Medicare SUPPLEMENT℠ 2019 Group Policy Checklist

BROUGHT TO YOU BY HEALTH ALLIANCE

Applicant's Name _____

Name of Existing Insurer _____

Existing Policy Number _____

Expiration Date of Existing Insurance ____/____/____

Please indicate your choice of coverage: ❑ Plan A ❑ Plan F ❑ Plan N

Service	Benefit	Medicare Pays	Existing Coverage Pays	Health Alliance Pays	You Pay
Hospital Inpatient	First 60 Days	All but $1,364		❑ $1,364 Part A deductible OR ❑ $0	❑ $1,364 Part A deductible OR ❑ $0
	61st-90th Days	All but $341 a day		$341 a day	$0
	91st-150th Days (Lifetime reserve)	All but $682		$682 a day	$0
	Beyond 150 Days	$0		All Medicare-approved amounts for an additional 365 days	$0
Skilled Nursing Home Care	First 20 Days	All approved amounts		$0	$0
	Additional 80 Days	All but $170.50 a day		❑ $170.50 a day OR ❑ $0	❑ $170.50 a day OR ❑ $0
	Beyond 100 Days	$0		$0	All costs
Medical Expenses	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 $185 deductible (per calendar year)		For charges covered under Medicare Part B: ❑ Part B deductible ❑ After $185 Medicare calendar-year deductible, 20% of Medicare allowable charges ❑ 100% Part B excess charges	Charges not covered by policy and Medicare
Prescription Drugs		Inpatient prescription drugs—80% of allowable charges for immunosuppressive 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 _____

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