLINE OF MEDICARE SUPPLEMENT COVERAGE DISCLOSURES**

**DISCLOSURES** Use this outline to compare benefits and premiums among policies. This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010, have different benefits and premiums. Plans E, H, I and J are no longer available for sale after June 1, 2010.

You do not need more than one Medicare Supplement Policy.

You must be enrolled in Part A and Part B Medicare coverage and use a Medicare-approved hospital.

**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 AHP.

**RIGHT TO RETURN POLICY** If you are not satisfied with your policy, You may return it to our Customer Service Center at Avera Health Plans, 2219 Rimland Drive, P.O. Box 5348, Bellingham, WA 98227-5348. You may return it to us or to the agent who sold it. 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 Avera Health Plans 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. We 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.

### **REFUND OF PREMIUM**

If termination is due to You ceasing to be eligible for this plan or We receive written notice that You wish to terminate Your coverage, the date of termination will be the first day of the month following the event. Any premium paid beyond the termination date will be refunded to You.

### **LIMITATIONS AND EXCLUSIONS**

Your coverage is conditional on Medicare's approval of Medicare Eligible Expenses. Services eligible for coverage must therefore be deemed as medically necessary by Medicare. If Medicare does not consider services rendered or expenses incurred as medically necessary, no benefits will be paid. We will not place any limitations on benefits that are more restrictive than Medicare's limitations and restrictions, except as noted in the Network Hospital Restrictions.

No benefits will be paid under Medicare Part A which duplicates payments under Medicare Part B. No benefits will be paid under Medicare Part B which duplicates payments under Medicare Part A. No benefits will duplicate payment made directly by Medicare.

## **NETWORK HOSPITAL RESTRICTIONS – MEDICARE SELECT PRODUCTS ONLY**

Benefit Plans A, B, C, & F are Medicare SELECT supplement insurance policies. **Both Part A and Part B (hospital and physician) benefits described in this policy will be denied if:**

- **You receive services in a Non-Network Hospital or**
- **Your services are billed by a Non-Network Hospital**

**Part B benefits for outpatient surgery will be provided only if performed at a physician's office, Network Hospital or outpatient surgery clinic which is owned or operated by a Network Hospital.**

The full benefits of your coverage will be paid if:

1. The services are provided for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition, and it is not reasonable to obtain such services through the Network Hospitals;
2. While Traveling outside the Service Area, services will be covered from the 1<sup>st</sup> day through the 90<sup>th</sup> day of each trip, travel must be for purposes other than the receipt of medical care; or
3. Required services are not available at a Network Hospital in Your Service Area.

**Other than outpatient surgery as noted above there are no restrictions on benefits for services received in a non-hospital setting beyond standard limitations of this policy.**

### **Network Hospitals**

A Network Hospital is one that has a written agreement with the AHP Select Hospital Network and has been designated by AHP to provide hospital services to insured under this policy. You may use any Network Hospital, which is listed, on your current AHP Medicare SELECT Supplement Insurance **Network Hospital Directory**. This directory is updated periodically. To verify the status of a hospital please call 1-800-688-0010 between the hours of 5AM and 5PM Pacific Time, Monday through Friday.

### **Non-Network Hospital Admission Procedures**

Prior to admission to a non-Network Hospital, You, either directly or through Your physician, should contact AHP's Customer Service Center. The Customer Service Center will confirm whether the required services are available from a Network Hospital, and if not available, will assist You in locating a hospital that provides the necessary service. **Utilizing AHP's Customer Service Center prior to use of a non-Network Hospital eliminates the need for retrospective inquiry as to the legitimacy of the filed claim.**

These non-Network Hospital Admission Procedures do not apply in emergency situations or while You are traveling outside of the service area during the 1<sup>st</sup> through 90<sup>th</sup> day of travel. Travel must be for purposes other than the receipt of medical care.

## **CONTINUATION OF COVERAGE**

Any claim for a continuous loss that begins while this policy is in force will not be affected by the ending of this policy. However, benefits for such continuous loss may be conditioned upon Your continuous total disability, and are limited to the duration of the Medicare Benefit Period, if any, or the maximum benefits payable. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

If the authority to issue Medicare SELECT policies is discontinued for whatever reason or the Service Area no longer exists, Your coverage can continue. Coverage will be continued under any other Medicare Supplement policy We have available containing comparable or lesser benefits and which does not contain Restricted Network Provisions. You will not need to provide evidence of insurability.

## **CONVERSION PRIVILEGE – MEDICARE SELECT PRODUCTS ONLY**

You may request to convert this policy to a policy that does not contain Restricted Network Provisions without submission of evidence of insurance at anytime. Your request must be received by AHP on or before the 20<sup>th</sup> day of the month, and will be effective the 1<sup>st</sup> day of the following month. The conversion will be to a Medicare Supplement policy with comparable or lesser benefits which is offered by AHP. Conversion is subject to the availability of an AHP Medicare Supplement policy for sale in Your state.

## **QUALITY ASSURANCE**

When you purchase an Avera Health Plans SELECT Plan, you agree to use an AHP Network Hospital whenever possible. Our goal is to ensure access to high quality health care and we are continually striving to improve our services. To achieve this goal, our Quality Assurance Program allows us to monitor and evaluate the quality of care received by our insured. In addition, AHP requires Network Hospitals to meet or exceed acceptable standards of quality care for their field and to maintain a quality assurance program that conforms with local and nationally recognized quality of care standards.

## **Complaint and Appeals Philosophy**

We seek to provide quality administration and services to insured of our Medicare SELECT supplement insurance plans and Network Hospitals. However, from time to time, an insured may not be fully satisfied with the administration, claims practices or services we provide. Or an insured may not be fully satisfied with the services provided by a Network Hospital. We desire to provide a fair, accessible and responsive method of evaluating and resolving complaints. The complaint and appeals procedure, along with a detailed description of how to file a complaint or appeal will be described in the policy and outline of coverage. Policyholders may submit a complaint or appeal within three (3) years from the date the complaint arose.

## **COMPLAINT PROCEDURE – MEDICARE SELECT PRODUCTS ONLY**

### **Complaints While Staying At A Network Hospital.**

If, while confined at a Network Hospital, You have a complaint regarding the hospital's services being provided, You may contact AHP's Customer Service Center by phone 1-800-688-0010 5AM to 5PM Pacific Time, Monday through Friday, to express the complaint. AHP's Customer Service representatives will relay the complaint within twenty-four (24) hours, to the hospital's Administrator for response within twenty (20) days. Calls received between 5PM and 5AM, weekends and holidays, will be transferred to automated voice-mail, where You may leave Your name, policyholder identification number, telephone number and comment, request or complaint. Return phone calls will be placed the following business day.

**Other Complaints.** If You have questions or are dissatisfied with the quality of care received from a Network Hospital, have a complaint or want to contest the disposition of a claim, You may direct such inquiries to the Customer Service Center, P.O. Box 5348, Bellingham, WA 98227-5348, 1-800-688-0010 without initiating a formal grievance.

Questions or complaints regarding any of these areas which are presented shall receive acknowledgment within three (3) business days of receipt. A response will be sent to You within thirty (30) business days of the complaint. If after thirty (30) business days a response is unavailable, we will provide a status update to You every ten (10) business days.

## **GRIEVANCE PROCEDURE – MEDICARE SELECT PRODUCTS ONLY**

In the event You are dissatisfied with the response received to a complaint or with the disposition of a claim, You may submit a formal grievance by writing to the Claims Administrator at P.O. Box 5348, Bellingham, WA 98227-5348. Formal grievances in all other areas should be submitted to Us in writing at the same address. A grievance must clearly state “This is a grievance”, or other words that clearly state that the intention of the written communication is to serve as a written grievance to be handled according to this procedure. Acknowledgment of receipt of the grievance will be mailed within three (3) business days and the grievance will be investigated. A response will be sent within thirty (30) days following the date the grievance is received and shall explain in detail the reasons for the determination.

If AHP upholds the grievance, corrective action will be taken promptly to remedy the situation.

**Grievance Appeal Committee.** In the event You are not satisfied with the results of Our determination, You have the right to file an appeal by written request with AHP. The appeal should be submitted to the Grievance Appeal Committee of AHP within sixty (60) days from the date You are notified of the complaint procedure results. The Grievance Appeal Committee shall be made up of individuals not involved in the decision making process of the original grievance or request for determination. The Grievance Appeal Committee shall schedule a hearing on the grievance within sixty (60) days of its receipt. Both You and the person or organization against whom the complaint has been made shall be notified of the time and place of the Grievance Appeal Committee hearing at which time such individuals shall have the right to appear in person or by telephone and present any information which supports their position. At the close of the hearing, the Grievance Appeal Committee shall make findings and issue a written decision within fifteen (15) business days after the hearing is held unless additional information is needed.

If You are dissatisfied with the decision, You should submit a written complaint to the South Dakota Insurance Division, 445 East Capitol Avenue, Pierre, SD 57501-5070 or call (605) 773-3563.

## PLAN A - BENEFITS CHART

### 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.

\*\* Indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY**
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: -While using 60 lifetime reserve days -Once lifetime reserve days are used: -Additional 365 days (✓See your policy for details of coverage.) -Beyond the Additional 365 days	All but \$1,100 All but \$275 a day  All but \$550 a day  \$0  \$0	\$0 \$275 a day  \$550 a day  100% of Medicare Eligible Expenses  \$0	\$1,100 (Part A Deductible) \$0  \$0  \$0 ✓See NOTICE below  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$137.50 a day \$0	\$0 \$0 \$0	\$0 Up to \$137.50 a day All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare’s requirements, including a doctor’s certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare cost sharing	\$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 “Basic 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 - BENEFITS CHART

### MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

\* Once you have been billed \$155 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.

\*\* Indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY**
<b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$155 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$155 (Part B Deductible) \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare-Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next \$155 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$155 (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES</b> Tests For Diagnostic Services	100%	\$0	\$0

### PARTS A & B

<b>HOME HEALTH CARE</b> <b>MEDICARE-APPROVED SERVICES</b> -Medically necessary skilled care services and medical supplies -Durable medical equipment First \$155 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$155 (Part B Deductible) \$0
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## PLAN B - BENEFITS CHART

### 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.

\*\* Indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY**
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: -While using 60 lifetime reserve days -Once lifetime reserve days are used: -Additional 365 days (✓See your policy for details of coverage.) -Beyond the Additional 365 days	All but \$1,100 All but \$275 a day  All but \$550 a day  \$0  \$0	\$1,100 (Part A Deductible) \$275 a day  \$550 a day  100% of Medicare Eligible Expenses  \$0	\$0 \$0  \$0  \$0 ✓See NOTICE below  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21st thru 100th day 101st day and after	All approved amounts All but \$137.50 a day \$0	\$0 \$0 \$0	\$0 Up to \$137.50 a day All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare cost sharing	\$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 "Basic 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 B - BENEFITS CHART

### MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

\* Once you have been billed \$155 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.

\*\* Indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY**
<b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$155 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$155 (Part B Deductible) \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare-Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next \$155 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$155 (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES</b> Blood Tests For Diagnostic Services	100%	\$0	\$0

### PARTS A & B

<b>HOME HEALTH CARE</b> <b>MEDICARE-APPROVED SERVICES</b> -Medically necessary skilled care services and medical supplies -Durable medical equipment First \$155 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$155 (Part B Deductible) \$0
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## PLAN C - BENEFITS CHART

### 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.

\*\* Indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY**
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: -While using 60 lifetime reserve days -Once lifetime reserve days are used: -Additional 365 days (✓See your policy for details of coverage.) -Beyond the Additional 365 days	All but \$1,100 All but \$275 a day All but \$550 a day \$0 \$0	\$1,100 (Part A Deductible) \$275 a day \$550 a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0 ✓See NOTICE below All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21st thru 100th day 101st day and after	All approved amounts All but \$137.50 a day \$0	\$0 Up to \$137.50 a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare cost sharing	\$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 "Basic 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 C - BENEFITS CHART

### MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

\* Once you have been billed \$155 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.

\*\* Indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY**
<b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$155 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$155 (Part B Deductible) Generally 20%	\$0 \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare-Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next \$155 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All costs \$155 (Part B Deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES</b> Tests For Diagnostic Services	100%	\$0	\$0

### PARTS A & B

<b>HOME HEALTH CARE</b> <b>MEDICARE-APPROVED SERVICES</b> -Medically Necessary skilled care services and medical supplies -Durable medical equipment First \$155 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	100%  \$0 80%	\$0  \$155 (Part B Deductible) 20%	\$0  \$0 \$0
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### OTHER BENEFITS - NOT COVERED BY MEDICARE

<b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b> Medically Necessary Emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each Calendar Year Remainder of Charges	\$0 \$0	\$0 80% to a Lifetime Maximum Benefit of \$50,000	\$250 20% and amounts over the \$50,000 Lifetime Maximum Benefit
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## PLAN F - BENEFITS CHART

### 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.

\*\* Indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY**
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: -While using 60 lifetime reserve days -Once lifetime reserve days are used: -Additional 365 days (✓See your policy for details of coverage.) -Beyond the Additional 365 days	All but \$1,100 All but \$275 a day All but \$550 a day \$0 \$0	\$1,100 (Part A Deductible) \$275 a day \$550 a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0 ✓See NOTICE below All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21st thru 100th day 101st day and after	All approved amounts All but \$137.50 a day \$0	\$0 Up to \$137.50 a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare cost sharing	\$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 "Basic 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 - BENEFITS CHART

### MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

\* Once you have been billed \$155 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.

\*\* Indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY**
<b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$155 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$155 (Part B Deductible) Generally 20%	\$0 \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare-Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$155 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All costs \$155 (Part B Deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES</b> Blood Tests For Diagnostic Services	100%	\$0	\$0

### PARTS A & B

<b>HOME HEALTH CARE</b> MEDICARE-APPROVED SERVICES -Medically Necessary skilled care services and medical supplies -Durable medical equipment First \$155 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	100%   \$0 80%	\$0   \$155 (Part B Deductible) 20%	\$0   \$0 \$0
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### OTHER BENEFITS - NOT COVERED BY MEDICARE

<b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b> Medically Necessary Emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each Calendar Year Remainder of Charges	\$0 \$0	\$0 80% to a Lifetime Maximum Benefit of \$50,000	\$250 20% and amounts over the \$50,000 Lifetime Maximum Benefit
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