



***2018 Outline of Coverage
for Arkansas Residents***

Outline of Medicare Supplement Coverage

Benefit Chart of Medicare Supplement Insurance plans

This chart shows the benefits included in each of the standard Medicare Supplement Insurance plans. Every company must make Plan A available. Some plans may not be available in Arkansas. MediQ65® offers benefit plans A, F, G, K and N. Plan F also offers a high deductible plan.

READING THE CHART: If the '■' appears in a column, the Medicare Supplement Insurance plan covers 100% of the described benefit. If a column lists a percentage, then the policy covers that percentage of the described benefit. If a column is blank, then the policy does not cover that benefit. Note: The Medicare Supplement Insurance plan covers coinsurance only after you have paid the deductible (unless the Medicare Supplement Insurance plan also covers the deductible).

Basic Benefits										
Hospitalization	Medical Expenses						Blood	Hospice		
Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.	Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insured to pay a portion of Part B coinsurance or copayments.						First three pints of blood each year	Part A coinsurance		
Medicare Supplement BENEFITS	A	B	C	D	F*	G	K	L	M	N**
Medicare Part A Coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used up (cost varies based on day)	■	■	■	■	■	■	■	■	■	■
Medicare Part B Coinsurance or Copayment (20% of Medicare Assignment)	■	■	■	■	■	■	50%	75%	■	■
Blood (First 3 units)	■	■	■	■	■	■	50%	75%	■	■
Part A Hospice Care Coinsurance or Copayment	■	■	■	■	■	■	50%	75%	■	■
Skilled Nursing Facility Care Coinsurance (cost varies based on day)			■	■	■	■	50%	75%	■	■
Medicare Part A Deductible		■	■	■	■	■	50%	75%	50%	■
Medicare Part B Deductible			■		■					
Medicare Part B Excess Charges (up to 15% above Medicare-approved amount if provider does not accept Medicare assignment)					■	■				
Foreign Travel Emergency (Up to Plan Limits)			■	■	■	■			■	■
Medicare Preventive Part B Coinsurance (most preventive screenings no longer require coinsurance payment)	■	■	■	■	■	■	■	■	■	■
Out-of-pocket annual limit for 2018 (will increase each year for inflation)							\$5,240	\$2,620		

*Plan F offers a high deductible plan. This plan pays the same benefits as Plan F after you've paid a calendar year deductible of \$2,240 (2018). Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed \$2,240. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include Medicare deductibles for Part A & Part B, but do not include the plan's separate foreign travel emergency deductible.

**Plan N pays 100% of the Part B coinsurance, except for a copayment of up to \$20 for some office visits and up to a \$50 copayment for emergency room visits that don't result in an inpatient admission.

Premium Information — MediQ65® Medicare Supplement Insurance Plans

Service Area

We are proud to offer our Medicare Supplement plans in these Arkansas counties: Ashley, Baxter, Benton, Boone, Bradley, Calhoun, Carroll, Clark, Columbia, Conway, Crawford, Dallas, Faulkner, Franklin, Garland, Grant, Hempstead, Hot Spring, Howard, Jefferson, Johnson, Lafayette, Little River, Logan, Lonoke, Madison, Marion, Miller, Montgomery, Nevada, Newton, Ouachita, Perry, Pike, Polk, Pope, Pulaski, Saline, Scott, Searcy, Sebastian, Sevier, Union, Van Buren, Washington and Yell.

Premium	Plan A	Plan F	Plan G	Plan K	Plan N	Plan F-HD
Monthly Rate*	\$123.44	\$189.60	\$141.65	\$68.48	\$114.90	\$61.50
Quarterly Rate	\$370.32	\$568.80	\$424.95	\$205.44	\$344.70	\$184.50

*A \$2.00 monthly service charge applies to monthly paper billing.

If you are under age 65, and on Medicare because of a disability: You may buy a Medicare supplement insurance policy. To learn more, call 1.855.MEDIQ65 (1.855.633.4765).



Premium Information

QualChoice can only raise your premium if we raise the premium for all policies like yours in the same service area as yours.

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 your insurance company.

Right to Return Policy

If you find that you are not satisfied with your **MediQ65®** policy, you have the right to return any policy within 30 days of receiving that policy to:

QualChoice Life and Health Insurance Company, Inc.

P.O. Box 25626

Little Rock, AR 72221-5626

If the policy is returned 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 QualChoice Life and Health Insurance Company 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 and You** for more details.

Complete Answers Are Very Important

When you fill out the application for the new policy, be sure to truthfully and completely answer 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. Keep a copy for your own file.



Plan A | Medicare Supplement Insurance Plans

Medicare Plan A (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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room & board, general nursing and miscellaneous services and supplies.			
Days 1-60	All but \$1,340	\$0	\$1,340 (Part A deductible)
Days 61-90	All but \$335 per day	\$335 per day	\$0
Days 91-150 (60 lifetime reserve days)	All but \$670 per day	\$670 per day	\$0
<i>Once lifetime reserve days are used:</i> 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.			
Days 1-20	All approved amounts	\$0	\$0
Days 21-100	All but \$167.50 per day	\$0	Up to \$167.50 per day
Days 101 and beyond	\$0	\$0	All costs
BLOOD			
First three pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0
HOSPICE CARE			
Must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited coinsurance/copayment for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, QualChoice 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.

Medicare Plan A (Part B) – Medical Services | Per Calendar Year

*Once you have been billed \$183 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. Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare* at **Medicare.gov**.

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 \$183 of Medicare-Approved Amounts*	\$0	\$0	\$183 (Part B deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare-Approved Amounts)	\$0	\$0	All costs
BLOOD			
First three pints	\$0	All costs	\$0
First \$183 of Medicare-Approved Amounts*	\$0	\$0	\$0 after 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 \$183 of Medicare-Approved Amounts*	\$0	\$0	\$0 after Part B deductible
Remainder of Medicare-Approved Amounts	80%	20%	\$0

Plan F | Medicare Supplement Insurance Plans

Medicare Plan F (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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room & board, general nursing and miscellaneous services and supplies.			
Days 1-60	All but \$1,340	\$1,340 (Part A deductible)	\$0
Days 61-90	All but \$335 per day	\$335 per day	\$0
Days 91-150 (60 lifetime reserve days)	All but \$670 per day	\$670 per day	\$0
<i>Once lifetime reserve days are used:</i> 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.			
Days 1-20	All approved amounts	\$0	\$0
Days 21-100	All but \$167.50 per day	Up to \$167.50 per day	\$0
Days 101 and beyond	\$0	\$0	All costs
BLOOD			
First three pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0
HOSPICE CARE			
Must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited coinsurance/copayment for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, QualChoice 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.

Medicare Plan F (Part B) – Medical Services | Per Calendar Year

*Once you have been billed \$183 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. Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare* at **Medicare.gov**.

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 \$183 of Medicare-Approved Amounts*	\$0	\$183 (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 three pints	\$0	All costs	\$0
First \$183 of Medicare-Approved Amounts*	\$0	\$183 (Part B deductible)	\$0
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 \$183 of Medicare-Approved Amounts*	\$0	\$183 (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 U.S.			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

Plan F High Deductible | Medicare Supplement Insurance Plans

Medicare Plan F (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.

**This high deductible plan pays the same benefits as Plan F after you have paid a calendar year deductible in the amount of \$2,240. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses reach \$2,240. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	After you pay \$2,240 deductible PLAN PAYS**	In addition to \$2,240 deductible YOU PAY **
HOSPITALIZATION* Semi-private room & board, general nursing and miscellaneous services and supplies.			
Days 1-60	All but \$1,340	\$1,340 (Part A deductible)	\$0
Days 61-90	All but \$335 per day	\$335 per day	\$0
Days 91-150 (60 lifetime reserve days)	All but \$670 per day	\$670 per day	\$0
<i>Once lifetime reserve days are used:</i> 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.			
Days 1-20	All approved amounts	\$0	\$0
Days 21-100	All but \$167.50 per day	Up to \$167.50 per day	\$0
Days 101 and beyond	\$0	\$0	All costs
BLOOD			
First three pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0
HOSPICE CARE			
Must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-insurance/copayment for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

*****NOTICE:** When your Medicare Part A hospital benefits are exhausted, QualChoice 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.

Medicare Plan F (Part B) – Medical Services | Per Calendar Year

*Once you have been billed \$183 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. Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare* at **Medicare.gov**.

**This high deductible plan pays the same benefits as Plan F after you have paid a calendar year deductible in the amount of \$2,240. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses reach \$2,240. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	After you pay \$2,240 deductible PLAN PAYS**	In addition to \$2,240 deductible 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 \$183 of Medicare-Approved Amounts*	\$0	\$183 (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 three pints	\$0	All costs	\$0
First \$183 of Medicare-Approved Amounts*	\$0	\$183 (Part B deductible)	\$0
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 \$183 of Medicare-Approved Amounts*	\$0	\$183 (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 U.S.			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

Plan G | Medicare Supplement Insurance Plans

Medicare Plan G (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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room & board, general nursing and miscellaneous services and supplies.			
Days 1-60	All but \$1,340	\$1,340 (Part A deductible)	\$0
Days 61-90	All but \$335 per day	\$335 per day	\$0
Days 91-150 (60 lifetime reserve days)	All but \$670 per day	\$670 per day	\$0
<i>Once lifetime reserve days are used:</i> 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 having entered a Medicare-approved facility within 30 days after leaving the hospital.			
Days 1-20	All approved amounts	\$0	\$0
Days 21-100	All but \$167.50 per day	Up to \$167.50 per day	\$0
Days 101 and beyond	\$0	\$0	All costs
BLOOD			
First three pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0
HOSPICE CARE			
Must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited coinsurance/copayment for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, QualChoice 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.

Medicare Plan G (Part B) – Medical Services | Per Calendar Year

*Once you have been billed \$183 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. Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare* at **Medicare.gov**.

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 \$183 of Medicare-Approved Amounts*	\$0	\$0	\$183 (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 three pints	\$0	All costs	\$0
First \$183 of Medicare-Approved Amounts*	\$0	\$0	\$0 after 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 \$183 of Medicare-Approved Amounts*	\$0	\$0	\$0 after Part B deductible
Remainder of Medicare-Approved Amounts	80%	20%	\$0

OTHER BENEFITS NOT COVERED BY MEDICARE

FOREIGN TRAVEL — not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

Plan K | Medicare Supplement Insurance Plans

Medicare Plan K (Part A) – Hospital Services | Per Benefit Period

*You will pay half of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$5,240 each calendar year. The amounts that count toward your annual limit are noted with '♦' 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.**

**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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY *
HOSPITALIZATION**			
Semi-private room & board, general nursing and miscellaneous services and supplies.			
Days 1-60	All but \$1,340	\$670 (50% of Part A deductible)	\$670 (50% of Part A deductible) ♦
Days 61-90	All but \$335 per day	\$335 per day	\$0
Days 91 -150 (60 lifetime reserve days)	All but \$670 per day	\$670 per day	\$0
<i>Once lifetime reserve days are used:</i> 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 having entered a Medicare-approved facility within 30 days after leaving the hospital.			
Days 1-20	All approved amounts	\$0	\$0
Days 21-100	All but \$167.50 per day	Up to \$83.75 per day	Up to \$83.75 per day ♦
Days 101 and beyond	\$0	\$0	All costs
BLOOD			
First three 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 coinsurance/copayment for outpatient drugs and inpatient respite care	50% of Medicare coinsurance/ copayment	50% of Medicare coinsurance/ copayment

*****NOTICE:** When your Medicare Part A hospital benefits are exhausted, QualChoice 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.

Medicare Plan K (Part B) – Medical Services | Per Calendar Year

*Once you have been billed \$183 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. Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare* at [Medicare.gov](https://www.medicare.gov).

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 \$183 of Medicare-Approved Amounts*	\$0	\$0	\$183 (Part B deductible)*♦
Preventive Benefits for Medicare covered services	Generally 80%	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 (they do not count toward annual out-of-pocket limit of \$5,240)**
BLOOD			
First three pints	\$0	50%	50% ♦
First \$183 of Medicare-Approved Amounts*	\$0	\$0	\$0 after deductible ♦
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
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 \$183 of Medicare-Approved Amounts*	\$0	\$0	\$0 after Part B deductible
Remainder of Medicare-Approved Amounts	80%	20%	\$0

**This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$5,240 per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called Excess Charges). You will be responsible for paying the difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

Plan N | Medicare Supplement Insurance Plans

Medicare Plan N (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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room & board, general nursing and miscellaneous services and supplies.			
Days 1-60	All but \$1,340	\$1,340 (Part A deductible)	\$0
Days 61-90	All but \$335 per day	\$335 per day	\$0
Days 91-150 (60 lifetime reserve days)	All but \$670 per day	\$670 per day	\$0
<i>Once lifetime reserve days are used:</i> 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 having entered a Medicare-approved facility within 30 days after leaving the hospital.			
Days 1-20	All approved amounts	\$0	\$0
Days 21-100	All but \$167.50 per day	Up to \$167.50 per day	\$0
Days 101 and beyond	\$0	\$0	All costs
BLOOD			
First three pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0
HOSPICE CARE			
Must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited coinsurance/copayment for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, QualChoice 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.

Medicare Plan N (Part B) – Medical Services | Per Calendar Year

*Once you have been billed \$183 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. Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare* at **Medicare.gov**.

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 \$183 of Medicare-Approved Amounts*	\$0	\$0	\$183 (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 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 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 three pints	\$0	All costs	\$0
First \$183 of Medicare-Approved Amounts*	\$0	\$0	\$0 after Part B deductible
Remainder of Medicare-Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES			
Tests for diagnostic services	100%	\$0	\$0

Continued on next page.

Plan N | Medicare Supplement Insurance Plans

Medicare Plan N (Parts A & B)

*Once you have been billed \$183 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. Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare* at **Medicare.gov**.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE — Medicare-Approved Services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable Medical Equipment: First \$183 of Medicare-Approved Amounts*	\$0	\$0	\$0 after Part B deductible
Remainder of Medicare-Approved Amounts	80%	20%	\$0
OTHER BENEFITS NOT COVERED BY MEDICARE			
FOREIGN TRAVEL — not covered by Medicare			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

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Medicare benefits are subject to change.

Notes

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

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