

# 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 \$2,370. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses reach \$2,370. 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 \$2,370 deductible PLAN PAYS** | In addition to \$2,370 deductible YOU PAY ** |
|--|---|--|--|
| <b>HOSPITALIZATION*</b>  |   |  |  |
| Semi-private room & board, general nursing and miscellaneous services and supplies.  |   |  |  |
| Days 1-60  | All but \$1,484   | \$1,484 (Part A deductible)                  | \$0  |
| Days 61-90   | All but \$371 per day   | \$371 per day                                | \$0  |
| Days 91-150 (60 lifetime reserve days)   | All but \$742 per day   | \$742 per day                                | \$0  |
| <i>Once lifetime reserve days are used:</i><br>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 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 \$185.50 per day  | Up to \$185.50 per day                       | \$0  |
| Days 101 and beyond  | \$0   | \$0  | All costs                                    |
| <b>BLOOD</b>   |   |  |  |
| First three pints  | \$0   | 3 pints                                      | \$0  |
| Additional Amounts   | 100%  | \$0  | \$0  |
| <b>HOSPICE CARE</b>  |   |  |  |
| 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.

**Call toll-free Monday – Friday 855.MEDIQ65 (855.633.4765) | (F) 501.707.6765 | MediQ65.com**

# Medicare Supplement Insurance Plans | High Deductible Plan F

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

\*Once you have been billed \$203 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).

\*\*This high deductible plan pays the same benefits as Plan F after you have paid a calendar year deductible in the amount of \$2,370. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses reach \$2,370. 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 \$2,370 deductible PLAN PAYS** | In addition to \$2,370 deductible YOU PAY ** |
|---|---------------|--|--|
| <b>MEDICAL EXPENSES</b> — 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 \$203 of Medicare-Approved Amounts*   | \$0           | \$203 (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  |
| <b>BLOOD</b>  |               |  |  |
| First three pints   | \$0           | All costs                                    | \$0  |
| First \$203 of Medicare-Approved Amounts*   | \$0           | \$203 (Part B deductible)                    | \$0  |
| Remainder of Medicare-Approved Amounts  | 80%           | 20%  | \$0  |
| <b>CLINICAL LABORATORY SERVICES</b>   |               |  |  |
| Tests for diagnostic services   | 100%          | \$0  | \$0  |

### Parts A & B

| <b>HOME HEALTH CARE</b> — Medicare-Approved Services                 |      |                           |     |
|--|------|---------------------------|-----|
| Medically necessary skilled care services and medical supplies       | 100% | \$0                       | \$0 |
| Durable Medical Equipment: First \$203 of Medicare-Approved Amounts* | \$0  | \$203 (Part B deductible) | \$0 |
| Remainder of Medicare-Approved Amounts                               | 80%  | 20%                       | \$0 |

### OTHER BENEFITS NOT COVERED BY MEDICARE

| <b>FOREIGN TRAVEL</b> – not covered by Medicare<br>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 |

\*\*\*Limited to the difference between the billed charge (not to exceed any charge limitation established by the Medicare program, state law or 15% over the Medicare-approved amount).

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