

Applicant's Name \_\_\_\_\_

Name of Existing Insurer \_\_\_\_\_

Existing Policy Number \_\_\_\_\_

Expiration Date of Existing Insurance \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

 Please indicate your choice of coverage:  Plan A  Plan G  Plan G – High Deductible  Plan F\*  Plan N

\* Plan F is only available to individuals who are Medicare eligible prior to 01/01/2020.

Service	Benefit	Medicare Pays	Existing Coverage Pays	Health Alliance Pays After you pay \$1,408 deductible*	You Pay In addition to \$1,408 deductible*
<b>Hospital Inpatient</b>	First 60 Days	All but \$1,408		<input type="checkbox"/> \$1,408 Part A deductible <b>OR</b> <input type="checkbox"/> \$0	<input type="checkbox"/> \$1,408 Part A deductible <b>OR</b> <input type="checkbox"/> \$0
	61 <sup>st</sup> to 90 <sup>th</sup> Days	All but \$352 a day		\$352 a day	\$0
	91 <sup>st</sup> to 150 <sup>th</sup> Day (lifetime reserve)	All but \$704 a day		\$704 a day	\$0
	Beyond 150 Days	\$0		All Medicare-approved amounts for an additional 365 days	\$0
<b>Skilled Nursing Home Care</b>	First 20 Days	All approved amounts		\$0	\$0
	Additional 80 Days	All but \$176 a day		<input type="checkbox"/> \$176 a day <b>OR</b> <input type="checkbox"/> \$0	<input type="checkbox"/> \$176 a day <b>OR</b> <input type="checkbox"/> \$0
	Beyond 100 Days	\$0		\$0	All costs
<b>Medical Expenses</b>	Physician's services in hospital, office or home; inpatient and outpatient medical services and supplies at a hospital; physical and speech therapy and ambulance	80% of the Medicare determined charges after a \$198 deductible (per calendar year)		For charges covered under Medicare Part B: <input type="checkbox"/> Part B deductible <input type="checkbox"/> After \$198 Medicare calendar year deductible, 20% of Medicare allowable charges <input type="checkbox"/> 100% Part B excess charges	Charges not covered by policy and Medicare
<b>Prescription Drugs</b>		Inpatient prescription drugs—80% of allowable charges for immuno-suppressive drugs during the first year following a covered transplant		No benefit	All costs; outpatient drugs

This policy does comply with the minimum standards set forth in Section 363 of the Illinois Insurance Code.

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Insurance Producer Signature \_\_\_\_\_ Date \_\_\_\_\_

Health Alliance Medical Plans

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