Medicare SUPPLEMENT[SM]
BROUGHT TO YOU BY HEALTH ALLIANCE

Outline of Coverage

Effective January 1, 2019

Medicare SUPPLEMENT[SM]
BROUGHT TO YOU BY HEALTH ALLIANCE

3310 Fields South Drive, Champaign, IL 61822
1-877-933-0028 (TTY 711)
www.HealthAlliance.org

med-ILindmsoutcov-18

med-ILindmsoutcov-1218

Health Alliance Medical Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Health Alliance Medical Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Health Alliance Medical Plans:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service.

If you believe that Health Alliance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Health Alliance Medical Plans, Customer Service, 3310 Fields South Drive, Champaign, IL 61822, telephone: 1-800-965-4022, TTY: 711, fax: 217-902-9705, CustomerService@healthalliance.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Customer Service is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, TTY: 1-800-537-7697.

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

For Language Access Services:

English:
If you, or someone you're helping, has questions about Health Alliance Medical Plans, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-965-4022.

Spanish:
Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Health Alliance Medical Plans, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-800-965-4022.

Chinese:
如果您，或是您正在協助的對象，有關於[插入SBM項目的名稱 Health Alliance Medical Plans,方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 在此插入數字 1-800-965-4022.

Polish:
Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie Health Alliance Medical Plans, masz prawo do uzyskania bezpłatnej informacji I pomocy we własnym języku .Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-800-965-4022.

Vietnamese:
Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Health Alliance Medical Plans quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-800-965-4022.

Korean:
만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Health Alliance Medical Plans, 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는1-800-965-4022 로 전화하십시오.

Russian:
Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Health Alliance Medical Plans, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-800-965-4022.

Tagalog:
Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Health Alliance Medical Plans, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-800-965-4022.

Arabic:
إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Health Alliance Medical Plans فلديك الحق في الحصول على المساعدة والمعلومات
الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل ب 1-800-965-4022.

German:
Falls Sie oder jemand, dem Sie helfen, Fragen zum Health Alliance Medical Plans haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-800-965-4022.

French:
Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Health Alliance Medical Plans, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-800-965-4022.

Gujarati:
જો તમે અથવા તમે કોઇને મદદ કરી રહ્યાં તેમ ાંથી કોઇને [એસબીએમ ક ર્યક્રમન ાં ન મ મ કો] વિશે પ્રશ્નો હોર્ તો તમને મદદ અને મ હહતી મેળિનો અવકિ ર છે. તે ખર્ચ વિના તમ રી ભ ષ મ ાં પ્ર પ્ત કરી શક ર્ છે. દ ભ વષર્ો તિ કરમિ ટે,આ [અહીં દ ખલ કરો નાંબર] પર કોલ કરો. 1-800-965-4022.

Japanese:
ご本人様、またはお客様の身の回りの方でも、Health Alliance Medical Plans,についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-800-965-4022 までお電話ください。

Pennsylvanian Dutch:
Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut Health Alliance Medical Plans, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 1-800-965-4022 uffrufe.

Ukrainian:
Якщо у Вас чи у когось, хто отримує Вашу допомогу, виникають питання про Health Alliance Medical Plans, у Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб зв'язатись з перекладачем, задзвоніть на 1-800-965-4022.

Italian:
Se tu o qualcuno che stai aiutando avete domande su Health Alliance Medical Plans, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-800-965-4022.

PREMIUM INFORMATION
Health Alliance Medical Plans, Inc. can only raise your premium if we raise the premium for all policies like yours in this State. We will not change your premium or cancel your policy because of poor health. If your premium changes, you will be notified at least 30 days in advance.

2019 MONTHLY PREMIUM RATES NORTHERN/CENTRAL AND SOUTHERN ILLINOIS
Rates shown are for Illinois residents living outside of Cook, DuPage, Kane, Lake, McHenry and Will counties. If you are an Illinois resident living in one of these counties, please call our toll-free number for the appropriate rates.

Non-Tobacco					
AGES	**Plan A**	**Plan C**	**Plan F**	**Plan G**	**Plan N**
<65	$218	$359	$363	$317	$273
65	$84	$139	$140	$123	$105
66	$92	$152	$154	$134	$115
67	$101	$166	$167	$146	$125
68	$106	$176	$178	$155	$133
69	$112	$185	$187	$163	$141
70	$118	$195	$197	$172	$147
71	$124	$204	$207	$181	$155
72	$130	$215	$217	$189	$162
73	$136	$224	$226	$198	$170
74	$142	$234	$236	$206	$177
75	$147	$243	$246	$215	$184
76	$153	$252	$255	$222	$191
77	$158	$260	$262	$230	$197
78	$162	$268	$271	$238	$203
79	$167	$276	$279	$244	$210
80	$173	$285	$288	$252	$216
81	$178	$294	$296	$259	$222
82	$182	$301	$304	$266	$228
83	$188	$310	$313	$274	$235
84	$193	$318	$321	$281	$241
85	$197	$325	$328	$287	$246
86	$201	$332	$335	$294	$252
87	$205	$339	$342	$299	$257
88	$210	$346	$350	$306	$262
89	$214	$352	$356	$312	$267
90+	$218	$359	$363	$317	$273

Tobacco					
AGES	**Plan A**	**Plan C**	**Plan F**	**Plan G**	**Plan N**
<65	$234	$386	$390	$341	$294
65	$90	$149	$150	$132	$112
66	$99	$163	$165	$144	$124
67	$108	$179	$180	$158	$135
68	$114	$189	$191	$166	$143
69	$121	$200	$201	$176	$151
70	$126	$209	$212	$185	$159
71	$134	$219	$222	$194	$166
72	$140	$231	$233	$203	$175
73	$146	$241	$243	$213	$182
74	$152	$251	$254	$221	$190
75	$159	$261	$264	$231	$199
76	$164	$271	$274	$239	$205
77	$169	$280	$282	$247	$212
78	$175	$288	$291	$256	$219
79	$180	$297	$300	$262	$226
80	$186	$307	$310	$271	$232
81	$191	$315	$318	$278	$239
82	$196	$324	$327	$286	$245
83	$202	$333	$336	$295	$253
84	$207	$342	$345	$302	$259
85	$212	$350	$352	$309	$264
86	$217	$356	$360	$315	$271
87	$220	$365	$368	$322	$276
88	$226	$371	$376	$329	$282
89	$230	$379	$383	$335	$287
90+	$234	$386	$390	$341	$294

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 January 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums.

READ YOUR POLICY VERY CAREFULLY
This is only an outline, describing each 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 Health Alliance Medical Plans, Inc.

RIGHT TO RETURN POLICY
If you find that you are not satisfied with your policy, you may return it to Health Alliance Medical Plans, Inc., Attn: Medicare Department, 3310 Fields South Drive, Champaign, IL 61822. 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 Health Alliance Medical Plans, Inc. 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. The 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.

Outline of Medicare Supplement Coverage

Benefit Chart of Medicare Supplement Plans Sold for Effective Dates on or After June 1, 2010

This chart shows 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 Illinois.

BASIC BENEFITS: Included in all plans.
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 3 pints of blood each year.
Hospice: Part A coinsurance.

A	B	C	D	F/F*	G		K**	L***	M	N
Basic Benefits including 100% Part B coinsurance	Basic Benefits including 100% Part B coinsurance	**Basic Benefits including 100% Part B coinsurance**	Basic Benefits including 100% Part B coinsurance	**Basic Benefits including 100% Part B coinsurance**	**Basic Benefits including 100% Part B coinsurance**		Hospitalization and Preventive Care paid at 100%; other Basic Benefits paid at 50%	Hospitalization and Preventive Care paid at 100%; other Basic Benefits paid at 75%	Basic Benefits including 100% Part B coinsurance	**Basic Benefits including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER**
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	**Skilled Nursing Facility Coinsurance**	**Skilled Nursing Facility Coinsurance**		50% Skilled Nursing Facility Coinsurance	75% 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**		50% Part A Deductible	75% Part A Deductible	50% 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**				Foreign Travel Emergency	**Foreign Travel Emergency**
							100% after $5,560 Out-of-pocket Annual Limit reached	100% after $2,780 Out-of-pocket Annual Limit reached		

*NOTE: **Plan F** also has an option called a high-deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,200 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed $2,200. 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.

** For Plan K: You will pay one-half of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $5,560 for the calendar year. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

*** For Plan L: You will pay one-half of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $2,780 for the calendar year. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

Medicare (Part A) Hospital Services Per Benefit Period[1]

	Medicare Pays	Plan A Health Alliance Pays	Plan A You Pay	Plan C Health Alliance Pays	Plan C You Pay		Plan F Health Alliance Pays	Plan F You Pay	Plan G Health Alliance Pays	Plan G You Pay	Plan N Health Alliance Pays	Plan N You Pay
HOSPITALIZATION[1] Semi-private room and board, general nursing and miscellaneous services and supplies												
• First 60 days	All but $1,364	$0	$1,364 (Part A deductible)	$1,364 (Part A deductible)	$0		$1,364 (Part A deductible)	$0	$1,364 (Part A deductible)	$0	$1,364 (Part A deductible)	$0
• 61st thru 90th day	All but $341 a day	$341 a day	$0	$341 a day	$0		$341 a day	$0	$341 a day	$0	$341 a day	$0
• 91st day and after while using 60 lifetime reserve days	All but $682 a day	$682 a day	$0	$682 a day	$0		$682 a day	$0	$682 a day	$0	$682 a day	$0
Once lifetime reserve days are used: • Additional 365 days	$0	100% of Medicare-eligible expenses	$0[3]	100% of Medicare-eligible expenses	$0[3]		100% of Medicare-eligible expenses	$0[3]	100% of Medicare-eligible expenses	$0[3]	100% of Medicare-eligible expenses	$0[3]
• Beyond additional 365 days	$0	$0	All costs	$0	All costs		$0	All costs	$0	All costs	$0	All costs
SKILLED NURSING FACILITY CARE[1] You must meet Medicare's requirements, including having been in a hospital for at least three days and having entered a Medicare-approved facility within 30 days of leaving the hospital												
• First 20 days	All approved amounts	$0	$0	$0	$0		$0	$0	$0	$0	$0	$0
• 21st through 100th day	All but $170.50 a day	$0	Up to $170.50 a day	Up to $170.50 a day	$0		Up to $170.50 a day	$0	Up to $170.50 a day	$0	Up to $170.50 a day	$0
• 101st day and after	$0	$0	All costs	$0	All costs		$0	All costs	$0	All costs	$0	All costs
BLOOD												
• First 3 pints	$0	3 pints	$0	3 pints	$0		3 pints	$0	3 pints	$0	3 pints	$0
• Additional amounts	100%	$0	$0	$0	$0		$0	$0	$0	$0	$0	$0

	Medicare Pays	Plan A Health Alliance Pays	Plan A You Pay	Plan C Health Alliance Pays	Plan C You Pay		Plan F Health Alliance Pays	Plan F You Pay	Plan G Health Alliance Pays	Plan G You Pay	Plan N Health Alliance Pays	Plan N You Pay
HOSPICE CARE 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 copayment/ coinsurnace	$0	Medicare copayment/ coinsurance	$0		Medicare copayment/ coinsurance	$0	Medicare copayment/ coinsurance	$0	Medicare copayment/ coinsurance	$0

1. 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.

3. 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 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.

Medicare (Part B) Medical Services Per Calendar Year

	Medicare Pays	Plan A Health Alliance Pays	Plan A You Pay	Plan C Health Alliance Pays	Plan C You Pay		Plan F Health Alliance Pays	Plan F You Pay	Plan G Health Alliance Pays	Plan G You Pay	Plan N Health Alliance Pays	Plan N You Pay
MEDICAL EXPENSES In or Out of the Hospital and Outpatient Hospital Treatment (physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment)												
• First $185 of Medicare-approved amounts[2]	$0	$0	$185 (Part B deductible)	$185 (Part B deductible)	$0		$185 (Part B deductible)	$0	$0	$185 (Part B deductible)	$0	$185 (Part B deductible)
• Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0	Generally 20%	$0		Generally 20%	$0	Generally 20%	$0	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of $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 $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	$0	All costs		100%	$0	100%	$0	$0	All costs
BLOOD												
• First 3 pints	$0	All costs	$0	All costs	$0		All costs	$0	All costs	$0	All costs	$0
• Next $185 of Medicare-approved amounts[2]	$0	$0	$185 (Part B deductible)	$185 (Part B deductible)	$0		$185 (Part B deductible)	$0	$0	$185 (Part B deductible)	$0	$185 (Part B deductible)
• Remainder of Medicare-approved amounts	80%	20%	$0	20%	$0		20%	$0	20%	$0	20%	$0
CLINICAL LABORATORY SERVICES OR BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0	$0	$0		$0	$0	$0	$0	$0	$0

2. Once you have been billed $185 of Medicare-approved amounts for covered services (which are noted with a [2]), your Part B deductible will have been met for the calendar year.

Medicare Parts A & B Services

	Medicare Pays	Plan A Health Alliance Pays	Plan A You Pay	Plan C Health Alliance Pays	Plan C You Pay		Plan F Health Alliance Pays	Plan F You Pay	Plan G Health Alliance Pays	Plan G You Pay	Plan N Health Alliance Pays	Plan N You Pay
HOME HEALTH CARE **Medicare-Approved Services**												
• Medically necessary skilled care services and medical supplies	100%	$0	$0	$0	$0		$0	$0	$0	$0	$0	$0
• Durable medical equipment - First $185 of Medicare-approved amounts[2]	$0	$0	$185 (Part B deductible)	$185 (Part B deductible)	$0		$185 (Part B deductible)	$0	$0	$185 (Part B deductible)	$0	$185 (Part B deductible)
- Remainder of Medicare-approved amounts	80%	20%	$0	20%	$0		20%	$0	20%	$0	20%	$0

Other Benefits Not Covered by Medicare

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	All costs	$0	$250		$0	$250	$0	$250	$0	$250
• Remainder of charges	$0	$0	All costs	80% to a lifetime maximum benefit of $50,000	20% and amount over the $50,000 lifetime maximum		80% to a lifetime maximum benefit of $50,000	20% and amount over the $50,000 lifetime maximum	80% to a lifetime maximum benefit of $50,000	20% and amount over the $50,000 lifetime maximum	80% to a lifetime maximum benefit of $50,000	20% and amount over the $50,000 lifetime maximum

2. Once you have been billed $185 of Medicare-approved amounts for covered services (which are noted with a [2]), your Part B deductible will have been met for the calendar year.