MediQ 65®

Medicare Supplement Insurance

# *2017 Outline of Coverage for Arkansas Residents*

QualChoice® HEALTH INSURANCE

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# 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 2017 (will increase each year for inflation) | | | | | | | $5,120 | $2,560 | | |

*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 $2,200 (2017). Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed $2,200. 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*** | $112.53 | $172.46 | $141.65 | $62.43 | $118.05 | $56.06 |
| **Quarterly Rate** | $337.59 | $517.38 | $424.95 | $187.29 | $354.15 | $168.18 |

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

## *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 $1,316 | $0 | $1,316 (Part A deductible) |
| Days 61-90 | All but $329 per day | $329 per day | $0 |
| Days 91-150 (60 lifetime reserve days) | All but $658 per day | $658 per 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. | | | |
| Days 1-20 | All approved amounts | $0 | $0 |
| Days 21-100 | All but $164.50 per day | $0 | Up to $164.50 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.



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## 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. 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 |
| Next $183 of Medicare-Approved Amounts* | $0 | $0 | $183 (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 | $183 (Part B deductible) |
| Remainder of Medicare-Approved Amounts | 80% | 20% | $0 |



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# 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 $1,316 | $1,316 (Part A deductible) | $0 |
| Days 61-90 | All but $329 per day | $329 per day | $0 |
| Days 91-150 (60 lifetime reserve days) | All but $658 per day | $658 per 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. | | | |
| Days 1-20 | All approved amounts | $0 | $0 |
| Days 21-100 | All but $164.50 per day | Up to $164.50 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.



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## 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. 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 |
| Next $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 |



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# 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 $2,200. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses reach $2,200. 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 $2,200 deductible PLAN PAYS** | In addition to $2,200 deductible YOU PAY ** |
|---|---|---|---|
| **HOSPITALIZATION*** Semi-private room & board, general nursing and miscellaneous services and supplies. | | | |
| Days 1-60 | All but $1,316 | $1,316 (Part A deductible) | $0 |
| Days 61-90 | All but $329 per day | $329 per day | $0 |
| Days 91-150 (60 lifetime reserve days) | All but $658 per day | $658 per 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. | | | |
| Days 1-20 | All approved amounts | $0 | $0 |
| Days 21-100 | All but $164.50 per day | Up to $164.50 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.



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## 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 $2,200. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses reach $2,200. 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 $2,200 deductible PLAN PAYS** | In addition to $2,200 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 |
| Next $183 of Medicare-Approved Amounts* | $0 | $183 (Part B deductible) | $0 |
| Remainder of Medicare-ApprovedAmounts | 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 |



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# 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 $1,316 | $1,316 (Part A deductible) | $0 |
| Days 61-90 | All but $329 per day | $329 per day | $0 |
| Days 91-150 (60 lifetime reserve days) | All but $658 per day | $658 per 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 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 $164.50 per day | Up to $164.50 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.



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## 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 |
| Next $183 of Medicare-Approved Amounts* | $0 | $0 | $183 (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 | $183 (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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# 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 $5,120 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****<br>Semi-private room & board, general nursing and miscellaneous services and supplies. | | | |
| Days 1-60 | All but $1,316 | $658 (50% of Part A deductible) | $658 (50% of Part A deductible) ♦ |
| Days 61-90 | All but $329 per day | $329 per day | $0 |
| Days 91 -150 (60 lifetime reserve days) | All but $658 per day | $658 per day | $0 |
| *Once lifetime reserve days are used:*<br>Additional 365 days | $0 | 100% of Medicare eligible expenses | $0*** |
| Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE****<br>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 $164.50 per day | Up to $82.25 per day | Up to $82.25 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.



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## 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**.

| 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 $5,120)** |
| **BLOOD** | | | |
| First three pints | $0 | 50% | 50% ♦ |
| Next $183 of Medicare-Approved Amounts* | $0 | $0 | $183 (Part B 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 | $183 (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 $5,120 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.



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# 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 $1,316 | $1,316 (Part A deductible) | $0 |
| Days 61-90 | All but $329 per day | $329 per day | $0 |
| Days 91-150 (60 lifetime reserve days) | All but $658 per day | $658 per 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 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 $164.50 per day | Up to $164.50 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.



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## 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 |
| Next $183 of Medicare-Approved Amounts* | $0 | $0 | $183 (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.*



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# Plan N | *Medicare Supplement Insurance Plans*

## Medicare Plan N (Parts A & B)

| 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 | $183 (Part B deductible) |
| Remainder of Medicare-Approved Amounts | 80% | 20% | $0 |
| **OTHER BENEFITS NOT COVERED BY MEDICARE** | | | |
| **FOREIGN TRAVEL** – 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 |





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Medicare benefits are subject to change.

## Notes



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MediQ65®

Medicare Supplement Insurance

*Underwritten by QualChoice Life and Health Insurance Company, Inc.*

**Toll Free 855.MEDIQ65 | (855.633.4765)**
**Monday–Friday, 8:00 a.m. to 5:00 p.m. (Central Time)**
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