

Plan I

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

- * 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.
- ** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

| Services | Medicare Pays | Plan Pays | You Pay |
|---|---|------------------------------------|-----------|
| HOSPITALIZATION* - Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but \$1,100 | \$1,100 (Part A Deductible) | \$0 |
| 61 st through 90 th day | All but \$275 a day | \$275 a day | \$0 |
| 91 st day and after: | | | |
| – While using 60 lifetime reserve days | All but \$550 a day | \$550 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 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | \$0 | \$0 |
| 21 st through 100 th day | All but \$137.50 a day | Up to \$137.50 a day | \$0 |
| 101 st day and after | \$0 | \$0 | All costs |
| BLOOD – First 3 pints | \$0 | 3 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 |

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

- *** Once you have been billed \$155 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.

| Services | Medicare Pays | Plan Pays | You Pay |
|--|---------------|---------------|---------------------------|
| 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 \$155 of Medicare-approved amounts*** | \$0 | \$0 | \$155 (Part B Deductible) |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 20% | \$0 |
| PART B EXCESS CHARGES (Above Medicare-approved amounts) | \$0 | 100% | \$0 |

Plan I

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

*** Once you have been billed \$155 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.

| Services | Medicare Pays | Plan Pays | You Pay |
|--|---------------|-----------|---------------------------|
| BLOOD – First 3 pints | \$0 | All costs | \$0 |
| Next \$155 of Medicare-approved amounts*** | \$0 | \$0 | \$155 (Part B Deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | \$0 |
| CLINICAL LABORATORY SERVICES – Tests For Diagnostic Services | 100% | \$0 | \$0 |

PARTS A & B

| HOME HEALTH CARE – MEDICARE-APPROVED SERVICES | | | |
|---|------|---|---------------------------|
| – Medically necessary skilled care services and medical supplies | 100% | \$0 | \$0 |
| – Durable medical equipment: | | | |
| ▪ First \$155 of Medicare-approved amounts*** | \$0 | \$0 | \$155 (Part B Deductible) |
| ▪ Remainder of Medicare-approved amounts | 80% | 20% | \$0 |
| AT-HOME RECOVERY SERVICES – NOT COVERED BY MEDICARE – Home care certified by your doctor, for personal care during recovery from any injury or sickness for which Medicare approved a Home Care Treatment Plan | | | |
| – Benefit for each visit | \$0 | Actual charges up to \$40 a visit | Balance |
| – Number of visits covered (must be received within 8 weeks of last Medicare-approved visit) | \$0 | Up to the number of Medicare-Approved visits, not to exceed 7 each week | Balance |
| – Calendar year maximum | \$0 | \$1,600 | Balance |

OTHER BENEFITS – NOT COVERED BY MEDICARE

| FOREIGN TRAVEL – NOT COVERED BY MEDICARE – Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA | | | |
|---|-----|---|--|
| First \$250 each calendar year | \$0 | \$0 | \$250 |
| Remainder of Charges | \$0 | 80% to a lifetime maximum benefit of \$50,000 | 20% and amounts over the \$50,000 lifetime maximum |