Health Alliance™

Medicare Supplement

Group Insurance
Outline of Coverage
Effective February 1, 2020

3310 Fields South Drive, Champaign, IL 61822
1-877-933-0028 TTY 711
HealthAlliance.org/Group-Medicare

DISCRIMINATION IS AGAINST THE LAW

Health Alliance 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 does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. Health Alliance:

- 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 Medicare, Member Services, 3310 Fields South Drive, Champaign, IL 61822 or 411 N. Chelan, Wenatchee, WA 98801, telephone for members in Illinois, Indiana, Iowa and Ohio: 1-800-965-4022; telephone for members in Washington: 1-877-750-3350 TTY: 711, fax: 217-902-9705, MemberServices@healthalliance.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Member Services 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

ATENCIÓN: Si habla Español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. IA, IL, IN, OH: Llame 1-800-965-4022, WA Llame: 1-877-750-3350 (TTY: 711).

注意：如果你講中文，語言協助服務，免費的，都可以給你。IA, IL, IN, OH: 呼叫 1-800-965-4022, WA: 呼叫 1-877-750-3350 (TTY: 711)。

UWAGA: Jeśli mówić Polskie, usługi pomocy języka, bezpłatnie, są dostępne dla Ciebie. IA, IL, IN, OH: Zadzwoń 1-800-965-4022, WA: Zadzwoń 1-877-750-3350 (TTY: 711).

Chú ý: Nếu bạn nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ, miễn phí, có sẵn cho bạn. IA, IL, IN, OH: Gọi 1-800-965-4022, WA: Gọi 1-877-750-3350 (TTY: 711).

주의 : 당신이한국어, 무료 언어 지원 서비스를 말하는 경우 사용할 수 있습니다. 1-800-965-4022 IA, IL, IN, OH: 전화 WA: 1-877-750-3350 전화 (TTY: 711).

ВНИМАНИЕ: Если вы говорите русский, вставки услуги языковой помощи, бесплатно, доступны для вас. IA, IL, IN, OH: Вызов 1-800-965-4022, WA: Вызов 1-877-750-3350 (TTY: 711).

Pansin: Kung magsalita ka Tagalog, mga serbisyo ng tulong sa wika, nang walang bayad, ay magagamit sa iyo. IA, IL, IN, OH: Tumawag 1-800-965-4022, WA: Tumawag 1-877-750-3350 (TTY: 711).

انتباه: إذا كنت تتكلم العربية، فإن خدمات المساعدة اللغوية متوفرة لك مجاناً. إيلينوي، إنديانا، أوهايو: اتصل بالرقم 1-800-965-4022، ولاية واشنطن: اتصل بالرقم: 1-877-750-3350 (إذا كنت تعاني من الصمم أو صعوبة في السمع فاتصل على الرقم 711)

Aufmerksamkeit: Wenn Sie Deutsch sprechen, Sprachassistenzdienste sind kostenlos, zur Verfügung. IA, IL, IN, OH: Anruf 1-800-965-4022, WA: Anruf 1-877-750-3350 (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. IA, IL, IN, OH: Appelez 1-800-965-4022, WA: Appelez 1-877-750-3350 (TTY: 711).

ધ્યાન: તમે વાત તો ગુજરાતી, ભાષા સહાય સેવાઓ, મફત, તમારા માટે ઉપલબ્ધ છે. IA, IL, IN, OH: કૉલ 1-800-965-4022, WA: કૉલ 1-877-750-3350 (TTY: 711).

注意：あなたは、日本語 、無料で言語支援サービスを、話す場合は、あなたに利用可能です。1-800-965-4022 IA, IL, IN, OH: コール 1-877-750-3350 WA: コール（TTY: 711)。

LET OP: Als je spreekt pennsylvania nederlandse, taalkundige bijstand diensten, gratis voor u beschikbaar zijn. IA, IL, IN, OH: Bel 1-800-965-4022, WA: Bel 1-877-750-3350 (TTY: 711).

УВАГА: Якщо ви говорите український, вставки послуги мовної допомоги, безкоштовно, доступні для вас. IA, IL, IN, OH: Виклик 1-800-965-4022, WA: Виклик 1-877-750-3350 (TTY: 711).

ATTENZIONE: Se si parla italiano, servizi di assistenza linguistica, a titolo gratuito, sono a vostra disposizione. IA, IL, IN, OH: Chiamare 1-800-965-4022, WA: Chiamare 1-877-750-3350 (TTY: 711).

Outline of Coverage

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. Premiums change annually based on your age at renewal. If your premium changes, you will be notified at least 30 days in advance.

2020 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.

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

AGES	Plan A	Plan F	Plan G	Plan G High Deductible	Plan N
Age 65	$ 91	$ 150	$ 135	$48	$107
Age 66	$ 96	$ 160	$ 144	$51	$114
Age 67	$ 104	$ 174	$ 157	$56	$123
Age 68	$ 109	$ 183	$ 165	$59	$130
Age 69	$ 120	$ 200	$ 179	$64	$142
Age 70	$ 128	$213	$ 192	$69	$151
Age 71	$ 135	$ 225	$ 202	$72	$160
Age 72	$ 143	$ 238	$ 214	$76	$169
Age 73	$ 150	$ 251	$ 226	$81	$178
Age 74	$ 157	$262	$ 236	$84	$186
Age 75	$ 170	$ 283	$ 255	$91	$201
Age 76	$ 178	$ 297	$ 267	$95	$211
Age 77	$ 185	$ 308	$ 278	$99	$220
Age 78	$ 191	$319	$ 286	$102	$226
Age 79	$ 197	$ 328	$ 296	$106	$233
Age 80	$ 199	$ 332	$ 299	$107	$236
Age 81	$ 205	$ 343	$ 308	$110	$243
Age 82	$ 209	$ 348	$ 314	$112	$248
Age 83	$ 212	$ 354	$ 318	$114	$251
Age 84	$ 217	$ 363	$ 327	$117	$257
Age 85 +	$ 237	$ 394	$ 354	$126	$280
Disabled Beneficiaries	$ 191	$ 319	$ 287	$ 102	$ 227

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.

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
Review the application carefully before you sign it. Be certain that all information has been properly recorded.

Health Alliance™

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 co-payments 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

Medicare Plans (A-D)			
A	**B**	**C**	**D**
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
		Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance
	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible	
		Foreign Travel Emergency	Foreign Travel Emergency

Outline of Medicare Supplement Coverage

Medicare Plans F-L			
F or F* Plan F is only available to individuals who are Medicare eligible prior to 01/01/2020.	**G or G***	**K****	**L*****
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%
Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible			
Part B Excess (100%)	Part B Excess (100%)		
Foreign Travel Emergency	Foreign Travel Emergency		
		100% after $50,000 Out-of-Pocket Annual Limit reached	100% after $50,000 Out-of-Pocket Annual Limit reached

* NOTE: **Plan F OR Plan G** also has an option called a high-deductible Plan F OR Plan G. This high deductible plan pays the same benefits as Plan F OR Plan G after one has paid a calendar year $2,340 deductible. Benefits from high deductible Plan F OR Plan G will not begin until out-of-pocket expenses exceed $2,340. 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 $5,880 for the calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. 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 25% of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $2,940 for the calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. 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 Plans (M-N)	
M	**N**
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
50% Part A Deductible	Part A Deductible
Foreign Travel Emergency	Foreign Travel Emergency

Medicare Supplement Benefit Plan A
Group Insurance
Outline of Coverage

	Medicare Pays	Medicare Supplement Pays	You Pay
Medicare Part A Hospital Services Per Benefit Period[1]			
Hospitalization[1] (Semi-private room and board, general nursing and miscellaneous services and supplies)			
First 60 days	All but $1,408	$0	$1,408 (Part A deductible)
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after while using 60 lifetime reserve days	All but $704 a day	$704 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare eligible expenses	$0[3]
Beyond additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] (You must meet Medicare's requirements, including having been in a hospital for at least 3 days and having entered a Medicare-approved facility within 30 days of leaving the hospital)			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $176 a day	$0	Up to $176 a day
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
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/ coinsurance	$0
Medicare Part B Medical Services Per Calendar Year			
Medical Expenses (In or Out of the Hospital) and Outpatient Hospital Treatment (Physician's services, inpatient/outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment)			
First $198 of Medicare-approved amounts[2]	$0	$0	$198 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0

	Medicare Pays	Medicare Supplement Pays	You Pay
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
Blood			
First 3 pints	$0	All costs	$0
Next $198 of Medicare-approved amounts[2]	$0	$0	$198 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services – Tests for Diagnostic Services	100%	$0	$0
Medicare Parts A & B Services			
Home Health Care, Medicare-Approved Services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment: -First $198 of Medicare-approved amounts[2] -Remainder of Medicare-approved amounts	 $0 80%	 $0 20%	 $198 (Part B deductible) $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)	$0	$0	All costs

[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.

[2] Once you have been billed $198 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.

[3]**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 "Core 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 Supplement Benefit 2010 Plan F
Group Insurance
Outline of Coverage

	Medicare Pays	Medicare Supplement Pays	You Pay
Medicare Part A Hospital Services Per Benefit Period[1]			
Hospitalization[1] (Semi-private room and board, general nursing and miscellaneous services and supplies)			
First 60 days	All but $1,408	$1,408 (Part A deductible)	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after while using 60 lifetime reserve days	All but $704 a day	$704 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare eligible expenses	$0[3]
Beyond additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] (You must meet Medicare's requirements, including having been in a hospital for at least 3 days and having entered a Medicare-approved facility within 30 days of leaving the hospital)			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $176 a day	Up to $176 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
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/ coinsurance	$0
Medicare Part B Medical Services Per Calendar Year			
Medical Expenses (In or Out of the Hospital) and Outpatient Hospital Treatment (Physician's services, inpatient/outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment)			
First $198 of Medicare-approved amounts[2]	$0	$0	$198 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	All costs

	Medicare Pays	Medicare Supplement Pays	You Pay
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
Blood			
First 3 pints	$0	All costs	$0
Next $198 of Medicare-approved amounts[2]	$0	$0	$198 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services – Tests for Diagnostic Services	100%	$0	$0
Medicare Parts A & B Services			
Home Health Care, Medicare-Approved Services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment: -First $198 of Medicare-approved amounts[2] -Remainder of Medicare-approved amounts	 $0 80%	 $0 20%	 $198 (Part B deductible) $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	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amount over the $50,000 lifetime maximum

[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.

[2] Once you have been billed $198 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.

[3]**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 "Core 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 Supplement Benefit 2010 Plan G*
Group Insurance
Outline of Coverage

	Medicare Pays	**After you pay $2,340 deductible* Medicare Supplement Pays**	**In addition to $2,340 deductible* You Pay**
Medicare Part A Hospital Services Per Benefit Period[1]			
Hospitalization[1] (Semi-private room and board, general nursing and miscellaneous services and supplies)			
First 60 days	All but $1,408	$1,408 (Part A Deductible)	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after while using 60 lifetime reserve days	All but $704 a day	$704 a day	$0
Once lifetime reserve days are used:	-	-	-
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0[3]
Beyond additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] (You must meet Medicare's requirements, including having been in a hospital for at least 3 days and having entered a Medicare-approved facility within 30 days of leaving the hospital)			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $176 a day	Up to $176 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0
Medicare Part B Medical Services Per Calendar Year			
Medical Expenses (In or Out of the Hospital) and Outpatient Hospital Treatment (Physician's services, inpatient/outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment)			
First $198 of Medicare-approved amounts[2]	$0	$0	$198 (Part B Deductible)
Remainder of Medicare-approved amounts	generally 80%	generally 20%	$0

	Medicare Pays	After you pay $2,340 deductible* Medicare Supplement Pays	In addition to $2,340 deductible* You Pay
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
Blood			
First 3 pints	$0	All costs	$0
Next $198 of Medicare-approved amounts[2]	$0	$0	$198 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services – Tests for Diagnostic Services	100%	$0	$0
Medicare Parts A & B Services			
Home Health Care, Medicare-Approved Services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment: -First $198 of Medicare-approved amounts[2] -Remainder of Medicare-approved amounts	 $0 80%	 $0 20%	 $198 (Part B deductible) $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	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amount over the $50,000 lifetime maximum

* NOTE: **Plan G** also has an option called a high-deductible Plan G. This high deductible plan pays the same benefits as Plan G after one has paid a calendar year $2,340 deductible. Benefits from high deductible Plan G will not begin until out-of-pocket expenses exceed $2,340. 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

[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.

[2] Once you have been billed $198 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.

[3]**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 "Core 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 Supplement Benefit Plan N
Group Insurance
Outline of Coverage

	Medicare Pays	Medicare Supplement Pays	You Pay
Medicare Part A Hospital Services Per Benefit Period[1]			
Hospitalization[1] (Semi-private room and board, general nursing and miscellaneous services and supplies)			
First 60 days	All but $1,408	$1,408 (Part A deductible)	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after while using 60 lifetime reserve days	All but $704 a day	$704 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare eligible expenses	$0[3]
Beyond additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] (You must meet Medicare's requirements, including having been in a hospital for at least 3 days and having entered a Medicare-approved facility within 30 days of leaving the hospital)			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $176 a day	Up to $176 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
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/ coinsurance	$0
Medicare Part B Medical Services Per Calendar Year			
Medical Expenses (In or Out of the Hospital) and Outpatient Hospital Treatment (Physician's services, inpatient/outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment)			
First $198 of Medicare-approved amounts[2]	$0	$0	$198 (Part B deductible)

	Medicare Pays	Medicare Supplement Pays	You Pay
Remainder of Medicare-approved amounts	Generally 80%	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 room 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 room visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
Blood			
First 3 pints	$0	All costs	$0
Next $198 of Medicare-approved amounts[2]	$0	$0	$198 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services – Tests for Diagnostic Services	100%	$0	$0
Medicare Parts A & B Services			
Home Health Care, Medicare-Approved Services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment: -First $198 of Medicare-approved amounts[2] -Remainder of Medicare-approved amounts	 $0 80%	 $0 20%	 $198 (Part B deductible) $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 -Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000	 $250 20% and amount over the $50,000 lifetime maximum

[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.

[2] Once you have been billed $198 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.

[3]**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 "Core 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.