



# UniCare Life & Health Insurance Company – Ohio

UNICARE. Administrative Office: P.O. Box 9090, Oxnard, CA 93031-9090 • Toll Free Telephone Number: 1-800-508-9355

## OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE

### STANDARD BENEFIT PLANS A, B, C, D AND F, AND SELECT BENEFIT PLANS C AND F

Medicare supplement insurance can be sold in 10 standard plans plus two high deductible plans. The SELECT Plan C and SELECT Plan F are approved Medicare SELECT plans. This chart shows the benefits included in each plan. Every company must make available Plan “A.” Some plans may not be available in your state. **Medicare SELECT Disclosures: Your right to purchase other plans.** You may replace your Medicare SELECT plan with any Medicare supplement plan we offer of comparable or lesser benefits. This offer does not require proof of good health.

- 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%) or in the case of hospital outpatient department services under a prospective payment system, applicable copayments.
  - **Blood:** First three pints of blood each year

Plan A	B	C	D	E	F/F*	G	H	I	J*
Standard Plan A	Standard Plan B	SELECT/ Standard Plan C	Standard Plan D		SELECT/ Standard Plan F				
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance
	Part A Deductible	Part A Deductible**	Part A Deductible	Part A Deductible	Part A Deductible**	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-home Recovery			At-home Recovery		At-home Recovery	At-home Recovery
							Basic Drugs (\$1,250 Limit)	Basic Drugs (\$1,250 Limit)	Extended Drugs (\$3,000 Limit)
									Preventive Care

\*Plans F and J also have an option called a High Deductible Plan F and a High Deductible Plan J. These high deductible plans pay the same or offer the same benefits as Plans F and J after one has paid a calendar year \$1,860 deductible. Benefits from High Deductible Plans F and J will not begin until out-of-pocket expenses are \$1,860. 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, in Plan J, the plan’s separate prescription drug deductible or, in Plans F and J, the plan’s separate foreign travel emergency deductible.

\*\*For SELECT Plans, the Part A deductible is covered only when using a network hospital.

## MEDICARE SUPPLEMENT COVERAGE

### Outline of Coverage for Policy Form Series

**OHA1001 - Standard Plan A**

**OHA2002 - Standard Plan B**

**OHA3003 - Standard Plan C**

**OHB1001 - SELECT Plan C**

**OHA5005 - Standard Plan D**

**OHA4004 - Standard Plan F**

**OHB2002 - SELECT Plan F**

### Retain This Outline For Your Records

### Premium Information

Your premium rate increases based upon your Attained Age. We will recalculate your age for each billing and your premium rate will be automatically increased based upon your Attained Age. UniCare can increase your premium if we raise our table of premium rates for all policies like yours in this state. If termination of this coverage results from the death of the insured, the insured's estate is entitled to a refund of the unused premium.

### Disclosures

Use this outline to compare benefits and premiums among policies.

### 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 UniCare.

### Right To Return Policy

If you find that you are not satisfied with your policy, you may return it to us at our Administrative Office: P.O. Box 9090, Oxnard, CA 93031-9090. 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 cost. Neither UniCare nor its associates 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 and You*" for more details.

### Complete Answers Are Very Important

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

**STANDARD PLAN A  
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

\*A benefit period begins on the first day you receive services 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.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

<b>Services</b>	<b>Medicare Pays</b>	<b>Standard Plan A Pays</b>	<b>You Pay</b>
<b>Hospitalization*</b>			
Semiprivate room and board, general nursing and miscellaneous hospital services and supplies:			
First 60 days	All but \$992	\$0	\$992 (Part A Deductible)
61st through 90th day	All but \$248 a day	\$248 a day	\$0**
91st day and after:			
• While using 60 lifetime reserve days	All but \$496 a day	\$496 a day	\$0**
• Once lifetime reserve days are used:			
— Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
— Beyond the additional 365 days	\$0	\$0	All costs
<b>Skilled Nursing Facility Care*</b>			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0**
21st through 100th day	All but \$124 a day	\$0	Up to \$124 a day
101st day and after	\$0	\$0	All costs
<b>Blood</b>			
First three pints	\$0	three pints	\$0**
Additional amounts	100%	\$0	\$0**
<b>Hospice Care</b>			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

**Part  
A  
Services**

**STANDARD PLAN A  
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

\*Once you have been billed \$131 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

<b>Services</b>	<b>Medicare Pays</b>	<b>Standard Plan A Pays</b>	<b>You Pay</b>
<b>Part B Services</b>			
<b>Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment</b> such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment			
First \$131 of Medicare-approved amounts*	\$0	\$0	\$131 (Part B Deductible)
Remainder of Medicare-approved amount	generally 80%	generally 20%	\$0**
Part B Excess Charges (Above Medicare-approved amounts)	\$0	\$0	All Costs
<b>Blood</b>			
First three pints	\$0	All costs	\$0**
Next \$131 of Medicare-approved amounts*	\$0	\$0	\$131 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0**
<b>Clinical Laboratory Services — Blood Tests for Diagnostic Services</b>			
	100%	\$0	\$0**

**STANDARD PLAN A  
PARTS A & B**

\*Once you have been billed \$131 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

<b>Services</b>	<b>Medicare Pays</b>	<b>Standard Plan A Pays</b>	<b>You Pay</b>
<b>Part A+ Services</b>			
<b>Home Healthcare Medicare-approved Services</b>			
• Medically-necessary skilled care services and medical supplies	100%	\$0	\$0**
• Durable medical equipment			
First \$131 of Medicare-approved amounts*	\$0	\$0	\$131 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0**

**STANDARD PLAN B  
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

\*A benefit period begins on the first day you receive services 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.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

<b>Services</b>	<b>Medicare Pays</b>	<b>Standard Plan B Pays</b>	<b>You Pay</b>
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**Part  
A  
Services**

**Hospitalization\***

Semiprivate room and board, general nursing and miscellaneous hospital services and supplies:

First 60 days	All but \$992	\$992 (Part A Deductible)	\$0**
61st through 90th day	All but \$248 a day	\$248 a day	\$0**
91st day and after:			
• While using 60 lifetime reserve days	All but \$496 a day	\$496 a day	\$0**
• Once lifetime reserve days are used:			
— Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
— Beyond the additional 365 days	\$0	\$0	All costs

**Skilled Nursing Facility Care\***

You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital

First 20 days	All approved amounts	\$0	\$0**
21st through 100th day	All but \$124 a day	\$0	Up to \$124 a day
101st day and after	\$0	\$0	All costs

**Blood**

First three pints	\$0	three pints	\$0**
Additional amounts	100%	\$0	\$0**

**Hospice Care**

Available as long as your doctor certifies you are terminally ill and you elect to receive these services

All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0		Balance
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**STANDARD PLAN B  
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

\*Once you have been billed \$131 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

<b>Services</b>	<b>Medicare Pays</b>	<b>Standard Plan B Pays</b>	<b>You Pay</b>
<b>Part B Services</b>			
<b>Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment</b> such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment			
First \$131 of Medicare-approved amounts*	\$0	\$0	\$131 (Part B Deductible)
Remainder of Medicare-approved amount	generally 80%	generally 20%	\$0**
Part B Excess Charges (Above Medicare-approved amounts)	\$0	\$0	All costs
<b>Blood</b>			
First three pints	\$0	All costs	\$0**
Next \$131 of Medicare-approved amounts*	\$0	\$0	\$131 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0**
<b>Clinical Laboratory Services — Blood Tests for Diagnostic Services</b>			
	100%	\$0	\$0**

**STANDARD PLAN B  
PARTS A & B**

\*Once you have been billed \$131 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

<b>Services</b>	<b>Medicare Pays</b>	<b>Standard Plan B Pays</b>	<b>You Pay</b>
<b>Part A+B Services</b>			
<b>Home Healthcare Medicare-approved Services</b>			
• Medically-necessary skilled care services and medical supplies	100%	\$0	\$0**
• Durable medical equipment			
First \$131 of Medicare-approved amounts*	\$0	\$0	\$131 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0**

**STANDARD PLAN C  
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

\*A benefit period begins on the first day you receive services 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

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

<b>Services</b>	<b>Medicare Pays</b>	<b>Standard Plan C Pays</b>	<b>You Pay</b>
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**Part  
A  
Services**

**Hospitalization\***

Semiprivate room and board, general nursing and miscellaneous hospital services and supplies:

First 60 days	All but \$992	\$992 (Part A Deductible)	\$0**
61st through 90th day	All but \$248 a day	\$248 a day	\$0**
91st day and after:			
• While using 60 lifetime reserve days	All but \$496 a day	\$496 a day	\$0**
• Once lifetime reserve days are used:			
— Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
— Beyond the additional 365 days	\$0	\$0	All costs

**Skilled Nursing Facility Care\***

You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital

First 20 days	All approved amounts	\$0	\$0**
21st through 100th day	All but \$124 a day	Up to \$124 a day	\$0**
101st day and after	\$0	\$0	All costs

**Blood**

First three pints	\$0	three pints	\$0**
Additional amounts	100%	\$0	\$0**

**Hospice Care**

Available as long as your doctor certifies you are terminally ill and you elect to receive these services

All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0		Balance
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**STANDARD PLAN C  
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

\*Once you have been billed \$131 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

<b>Services</b>	<b>Medicare Pays</b>	<b>Standard Plan C Pays</b>	<b>You Pay</b>
<b>Part B Services</b>			
<b>Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment</b> such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment			
First \$131 of Medicare-approved amounts*	\$0	\$131 (Part B Deductible)	\$0**
Remainder of Medicare-approved amount	generally 80%	generally 20%	\$0**
Part B Excess Charges (Above Medicare-approved amounts)	\$0	\$0	All Costs
<b>Blood</b>			
First three pints	\$0	All costs	\$0**
Next \$131 of Medicare-approved amounts*	\$0	\$131 (Part B Deductible)	\$0**
Remainder of Medicare-approved amounts	80%	20%	\$0**
<b>Clinical Laboratory Services — Blood Tests for Diagnostic Services</b>	100%	\$0	\$0**

**STANDARD PLAN C  
PARTS A & B**

\*Once you have been billed \$131 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

<b>Services</b>	<b>Medicare Pays</b>	<b>Standard Plan C Pays</b>	<b>You Pay</b>
<b>Part A+ Services</b>			
<b>Home Healthcare Medicare-approved Services</b>			
• Medically-necessary skilled care services and medical supplies	100%	\$0	\$0**
• Durable medical equipment			
First \$131 of Medicare-approved amounts*	\$0	\$131 (Part B Deductible)	\$0**
Remainder of Medicare-approved amounts	80%	20%	\$0**

**STANDARD PLAN C  
OTHER BENEFITS — NOT COVERED BY MEDICARE**

\*Once you have been billed \$131 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

<b>Services</b>	<b>Medicare Pays</b>	<b>Standard Plan C Pays</b>	<b>You Pay</b>
<b>Other Benefits</b>			
<b>Foreign Travel — Not Covered by Medicare</b>			
Medically-necessary emergency care services beginning during the first 60 days of each trip outside the United States			
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

**SELECT PLAN C  
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

\*A benefit period begins on the first day you receive services 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

\*\*\$0 indicates your liability for covered charges. **You are responsible for all other non-covered charges.**

\*\*\*Part A deductible covered only when using a network hospital.

<b>Services</b>	<b>Medicare Pays</b>	<b>SELECT Plan C Pays</b>	<b>You Pay</b>
<b>Hospitalization*</b>			
Semiprivate room and board, general nursing and miscellaneous hospital services and supplies:			
First 60 days	All but \$992	\$992 (Part A deductible) when using a network hospital only	\$0** when using a network hospital. \$992 (Part A Deductible) when using any other hospital***
61st through 90th day	All but \$248 a day	\$248 a day	\$0**
91st day and after:			
• While using 60 lifetime reserve days	All but \$496 a day	\$496 a day	\$0**
• Once lifetime reserve days are used:			
— Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
— Beyond the additional 365 days	\$0	\$0	All costs
<b>Skilled Nursing Facility Care*</b>			
You must meet Medicare’s requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0**
21st through 100th day	All but \$124 a day	Up to \$124 a day	\$0**
101st day and after	\$0	\$0	All costs
<b>Blood</b>			
First three pints	\$0	three pints	\$0**
Additional amounts	100%	\$0	\$0**
<b>Hospice Care</b>			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

**Part  
A  
Services**

**SELECT PLAN C  
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

\*Once you have been billed \$131 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

**Part  
B  
Services**

<b>Services</b>	<b>Medicare Pays</b>	<b>SELECT Plan C Pays</b>	<b>You Pay</b>
<b>Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment</b> such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment			
First \$131 of Medicare-approved amounts*	\$0	\$131 (Part B Deductible)	\$0**
Remainder of Medicare-approved amount	generally 80%	generally 20%	\$0**
Part B Excess Charges (Above Medicare-approved amounts)	\$0	\$0	All Costs
<b>Blood</b>			
First three pints	\$0	All costs	\$0**
Next \$131 of Medicare-approved amounts*	\$0	\$131 (Part B Deductible)	\$0**
Remainder of Medicare-approved amounts	80%	20%	\$0**
<b>Clinical Laboratory Services — Blood Tests for Diagnostic Services</b>			
	100%	\$0	\$0**

**SELECT PLAN C  
PARTS A & B**

\*Once you have been billed \$131 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

**Part  
A+  
B  
Services**

<b>Services</b>	<b>Medicare Pays</b>	<b>SELECT Plan C Pays</b>	<b>You Pay</b>
<b>Home Healthcare Medicare-approved Services</b>			
• Medically-necessary skilled care services and medical supplies	100%	\$0	\$0**
• Durable medical equipment			
First \$131 of Medicare-approved amounts*	\$0	\$131 (Part B Deductible)	\$0**
Remainder of Medicare-approved amounts	80%	20%	\$0**

**SELECT PLAN C  
OTHER BENEFITS — NOT COVERED BY MEDICARE**

\*Once you have been billed \$131 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

Services	Medicare Pays	SELECT Plan C Pays	You Pay	
<b>Other Benefits</b>	<b>Foreign Travel — Not Covered by Medicare</b> Medically-necessary emergency care services beginning during the first 60 days of each trip outside the United States			
	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

**STANDARD PLAN D  
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

\*A benefit period begins on the first day you receive services 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.

\*\* \$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

<b>Services</b>	<b>Medicare Pays</b>	<b>Standard Plan D Pays</b>	<b>You Pay</b>
<b>Hospitalization*</b>			
Semiprivate room and board, general nursing and miscellaneous hospital services and supplies:			
First 60 days	All but \$992	\$992 (Part A Deductible)	\$0**
61st through 90th day	All but \$248 a day	\$248 a day	\$0**
91st day and after:			
• While using 60 lifetime reserve days	All but \$496 a day	\$496 a day	\$0**
• Once lifetime reserve days are used:			
— Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
— Beyond the additional 365 days	\$0	\$0	All costs
<b>Skilled Nursing Facility Care*</b>			
You must meet Medicare’s requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0**
21st through 100th day	All but \$124 a day	Up to \$124 a day	\$0**
101st day and after	\$0	\$0	All costs
<b>Blood</b>			
First three pints	\$0	three pints	\$0**
Additional amounts	100%	\$0	\$0**
<b>Hospice Care</b>			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

**Part  
A  
Services**

**STANDARD PLAN D  
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

\*Once you have been billed \$131 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

\*\* \$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

<b>Services</b>	<b>Medicare Pays</b>	<b>Standard Plan D Pays</b>	<b>You Pay</b>
<b>Part B Services</b>			
<b>Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment</b> such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment			
First \$131 of Medicare-approved amounts*	\$0	\$0	\$131 (Part B Deductible)
Remainder of Medicare-approved amount	generally 80%	generally 20%	\$0**
Part B Excess Charges (Above Medicare-approved amounts)	\$0	\$0	All Costs
<b>Blood</b>			
First three pints	\$0	All costs	\$0**
Next \$131 of Medicare-approved amounts*	\$0	\$0	\$131 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0**
<b>Clinical Laboratory Services — Blood Tests for Diagnostic Services</b>			
	100%	\$0	\$0**

**STANDARD PLAN D  
PARTS A & B**

\*Once you have been billed \$131 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

\*\* \$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

<b>Services</b>	<b>Medicare Pays</b>	<b>Standard Plan D Pays</b>	<b>You Pay</b>
<b>Part A+B Services</b>			
<b>Home Healthcare Medicare-approved Services</b>			
• Medically-necessary skilled care services and medical supplies	100%	\$0	\$0**
• Durable medical equipment			
First \$131 of Medicare-approved amounts*	\$0	\$0	\$131 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0**
<b>Other Benefits Not covered by Medicare</b>			
<b>Foreign Travel — Not Covered by Medicare</b>			
Medically-necessary emergency care services beginning during the first 60 days of each trip outside the United States			
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
<b>At-home Recovery — Not Covered by Medicare</b>			
Includes short-term, at-home assistance with activities of daily living (bathing, dressing, personal hygiene, etc.) for those recovering from illness, injury or surgery			
Benefit for each visit	\$0	Actual charges up to \$40 per visit	Any charges above \$40 per visit
Number of visits covered (must be received within eight weeks of last Medicare-approved visits)	\$0	Up to the number of Medicare-approved visits, not to exceed seven each week	Any visits exceeding seven per week
Calendar year maximum	\$0	\$1,600	Any amount over \$1,600 per year

**STANDARD PLAN F  
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

\*A benefit period begins on the first day you receive services 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.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

<b>Services</b>	<b>Medicare Pays</b>	<b>Standard Plan F Pays</b>	<b>You Pay</b>
<b>Hospitalization*</b>			
Semiprivate room and board, general nursing and miscellaneous hospital services and supplies:			
First 60 days	All but \$992	\$992 (Part A Deductible)	\$0**
61st through 90th day	All but \$248 a day	\$248 a day	\$0**
91st day and after:			
• While using 60 lifetime reserve days	All but \$496 a day	\$496 a day	\$0**
• Once lifetime reserve days are used:			
— Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
— Beyond the additional 365 days	\$0	\$0	All costs
<b>Skilled Nursing Facility Care*</b>			
You must meet Medicare’s requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0**
21st through 100th day	All but \$124 a day	Up to \$124 a day	\$0**
101st day and after	\$0	\$0	All costs
<b>Blood</b>			
First three pints	\$0	three pints	\$0**
Additional amounts	100%	\$0	\$0**
<b>Hospice Care</b>			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

**Part  
A  
Services**

**STANDARD PLAN F  
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

\*Once you have been billed \$131 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

<b>Services</b>	<b>Medicare Pays</b>	<b>Standard Plan F Pays</b>	<b>You Pay</b>
<b>Part B Services</b>			
<b>Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment</b> such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment			
First \$131 of Medicare-approved amounts*	\$0	\$131 (Part B Deductible)	\$0**
Remainder of Medicare-approved amount	generally 80%	generally 20%	\$0**
Part B Excess Charges (Above Medicare-approved amounts)	\$0	100%	\$0**
<b>Blood</b>			
First three pints	\$0	All costs	\$0**
Next \$131 of Medicare-approved amounts*	\$0	\$131 (Part B Deductible)	\$0**
Remainder of Medicare-approved amounts	80%	20%	\$0**
<b>Clinical Laboratory Services — Blood Tests for Diagnostic Services</b>	100%	\$0	\$0**

**STANDARD PLAN F  
PARTS A & B**

\*Once you have been billed \$131 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

<b>Services</b>	<b>Medicare Pays</b>	<b>Standard Plan F Pays</b>	<b>You Pay</b>
<b>Home Healthcare Medicare-approved Services</b>			
• Medically-necessary skilled care services and medical supplies	100%	\$0	\$0**
• Durable medical equipment			
First \$131 of Medicare-approved amounts*	\$0	\$131 (Part B Deductible)	\$0**
Remainder of Medicare-approved amounts	80%	20%	\$0**

**Part  
A+B  
Services**

**STANDARD PLAN F  
OTHER BENEFITS — NOT COVERED BY MEDICARE**

\*Once you have been billed \$131 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

<b>Services</b>	<b>Medicare Pays</b>	<b>Standard Plan F Pays</b>	<b>You Pay</b>
<b>Other Benefits</b>			
<b>Foreign Travel — Not Covered by Medicare</b>			
Medically-necessary emergency care services beginning during the first 60 days of each trip outside the United States			
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

**SELECT PLAN F  
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

\*A benefit period begins on the first day you receive services 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.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

\*\*\*Part A deductible covered only when using a network hospital.

<b>Services</b>	<b>Medicare Pays</b>	<b>SELECT Plan F Pays</b>	<b>You Pay</b>
<b>Hospitalization*</b>			
Semiprivate room and board, general nursing and miscellaneous hospital services and supplies:			
First 60 days	All but \$992	\$992 (Part A Deductible) when using a network hospital only	\$0** when using a network hospital. \$992 (Part A Deductible) when using any other
hospital***			
61st through 90th day	All but \$248 a day	\$248 a day	\$0**
91st day and after:			
• While using 60 lifetime reserve days	All but \$496 a day	\$496 a day	\$0**
• Once lifetime reserve days are used:			
— Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
— Beyond the additional 365 days	\$0	\$0	All costs
<b>Skilled Nursing Facility Care*</b>			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0**
21st through 100th day	All but \$124 a day	Up to \$124 a day	\$0**
101st day and after	\$0	\$0	All costs
<b>Blood</b>			
First three pints	\$0	three pints	\$0**
Additional amounts	100%	\$0	\$0**
<b>Hospice Care</b>			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

**Part  
A  
Services**

**SELECT PLAN F  
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

\*Once you have been billed \$131 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

**Part  
B  
Services**

<b>Services</b>	<b>Medicare Pays</b>	<b>SELECT Plan F Pays</b>	<b>You Pay</b>
<b>Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment</b> such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment			
First \$131 of Medicare-approved amounts*	\$0	\$131 (Part B Deductible)	\$0**
Remainder of Medicare-approved amount	generally 80%	generally 20%	\$0**
Part B Excess Charges (Above Medicare-approved amounts)	\$0	100%	\$0**
<b>Blood</b>			
First three pints	\$0	All costs	\$0**
Next \$131 of Medicare-approved amounts*	\$0	\$131 (Part B Deductible)	\$0**
Remainder of Medicare-approved amounts	80%	20%	\$0**
<b>Clinical Laboratory Services — Blood Tests for Diagnostic Services</b>			
	100%	\$0	\$0**

**SELECT PLAN F  
PARTS A & B**

\*Once you have been billed \$131 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

**Part  
A+B  
Services**

<b>Services</b>	<b>Medicare Pays</b>	<b>SELECT Plan F Pays</b>	<b>You Pay</b>
<b>Home Healthcare Medicare-approved Services</b>			
• Medically-necessary skilled care services and medical supplies	100%	\$0	\$0**
• Durable medical equipment			
First \$131 of Medicare-approved amounts*	\$0	\$131 (Part B Deductible)	\$0**
Remainder of Medicare-approved amounts	80%	20%	\$0**

**SELECT PLAN F  
OTHER BENEFITS — NOT COVERED BY MEDICARE**

\*Once you have been billed \$131 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

\*\*\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

<b>Services</b>	<b>Medicare Pays</b>	<b>SELECT Plan F Pays</b>	<b>You Pay</b>	
<b>Other Benefits</b>	<b>Foreign Travel — Not Covered by Medicare</b> Medically-necessary emergency care services beginning during the first 60 days of each trip outside the United States			
	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



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