Medicare SUPPLEMENT℠
BROUGHT TO YOU BY HEALTH ALLIANCE

Outline of Group Medicare Supplement Coverage

Effective January 1, 2019

Medicare SUPPLEMENT℠
BROUGHT TO YOU BY HEALTH ALLIANCE
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grp-msgrpoutcov19-1118 • November 2018

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.

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, 2019. Plans E, H, I and J will no longer be available for sale after May 31, 2010.

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, 301 S. Vine St., Urbana, IL 61801-3347. 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.

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.

AGES	Plan A	Plan F	Plan N
<65	$186	$310	$221
65	$88	$146	$104
66	$93	$155	$110
67	$101	$169	$120
68	$106	$177	$126
69	$117	$194	$138
70	$124	$207	$147
71	$131	$218	$155
72	$139	$231	$164
73	$146	$244	$173
74	$152	$254	$181
75	$165	$275	$195
76	$173	$289	$205
77	$180	$299	$213
78	$186	$310	$219
79	$191	$318	$226
80	$193	$322	$229
81	$200	$333	$236
82	$203	$338	$240
83	$206	$343	$244
84	$211	$353	$250
85+	$230	$382	$272

COMPLETE ANSWERS ARE VERY IMPORTANT
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. Plans E, H, I and J are no longer available for sale.

A	B	**C**	D	**F/F***	G	
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	
		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	

*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.

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 three pints of blood each year.
Hospice: Part A coinsurance.

	K	L	M	N
	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**
	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**
	100% after $5,120 Out-of-pocket Annual Limit	100% after $2,560 Out-of-pocket Annual Limit		

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

	Medicare Pays	Plan A Health Alliance Pays	Plan A 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)	
• 61st thru 90th day	All but $341 a day	$341 a day	$0	
• 91st day and after while using 60 lifetime reserve days	All but $682 a day	$682 a day	$0	
Once lifetime reserve days are used: • Additional 365 days	$0	100% of Medicare-eligible expenses	$0[2]	
• 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 three days and having entered a Medicare-approved facility within 30 days of leaving the hospital				
• First 20 days	All approved amounts	$0	$0	
• 21st through 100th day	All but $170.50 a day	$0	Up to $170.50 a day	
• 101st day and after	$0	$0	All costs	
BLOOD				
• First three pints	$0	Cost of 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 coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurnace	$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.

2. 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.

	Plan F Health Alliance Pays	Plan F You Pay	Plan N Health Alliance Pays	Plan N You Pay
	$1,364 (Part A deductible)	$0	$1,364 (Part A deductible)	$0
	$341 a day	$0	$341 a day	$0
	$682 a day	$0	$682 a day	$0
	100% of Medicare-eligible expenses	$0[2]	100% of Medicare-eligible expenses	$0[2]
	$0	All costs	$0	All costs
	$0	$0	$0	$0
	Up to $170.50 a day	$0	Up to $170.50 a day	$0
	$0	All costs	$0	All costs
	Cost of 3 pints	$0	Cost of 3 pints	$0
	$0	$0	$0	$0
	Medicare copayment/ coinsurance	$0	Medicare copayment/ coinsurance	$0

Medicare (Part B) Medical Services Per Calendar Year

	Medicare Pays	Plan A Health Alliance Pays	Plan A You Pay	
MEDICAL EXPENSES In or Out of the Hospital and Outpatient Hospital Treatment such as physician's services, inpatient/outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment				
• First $185 of Medicare-approved amounts[3]	$0	$0	$185 (Part B deductible)	
• Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0	
PART B EXCESS CHARGES (above Medicare-approved amounts)	$0	$0	All costs	
BLOOD				
• First three pints	$0	All costs	$0	
• Next $185 of Medicare-approved amounts[3]	$0	$0	$185 (Part B deductible)	
• Remainder of Medicare-approved amounts	80%	20%	$0	
CLINICAL LABORATORY SERVICES OR TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0	

3. Once you have been billed $185 of Medicare-approved amounts for covered services (which are noted with a [3]), your Part B deductible will have been met for the calendar year.

	Plan F Health Alliance Pays	Plan F You Pay	Plan N Health Alliance Pays	Plan N You Pay
	$185 (Part B deductible)	$0	$0	$185 (Part B deductible)
	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 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.
	100%	$0	$0	All costs
	All costs	$0	All costs	$0
	$185 (Part B deductible)	$0	$0	$185 (Part B deductible)
	20%	$0	20%	$0
	$0	$0	$0	$0

Medicare (Parts A & B) Services

	Medicare Pays	Plan A Health Alliance Pays	Plan A You Pay	
HOME HEALTH CARE Medicare-Approved Services				
• Medically necessary skilled care services and medical supplies	100%	$0	$0	
• Durable medical equipment - First $185 of Medicare-approved amounts[3]	$0	$0	$185 (Part B deductible)	
- Remainder of Medicare-approved amounts	80%	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	
• Remainder of charges	$0	$0	All costs	

3. Once you have been billed $185 of Medicare-approved amounts for covered services (which are noted with a [3]), your Part B deductible will have been met for the calendar year.

	Plan F Health Alliance Pays	Plan F You Pay	Plan N Health Alliance Pays	Plan N You Pay
	$0	$0	$0	$0
	$185 (Part B deductible)	$0	$0	$185 (Part B deductible)
	20%	$0	20%	$0

	$0	$250	$0	$250
	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