Avera Health Plans

Medicare Supplement Insurance

Outline of Coverage | South Dakota 2020

SOUTH DAKOTA – OCTOBER 2020

Benefit Chart of Medicare Supplement Insurance Plans with effective dates on or after October 1, 2020

Standard Medicare Supplement Plans A, B, C, F, G, K, L and N

Medicare Select Supplement Plans A, B, C, F, G, K, L and N are available.

These charts show 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 your state. Plans A, B, C, F, G, K, L and N are also available as Medicare Select Plans. Medicare Select plans contain restrictions on your use of specific hospitals and, in some cases, specific doctors or other healthcare providers to get full coverage. See Outline of Coverage sections for details about available plans.

Note: A ✔means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G[1]	K	L	M	N	C	F
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Medicare Part B coinsurance or Copayment	✔	✔	✔	✔	50%	75%	✔	✔ copays apply[3]	✔	✔
Blood (first three pints)	✔	✔	✔	✔	50%	75%	✔	✔	✔	✔
Part A hospice care coinsurance or copayment	✔	✔	✔	✔	50%	75%	✔	✔	✔	✔
Skilled nursing facility coinsurance			✔	✔	50%	75%	✔	✔	✔	✔
Medicare Part A deductible		✔	✔	✔	50%	75%	50%	✔	✔	✔
Medicare Part B deductible									✔	✔
Medicare Part B excess charges				✔						✔
Foreign travel emergency (up to plan limits)			✔	✔			✔	✔	✔	✔
Out-of-pocket limit in 2020[2]					$5,880	$2,940				

1 Plan G also h has a high deductible option which requires first paying a plan deductible of [$2,340] before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plan G counts your payment of the Medicare Part B deductible toward meeting the plan deductible.

2 Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

3 Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to $20 for some office visits and up to a $50 co-payment for emergency room visits that do not result in an inpatient admission.

Service Area

Standard Plan Service Area: All counties in South Dakota are included in the service area for the Standard Plan.

Select Plan Service Area: Aurora, Beadle, Bon Homme, Brookings, Brown, Brule, Buffalo, Butte, Campbell, Charles Mix, Clark, Clay, Codington, Corson, Custer, Davison, Day, Deuel, Dewey, Douglas, Edmunds, Fall River, Faulk, Grant, Gregory, Haakon, Hamlin, Hand, Hanson, Harding, Hughes, Hutchinson, Hyde, Jackson, Jerauld, Jones, Kingsbury, Lake, Lawrence, Lincoln, Lyman, Marshall, McCook, McPherson, Meade, Mellette, Miner, Minnehaha, Moody, Pennington, Perkins, Potter, Roberts, Sanborn, Shannon, Spink, Stanley, Sully, Todd, Tripp, Turner, Union, Walworth, Yankton and Ziebach Counties. (Updated 2/19/2014)

Premium Information

Avera Health Plans can only raise your premium if we raise the premium for all policies like yours in this state. Your premiums are based on your attained age on the annual effective date of your policy.

HOUSEHOLD PREMIUM DISCOUNT

You may be eligible for a Select Plan G policy with a lower premium rate if you currently reside with an individual with whom you have continuously resided for the last 12 months and who is age 60 or older, or with whom you reside and to whom you are either married or in a civil union partnership.

Monthly Premium

ATTAINED AGE	Standard Plan A		Select Plan A		Standard Plan B		Select Plan B		Standard Plan C		Select Plan C	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Under 65	300.58	279.00	146.74	136.06	348.36	323.27	163.84	151.87	405.07	376.16	170.88	158.55
65	214.55	199.09	89.24	82.84	248.65	230.68	99.64	92.46	289.13	268.42	103.92	96.53
66	222.81	206.81	91.57	84.94	258.22	239.63	102.24	94.80	300.26	278.83	106.63	98.97
67	225.92	209.54	96.81	89.85	261.83	242.79	108.09	100.28	304.45	282.51	112.73	104.70
68	228.90	212.47	102.28	94.84	265.28	246.18	114.20	105.86	308.47	286.46	119.10	110.52
69	237.94	220.85	108.68	100.87	275.75	255.89	121.34	112.58	320.65	297.76	126.55	117.53
70	247.31	229.51	113.45	105.22	286.62	265.93	126.67	117.44	333.28	309.43	132.11	122.61
71	257.18	238.71	118.52	109.91	298.06	276.59	132.33	122.68	346.58	321.84	138.02	128.08
72	267.29	248.01	126.65	117.48	309.77	287.36	141.41	131.13	360.20	334.37	147.48	136.90
73	278.08	258.04	132.27	122.64	322.28	298.98	147.69	136.88	374.74	347.90	154.03	142.90
74	289.17	268.43	139.30	129.27	335.13	311.03	155.54	144.28	389.69	361.91	162.22	150.64
75	300.58	279.00	146.74	136.06	348.36	323.27	163.84	151.87	405.07	376.16	170.88	158.55
76	312.79	290.21	153.07	141.92	362.51	336.26	170.91	158.40	421.52	391.28	178.25	165.38
77	316.72	293.96	159.08	147.46	367.06	340.60	177.62	164.59	426.81	396.32	185.25	171.83
78	320.90	297.78	163.22	151.28	371.91	345.03	182.24	168.85	432.45	401.48	190.07	176.28
79	325.00	301.52	168.69	156.44	376.66	349.36	188.35	174.61	437.97	406.52	196.44	182.30
80+	355.19	329.69	178.07	165.19	411.64	382.01	198.82	184.37	478.65	444.50	207.36	192.49

Monthly Premium

ATTAINED AGE	Standard Plan F		Select Plan F		Standard Plan G		Select Plan G		High Deductible Select Plan G		Select Plan G Household Discount	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Under 65	432.07	401.15	182.53	169.42	366.78	340.48	152.10	140.99	66.63	61.76	133.85	124.07
65	308.40	286.25	111.01	103.15	261.80	242.96	92.50	85.84	40.52	37.60	81.40	75.54
66	320.27	297.36	113.91	105.76	271.88	252.39	94.91	88.01	41.58	38.55	83.52	77.45
67	324.75	301.28	120.42	111.88	275.68	255.72	100.34	93.10	43.96	40.78	88.30	81.93
68	329.03	305.49	127.23	118.10	279.31	259.29	106.01	98.28	46.44	43.05	93.29	86.49
69	342.02	317.54	135.19	125.60	290.34	269.52	112.65	104.52	49.35	45.78	99.13	91.98
70	355.49	329.99	141.13	131.02	301.78	280.08	117.60	109.03	51.51	47.76	103.48	95.95
71	369.68	343.21	147.43	136.86	313.82	291.31	122.85	113.89	53.81	49.89	108.11	100.23
72	384.20	356.58	157.55	146.29	326.15	302.66	131.28	121.74	57.51	53.32	115.52	107.13
73	399.72	371.01	164.54	152.70	339.32	314.90	137.10	127.08	60.06	55.66	120.65	111.83
74	415.66	385.95	173.29	160.97	352.85	327.58	144.39	133.95	63.25	58.67	127.07	117.88
75	432.07	401.15	182.53	169.42	366.78	340.48	152.10	140.99	66.63	61.76	133.85	124.07
76	449.62	417.27	190.42	176.72	381.68	354.16	158.67	147.06	69.50	64.42	139.63	129.42
77	455.26	422.65	197.89	183.62	386.47	358.73	164.89	152.80	72.23	66.93	145.10	134.47
78	461.27	428.14	203.04	188.37	391.57	363.40	169.18	156.76	74.11	68.67	148.88	137.95
79	467.16	433.53	209.84	194.80	396.57	367.96	174.85	162.11	76.59	71.01	153.87	142.66
80+	510.56	474.03	221.51	205.69	433.41	402.34	184.57	171.17	80.85	74.98	162.43	150.63

Monthly Premium

ATTAINED AGE	Standard Plan K		Select Plan K		Standard Plan L		Select Plan L		Standard Plan N		Select Plan N	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Under 65	209.53	194.70	88.73	82.24	312.72	290.22	132.35	122.79	368.48	342.11	148.38	137.74
65	149.56	138.93	53.96	50.07	223.21	207.09	80.49	74.76	263.01	244.12	90.24	83.86
66	155.32	144.32	55.37	51.34	231.80	215.13	82.59	76.65	273.14	253.59	92.60	85.98
67	157.49	146.22	58.54	54.31	235.04	217.96	87.32	81.08	276.95	256.94	97.89	90.95
68	159.57	148.27	61.84	57.33	238.14	221.01	92.25	85.59	280.61	260.52	103.42	96.01
69	165.86	154.12	65.71	60.97	247.54	229.72	98.02	91.03	291.68	270.80	109.89	102.11
70	172.40	160.16	68.60	63.60	257.29	238.73	102.33	94.96	303.17	281.42	114.72	106.52
71	179.28	166.58	71.66	66.43	267.56	248.30	106.90	99.19	315.27	292.70	119.85	111.27
72	186.32	173.07	76.58	71.01	278.08	257.97	114.23	106.02	327.66	304.10	128.07	118.93
73	193.84	180.07	79.98	74.12	289.30	268.41	119.30	110.67	340.89	316.40	133.75	124.15
74	201.58	187.32	84.23	78.13	300.84	279.22	125.64	116.66	354.48	329.15	140.86	130.86
75	209.53	194.70	88.73	82.24	312.72	290.22	132.35	122.79	368.48	342.11	148.38	137.74
76	218.04	202.52	92.56	85.78	325.42	301.88	138.06	128.08	383.44	355.85	154.79	143.67
77	220.78	205.13	96.19	89.13	329.50	305.77	143.48	133.08	388.26	360.44	160.86	149.28
78	223.70	207.80	98.69	91.44	333.86	309.74	147.22	136.53	393.38	365.13	165.05	153.15
79	226.55	210.41	102.00	94.56	338.12	313.64	152.15	141.18	398.41	369.72	170.58	158.37
80+	247.60	230.07	107.67	99.84	369.52	342.94	160.61	149.08	435.41	404.26	180.06	167.23

DISCLOSURES

Use this Outline of Coverage to compare benefits and premiums among policies. This outline shows benefits of policies sold for effective dates on or after October 1, 2020. Policies sold for effective dates prior to October 1, 2020 may have different premiums. You do not need more than one Medicare Supplement Insurance policy. You must be enrolled in Part A and Part B Medicare coverage and use a Medicare-approved hospital.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and complete all questions about your medical and health history. We 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.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your 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 Avera Health Plans.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to our Service Center at Avera Health Plans, 5300 S. Broadband Ln., Sioux Falls, SD 57108-2221 or your agent. If you send your policy back to us within 30 days after you receive it, we will treat your policy as if it had never been issued and return all of your payments.

REFUND OF PREMIUM

If termination is due to you ceasing to be eligible for this plan or we receive written notice that you wish to terminate your coverage, the date of termination will be the first day of the month following the event. Any premium paid beyond the termination date will be refunded.

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 Avera Health Plans 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" handbook for more details.

We offer Medicare Supplement plans, which do not restrict your use of hospitals. You have the right to purchase Standard Plan A, B, G, K, L or N at any time. Plans C and F are only available to Medicare Beneficiaries first eligible prior to 2020.

LIMITATIONS AND EXCLUSIONS

Your coverage is conditional on Medicare's approval of Medicare Eligible Expenses. Services eligible for coverage must be deemed as medically necessary by Medicare. If Medicare does not consider services rendered or expenses incurred as medically necessary, no benefits will be paid. We will not place any limitations on benefits that are more restrictive than Medicare's limitations and restrictions, except as noted in the Network Hospital Restrictions.

No benefits will be paid under Medicare Part A which duplicates payments under Medicare Part B. No benefits will be paid under Medicare Part B which duplicates payments under Medicare Part A. No benefits will duplicate payment made directly by Medicare.

NETWORK HOSPITAL RESTRICTIONS

(Applies to Medicare Select Products Only)
Benefit Plans A, B, C, F, G, K, L and N are Medicare Select Supplement Insurance policies.

Services for outpatient surgery will be covered only if performed at an Avera owned or operated network hospital or outpatient surgery center which has a written agreement with Avera Health Plans to provide services.

Services for renal dialysis will be covered only if performed at a network hospital or dialysis center which has either a written agreement with Avera Health Plans or a written agreement with a network hospital to facilitate the network hospital's dialysis services.

Both inpatient and outpatient services provided and billed by any non-network hospital will NOT be covered except as described below.

Full benefits of your coverage will be paid if:

1. Services are provided in the following places: a physician's office, in another office setting (other than an outpatient surgery center); or at a skilled nursing facility.

2. The services are provided for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition and it is not reasonable to obtain such services through the network hospitals.

3. While traveling outside the service area, services will be covered from the first day you receive non-emergency services at a non-network hospital, up to 90 consecutive days, once per calendar year. Please refer to the Calendar Year Travel Benefit outlined in the next section. Travel must be for purposes other than receiving medical care.

4. Required services are not available at a network hospital in your service area.

Other than hospital inpatient, hospital outpatient and facility services for outpatient surgery as noted above, you have no restrictions on benefits for services received in a non-hospital setting beyond standard limitations of this policy.

CALENDAR YEAR TRAVEL BENEFITS

You are entitled to a 90-consecutive-day travel benefit, once per calendar year. This travel benefit allows you to receive the full benefits of your coverage at a non-network hospital outside of the service area for non-emergency services. Your 90 days begins on the first day you receive non-emergency services from a non-network hospital.

NETWORK HOSPITALS

A network hospital is one that has a written agreement with Avera Health Plans Medicare Supplement product and has been designated by us to provide hospital services to our members under this policy. You may use any network hospital listed on your current Avera Health Plans Medicare Supplement Insurance Network Hospital Directory. This directory is updated periodically. To verify the status of a hospital, please call toll-free at 1-888-322-2115 between 8 a.m. to 5 p.m. CT, Monday through Friday or refer to our website at AveraHealthPlans.com and click Medicare Options.

NON-NETWORK HOSPITAL ADMISSION PROCEDURES

Prior to admission to a non-network hospital, you or your physician should call our Service Center at 1-888-322-2115 between 8 a.m. and 5 p.m. CT. We will confirm if the required services are available from a network hospital, and if not available, we will assist you in locating a hospital that provides the necessary service. Calling Avera Health Plans Service Center prior to use of a non-network hospital eliminates the need for retrospective inquiry.

These non-network hospital admission procedures do not apply in emergency situations or while you are traveling outside of the service area during your Calendar Year Travel Benefit period, as outlined above. Travel must be for purposes other than the receipt of medical care.

CONTINUATION OF COVERAGE

Any claim for continuous loss that begins while this policy is in force will not be affected by the ending of this policy. However, benefits for such continuous loss may be conditional upon your continuous total disability, and are limited to the duration of the Medicare Benefit Period, if any, or the maximum benefits payable. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

If the authority to issue Medicare Select policies is discontinued for whatever reason or the service area no longer exists, your coverage can continue. Coverage will be continued under any other Medicare Supplement Insurance policy we have available continuing comparable or lesser benefits and which does not contain Restricted Network Provisions. You will not need to provide evidence of insurability.

CONVERSION PRIVILEGE – MEDICARE SELECT PRODUCTS ONLY

You may request to convert this policy to a policy that does not contain a Network Hospital Restriction without submission of evidence of insurance at any time. Your request must be received by Avera Health Plans on or before the 20th day of the month, and will be effective the first day of the following month. The conversion will be to a Medicare Supplement Insurance policy with comparable or lesser benefits which is offered by us. Conversion is subject to the availability of an Avera Health Plans Medicare Supplement Insurance policy for sale in your state.

If you choose to convert back to a network hospital restricted plan, you will be subject to medical underwriting.

QUALITY ASSURANCE

When you purchase an Avera Health Plans Medicare Select Supplement Insurance plan, you agree to use a Network Hospital or Outpatient Surgical Center whenever possible. Our goal is to ensure access to high quality health care and we are continually striving to improve our services. To achieve this goal, our Quality Improvement Program allows us to monitor and evaluate the quality of care received by our insured. In addition, Avera Health Plans requires the network hospitals to meet or exceed acceptable standards of quality care for their field and to maintain a quality assurance program that conforms to local and nationally recognized quality of care standards.

COMPLAINT AND APPEALS PHILOSOPHY - MEDICARE SELECT PRODUCTS ONLY

We seek to provide quality administration and services to insureds of our Medicare Supplement Insurance plans and network hospitals. There may be a time you are not fully satisfied with the administration, claims practices or services we provide or provided by a network hospital. It is the policy of Avera Health Plans to make reasonable efforts to resolve member and provider complaints. If you or your authorized representative is not satisfied, you have the right to file a complaint or grievance. You may submit a complaint or grievance within 180 days from the date you were notified of the action that is causing the complaint.

COMPLAINTS WHILE STAYING AT A NETWORK HOSPITAL

If, while staying at a network hospital, you have a complaint regarding the hospital's services, you may contact our Service Center by phone at 1-888-322-2115, 8 a.m. to 5 p.m. CT, Monday through Friday to express the complaint. The complaint will be researched and you will receive a response within 30 days. Calls received by our Service Center between 5 p.m. and 8 a.m., weekends and holidays, will be transferred to our afterhours answering service, where you may leave your name, policyholder identification number and phone number. Return calls will be placed the following business day.

OTHER COMPLAINTS

If you have questions or are dissatisfied with the quality of service received from Avera Health Plans, care received from a network hospital, have a complaint or want to contest the disposition of a claim, you may direct such inquires to Avera Health Plans Service Center, 5300 S. Broadband Ln., Sioux Falls, SD 57108-2221, or you can call toll-free at 1-888-322-2115, 8 a.m. to 5 p.m. CT, Monday through Friday without initiating a formal grievance. You will receive acknowledgement within three business days of receipt of the complaint. A written response will be sent to you within 30 business days of the complaint.

GRIEVANCE PROCEDURE – MEDICARE SELECT PRODUCTS ONLY
In the event you are dissatisfied with the response received to a complaint or with the disposition of a claim, you may submit a formal grievance by writing to Avera Health Plans Complaint and Appeals Coordinator, 5300 S. Broadband Ln., Sioux Falls, SD 57108-2221.

Formal grievances in all other areas should be submitted to us in writing at the same address. A grievance must clearly state "this is a grievance", or other words that clearly state that the intention of the written communication is to serve as a written grievance to be handled according to this procedure

Acknowledgement of receipt of the grievance will be mailed within three business days and the grievance will be investigated. A response will be sent within 30 days following the date the grievance is received and shall explain in detail the reasons for the determination. If you are dissatisfied with an adverse outcome on a complaint or a grievance, you have the right to contact the South Dakota Division of Insurance by phone at 1-605-773-3563 or at the address below:

South Dakota Division of Insurance
124 S. Euclid Ave., 2nd Floor
Pierre, SD 57501

PLAN A

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY[1]
HOSPITALIZATION[2] Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,408	$0	$1,408 (Part A Deductible)
61st day through 90th day	All but $352 per day	$352 per day	$0
91st day and after (While using 60 lifetime reserve days)	All but $704 per day	$704 per day	$0
Once lifetime reserve days are used			
-Additional 365 days	$0	100% Medicare Eligible Expense	$0 [3]
-Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE[2] You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $176 per day	$0	Up to $176 per 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

[1] Indicates your liability for covered charges. You are responsible for all other non-covered charges.

[2] 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 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.

PLAN A

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY[1]
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and 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
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 SERVICE			
Tests For Diagnostic Services	100%	$0	$0

MEDICARE (PARTS A and B) – MEDICAL SERVICES – PER CALENDAR YEAR

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]	$0	$0	$198 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$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

[1] Indicates your liability for covered charges. You are responsible for all other non-covered charges.

[2] After you have been billed $198 of Medicare approved amounts for covered services, your Part B deductible will have been met for the calendar year.

PLAN B

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY[1]
HOSPITALIZATION[2] Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,408	$1,408 (Part A Deductible)	$0
61st day through 90th day	All but $352 per day	$352 per day	$0
91st day and after (While using 60 lifetime reserve days)	All but $704 per day	$704 per day	$0
Once lifetime reserve days are used			
-Additional 365 days	$0	100% Medicare Eligible Expense	$0 [3]
-Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE[2] You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $176 per day	$0	Up to $176 per 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

[1] Indicates your liability for covered charges. You are responsible for all other non-covered charges.

[2] 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 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.

PLAN B

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY[1]
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and 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
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 SERVICE			
Tests For Diagnostic Services	100%	$0	$0

MEDICARE (PARTS A and B) – MEDICAL SERVICES – PER CALENDAR YEAR

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]	$0	$0	$198 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

[1] Indicates your liability for covered charges. You are responsible for all other non-covered charges.

[2] After you have been billed $198 of Medicare approved amounts for covered services, your Part B deductible will have been met for the calendar year.

PLAN C

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY[1]
HOSPITALIZATION[2] Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,408	$1,408 (Part A Deductible)	$0
61st day through 90th day	All but $352 per day	$352 per day	$0
91st day and after (While using 60 lifetime reserve days)	All but $704 per day	$704 per day	$0
Once lifetime reserve days are used			
-Additional 365 days	$0	100% Medicare Eligible Expense	$0 [3]
-Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE[2] You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $176 per day	Up to $176 per 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

[1] Indicates your liability for covered charges. You are responsible for all other non-covered charges.

[2] 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 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.

PLAN C

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY[1]
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $198 of Medicare-Approved Amounts[2]	$0	$198 (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
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	$198 (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICE			
Tests For Diagnostic Services	100%	$0	$0

MEDICARE (PARTS A and B) – MEDICAL SERVICES – PER CALENDAR YEAR

HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES			
-Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment	$0	$198 (Part B Deductible)	$0
First $198 of Medicare-Approved Amounts[2]			
Remainder of Medicare-Approved Amounts	80%	20%	$0
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 amounts over the $50,000 lifetime maximum

[1] Indicates your liability for covered charges. You are responsible for all other non-covered charges.

[2] After you have been billed $198 of Medicare approved amounts for covered services, your Part B deductible will have been met for the calendar year.

PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY[1]
HOSPITALIZATION[2] Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,408	$1,408 (Part A Deductible)	$0
61st day through 90th day	All but $352 per day	$352 per day	$0
91st day and after (While using 60 lifetime reserve days)	All but $704 per day	$704 per day	$0
Once lifetime reserve days are used			
-Additional 365 days	$0	100% Medicare Eligible Expense	$0 [3]
-Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE[2] You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $176 per day	Up to $176 per 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

[1] Indicates your liability for covered charges. You are responsible for all other non-covered charges.

[2] 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 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.

PLAN F

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY[1]
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $198 of Medicare-Approved Amounts[2]	$0	$198 (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES			
Above Medicare-Approved Amounts	$0	100% of Medicare Eligible Costs	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $198 of Medicare-Approved Amounts[2]	$0	$198 (Part B Deductible	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICE			
Tests For Diagnostic Services	100%	$0	$0

MEDICARE (PARTS A and B) – MEDICAL SERVICES – PER CALENDAR YEAR

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]	$0	$198 (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
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 amounts over the $50,000 lifetime maximum

[1] Indicates your liability for covered charges. You are responsible for all other non-covered charges.

[2] After you have been billed $198 of Medicare approved amounts for covered services, your Part B deductible will have been met for the calendar year.

PLAN G or High Deductible Plan G

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,340 DEDUCTIBLE[4] PLAN PAYS	IN ADDITION TO $2,340 DEDUCTIBLE[4] YOU PAY[1]
HOSPITALIZATION[2] Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,408	$1,408 (Part A Deductible)	$0
61st day through 90th day	All but $352 per day	$352 per day	$0
91st day and after (While using 60 lifetime reserve days)	All but $704 per day	$704 per day	$0
Once lifetime reserve days are used			
-Additional 365 days	$0	100% Medicare Eligible Expense	$0 [3]
-Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE[2] You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $176 per day	Up to $176 per 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

[1] Indicates your liability for covered charges. You are responsible for all other non-covered charges.

[2] 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 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.

[4] This high deductible plan pays the same benefits as Plan G after you have paid a calendar year [$2,340] deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are [$2,340]. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

PLAN G

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,340 DEDUCTIBLE PLAN PAYS	IN ADDITION TO $2,340 DEDUCTIBLE YOU PAY[1]
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and 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
PART B EXCESS CHARGES			
Above Medicare-Approved Amounts	$0	100% Medicare Eligible Costs	$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 SERVICE			
Tests For Diagnostic Services	100%	$0	$0

MEDICARE (PARTS A and B) – MEDICAL SERVICES – PER CALENDAR YEAR

HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES			
-Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment	$0	$0	$198 (Part B Deductible)
First $198 of Medicare-Approved Amounts[2]			
Remainder of Medicare-Approved Amounts	80%	20%	$0
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 amounts over the $50,000 lifetime maximum

[1] Indicates your liability for covered charges. You are responsible for all other non-covered charges.

[2] After you have been billed $198 of Medicare approved amounts for covered services, your Part B deductible will have been met for the calendar year.

PLAN K

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

You will pay one-half the coinsurance / copayment of some covered services until you reach the annual out-of-pocket limit of $5,880 each calendar year. The amounts that apply 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 co-payment 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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY[1]
HOSPITALIZATION[2] Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,408	$704 (50% Part A Deductible)	$704 (50% Part A Deductible) ◆
61st day through 90th day	All but $352 per day	$352 per day	$0
91st day and after (While using 60 lifetime reserve days)	All but $704 per day	$704 per day	$0
Once lifetime reserve days are used			
-Additional 365 days	$0	100% Medicare Eligible Expense	$0 [3]
-Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE[2] You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $176 per day	Up to $88 a day (50% of Part A Coinsurance)	Up to $88 a day (50% of Part A Coinsurance)◆
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	50%	50%◆
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.	50% of Medicare copayment/coinsurance	50% of Medicare copayment/coinsurance

[1] Indicates your liability for covered charges. You are responsible for all other non-covered charges.

[2] 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 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.

PLAN K

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY[1]
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and 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) ◆
Preventive Benefits for Medicare covered services	Generally 80% Medicare Approved Amounts	Remainder of Medicare Approved Amounts	All costs above Medicare-Approved Amounts
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 10%	Generally 10%◆
PART B EXCESS CHARGES Above Medicare-Approved Amounts	$0	$0	All Costs (and they do not count toward annual out-of-pocket limit of $5,880)*
BLOOD			
First 3 pints	$0	50%	50%◆
Next $198 of Medicare-Approved Amounts[2]	$0	$0	$198 (Part B Deductible) ◆
Remainder of Medicare-Approved Amounts	Generally 80%	Generally10%	Generally 10%◆
CLINICAL LABORATORY SERVICE Tests For Diagnostic Services	100%	$0	$0

MEDICARE (PARTS A and B) – MEDICAL SERVICES – PER CALENDAR YEAR

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]	$0	$0	$198 (Part B Deductible) ◆
Remainder of Medicare-Approved Amounts	80%	10%	10%◆

[1] Indicates your liability for covered charges. You are responsible for all other non-covered charges.

[2] After you have been billed $198 of Medicare approved amounts for covered services, your Part B deductible will have been met for 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 benefits are subject to change. Please consult the latest "*Medicare & You*".

PLAN L

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

You will pay one-fourth the coinsurance / copayment of some covered services until you reach the annual out-of-pocket limit of $2,940 each calendar year. The amounts that apply 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 co-payment 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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY[1]
HOSPITALIZATION[2] Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,408	$1,056 (75% Part A Deductible)	$352 (25% Part A Deductible) ◆
61st day through 90th day	All but $352 per day	$352 per day	$0
91st day and after (While using 60 lifetime reserve days)	All but $704 per day	$704 per day	$0
Once lifetime reserve days are used			
-Additional 365 days	$0	100% Medicare Eligible Expense	$0 [3]
-Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE[2] You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $176 per day	Up to $132 a day (75% of Part A Coinsurance)	Up to $44 a day (25% of Part A Coinsurance)◆
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	75%	25%◆
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.	75% of Medicare copayment/coinsurance	25% of Medicare copayment/coinsurance

PLAN L

[1] Indicates your liability for covered charges. You are responsible for all other non-covered charges.

[2] 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 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.[4] Indicates your liability for covered charges. You are responsible for all other non-covered charges.

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY[1]
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and 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) ◆
Preventive Benefits for Medicare covered services	Generally 80% Medicare Approved Amounts	Remainder of Medicare Approved Amounts	All costs above Medicare-Approved Amounts
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 15%	Generally 5%◆
PART B EXCESS CHARGES			
Above Medicare-Approved Amounts	$0	$0	All Costs (and they do not count toward annual out-of-pocket limit of $2,780)*
BLOOD			
First 3 pints	$0	75%	25%◆
Next $198 of Medicare-Approved Amounts[2]	$0	$0	$198 (Part B Deductible) ◆
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 15%	Generally 5%◆
CLINICAL LABORATORY SERVICE			
Tests For Diagnostic Services	100%	$0	$0

MEDICARE (PARTS A and B) – MEDICAL SERVICES – PER CALENDAR YEAR

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]	$0	$0	$198 (Part B Deductible) ◆
Remainder of Medicare-Approved Amounts	80%	15%	Generally 5%◆

PLAN N

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

[1] Indicates your liability for covered charges. You are responsible for all other non-covered charges.

[2] After you have been billed $198 of Medicare approved amounts for covered services, your Part B deductible will have been met for 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 benefits are subject to change. Please consult the latest "*Medicare & You*".

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY[1]
HOSPITALIZATION[2] Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,408	$1,408 (Part A Deductible)	$0
61st day through 90th day	All but $352 per day	$352 per day	$0
91st day and after (While using 60 lifetime reserve days)	All but $704 per day	$704 per day	$0
Once lifetime reserve days are used			
-Additional 365 days	$0	100% Medicare Eligible Expense	$0 [3]
-Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE[2] You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $176 per day	Up to $176 per 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

PLAN N

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

[1] Indicates your liability for covered charges. You are responsible for all other non-covered charges.

[2] 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 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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY[1]
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and 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%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $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 up to $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	100% Medicare Eligible 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 SERVICE Tests For Diagnostic Services	100%	$0	$0

MEDICARE (PARTS A and B) – MEDICAL SERVICES – PER CALENDAR YEAR

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]	$0	$0	$198 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
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 amounts over the $50,000 lifetime maximum

[1] Indicates your liability for covered charges. You are responsible for all other non-covered charges.

[2] After you have been billed $198 of Medicare approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Avera Health Plans

5300 S. Broadband Lane
Sioux Falls, SD 57108

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