



Medicare Supplement

Individual Insurance Outline of Coverage

Effective February 1, 2025

Benefit plans offered by Health Alliance: A, G, G High Deductible and N



3310 Fields South Drive, Champaign, Illinois 61822
(877) 933-0028 TTY 711
HealthAlliance.org

DISCRIMINATION IS AGAINST THE LAW

Health Alliance™ complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex (including discrimination on the basis of sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes). Health Alliance does not exclude people or treat them differently because of race, color, national origin, age, disability or sex (including discrimination on the basis of sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes). Health Alliance:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

Qualified sign language interpreters.

Written information in other formats (large print audio, accessible electronic formats, other formats).

Provides free language services to people whose primary language is not English, such as:

Qualified interpreters.

Information written in other languages.

If you need these services, contact Customer Service.

If you believe that Health Alliance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex (including discrimination on the basis of sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes), you can file a grievance with: Health Alliance Medicare, Member Services, 3310 Fields South Drive, Champaign, IL 61822, telephone for members: (800) 965-4022 TTY:711, fax: (217) 902-9705, MemberServices@HealthAlliance.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Member Services is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, (800) 368-1019, TTY: (800) 537-7697. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ATENCIÓN: Si habla Español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame (800) 965-4022 (TTY: 711).

注意: 如果你講中文，語言協助服務，免費的，都可以給你。呼叫 (800) 965-4022 (TTY: 711)。

UWAGA: Jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń (800) 965-4022 (TTY: 711).

LƯU Ý: Nếu bạn nói tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi (800) 965-4022 (TTY: 711).

주의: 한국어를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. (800) 965-4022로 전화하세요. (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вам доступны бесплатные услуги языковой помощи. Звоните (800) 965-4022. (TTY: 711).

Aird: Má tá Gaeilge agat, tá seirbhísí cúnaimh teanga, saor in aisce, ar fáil duit. Glaoigh ar (800) 965-4022 (TTY: 711). كنت إذا: تنبيه. (800) 965-4022 (النصي: الهاتف) بالرقم اتصل. مجاناً لك متاحة اللغوية المساعدة عندما فإن، العربية تحدث

Aufmerksamkeit: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Rufen Sie (800) 965-4022 an (TTY: 711).

ATTENTION: Si vous parlez français, des services d'assistance linguistique, gratuits, sont à votre disposition. Appelez le (800) 965-4022 (ATS: 711).

ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો ભાષા સહાય સેવાઓ, તમારા માટે નિ:શુલ્ક ઉપલબ્ધ છે. (800) 965-4022 પર કોલ કરો (TTY: 711).

注意: 日本語を話せる場合は、言語支援サービスを無料でご利用いただけます。(800) 965-4022 に電話してください。(TTY: 711)

LET OP: Als u Nederlands spreekt, zijn er gratis taalhulpdiensten voor u beschikbaar. Bel (800) 965-4022 (TTY: 711).

УВАГА: Якщо ви володієте українською мовою, вам надаються послуги мовної допомоги, безкоштовні. Телефонуйте (800) 965-4022 (TTY: 711).

ATTENZIONE: Se parli italiano sono a tua disposizione servizi di assistenza linguistica gratuiti. Chiama il numero (800) 965-4022 (TTY: 711).

Outline of Coverage

PREMIUM INFORMATION

Health Alliance Medical Plans, Inc. can only raise your premium if we raise the premium for all policies like yours in this State. We will not change your premium or cancel your policy because of poor health. If your premium changes, you will be notified at least 30 days in advance.

2025 MONTHLY PREMIUM RATES NORTHERN/CENTRAL AND SOUTHERN ILLINOIS

Rates shown are for Illinois residents living *outside* of Cook, DuPage, Kane, Lake, McHenry and Will counties. If you are an Illinois resident living in one of these counties, please call our toll-free number for the appropriate rates.

* Plan C and Plan F were previously available to individuals prior to 01/01/2020.

Non-Tobacco						
AGES	Plan A	Plan C*	Plan F*	Plan G	Plan G High Deductible	Plan N
Age <65	\$261	\$430	\$434	\$381	\$135	\$327
Age 65	\$100	\$166	\$167	\$148	\$51	\$126
Age 66	\$111	\$182	\$185	\$159	\$58	\$137
Age 67	\$121	\$199	\$201	\$175	\$63	\$151
Age 68	\$128	\$211	\$214	\$186	\$66	\$158
Age 69	\$134	\$221	\$224	\$196	\$70	\$169
Age 70	\$142	\$233	\$236	\$207	\$73	\$177
Age 71	\$150	\$245	\$249	\$217	\$79	\$186
Age 72	\$156	\$257	\$260	\$227	\$82	\$195
Age 73	\$163	\$269	\$272	\$238	\$86	\$203
Age 74	\$171	\$279	\$282	\$247	\$89	\$212
Age 75	\$177	\$292	\$295	\$257	\$92	\$220
Age 76	\$184	\$302	\$306	\$266	\$94	\$229
Age 77	\$188	\$311	\$315	\$276	\$98	\$236
Age 78	\$195	\$321	\$324	\$285	\$102	\$244
Age 79	\$201	\$332	\$336	\$294	\$105	\$251
Age 80	\$208	\$341	\$345	\$302	\$107	\$259
Age 81	\$214	\$352	\$356	\$310	\$111	\$266
Age 82	\$218	\$362	\$365	\$319	\$113	\$274
Age 83	\$225	\$371	\$375	\$328	\$117	\$281
Age 84	\$232	\$382	\$384	\$338	\$121	\$289
Age 85	\$236	\$389	\$394	\$343	\$124	\$295
Age 86	\$242	\$398	\$402	\$352	\$126	\$302
Age 87	\$246	\$407	\$410	\$360	\$128	\$308
Age 88	\$251	\$413	\$419	\$367	\$131	\$315
Age 89	\$256	\$424	\$428	\$373	\$133	\$320
Age 90+	\$261	\$430	\$434	\$381	\$135	\$327

* Plan C and Plan F were previously available to individuals who are Medicare eligible prior to 01/01/2020.

<i>Tobacco</i>						
AGES	Plan A	Plan C*	Plan F*	Plan G	Plan G High Deductible	Plan N
Age <65	\$279	\$462	\$469	\$409	\$148	\$352
Age 65	\$109	\$179	\$180	\$157	\$58	\$134
Age 66	\$119	\$196	\$198	\$174	\$62	\$149
Age 67	\$129	\$215	\$216	\$188	\$67	\$161
Age 68	\$136	\$227	\$229	\$199	\$71	\$173
Age 69	\$144	\$240	\$242	\$211	\$74	\$181
Age 70	\$152	\$250	\$254	\$221	\$80	\$189
Age 71	\$159	\$264	\$266	\$233	\$83	\$199
Age 72	\$167	\$277	\$278	\$244	\$88	\$210
Age 73	\$175	\$289	\$292	\$255	\$91	\$218
Age 74	\$182	\$301	\$305	\$265	\$94	\$228
Age 75	\$189	\$314	\$317	\$277	\$98	\$239
Age 76	\$197	\$324	\$328	\$287	\$103	\$246
Age 77	\$203	\$337	\$339	\$296	\$106	\$254
Age 78	\$210	\$345	\$349	\$307	\$110	\$263
Age 79	\$216	\$357	\$361	\$315	\$112	\$272
Age 80	\$223	\$368	\$371	\$324	\$116	\$278
Age 81	\$229	\$379	\$382	\$335	\$120	\$287
Age 82	\$234	\$388	\$392	\$342	\$122	\$294
Age 83	\$243	\$400	\$403	\$353	\$126	\$304
Age 84	\$249	\$410	\$413	\$363	\$129	\$310
Age 85	\$254	\$419	\$424	\$369	\$132	\$317
Age 86	\$260	\$428	\$431	\$379	\$135	\$324
Age 87	\$264	\$437	\$441	\$386	\$137	\$331
Age 88	\$272	\$445	\$452	\$395	\$141	\$339
Age 89	\$276	\$455	\$459	\$402	\$143	\$343
Age 90+	\$279	\$462	\$469	\$409	\$148	\$352

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

This outline shows benefits and premiums of policies sold for effective dates on or after January 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums.

NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application, and the coverage originally applied for has not been issued.

WARNING: The (policy or certificate) you have received is not the same as the one for which you made application.

READ YOUR POLICY VERY CAREFULLY.

This is only an outline, describing each policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and Health Alliance Medical Plans, Inc.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to Health Alliance Medical Plans, Inc., Attn: Medicare Department, 3310 Fields South Drive, Champaign, IL 61822. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, DO NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs.

Neither Health Alliance Medical Plans, Inc. nor its agents, are connected with Medicare.

This Outline of Coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare & You* for more details.

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. The company 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.



Outline of Medicare Supplement Coverage

Benefit Chart of Medicare Supplement Plans Sold for Effective Dates on or After June 1, 2010

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan A available. Some plans may not be available in Illinois.

BASIC BENEFITS: Included in all plans.

Hospitalization: Part A Coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B Coinsurance (generally 20% of Medicare-approved expenses) or co-payments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B Coinsurance or copayments.

Blood: First 3 pints of blood each year.

Hospice: Part A Coinsurance

Medicare Plans A-E				
A	B	C	D	E
Basic Benefits including 100% Part B Coinsurance	Basic Benefits including 100% Part B Coinsurance	Basic Benefits including 100% Part B Coinsurance	Basic Benefits including 100% Part B Coinsurance	Basic Benefits including 100% Part B Coinsurance
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible		
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery	
				Preventive Care NOT Covered by Medicare

Outline of Medicare Supplement Coverage

Medicare Plans F-J				
F or F*	G or G*	H	I	J or J*
Basic Benefits including 100% Part B Coinsurance	Basic Benefits including 100% Part B Coinsurance	Basic Benefits including 100% Part B Coinsurance	Basic Benefits including 100% Part B Coinsurance	Basic Benefits including 100% Part B Coinsurance
Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
Part B Deductible				Part B Deductible
Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
	At-Home Recovery		At-Home Recovery	At-Home Recovery
				Preventive Care NOT Covered by Medicare

* NOTE: **Plan F OR Plan G OR Plan J** also has an option called a high-deductible Plan F OR Plan G OR Plan J. This high deductible plan pays the same benefits as Plan F OR Plan G OR Plan J after one has paid a calendar year \$2,870 deductible. Benefits from high-deductible Plan F OR Plan G OR Plan J will not begin until out-of-pocket expenses exceed \$2,870. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

Medicare Plans K-L	
K**	L***
Hospitalization and Preventive Care paid at 100%; other Basic Benefits paid at 50%	Hospitalization and Preventive Care paid at 100%; other Basic Benefits paid at 75%
50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
50% Part A Deductible	75% Part A Deductible
100% after \$7,220 Out-of-Pocket Annual Limit reached	100% after \$3,610 Out-of-Pocket Annual Limit reached

** For Plan K: You will pay one-half of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$7,220 for the calendar year. The amounts that count 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 copayment 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** MSCMHA24-ooc-0724

“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.

*** For Plan L: You will pay one-half of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$3,610 for the calendar year. The amounts that count 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 copayment 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.**

Medicare Supplement Benefit Plan A
Individual Insurance
Outline of Coverage

Medicare Part A - Hospital Services - Per Benefit Period*			
	Medicare Pays	Health Alliance Pays	You Pay
Hospitalization*			
Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,676	\$0	\$1,676 (Part A Deductible)
61st thru 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after while using 60 lifetime reserve days	All but \$838 a day	\$838 a day	\$0
Once lifetime reserve days are used			
Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
Beyond 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 having entered a Medicare-approved facility within 30 days of leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$209.50 a day	\$0	Up to \$209.50 a 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

Medicare Part B Medical Services - Per Calendar Year			
	Medicare Pays	Health Alliance Pays	You Pay
Medical Expenses (In or Out of the Hospital) and Outpatient Hospital Treatment			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$257 of Medicare-approved amounts***	\$0	\$0	\$257 (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 \$257 of Medicare-approved amounts***	\$0	\$0	\$257 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services or Blood Tests for Diagnostic Services	100%	\$0	\$0
Medicare Parts A & B Services			
Home Health Care, Medicare-Approved Services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment:			
- First \$257 of Medicare-approved amounts***	\$0	\$0	\$257 (Part B Deductible)
- Remainder of Medicare-approved amounts	80%	20%	\$0
Other Benefits Not Covered by Medicare			
	Medicare Pays	Health Alliance Pays	You Pay
Foreign Travel - Not Covered by Medicare			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	All costs
Remainder of charges	\$0	\$0	All costs

* 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.

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** 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 "Basic Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

*** Once you have been billed \$257 of Medicare-approved amounts for covered services (which are noted with a ***), your Part B Deductible will have been met for the calendar year.

Medicare Supplement Benefit Plan C
Individual Insurance
Outline of Coverage

Medicare Part A - Hospital Services - Per Benefit Period*			
	Medicare Pays	Health Alliance Pays	You Pay
Hospitalization*			
Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,676	\$1,676 (Part A Deductible)	\$0
61st thru 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after while using 60 lifetime reserve days	All but \$838 a day	\$838 a day	\$0
Once lifetime reserve days are used			
Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
Beyond 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 having entered a Medicare-approved facility within 30 days of leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$209.50 a day	Up to \$209.50 a 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

Medicare Part B Medical Services - Per Calendar Year			
	Medicare Pays	Health Alliance Pays	You Pay
Medical Expenses (In or Out of the Hospital) and Outpatient Hospital Treatment			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$257 of Medicare-approved amounts***	\$0	\$257 (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 \$257 of Medicare-approved amounts***	\$0	\$257 (Part B Deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services or Blood Tests for Diagnostic Services	100%	\$0	\$0
Medicare Parts A & B Services			
Home Health Care, Medicare-Approved Services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment:			
- First \$257 of Medicare-approved amounts***	\$0	\$257 (Part B Deductible)	\$0
- Remainder of Medicare-approved amounts	80%	20%	\$0
Other Benefits Not Covered by Medicare			
Foreign Travel - Not Covered by Medicare			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amount over the \$50,000 lifetime maximum

* 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.

** 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 "Basic Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

*** Once you have been billed \$257 of Medicare-approved amounts for covered services (which are noted with a ***), your Part B Deductible will have been met for the calendar year.

Medicare Supplement Benefit Plan F/F*
Individual Insurance
Outline of Coverage

Medicare Part A - Hospital Services - Per Benefit Period**			
	Medicare Pays	Medicare Supplement Pays (High deductible plans must pay \$2,870 before cost sharing applies)*	You Pay (High deductible plans must pay \$2,870 before cost sharing applies)*
Hospitalization**			
Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,676	\$1,676 (Part A Deductible)	\$0
61st thru 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after while using 60 lifetime reserve days	All but \$838 a day	\$838 a day	\$0
Once lifetime reserve days are used			
Additional 365 days	\$0	100% of Medicare eligible expenses	\$0***
Beyond 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 having entered a Medicare-approved facility within 30 days of leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$209.50 a day	Up to \$209.50 a day	\$0
101st day and after	\$0	\$0	All costs

	Medicare Pays	Medicare Supplement Pays (High deductible plans must pay \$2,870 before cost sharing applies)*	You Pay (High deductible plans must pay \$2,870 before cost sharing applies)*
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
Medicare Part B Medical Services - Per Calendar Year			
Medical Expenses (In or Out of the Hospital) and Outpatient Hospital Treatment			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$257 of Medicare- approved amounts****	\$0	\$257 (Part B Deductible)	\$0
Remainder of Medicare- approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges			
Above Medicare-approved amounts	\$0	100%	\$0
Blood			
First 3 pints	\$0	All costs	\$0
Next \$257 of Medicare- approved amounts****	\$0	\$257 (Part B Deductible)	\$0
Remainder of Medicare- approved amounts	80%	20%	\$0
Clinical Laboratory Services or Blood Tests for Diagnostic Services	100%	\$0	\$0

Medicare Parts A & B Services			
	Medicare Pays	Medicare Supplement Pays (High deductible plans must pay \$2,870 before cost sharing applies)*	You Pay (High deductible plans must pay \$2,870 before cost sharing applies)*
Home Health Care, Medicare-Approved Services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment: - First \$257 of Medicare-approved amounts****	\$0	\$257 (Part Deductible)	\$0
- Remainder of Medicare-approved amounts	80%	20%	\$0
Other Benefits Not Covered by Medicare			
Foreign Travel - Not Covered by Medicare			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amount over the \$50,000 lifetime maximum

* NOTE: Plan F also has an option called a high-deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2,870 deductible. Benefits from high-deductible Plan F will not begin until out-of-pocket expenses exceed \$2,870. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

** 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.

*** 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 "Basic Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**** Once you have been billed \$257 of Medicare-approved amounts for covered services (which are noted with a ****), your Part B deductible will have been met for the calendar year.

Medicare Supplement Benefit Plan G/G*
Individual Insurance
Outline of Coverage

Medicare Part A - Hospital Services - Per Benefit Period**			
	Medicare Pays	Medicare Supplement Pays (High deductible plans must pay \$2,870 before cost sharing applies)*	You Pay (High deductible plans must pay \$2,870 before cost sharing applies)*
Hospitalization**			
Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,676	\$1,676 (Part A Deductible)	\$0
61st thru 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after while using 60 lifetime reserve days	All but \$838 a day	\$838 a day	\$0
Once lifetime reserve days are used			
Additional 365 days	\$0	100% of Medicare eligible expenses	\$0***
Beyond 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 having entered a Medicare-approved facility within 30 days of leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$209.50 a day	Up to \$209.50 a 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

Medicare Part B Medical Services - Per Calendar Year			
	Medicare Pays	Medicare Supplement Pays (High deductible plans must pay \$2,870 before cost sharing applies)*	You Pay (High deductible plans must pay \$2,870 before cost sharing applies)*
Medical Expenses (In or Out of the Hospital) and Outpatient Hospital Treatment Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$257 of Medicare-approved amounts****	\$0	\$0	\$257 (Part B Deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges			
Above Medicare-approved amounts	\$0	100%	\$0
Blood			
First 3 pints	\$0	All costs	\$0
Next \$257 of Medicare-approved amounts****	\$0	\$0	\$257 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services or Blood Tests for Diagnostic Services	100%	\$0	\$0
Medicare Parts A & B Services			
Home Health Care, Medicare-Approved Services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment:			
- First \$257 of Medicare-approved amounts****	\$0	\$0	\$257 (Part B Deductible)
- Remainder of Medicare-approved amounts	80%	20%	\$0

Other Benefits Not Covered by Medicare			
	Medicare Pays	Medicare Supplement Pays (High deductible plans must pay \$2,870 before cost sharing applies)*	You Pay (High deductible plans must pay \$2,870 before cost sharing applies)*
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 over the \$50,000 lifetime maximum

* NOTE: Plan G also has an option called a high-deductible Plan G. This high deductible plan pays the same benefits as Plan G after one has paid a calendar year \$2,870 deductible. Benefits from high-deductible Plan G will not begin until out-of-pocket expenses exceed \$2,870. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

** 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.

*** 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 "Basic Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**** Once you have been billed \$257 of Medicare-approved amounts for covered services (which are noted with a ****), your Part B deductible will have been met for the calendar year.

Medicare Supplement Benefit Plan N
Individual Insurance
Outline of Coverage

Medicare Part A - Hospital Services - Per Benefit Period*			
	Medicare Pays	Health Alliance Pays	You Pay
Hospitalization*			
Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,676	\$1,676 (Part A Deductible)	\$0
61st thru 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after while using 60 lifetime reserve days	All but \$838 a day	\$838 a day	\$0
Once lifetime reserve days are used			
Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
Beyond 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 having entered a Medicare-approved facility within 30 days of leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$209.50 a day	Up to \$209.50 a 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

Medicare Part B Medical Services - Per Calendar Year			
	Medicare Pays	Health Alliance Pays	You Pay
Medical Expenses (In or Out of the Hospital) and Outpatient Hospital Treatment			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$257 of Medicare-approved amounts***	\$0	\$0	\$257 (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	All costs
Blood			
First 3 pints	\$0	All costs	\$0
Next \$257 of Medicare-approved amounts***	\$0	\$0	\$257 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services or Blood Tests for Diagnostic Services	100%	\$0	\$0
Medicare Parts A & B Services			
Home Health Care, Medicare-Approved Services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment: - First \$257 of Medicare-approved amounts***	\$0	\$0	\$257 (Part B Deductible)
- Remainder of Medicare-approved amounts	80%	20%	\$0

Other Benefits Not Covered by Medicare			
	Medicare Pays	Health Alliance Pays	You Pay
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 over the \$50,000 lifetime maximum

* 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.

** 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 "Basic Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

*** Once you have been billed \$257 of Medicare-approved amounts for covered services (which are noted with a ***), your Part B Deductible will have been met for the calendar year.