

# 2026 Outline of Coverage

INDIVIDUAL MEDICARE SUPPLEMENT PLANS





# Health Net Life

## OUTLINE OF INDIVIDUAL MEDICARE SUPPLEMENT PLAN COVERAGE

Benefit plans A, D, F, High Deductible Plan F, Innovative Plan F, Plan G, High Deductible Plan G, Innovative Plan G and N are offered by Health Net Life Insurance Company (HNL)

*The chart on the next page shows the benefits included in each plan. Every insurance company must offer Plan A. Some plans may not be available.*

**The basic benefits included in all plans are:**



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

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**Blood:** First three pints of blood each year.

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**Hospice:** Part A coinsurance.

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**Medical expenses:** Medicare Part B coinsurance (usually 20 percent of the Medicare-approved amount) or copayments for hospital outpatient services. Plan N requires members to pay a portion of Part B coinsurance or copayments.

<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>	<b>F, High Deductible F,<sup>1</sup> Innovative Plan F<sup>2</sup></b>
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, 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		Part B deductible
				Part B excess (100%)
		Foreign travel emergency	Foreign travel emergency	Foreign travel emergency

<b>G, High Deductible G<sup>1</sup>, Innovative Plan G<sup>2</sup></b>	<b>K</b>	<b>L</b>	<b>M</b>	<b>N</b>
Basic, including 100% Part B coinsurance	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%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER
Skilled nursing facility coinsurance	50% skilled nursing facility coinsurance	75% skilled nursing facility coinsurance	Skilled nursing facility coinsurance	Skilled nursing facility coinsurance
Part A deductible	50% Part A deductible	75% Part A deductible	50% Part A deductible	Part A deductible
Part B excess (100%)				
Foreign travel emergency			Foreign travel emergency	Foreign travel emergency
	Out-of-pocket limit \$8,000; paid at 100% after limit reached	Out-of-pocket limit \$4,000; paid at 100% after limit reached		

<sup>1</sup>Plans F and G also have a High Deductible Plan option. These high deductible plans pay the same benefits as Plan F or Plan G after the member has paid a calendar year \$2,950 deductible. Benefits from High Deductible Plan F or High Deductible Plan G will not begin until out-of-pocket expenses exceed \$2,950. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by this policy.

<sup>2</sup>Innovative Plan F and Innovative Plan G includes additional benefits not contained in other standardized Medicare Supplement Plans as outlined in the following pages. Shaded plans are currently not offered by Health Net.

## Premium information

We, Health Net Life Insurance Company (HNL), can only raise your premium if we raise the premium for all policies like yours in California. Premiums in this *Outline of Coverage* will increase periodically due to the increase in your age. Upon attainment of an age requiring a rate increase, the renewal premium for the Medicare Supplement Plan Policy will be the renewal premium in effect for your attained age. You will receive written notification of any changes in payment fees at least 30 days prior to the effective date of the new rate. Your premium will also be adjusted when you move to a county in a different rating region as set out in this *Outline of Coverage*. The adjustment will be effective on the first of the month following your change of address.

HNL provides an initial 6-month rate guarantee to members enrolling for the first time into an HNL Medicare Supplement plan. During your 6-month rate guarantee period, your premium will not increase even if HNL has a rate increase or you have a birthday which moves you into the next higher age rate bracket. If, during your 6-month rate guarantee period, you choose to enroll in a different HNL Medicare Supplement plan, your 6-month rate guarantee period will end, and you will be charged the premium for the new plan selected.

The term of your health plan is month-to-month, commencing on the date set forth in the Notice of Acceptance. Your coverage will remain in effect for each month for which premiums are received on or before the date they are due, or within the grace period.

This plan is subject to  
Guaranteed Renewability



**HNL offers various payment options: monthly billing, Automatic Bank Draft (ABD) and via phone with a debit or credit card with a Visa or Mastercard logo.**

# Choosing the Right Medicare Supplement Plan for Your Needs

Please review the following pages to learn about plan options, monthly premiums and detailed benefit descriptions.

Once you have selected a plan, your monthly premium is based on your age at the time of enrollment, and county or zip code (where applicable) where you reside. Los Angeles and San Diego County monthly premiums are rated by zip code for plans D, High Deductible G, Innovative Plan G and N. For plans A, F, High Deductible F, Innovative F, and G (refer to region 3 for Los Angeles and region 2 for San Diego), rates are based on age at the time of enrollment, and not specific zip codes.

After locating your monthly premium for a particular plan, please review each of the Medicare Supplement plan descriptions in this booklet. You'll find benefit information, details on covered services, and what each plan pays.



## Los Angeles County (Region 1)

Los Angeles County monthly premiums are rated by zip code for plans D, High Deductible G, Innovative Plan G and N. For plans A, F, High Deductible F, Innovative F, and G (refer to region 3), rates are based on age at the time of enrollment, and not specific zip codes.

Region 1 Zip Codes (Within Los Angeles County)			
90001	90060	90266 - 90270	91016
90004 - 90007	90063	90274 - 90280	91030
90009	90065	90295 - 90296	91105
90011 - 90015	90071	90501	91204 - 91206
90017	90081	90503 - 90505	91702 - 91722
90021 - 90023	90083 - 90088	90507 - 90707	91724 - 91735
90026 - 90027	90090 - 90091	90711 - 90734	91744 - 91756
90029 - 90033	90096	90748	91765 - 91773
90039 - 90042	90099 - 90202	90755 - 90804	91776
90050	90239 - 90242	90806 - 90809	91780 - 91793
90053 - 90055	90254 - 90255	90813 - 90899	92821 - 92823
90057 - 90058		91010	

Age range	Nonsmoking			
	Plan D	High Ded. G	Innovative Plan G	Plan N
65-66	\$194	\$83	\$199	\$168
67-68	\$215	\$94	\$222	\$187
69-70	\$239	\$104	\$243	\$207
71-72	\$262	\$114	\$265	\$226
73-74	\$285	\$124	\$287	\$246
75-76	\$309	\$134	\$310	\$267
77-78	\$332	\$147	\$333	\$287
79-80	\$354	\$153	\$354	\$305
81-82	\$377	\$165	\$377	\$327
83-84	\$401	\$174	\$397	\$345
85-86	\$422	\$185	\$419	\$365
87-88	\$442	\$192	\$439	\$383
89-90	\$459	\$200	\$457	\$397
91-92	\$478	\$208	\$474	\$414
93-94	\$493	\$215	\$490	\$428
95+	\$524	\$228	\$518	\$451
Disabled under 65	\$524	\$228	\$518	\$451

Age range	Smoking <sup>1</sup>			
	Plan D	High Ded. G	Innovative Plan G	Plan N
65-66	\$225	\$99	\$229	\$196
67-68	\$255	\$111	\$256	\$221
69-70	\$280	\$122	\$281	\$240
71-72	\$304	\$132	\$306	\$264
73-74	\$332	\$147	\$333	\$287
75-76	\$358	\$155	\$359	\$311
77-78	\$390	\$171	\$388	\$336
79-80	\$414	\$180	\$412	\$358
81-82	\$438	\$192	\$437	\$379
83-84	\$465	\$202	\$463	\$403
85-86	\$492	\$215	\$489	\$425
87-88	\$513	\$225	\$510	\$445
89-90	\$537	\$235	\$529	\$464
91-92	\$556	\$243	\$550	\$481
93-94	\$578	\$252	\$570	\$498
95+	\$610	\$267	\$600	\$525
Disabled under 65	\$610	\$267	\$600	\$525

<sup>1</sup>A tobacco premium rate applies if you have smoked or used any tobacco products in the past two (2) years.

## Los Angeles County (Region 2)

Los Angeles County monthly premiums are rated by zip code for plans D, High Deductible G, Innovative Plan G and N. For plans A, F, High Deductible F, Innovative F, and G (refer to region 3), rates are based on age at the time of enrollment, and not specific zip codes.

Region 2 Zip Codes (Within Los Angeles County)	
91001 - 91009	92397
91011 - 91012	93243 - 93591
91017 - 91025	91354 - 91355
91031	91380 - 91390
91041 - 91104	91394
91106 - 91203	91501 - 91504
91207 - 91226	91507 - 91526
91310	91723
91321 - 91322	91740 - 91741
91326 - 91327	91759
91350 - 91351	91775
91801-91899	91778

Age range	Nonsmoking			
	Plan D	High Ded. G	Innovative Plan G	Plan N
65-66	\$183	\$79	\$188	\$158
67-68	\$207	\$91	\$211	\$178
69-70	\$225	\$99	\$229	\$196
71-72	\$248	\$107	\$251	\$214
73-74	\$270	\$118	\$272	\$232
75-76	\$291	\$126	\$292	\$251
77-78	\$315	\$138	\$316	\$272
79-80	\$335	\$147	\$335	\$289
81-82	\$357	\$155	\$356	\$309
83-84	\$378	\$165	\$377	\$328
85-86	\$401	\$174	\$397	\$345
87-88	\$418	\$182	\$416	\$361
89-90	\$434	\$189	\$432	\$376
91-92	\$452	\$198	\$449	\$391
93-94	\$468	\$203	\$464	\$404
95+	\$493	\$215	\$490	\$428
Disabled under 65	\$493	\$215	\$490	\$428

Age range	Smoking <sup>1</sup>			
	Plan D	High Ded. G	Innovative Plan G	Plan N
65-66	\$214	\$94	\$218	\$185
67-68	\$239	\$104	\$243	\$207
69-70	\$265	\$117	\$267	\$228
71-72	\$289	\$126	\$291	\$251
73-74	\$315	\$138	\$316	\$272
75-76	\$341	\$149	\$341	\$294
77-78	\$369	\$160	\$366	\$317
79-80	\$391	\$171	\$389	\$338
81-82	\$417	\$182	\$415	\$360
83-84	\$442	\$192	\$439	\$383
85-86	\$466	\$203	\$464	\$404
87-88	\$487	\$213	\$483	\$420
89-90	\$507	\$223	\$502	\$439
91-92	\$526	\$229	\$521	\$454
93-94	\$547	\$239	\$540	\$473
95+	\$578	\$252	\$570	\$498
Disabled under 65	\$578	\$252	\$570	\$498

<sup>1</sup>A tobacco premium rate applies if you have smoked or used any tobacco products in the past two (2) years.

### Los Angeles County (Region 3)

Los Angeles County monthly premiums are rated by zip code for plans D, High Deductible G, Innovative Plan G and N. For plans A, F, High Deductible F, Innovative F, and G, rates are based on age at the time of enrollment, and not specific zip codes.

Region 3 Zip Codes (Within Los Angeles County)				
90002 - 90003	90051 - 90052	90744 - 90747	90072 - 90080	91324 - 91325
90008	90056	90749	90082	91328 - 91346
90010	90260 - 90265	90805	90089	91352 - 91353
90016	90272	90810	90093 - 90095	91356 - 91376
90018 - 90020	90290 - 90294	91040	90209 - 90233	91392 - 91393
90024 - 90025	90301 - 90411	90059	90245 - 90251	91395 - 91436
90028	90502	90061 - 90062	93599	91470 - 91499
90034 - 90038	90506	90064	91301 - 91309	91505 - 91506
90043 - 90049	90710	90066 - 90070	91311 - 91316	91601 - 91618

Age range	Nonsmoking				
	Plan A	Plan F	High Ded. F	Innovative Plan F	Plan G
65-66	\$177	\$251	\$103	\$258	\$224
67-68	\$195	\$277	\$115	\$285	\$247
69-70	\$211	\$301	\$126	\$310	\$269
71-72	\$228	\$327	\$134	\$332	\$289
73-74	\$245	\$350	\$146	\$358	\$313
75-76	\$264	\$376	\$155	\$383	\$335
77-78	\$280	\$401	\$166	\$406	\$356
79-80	\$296	\$421	\$175	\$429	\$376
81-84	\$318	\$454	\$188	\$462	\$405
85+	\$357	\$510	\$212	\$516	\$454
Disabled under 65	\$357	\$510	\$212	\$516	\$454

Age range	Smoking <sup>1</sup>				
	Plan A	Plan F	High Ded. F	Innovative Plan F	Plan G
65-66	\$206	\$294	\$120	\$299	\$260
67-68	\$225	\$324	\$134	\$330	\$288
69-70	\$246	\$354	\$147	\$359	\$315
71-72	\$267	\$379	\$158	\$386	\$338
73-74	\$287	\$409	\$171	\$418	\$365
75-76	\$305	\$437	\$182	\$445	\$390
77-78	\$327	\$466	\$195	\$475	\$416
79-80	\$345	\$492	\$204	\$500	\$439
81-84	\$372	\$531	\$220	\$538	\$473
85+	\$417	\$595	\$246	\$600	\$527
Disabled under 65	\$417	\$595	\$246	\$600	\$527

### Los Angeles County (Region 3)

Age range	Nonsmoking			
	Plan D	High Ded. G	Innovative Plan G	Plan N
65-66	\$214	\$94	\$218	\$185
67-68	\$239	\$104	\$243	\$207
69-70	\$264	\$114	\$267	\$227
71-72	\$288	\$126	\$289	\$250
73-74	\$315	\$138	\$316	\$272
75-76	\$341	\$149	\$341	\$294
77-78	\$369	\$160	\$366	\$317
79-80	\$391	\$171	\$389	\$338
81-82	\$416	\$180	\$414	\$359
83-84	\$439	\$192	\$438	\$380
85-86	\$466	\$203	\$464	\$404
87-88	\$487	\$213	\$483	\$420
89-90	\$506	\$222	\$501	\$438
91-92	\$526	\$229	\$521	\$454
93-94	\$546	\$238	\$540	\$471
95+	\$578	\$252	\$570	\$498
Disabled under 65	\$578	\$252	\$570	\$498

Age range	Smoking <sup>1</sup>			
	Plan D	High Ded. G	Innovative Plan G	Plan N
65-66	\$248	\$107	\$252	\$215
67-68	\$282	\$123	\$282	\$241
69-70	\$309	\$134	\$310	\$267
71-72	\$338	\$148	\$338	\$292
73-74	\$366	\$160	\$365	\$317
75-76	\$395	\$173	\$394	\$343
77-78	\$429	\$187	\$425	\$370
79-80	\$454	\$199	\$451	\$393
81-82	\$483	\$212	\$481	\$419
83-84	\$513	\$225	\$510	\$445
85-86	\$542	\$238	\$538	\$470
87-88	\$567	\$248	\$562	\$491
89-90	\$591	\$259	\$585	\$512
91-92	\$613	\$268	\$607	\$533
93-94	\$636	\$277	\$627	\$550
95+	\$672	\$294	\$663	\$582
Disabled under 65	\$672	\$294	\$663	\$582

<sup>1</sup>A tobacco premium rate applies if you have smoked or used any tobacco products in the past two (2) years.

### Orange County (Region 3)

Age range	Nonsmoking				
	Plan A	Plan F	High Ded. F	Innovative Plan F	Plan G
65-66	\$177	\$251	\$103	\$258	\$224
67-68	\$195	\$277	\$115	\$285	\$247
69-70	\$211	\$301	\$126	\$310	\$269
71-72	\$228	\$327	\$134	\$332	\$289
73-74	\$245	\$350	\$146	\$358	\$313
75-76	\$264	\$376	\$155	\$383	\$335
77-78	\$280	\$401	\$166	\$406	\$356
79-80	\$296	\$421	\$175	\$429	\$376
81-84	\$318	\$454	\$188	\$462	\$405
85+	\$357	\$510	\$212	\$516	\$454
Disabled under 65	\$357	\$510	\$212	\$516	\$454

Age range	Smoking <sup>1</sup>				
	Plan A	Plan F	High Ded. F	Innovative Plan F	Plan G
65-66	\$206	\$294	\$120	\$299	\$260
67-68	\$225	\$324	\$134	\$330	\$288
69-70	\$246	\$354	\$147	\$359	\$315
71-72	\$267	\$379	\$158	\$386	\$338
73-74	\$287	\$409	\$171	\$418	\$365
75-76	\$305	\$437	\$182	\$445	\$390
77-78	\$327	\$466	\$195	\$475	\$416
79-80	\$345	\$492	\$204	\$500	\$439
81-84	\$372	\$531	\$220	\$538	\$473
85+	\$417	\$595	\$246	\$600	\$527
Disabled under 65	\$417	\$595	\$246	\$600	\$527

<sup>1</sup>A tobacco premium rate applies if you have smoked or used any tobacco products in the past two (2) years.

### Orange County (Region 3)

Age range	Nonsmoking			
	Plan D	High Ded. G	Innovative Plan G	Plan N
65-66	\$214	\$94	\$218	\$185
67-68	\$239	\$104	\$243	\$207
69-70	\$264	\$114	\$267	\$227
71-72	\$288	\$126	\$289	\$250
73-74	\$315	\$138	\$316	\$272
75-76	\$341	\$149	\$341	\$294
77-78	\$369	\$160	\$366	\$317
79-80	\$391	\$171	\$389	\$338
81-82	\$416	\$180	\$414	\$359
83-84	\$439	\$192	\$438	\$380
85-86	\$466	\$203	\$464	\$404
87-88	\$487	\$213	\$483	\$420
89-90	\$506	\$222	\$501	\$438
91-92	\$526	\$229	\$521	\$454
93-94	\$546	\$238	\$540	\$471
95+	\$578	\$252	\$570	\$498
Disabled under 65	\$578	\$252	\$570	\$498

Age range	Smoking <sup>1</sup>			
	Plan D	High Ded. G	Innovative Plan G	Plan N
65-66	\$248	\$107	\$252	\$215
67-68	\$282	\$123	\$282	\$241
69-70	\$309	\$134	\$310	\$267
71-72	\$338	\$148	\$338	\$292
73-74	\$366	\$160	\$365	\$317
75-76	\$395	\$173	\$394	\$343
77-78	\$429	\$187	\$425	\$370
79-80	\$454	\$199	\$451	\$393
81-82	\$483	\$212	\$481	\$419
83-84	\$513	\$225	\$510	\$445
85-86	\$542	\$238	\$538	\$470
87-88	\$567	\$248	\$562	\$491
89-90	\$591	\$259	\$585	\$512
91-92	\$613	\$268	\$607	\$533
93-94	\$636	\$277	\$627	\$550
95+	\$672	\$294	\$663	\$582
Disabled under 65	\$672	\$294	\$663	\$582

<sup>1</sup>A tobacco premium rate applies if you have smoked or used any tobacco products in the past two (2) years.

**San Diego County (Region 1)**

San Diego County monthly premiums are rated by zip code for plans D, High Deductible G, Innovative Plan G and N. For plans A, F, High Deductible F, Innovative F, and G (refer to region 2), rates are based on age at the time of enrollment, and not specific zip codes.

<b>Region 1 Zip Codes (Within San Diego County)</b>	
91901 - 92013	92143
92018 - 92036	92153 - 92155
92040 - 92061	92170
92065 - 92072	92173
92075 - 92091	92179
92096	

Age range	Nonsmoking			
	Plan D	High Ded. G	Innovative Plan G	Plan N
65-66	\$194	\$83	\$199	\$168
67-68	\$215	\$94	\$222	\$187
69-70	\$239	\$104	\$243	\$207
71-72	\$262	\$114	\$265	\$226
73-74	\$285	\$124	\$287	\$246
75-76	\$309	\$134	\$310	\$267
77-78	\$332	\$147	\$333	\$287
79-80	\$354	\$153	\$354	\$305
81-82	\$377	\$165	\$377	\$327
83-84	\$401	\$174	\$397	\$345
85-86	\$422	\$185	\$419	\$365
87-88	\$442	\$192	\$439	\$383
89-90	\$459	\$200	\$457	\$397
91-92	\$478	\$208	\$474	\$414
93-94	\$493	\$215	\$490	\$428
95+	\$524	\$228	\$518	\$451
Disabled under 65	\$524	\$228	\$518	\$451

Age range	Smoking <sup>1</sup>			
	Plan D	High Ded. G	Innovative Plan G	Plan N
65-66	\$225	\$99	\$229	\$196
67-68	\$255	\$111	\$256	\$221
69-70	\$280	\$122	\$281	\$240
71-72	\$304	\$132	\$306	\$264
73-74	\$332	\$147	\$333	\$287
75-76	\$358	\$155	\$359	\$311
77-78	\$390	\$171	\$388	\$336
79-80	\$414	\$180	\$412	\$358
81-82	\$438	\$192	\$437	\$379
83-84	\$465	\$202	\$463	\$403
85-86	\$492	\$215	\$489	\$425
87-88	\$513	\$225	\$510	\$445
89-90	\$537	\$235	\$529	\$464
91-92	\$556	\$243	\$550	\$481
93-94	\$578	\$252	\$570	\$498
95+	\$610	\$267	\$600	\$525
Disabled under 65	\$610	\$267	\$600	\$525

<sup>1</sup>A tobacco premium rate applies if you have smoked or used any tobacco products in the past two (2) years.

## San Diego County (Region 2)

San Diego County monthly premiums are rated by zip code for plans D, High Deductible G, Innovative Plan G and N. For plans A, F, High Deductible F, Innovative F, and G, rates are based on age at the time of enrollment, and not specific zip codes.

Region 2 Zip Codes (Within San Diego County)	
92014	92145 - 92152
92037 - 92039	92158 - 92169
92064	92171 - 92172
92074	92174 - 92178
92092 - 92093	92182 - 92199
92101-92142	

Age range	Nonsmoking				
	Plan A	Plan F	High Ded. F	Innovative Plan F	Plan G
65-66	\$155	\$223	\$92	\$229	\$199
67-68	\$174	\$246	\$102	\$255	\$221
69-70	\$188	\$269	\$111	\$274	\$239
71-72	\$203	\$289	\$119	\$297	\$259
73-74	\$219	\$313	\$129	\$319	\$277
75-76	\$235	\$334	\$138	\$342	\$298
77-78	\$248	\$356	\$148	\$362	\$317
79-80	\$264	\$376	\$155	\$383	\$335
81-84	\$284	\$405	\$167	\$412	\$361
85+	\$317	\$453	\$187	\$461	\$404
Disabled under 65	\$317	\$453	\$187	\$461	\$404

Age range	Smoking <sup>1</sup>				
	Plan A	Plan F	High Ded. F	Innovative Plan F	Plan G
65-66	\$183	\$260	\$109	\$268	\$231
67-68	\$202	\$288	\$119	\$296	\$257
69-70	\$221	\$315	\$130	\$320	\$280
71-72	\$237	\$340	\$139	\$345	\$301
73-74	\$256	\$365	\$152	\$372	\$325
75-76	\$272	\$390	\$161	\$395	\$346
77-78	\$291	\$417	\$173	\$422	\$370
79-80	\$305	\$437	\$182	\$445	\$390
81-84	\$330	\$474	\$196	\$479	\$420
85+	\$371	\$529	\$219	\$536	\$470
Disabled under 65	\$371	\$529	\$219	\$536	\$470

**San Diego County (Region 2)**

Age range	Nonsmoking			
	Plan D	High Ded. G	Innovative Plan G	Plan N
65-66	\$183	\$79	\$188	\$158
67-68	\$207	\$91	\$211	\$178
69-70	\$225	\$99	\$229	\$196
71-72	\$248	\$107	\$251	\$214
73-74	\$270	\$118	\$272	\$232
75-76	\$291	\$126	\$292	\$251
77-78	\$315	\$138	\$316	\$272
79-80	\$335	\$147	\$335	\$289
81-82	\$357	\$155	\$356	\$309
83-84	\$378	\$165	\$377	\$328
85-86	\$401	\$174	\$397	\$345
87-88	\$418	\$182	\$416	\$361
89-90	\$434	\$189	\$432	\$376
91-92	\$452	\$198	\$449	\$391
93-94	\$468	\$203	\$464	\$404
95+	\$493	\$215	\$490	\$428
Disabled under 65	\$493	\$215	\$490	\$428

Age range	Smoking <sup>1</sup>			
	Plan D	High Ded. G	Innovative Plan G	Plan N
65-66	\$214	\$94	\$218	\$185
67-68	\$239	\$104	\$243	\$207
69-70	\$265	\$117	\$267	\$228
71-72	\$289	\$126	\$291	\$251
73-74	\$315	\$138	\$316	\$272
75-76	\$341	\$149	\$341	\$294
77-78	\$369	\$160	\$366	\$317
79-80	\$391	\$171	\$389	\$338
81-82	\$417	\$182	\$415	\$360
83-84	\$442	\$192	\$439	\$383
85-86	\$466	\$203	\$464	\$404
87-88	\$487	\$213	\$483	\$420
89-90	\$507	\$223	\$502	\$439
91-92	\$526	\$229	\$521	\$454
93-94	\$547	\$239	\$540	\$473
95+	\$578	\$252	\$570	\$498
Disabled under 65	\$578	\$252	\$570	\$498

<sup>1</sup>A tobacco premium rate applies if you have smoked or used any tobacco products in the past two (2) years.

**Alameda, Contra Costa, Shasta Counties (Region 1)**

Age range	Nonsmoking				
	Plan A	Plan F	High Ded. F	Innovative Plan F	Plan G
65-66	\$160	\$229	\$95	\$237	\$203
67-68	\$177	\$252	\$103	\$259	\$225
69-70	\$192	\$274	\$115	\$283	\$246
71-72	\$208	\$297	\$123	\$303	\$264
73-74	\$224	\$320	\$132	\$328	\$286
75-76	\$239	\$343	\$143	\$348	\$305
77-78	\$256	\$365	\$152	\$372	\$325
79-80	\$270	\$385	\$160	\$392	\$343
81-84	\$289	\$416	\$172	\$421	\$369
85+	\$325	\$464	\$192	\$471	\$414
Disabled under 65	\$325	\$464	\$192	\$471	\$414

Age range	Smoking <sup>1</sup>				
	Plan A	Plan F	High Ded. F	Innovative Plan F	Plan G
65-66	\$186	\$268	\$111	\$273	\$238
67-68	\$208	\$296	\$123	\$301	\$262
69-70	\$225	\$323	\$132	\$329	\$287
71-72	\$241	\$346	\$144	\$354	\$309
73-74	\$262	\$374	\$155	\$380	\$334
75-76	\$280	\$401	\$166	\$406	\$356
77-78	\$298	\$425	\$177	\$432	\$379
79-80	\$315	\$450	\$186	\$456	\$400
81-84	\$340	\$483	\$201	\$491	\$432
85+	\$379	\$541	\$226	\$550	\$483
Disabled under 65	\$379	\$541	\$226	\$550	\$483

<sup>1</sup>A tobacco premium rate applies if you have smoked or used any tobacco products in the past two (2) years.

**Alameda, Contra Costa, Shasta Counties (Region 1)**

Age range	Nonsmoking			
	Plan D	High Ded. G	Innovative Plan G	Plan N
65-66	\$194	\$83	\$199	\$168
67-68	\$215	\$94	\$222	\$187
69-70	\$239	\$104	\$243	\$207
71-72	\$262	\$114	\$265	\$226
73-74	\$285	\$124	\$287	\$246
75-76	\$309	\$134	\$310	\$267
77-78	\$332	\$147	\$333	\$287
79-80	\$354	\$153	\$354	\$305
81-82	\$377	\$165	\$377	\$327
83-84	\$401	\$174	\$397	\$345
85-86	\$422	\$185	\$419	\$365
87-88	\$442	\$192	\$439	\$383
89-90	\$459	\$200	\$457	\$397
91-92	\$478	\$208	\$474	\$414
93-94	\$493	\$215	\$490	\$428
95+	\$524	\$228	\$518	\$451
Disabled under 65	\$524	\$228	\$518	\$451

Age range	Smoking <sup>1</sup>			
	Plan D	High Ded. G	Innovative Plan G	Plan N
65-66	\$225	\$99	\$229	\$196
67-68	\$255	\$111	\$256	\$221
69-70	\$280	\$122	\$281	\$240
71-72	\$304	\$132	\$306	\$264
73-74	\$332	\$147	\$333	\$287
75-76	\$358	\$155	\$359	\$311
77-78	\$390	\$171	\$388	\$336
79-80	\$414	\$180	\$412	\$358
81-82	\$438	\$192	\$437	\$379
83-84	\$465	\$202	\$463	\$403
85-86	\$492	\$215	\$489	\$425
87-88	\$513	\$225	\$510	\$445
89-90	\$537	\$235	\$529	\$464
91-92	\$556	\$243	\$550	\$481
93-94	\$578	\$252	\$570	\$498
95+	\$610	\$267	\$600	\$525
Disabled under 65	\$610	\$267	\$600	\$525

<sup>1</sup>A tobacco premium rate applies if you have smoked or used any tobacco products in the past two (2) years.

**Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Madera, Marin, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Nevada, Plumas, San Benito, San Francisco, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Sierra, Siskiyou, Sonoma, Sutter, Tehama, Trinity, Tuolumne, Yuba Counties (Region 2)**

Age range	Nonsmoking				
	Plan A	Plan F	High Ded. F	Innovative Plan F	Plan G
65-66	\$155	\$223	\$92	\$229	\$199
67-68	\$174	\$246	\$102	\$255	\$221
69-70	\$188	\$269	\$111	\$274	\$239
71-72	\$203	\$289	\$119	\$297	\$259
73-74	\$219	\$313	\$129	\$319	\$277
75-76	\$235	\$334	\$138	\$342	\$298
77-78	\$248	\$356	\$148	\$362	\$317
79-80	\$264	\$376	\$155	\$383	\$335
81-84	\$284	\$405	\$167	\$412	\$361
85+	\$317	\$453	\$187	\$461	\$404
Disabled under 65	\$317	\$453	\$187	\$461	\$404

Age range	Smoking <sup>1</sup>				
	Plan A	Plan F	High Ded. F	Innovative Plan F	Plan G
65-66	\$183	\$260	\$109	\$268	\$231
67-68	\$202	\$288	\$119	\$296	\$257
69-70	\$221	\$315	\$130	\$320	\$280
71-72	\$237	\$340	\$139	\$345	\$301
73-74	\$256	\$365	\$152	\$372	\$325
75-76	\$272	\$390	\$161	\$395	\$346
77-78	\$291	\$417	\$173	\$422	\$370
79-80	\$305	\$437	\$182	\$445	\$390
81-84	\$330	\$474	\$196	\$479	\$420
85+	\$371	\$529	\$219	\$536	\$470
Disabled under 65	\$371	\$529	\$219	\$536	\$470

<sup>1</sup>A tobacco premium rate applies if you have smoked or used any tobacco products in the past two (2) years.

**Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Madera, Marin, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Nevada, Plumas, San Benito, San Francisco, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Sierra, Siskiyou, Sonoma, Sutter, Tehama, Trinity, Tuolumne, Yuba Counties (Region 2)**

Age range	Nonsmoking			
	Plan D	High Ded. G	Innovative Plan G	Plan N
65-66	\$183	\$79	\$188	\$158
67-68	\$207	\$91	\$211	\$178
69-70	\$225	\$99	\$229	\$196
71-72	\$248	\$107	\$251	\$214
73-74	\$270	\$118	\$272	\$232
75-76	\$291	\$126	\$292	\$251
77-78	\$315	\$138	\$316	\$272
79-80	\$335	\$147	\$335	\$289
81-82	\$357	\$155	\$356	\$309
83-84	\$378	\$165	\$377	\$328
85-86	\$401	\$174	\$397	\$345
87-88	\$418	\$182	\$416	\$361
89-90	\$434	\$189	\$432	\$376
91-92	\$452	\$198	\$449	\$391
93-94	\$468	\$203	\$464	\$404
95+	\$493	\$215	\$490	\$428
Disabled under 65	\$493	\$215	\$490	\$428

Age range	Smoking <sup>1</sup>			
	Plan D	High Ded. G	Innovative Plan G	Plan N
65-66	\$214	\$94	\$218	\$185
67-68	\$239	\$104	\$243	\$207
69-70	\$265	\$117	\$267	\$228
71-72	\$289	\$126	\$291	\$251
73-74	\$315	\$138	\$316	\$272
75-76	\$341	\$149	\$341	\$294
77-78	\$369	\$160	\$366	\$317
79-80	\$391	\$171	\$389	\$338
81-82	\$417	\$182	\$415	\$360
83-84	\$442	\$192	\$439	\$383
85-86	\$466	\$203	\$464	\$404
87-88	\$487	\$213	\$483	\$420
89-90	\$507	\$223	\$502	\$439
91-92	\$526	\$229	\$521	\$454
93-94	\$547	\$239	\$540	\$473
95+	\$578	\$252	\$570	\$498
Disabled under 65	\$578	\$252	\$570	\$498

<sup>1</sup>A tobacco premium rate applies if you have smoked or used any tobacco products in the past two (2) years.

**Kern, Napa, Riverside, San Bernardino, Ventura Counties (Region 4)**

Age range	Nonsmoking				
	Plan A	Plan F	High Ded. F	Innovative Plan F	Plan G
65-66	\$171	\$245	\$101	\$252	\$218
67-68	\$189	\$271	\$113	\$277	\$241
69-70	\$208	\$297	\$123	\$303	\$264
71-72	\$223	\$319	\$131	\$327	\$285
73-74	\$241	\$345	\$143	\$350	\$306
75-76	\$258	\$369	\$153	\$374	\$328
77-78	\$273	\$392	\$162	\$400	\$349
79-80	\$288	\$414	\$172	\$420	\$368
81-84	\$312	\$446	\$185	\$452	\$395
85+	\$348	\$500	\$208	\$506	\$444
Disabled under 65	\$348	\$500	\$208	\$506	\$444

Age range	Smoking <sup>1</sup>				
	Plan A	Plan F	High Ded. F	Innovative Plan F	Plan G
65-66	\$202	\$287	\$118	\$295	\$256
67-68	\$222	\$317	\$131	\$324	\$282
69-70	\$241	\$345	\$143	\$350	\$306
71-72	\$260	\$373	\$154	\$379	\$333
73-74	\$282	\$402	\$166	\$407	\$358
75-76	\$300	\$430	\$178	\$436	\$383
77-78	\$319	\$458	\$190	\$464	\$408
79-80	\$338	\$481	\$200	\$489	\$429
81-84	\$364	\$521	\$215	\$527	\$464
85+	\$407	\$583	\$243	\$589	\$518
Disabled under 65	\$407	\$583	\$243	\$589	\$518

<sup>1</sup>A tobacco premium rate applies if you have smoked or used any tobacco products in the past two (2) years.

**Kern, Napa, Riverside, San Bernardino, Ventura Counties (Region 4)**

Age range	Nonsmoking			
	Plan D	High Ded. G	Innovative Plan G	Plan N
65-66	\$203	\$89	\$207	\$174
67-68	\$225	\$99	\$229	\$196
69-70	\$250	\$109	\$253	\$215
71-72	\$273	\$120	\$276	\$237
73-74	\$297	\$128	\$299	\$256
75-76	\$320	\$140	\$320	\$276
77-78	\$347	\$151	\$346	\$300
79-80	\$370	\$162	\$368	\$318
81-82	\$393	\$172	\$392	\$341
83-84	\$418	\$182	\$416	\$361
85-86	\$442	\$192	\$439	\$383
87-88	\$461	\$201	\$458	\$398
89-90	\$480	\$210	\$475	\$415
91-92	\$498	\$216	\$493	\$430
93-94	\$516	\$226	\$512	\$446
95+	\$546	\$238	\$540	\$471
Disabled under 65	\$546	\$238	\$540	\$471

Age range	Smoking <sup>1</sup>			
	Plan D	High Ded. G	Innovative Plan G	Plan N
65-66	\$237	\$103	\$239	\$203
67-68	\$265	\$117	\$267	\$228
69-70	\$294	\$127	\$294	\$252
71-72	\$319	\$139	\$320	\$276
73-74	\$347	\$151	\$346	\$300
75-76	\$374	\$164	\$373	\$324
77-78	\$405	\$177	\$404	\$350
79-80	\$431	\$188	\$429	\$372
81-82	\$459	\$200	\$454	\$395
83-84	\$487	\$213	\$483	\$420
85-86	\$513	\$225	\$510	\$445
87-88	\$537	\$236	\$533	\$465
89-90	\$560	\$244	\$552	\$486
91-92	\$582	\$255	\$574	\$502
93-94	\$603	\$262	\$595	\$521
95+	\$636	\$277	\$627	\$550
Disabled under 65	\$636	\$277	\$627	\$550

<sup>1</sup>A tobacco premium rate applies if you have smoked or used any tobacco products in the past two (2) years.

**El Dorado, Fresno, Imperial, Placer, Sacramento, San Joaquin, Santa Cruz, Solano, Stanislaus, Tulare, Yolo Counties (Region 5)**

Age range	Nonsmoking				
	Plan A	Plan F	High Ded. F	Innovative Plan F	Plan G
65-66	\$142	\$206	\$85	\$211	\$182
67-68	\$158	\$225	\$94	\$233	\$200
69-70	\$171	\$245	\$101	\$252	\$218
71-72	\$185	\$267	\$111	\$272	\$237
73-74	\$200	\$286	\$118	\$294	\$255
75-76	\$213	\$305	\$127	\$313	\$273
77-78	\$228	\$327	\$134	\$332	\$289
79-80	\$240	\$344	\$143	\$349	\$305
81-84	\$259	\$371	\$153	\$377	\$330
85+	\$289	\$416	\$172	\$421	\$369
Disabled under 65	\$289	\$416	\$172	\$421	\$369

Age range	Smoking <sup>1</sup>				
	Plan A	Plan F	High Ded. F	Innovative Plan F	Plan G
65-66	\$166	\$239	\$99	\$245	\$213
67-68	\$185	\$265	\$110	\$271	\$236
69-70	\$202	\$287	\$118	\$295	\$256
71-72	\$215	\$311	\$128	\$317	\$275
73-74	\$235	\$334	\$138	\$342	\$298
75-76	\$250	\$357	\$148	\$364	\$318
77-78	\$268	\$380	\$159	\$389	\$340
79-80	\$282	\$402	\$166	\$407	\$358
81-84	\$303	\$433	\$179	\$439	\$386
85+	\$340	\$483	\$201	\$491	\$432
Disabled under 65	\$340	\$483	\$201	\$491	\$432

<sup>1</sup>A tobacco premium rate applies if you have smoked or used any tobacco products in the past two (2) years.

**El Dorado, Fresno, Imperial, Placer, Sacramento, San Joaquin, Santa Cruz, Solano, Stanislaus, Tulare, Yolo Counties (Region 5)**

Age range	Nonsmoking			
	Plan D	High Ded. G	Innovative Plan G	Plan N
65-66	\$167	\$74	\$173	\$144
67-68	\$189	\$81	\$195	\$164
69-70	\$208	\$91	\$212	\$179
71-72	\$227	\$99	\$231	\$197
73-74	\$248	\$107	\$251	\$214
75-76	\$268	\$117	\$269	\$231
77-78	\$289	\$126	\$291	\$251
79-80	\$309	\$134	\$310	\$267
81-82	\$327	\$143	\$328	\$282
83-84	\$347	\$151	\$346	\$300
85-86	\$369	\$160	\$366	\$317
87-88	\$383	\$168	\$383	\$331
89-90	\$400	\$174	\$397	\$344
91-92	\$416	\$180	\$413	\$359
93-94	\$430	\$187	\$428	\$371
95+	\$453	\$198	\$450	\$392
Disabled under 65	\$453	\$198	\$450	\$392

Age range	Smoking <sup>1</sup>			
	Plan D	High Ded. G	Innovative Plan G	Plan N
65-66	\$196	\$86	\$201	\$171
67-68	\$221	\$97	\$224	\$189
69-70	\$243	\$105	\$246	\$211
71-72	\$267	\$117	\$268	\$229
73-74	\$288	\$126	\$289	\$250
75-76	\$313	\$137	\$313	\$270
77-78	\$338	\$148	\$338	\$292
79-80	\$358	\$155	\$358	\$310
81-82	\$380	\$166	\$380	\$330
83-84	\$404	\$177	\$403	\$349
85-86	\$429	\$187	\$425	\$370
87-88	\$449	\$196	\$444	\$388
89-90	\$465	\$202	\$463	\$403
91-92	\$482	\$211	\$479	\$418
93-94	\$502	\$218	\$495	\$434
95+	\$530	\$231	\$524	\$459
Disabled under 65	\$530	\$231	\$524	\$459

<sup>1</sup>A tobacco premium rate applies if you have smoked or used any tobacco products in the past two (2) years.

## Read your Medicare Supplement Plan Policy very carefully

This is only an outline describing your Medicare Supplement Plan Policy's most important features. The Policy is your contract. You must read the Policy itself to understand all of the rights and duties of both you and HNL.

## 30-day right to return the Medicare Supplement Plan Policy

If you find you are not satisfied with your Medicare Supplement Plan Policy, you may return it to HNL Medicare Supplement Plan at:

PO Box 10420  
Van Nuys, CA 91499  
Attn.: Membership Accounting

If you send the Medicare Supplement Plan Policy back to us within 30 days after you receive it, we will treat the Contract as if it had never been issued and return all of your payments, less any payments made on claims.

## Disclosures

This Policy may not fully cover all your medical costs. Neither HNL nor any of 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 the *Medicare Handbook* for more details. For additional information concerning Policy benefits, contact the Health Insurance Counseling and Advocacy Program (HICAP) or your agent. Call the HICAP toll-free telephone number, 1-800-434-0222, for a referral to your local HICAP office. HICAP is a service provided free of charge by the State of California.



## AN EXAMPLE SHOWING A DOCTOR'S CHARGES

The following are examples of how the plans pay benefits for Part B charges, assuming a doctor bill of \$2,000 and the annual Medicare Part B deductible of \$283 has been met.

Plan: A, D, and N	Doctor accepts assignment	Doctor does not accept assignment
Charges approved for payment by Medicare	\$1,850	\$1,850
Medicare pays 80% of approved charges	\$1,480	\$1,480
This policy pays	\$370	\$370
You pay coinsurance	\$0	\$150

If your doctor accepts assignment of Medicare benefits, the difference between your doctor's charge (\$2,000) and the Part B charges approved for payment by Medicare (\$1,850) is absorbed by your doctor and you pay no coinsurance. If your doctor does not accept assignment of Medicare benefits, you pay the Part B excess charges.

Plan: F, High Deductible F, Innovative Plan F, G, High Deductible G and Innovative Plan G	Doctor accepts assignment	Doctor does not accept assignment
Charges approved for payment by Medicare	\$1,850	\$1,850
Medicare pays 80% of approved charges	\$1,480	\$1,480
This policy pays	\$370	\$520
You pay coinsurance	\$0	\$0

Unlike plans A, D, and N, plans F, High Deductible F, Innovative Plan F, G, High Deductible G, and Innovative Plan G pay Part B excess charges. Part B excess charges are the difference between doctor charges and the charges approved for payment by Medicare.

# Plan **A** Medicare (Part A)

## Hospital services – per benefit period

Services	Medicare pays	Plan pays	You pay
<b>Hospitalization*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,736	\$0	\$1,736 (Part A ded.)
61st through 90th day	All but \$434 a day	\$434 a day	\$0
91st day and after:			
• While using 60 lifetime reserve days	All but \$868 a day	\$868 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
<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.			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$217 a day	\$0	Up to \$217 a day
101st day and after	\$0	\$0	All costs
<b>Blood</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>Hospice care</b> 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.

# Plan **A** Medicare (Part B)

## Medical services – per calendar year

Services	Medicare pays	Plan pays	You pay
<b>Medical expenses – in or out of the hospital and outpatient hospital treatment</b> , such as doctor’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$283 of Medicare-approved amounts*	\$0	\$0	\$283 (Part B ded.)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B excess charges</b> (above Medicare-approved amounts)	\$0	\$0	All costs
<b>Blood</b> First 3 pints	\$0	All costs	\$0
Next \$283 of Medicare-approved amounts*	\$0	\$0	\$283 (Part B ded.)
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>Clinical laboratory services</b> Tests for diagnostic services	100%	\$0	\$0

\*Once you have been billed \$283 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
<b>Home health care – Medicare-approved services</b> Medically necessary skilled care services and medical supplies such as durable medical equipment	100%	\$0	\$0
First \$283 of Medicare-approved amounts*	\$0	\$0	\$283 (Part B ded.)
Remainder of Medicare-approved amounts	80%	20%	\$0

\*Once you have been billed \$283 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.

# Plan **D** Medicare (Part A)

## Hospital services – per benefit period

Services	Medicare pays	Plan pays	You pay
<b>Hospitalization*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,736	\$1,736 (Part A ded.)	\$0
61st through 90th day	All but \$434 a day	\$434 a day	\$0
91st day and after:			
• While using 60 lifetime reserve days	All but \$868 a day	\$868 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
<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.			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$217 a day	Up to \$217 a day	\$0
101st day and after	\$0	\$0	All costs
<b>Blood</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>Hospice care</b>			
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.

# Plan **D** Medicare (Part B)

## Medical services – per calendar year

Services	Medicare pays	Plan pays	You pay
<b>Medical expenses – in or out of the hospital and outpatient hospital treatment, such as doctor’s services,</b> inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$283 of Medicare-approved amounts*	\$0	\$0	\$283 (Part B ded.)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B excess charges</b> (above Medicare-approved amounts)	\$0	\$0	All costs
<b>Blood</b> First 3 pints	\$0	All costs	\$0
Next \$283 of Medicare-approved amounts*	\$0	\$0	\$283 (Part B ded.)
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>Clinical laboratory services</b> Tests for diagnostic services	100%	\$0	\$0

\*Once you have been billed \$283 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
<b>Home health care – Medicare-approved services</b> Medically necessary skilled care services and medical supplies such as durable medical equipment	100%	\$0	\$0
First \$283 of Medicare-approved amounts*	\$0	\$0	\$283 (Part B ded.)
Reminder of Medicare-approved amounts	80%	20%	\$0

## OTHER BENEFITS – NOT COVERED BY MEDICARE

Services	Medicare pays	Plan pays	You pay
<b>Foreign travel – not covered by Medicare</b> 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 \$283 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.

# Plan **F** Medicare (Part A)

## Hospital services – per benefit period

Services	Medicare pays	Plan pays	You pay
<b>Hospitalization*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,736	\$1,736 (Part A ded.)	\$0
61st through 90th day	All but \$434 a day	\$434 a day	\$0
91st day and after:			
• While using 60 lifetime reserve days	All but \$868 a day	\$868 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
<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.			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$217 a day	Up to \$217 a day	\$0
101st day and after	\$0	\$0	All costs
<b>Blood</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>Hospice care</b> 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.

# Plan **F** Medicare (Part B)

## Medical services – per calendar year

Services	Medicare pays	Plan pays	You pay
<b>Medical expenses – in or out of the hospital and outpatient hospital treatment, such as doctor’s services,</b> inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$283 of Medicare-approved amounts*	\$0	\$283 (Part B ded.)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B excess charges</b> (above Medicare-approved amounts)	\$0	100%	\$0
<b>Blood</b> First 3 pints	\$0	All costs	\$0
Next \$283 of Medicare-approved amounts*	\$0	\$283 (Part B ded.)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>Clinical laboratory services</b> Tests for diagnostic services	100%	\$0	\$0

\*Once you have been billed \$283 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
<b>Home health care – Medicare-approved services</b> Medically necessary skilled care services and medical supplies such as durable medical equipment	100%	\$0	\$0
First \$283 of Medicare-approved amounts*	\$0	\$283 (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
<b>Foreign travel – not covered by Medicare</b> 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 \$283 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.

# High Deductible Plan **F** Medicare (Part A)

## Hospital services – per benefit period

This high deductible plan pays the same benefits as Plan F after one has paid a \$2,950 calendar year deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses exceed \$2,950. 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 \$2,950 ded., plan pays	In addition to \$2,950 ded., you pay
<b>Hospitalization*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,736	\$1,736 (Part A ded.)	\$0
61st through 90th day	All but \$434 a day	\$434 a day	\$0
91st day and after:			
• While using 60 lifetime reserve days	All but \$868 a day	\$868 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
<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.			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$217 a day	Up to \$217 a day	\$0
101st day and after	\$0	\$0	All costs

\*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.

Services	Medicare pays	After you pay \$2,950 ded., plan pays	In addition to \$2,950 ded., you pay
<b>Blood</b> First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>Hospice care</b> 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.

# High Deductible Plan **F** Medicare (Part B)

## Medical services – per calendar year

This high deductible plan pays the same benefits as Plan F after one has paid a \$2,950 calendar year deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses exceed \$2,950. 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 \$2,950 ded., plan pays	In addition to \$2,950 ded., you pay
<b>Medical expenses – in or out of the hospital and outpatient hospital treatment, such as doctor's services,</b> inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$283 of Medicare-approved amounts*	\$0	\$283 (Part B ded.)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B excess charges</b> (above Medicare-approved amounts)	\$0	100%	\$0
<b>Blood</b>			
First 3 pints	\$0	All costs	\$0
Next \$283 of Medicare-approved amounts*	\$0	\$283 (Part B ded.)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0

\*Once you have been billed \$283 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	After you pay \$2,950 ded., plan pays	In addition to \$2,950 ded., you pay
<b>Clinical laboratory services</b> Tests for diagnostic services	100%	\$0	\$0
<b>Home health care – Medicare-approved services</b> Medically necessary skilled care services and medical supplies such as durable medical equipment	100%	\$0	\$0
First \$283 of Medicare-approved amounts*	\$0	\$283 (Part B ded.)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0

## OTHER BENEFITS – NOT COVERED BY MEDICARE

Services	Medicare pays	After you pay \$2,950 ded., plan pays	In addition to \$2,950 ded., you pay
<b>Foreign travel – not covered by Medicare</b> 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 \$283 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** Medicare (Part A)

## Hospital services – per benefit period

Services	Medicare pays	Plan pays	You pay
<b>Hospitalization*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,736	\$1,736 (Part A ded.)	\$0
61st through 90th day	All but \$434 a day	\$434 a day	\$0
91st day and after:			
• While using 60 lifetime reserve days	All but \$868 a day	\$868 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
<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.			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$217 a day	Up to \$217 a day	\$0
101st day and after	\$0	\$0	All costs
<b>Blood</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>Hospice care</b>			
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
<b>Medical expenses – in or out of the hospital and outpatient hospital treatment, such as doctor’s services,</b> inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$283 of Medicare-approved amounts*	\$0	\$283 (Part B ded.)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B excess charges</b> (above Medicare-approved amounts)	\$0	100%	\$0
<b>Blood</b> First 3 pints	\$0	All costs	\$0
Next \$283 of Medicare-approved amounts*	\$0	\$283 (Part B ded.)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>Clinical laboratory services</b> Tests for diagnostic services	100%	\$0	\$0

\*Once you have been billed \$283 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
<b>Home health care – Medicare-approved services</b> Medically necessary skilled care services and medical supplies such as durable medical equipment	100%	\$0	\$0
First \$283 of Medicare-approved amounts*	\$0	\$283 (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
<b>Foreign travel – not covered by Medicare</b> 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 \$283 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
<b>Routine eye exam</b> (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
<b>Frame and lens package</b> (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
<ul style="list-style-type: none"> <li>• Contact lenses – Includes materials only, once every 24 months                             <ul style="list-style-type: none"> <li>– Conventional</li> </ul> </li> </ul>	\$0	Up to \$250 allowance	85% of the remaining balance
<ul style="list-style-type: none"> <li>– Disposable</li> </ul>	\$0	Up to \$250 allowance	100% of the remaining balance
<ul style="list-style-type: none"> <li>– Medically Necessary</li> </ul>	\$0	Medically: \$0 copay, paid in full	Up to \$250
<b>Routine hearing benefit</b> Hearing exam – Coverage for up to (1) routine hearing exam every 12 months	\$0	\$0	\$0
Hearing aids <ul style="list-style-type: none"> <li>• Two hearing aids every calendar year</li> <li>• All sizes and styles offered by Hearing Care Solutions.</li> <li>• Four levels of technology to choose from. All instruments are fully digital.</li> <li>• Covered when determined to be medically necessary based on a hearing exam</li> </ul>	\$0	\$0	Level 4 – \$1,580 Level 3 – \$1,125 Level 2 – \$700 Level 1 – \$0

# Plan **G** Medicare (Part A)

## Hospital services – per benefit period

Services	Medicare pays	Plan pays	You pay
<b>Hospitalization*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,736	\$1,736 (Part A ded.)	\$0
61st through 90th day	All but \$434 a day	\$434 a day	\$0
91st day and after:			
• While using 60 lifetime reserve days	All but \$868 a day	\$868 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
<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.			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$217 a day	Up to \$217 a day	\$0
101st day and after	\$0	\$0	All costs
<b>Blood</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>Hospice care</b>			
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.

# Plan **G** Medicare (Part B)

## Medical services – per calendar year

Services	Medicare pays	Plan pays	You pay
<b>Medical expenses – in or out of the hospital and outpatient hospital treatment</b> , such as doctor’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$283 of Medicare-approved amounts*	\$0	\$0	\$283 (Part B ded.)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B excess charges</b> (above Medicare-approved amounts)	\$0	100%	\$0
<b>Blood</b> First 3 pints	\$0	All costs	\$0
Next \$283 of Medicare-approved amounts*	\$0	\$0	\$283 (Part B ded.)
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>Clinical laboratory services</b> Tests for diagnostic services	100%	\$0	\$0

\*Once you have been billed \$283 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
<b>Home health care – Medicare-approved services</b> Medically necessary skilled care services and medical supplies such as durable medical equipment	100%	\$0	\$0
First \$283 of Medicare-approved amounts*	\$0	\$0	\$283 (Part B ded.)
Remainder of Medicare-approved amounts	80%	20%	\$0

## OTHER BENEFITS – NOT COVERED BY MEDICARE

Services	Medicare pays	Plan pays	You pay
<b>Foreign travel – not covered by Medicare</b> 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 \$283 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.

# High Deductible Plan Medicare (Part A)

## Hospital services – per benefit period

This high deductible plan pays the same benefits as Plan G after one has paid a \$2,950 calendar year deductible. Benefits from High Deductible Plan G will not begin until out-of-pocket expenses exceed \$2,950. 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 \$2,950 ded., plan pays	In addition to \$2,950 ded., you pay
<b>Hospitalization*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,736	\$1,736 (Part A ded.)	\$0
61st through 90th day	All but \$434 a day	\$434 a day	\$0
91st day and after:			
• While using 60 lifetime reserve days	All but \$868 a day	\$868 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
<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.			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$217 a day	Up to \$217 a day	\$0
101st day and after	\$0	\$0	All costs

\*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.

Services	Medicare pays	After you pay \$2,950 ded., plan pays	In addition to \$2,950 ded., you pay
<b>Blood</b> First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>Hospice care</b> 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

# High Deductible Plan Medicare (Part B)

## Medical services – per calendar year

This high deductible plan pays the same benefits as Plan G after one has paid a \$2,950 calendar year deductible. Benefits from High Deductible Plan G will not begin until out-of-pocket expenses exceed \$2,950. 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 \$2,950 ded., plan pays	In addition to \$2,950 ded., you pay
<b>Medical expenses – in or out of the hospital and outpatient hospital treatment, such as doctor's services,</b> inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$283 of Medicare-approved amounts*	\$0	\$0	\$283 (Part B ded.)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B excess charges</b> (above Medicare-approved amounts)	\$0	100%	\$0
<b>Blood</b>			
First 3 pints	\$0	All costs	\$0
Next \$283 of Medicare-approved amounts*	\$0	\$0	\$283 (Part B ded.)
Remainder of Medicare-approved amounts	80%	20%	\$0

\*Once you have been billed \$283 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	After you pay \$2,950 ded., plan pays	In addition to \$2,950 ded., you pay
<b>Clinical laboratory services</b> Tests for diagnostic services	100%	\$0	\$0
<b>Home health care – Medicare-approved services</b> Medically necessary skilled care services and medical supplies such as durable medical equipment	100%	\$0	\$0
First \$283 of Medicare-approved amounts*	\$0	\$0	\$283 (Part B ded.)
Remainder of Medicare-approved amounts	80%	20%	\$0

## OTHER BENEFITS – NOT COVERED BY MEDICARE

Services	Medicare pays	After you pay \$2,950 ded., plan pays	In addition to \$2,950 ded., you pay
<b>Foreign travel – not covered by Medicare</b> 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 \$283 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 Medicare (Part A)

## Hospital services – per benefit period

Services	Medicare pays	Plan pays	You pay
<b>Hospitalization*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,736	\$1,736 (Part A ded.)	\$0
61st through 90th day	All but \$434 a day	\$434 a day	\$0
91st day and after:			
• While using 60 lifetime reserve days	All but \$868 a day	\$868 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
<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.			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$217 a day	Up to \$217 a day	\$0
101st day and after	\$0	\$0	All costs
<b>Blood</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>Hospice care</b>			
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 Medicare (Part B)

## Medical services – per calendar year

Services	Medicare pays	Plan pays	You pay
<b>Medical expenses – in or out of the hospital and outpatient hospital treatment</b> , such as doctor’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$283 of Medicare-approved amounts*	\$0	\$0	\$283 (Part B ded.)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B excess charges</b> (above Medicare-approved amounts)	\$0	100%	\$0
<b>Blood</b> First 3 pints	\$0	All costs	\$0
Next \$283 of Medicare-approved amounts*	\$0	\$0	\$283 (Part B ded.)
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>Clinical laboratory services</b> Tests for diagnostic services	100%	\$0	\$0

\*Once you have been billed \$283 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
<b>Home health care – Medicare-approved services</b> Medically necessary skilled care services and medical supplies such as durable medical equipment	100%	\$0	\$0
First \$283 of Medicare-approved amounts*	\$0	\$0	\$283 (Part B ded.)
Remainder of Medicare-approved amounts	80%	20%	\$0

## OTHER BENEFITS – NOT COVERED BY MEDICARE

Services	Medicare pays	Plan pays	You pay
<b>Foreign travel – not covered by Medicare</b> 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 \$283 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

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

Services	Medicare pays	Plan pays	You pay
<b>Routine eye exam</b> (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
<b>Frame and lens package</b> (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
<ul style="list-style-type: none"> <li>Contact lenses – Includes materials only, once every 24 months                             <ul style="list-style-type: none"> <li>– Conventional</li> </ul> </li> </ul>	\$0	Up to \$250 allowance	85% of the remaining balance
<ul style="list-style-type: none"> <li>– Disposable</li> </ul>	\$0	Up to \$250 allowance	100% of the remaining balance
<ul style="list-style-type: none"> <li>– Medically Necessary</li> </ul>	\$0	Medically: \$0 copay, paid in full	Up to \$250
<b>Routine hearing benefit</b> Hearing exam – Coverage for up to (1) routine hearing exam every 12 months	\$0	\$0	\$0
Hearing aids <ul style="list-style-type: none"> <li>• Two hearing aids every calendar year</li> <li>• All sizes and styles offered by Hearing Care Solutions.</li> <li>• Four levels of technology to choose from. All instruments are fully digital.</li> <li>• Covered when determined to be medically necessary based on a hearing exam</li> </ul>	\$0	\$0	Level 4 – \$1,580 Level 3 – \$1,125 Level 2 – \$700 Level 1 – \$0
<b>Routine Chiropractic and Acupuncture benefit</b> Routine chiropractic services are covered at 100%. Coverage up to 20 visits each calendar year, visit limit is combined with acupuncture services.	\$0	\$0	\$0

# Plan N Medicare (Part A)

## Hospital services – per benefit period

Services	Medicare pays	Plan pays	You pay
<b>Hospitalization<sup>1</sup></b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$1,736	\$1,736 (Part A ded.)	\$0
61st through 90th day	All but \$434 a day	\$434 a day	\$0
91st day and after:			
• While using 60 lifetime reserve days	All but \$868 a day	\$868 a day	\$0
• Once lifetime reserve days are used:	\$0	100% of Medicare-eligible expenses	\$0 <sup>2</sup>
– Additional 365 days	\$0	\$0	All costs
– Beyond the additional 365 days	\$0	\$0	All costs
<b>Skilled nursing facility care<sup>1</sup></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.			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$217 a day	Up to \$217 a day	\$0
101st day and after	\$0	\$0	All costs
<b>Blood</b> First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>Hospice care</b> 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

<sup>1</sup>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.

<sup>2</sup>**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.

# Plan N Medicare (Part B)

## Medical services – per calendar year

Services	Medicare pays	Plan pays	You pay
<b>Medical expenses – in or out of the hospital and outpatient hospital treatment</b> , such as doctor’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$283 of Medicare-approved amounts*	\$0	\$0	\$283 (Part B ded.)
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 co-payment 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.
<b>Part B Excess Charges</b> (above Medicare-approved amounts)	\$0	\$0	All costs
<b>Blood</b> First 3 pints	\$0	All costs	\$0
Next \$283 of Medicare-approved amounts*	\$0	\$0	\$283 (Part B ded.)
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>Clinical laboratory services</b> Tests for diagnostic services	100%	\$0	\$0

\*Once you have been billed \$283 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
<b>Home health care – Medicare-approved services</b> Medically necessary skilled care services and medical supplies such as durable medical equipment	100%	\$0	\$0
First \$283 of Medicare-approved amounts*	\$0	\$0	\$283 (Part B ded.)
Remainder of Medicare-approved amounts	80%	20%	\$0

## OTHER BENEFITS – NOT COVERED BY MEDICARE

Services	Medicare pays	Plan pays	You pay
<b>Foreign travel – not covered by Medicare</b> 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 \$283 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.

## Eligibility provisions

Your continued eligibility to participate in this health plan depends on your continued Medicare enrollment.

## Claims reimbursement

HNL Medicare Supplement plans feature electronic claims processing, a claims payment process between HNL and Medicare. Medicare-certified and Medicare-accepting providers bill Medicare for services provided and, upon processing, Medicare then sends claims electronically to HNL for secondary payment. Electronic claims processing is provided with your membership in an HNL Medicare Supplement plan. There is no registration necessary.

For claims for services covered by your HNL Medicare Supplement plan, but not by Medicare, such as foreign travel emergency care, you or your medical provider should submit the claims directly to HNL at:

Health Net Claims  
P.O. Box 9040  
Farmington, MO 63640-9040

You may request an HNL claim form by contacting the Member Services number provided on your HNL member identification card.

## Termination provisions

You can terminate your enrollment in this health plan by giving written notice to HNL that you wish to disenroll at least 30 days prior to the month in which you wish to end your enrollment. HNL can terminate your coverage:

- If your premium is not paid by the end of the 31-day grace period, your coverage will be canceled at the end of the 31-day grace period.
- If you have performed an act or practice constituting fraud or made an intentional misrepresentation of material fact as prohibited by the terms of this policy, HNL may terminate your coverage upon 30 days notice, except that no such termination shall be allowed after the expiration of two years from your initial effective date of coverage under this Policy.

If your coverage is terminated by HNL and you have reason to believe that the termination was based upon your health status or requirements for health care services, you may request a review of the termination by the Commissioner of the California Department of Insurance. Information relative to this procedure is available by contacting the Member Services Department.

In the event of cancellation by either HNL (except in the case that HNL demonstrates you performed an act constituting fraud or an intentional misrepresentation of material fact as prohibited by the terms of this policy) or yourself, HNL shall within 30 days return to you the pro-rated portion of the money paid to HNL which corresponds to any unexpired period for which payment had been received. The amounts shall be adjusted to reflect amounts due on claims, if any.

### Grace period

A grace period of 31-days is allowed after each premium due date. When payment is not received within the first two weeks of the month for which it is due, a final bill showing the amount owed will be sent to you. If payment is not received within the last day of the 31-day grace period after the final bill is sent, your coverage will be terminated at the end of the 31-day grace period.

### Grievance and arbitration

If you have a grievance against HNL, or are ever dissatisfied with our services, and our HNL Medicare Supplement Plan Member Services Department is not able to solve the problem, there is a procedure for appealing the issue. You may write a letter explaining the problem to:

HNL Medicare Supplement Plan Appeals and Grievances Department  
PO Box 10344  
Van Nuys, CA 91410-0344

HNL uses neutral, binding arbitration to settle disputes that arise out of or relate to coverage under the Policy. When you enroll in an HNL Medicare Supplement Plan, you agree to submit any disputes to arbitration, in lieu of a jury or court trial.

This binding arbitration provision does not apply to claims, disputes or controversies relating to alleged professional negligence (medical malpractice) and applies only to matters arising under this Policy.

Medicare has specific appeals procedures for the portion of the bill it pays. If you feel a decision made on a claim is incorrect, any Social Security office can help you request a review.

### Department of Insurance

If the covered person is unable to resolve a dispute with HNL, the covered person may wish to contact:

California Department of Insurance  
300 South Spring St.  
Los Angeles, CA 90013  
**1-800-927-HELP**

For more information, please contact Health Net Life Insurance Company (Health Net Life)



Health Net Life  
Medicare Supplement Plan  
PO Box 10420  
Van Nuys, CA 91499



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**HEALTH NET LIFE MEMBER SERVICES**

1-800-926-4178

**PARA LOS QUE HABLAN ESPAÑOL**

1-800-926-4178

**ASSISTANCE FOR THE HEARING AND  
SPEECH IMPAIRED**

TTY users call 711.

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