Innovative Plan F Medicare (Part A)

Hospital services – per benefit period

Services	Medicare pays	Plan pays	You pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,556	$1,556 (Part A ded.)	$0
61st through 90th day	All but $389 a day	$389 a day	$0
91st day and after: • While using 60 lifetime reserve days	All but $778 a day	$778 a day	$0
• Once lifetime reserve days are used: – Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
– Beyond the additional 365 days	$0	$0	All costs
Skilled nursing facility care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $194.50 a day	Up to $194.50 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

*A benefit period begins on the first day you receive service(s) as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

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

Innovative Plan F Medicare (Part B)

Medical services – per calendar year

Services	Medicare pays	Plan pays	You pay
Medical expenses – in or out of the hospital and outpatient hospital treatment, such as doctor's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First $233 of Medicare-approved amounts*	$0	$233 (Part B ded.)	$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 $233 of Medicare-approved amounts*	$0	$233 (Part B ded.)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical laboratory services Tests for diagnostic services	100%	$0	$0

*Once you have been billed $233 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.

(Parts A and B)

Services	Medicare pays	Plan pays	You pay
Home health care – Medicare-approved services Medically necessary skilled care services and medical supplies such as durable medical equipment	100%	$0	$0
First $233 of Medicare-approved amounts*	$0	$233 (Part B ded.)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

Services	Medicare pays	Plan 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 U.S. First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

*Once you have been billed $233 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.

Innovative Plan F

Innovative benefits – Not covered by Medicare or standardized Medicare Supplement plans

Services	Medicare pays	Plan pays	You pay
Routine eye exam (with dilation as needed) once every 12 months	$0	In-network: 100% after the copayment Out-of-network: Up to $45 allowance	In-network: $10 copay Out-of-network: Any amounts remaining after the plan pays
Frame and lens package (Any frame and lens available at provider location) – once every 24 months	$0	Up to $250 allowance for frame and lens package	80% of the remaining balance
• Contact lenses – Includes materials only, once every 24 months – Conventional	$0	Up to $250 allowance	85% of the remaining balance
– Disposable	$0	Up to $250 allowance	100% of the remaining balance
– Medically Necessary	$0	Medically: $0 copay, paid in full	Up to $250
Routine hearing benefit Hearing exam – Coverage for up to (1) routine hearing exam every 12 months	$0	$0	$0
Hearing aids • Two hearing aids every calendar year • All sizes and styles offered by Hearing Care Solutions. • Four levels of technology to choose from. All instruments are fully digital. • Covered when determined to be medically necessary based on a hearing exam	$0	$0	Level 4 – $1,580 Level 3 – $1,125 Level 2 – $700 Level 1 – $0