

2024 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)

Medicare supplement insurance can only be sold in standard plans. The chart on the next page shows the benefits included in each plan that can be sold on or after June 1, 2010. Every insurance company must offer Plan A. Some plans may not be available.

The basic benefits included in all plans are:



*Policies for Plans F, High Deductible F and Innovative Plan F are prohibited from sales, on or after January 1, 2020 to newly eligible Medicare beneficiaries. A newly eligible beneficiary is defined as an individual who becomes eligible for Medicare on or after January 1, 2020, because the individual attained 65 years of age on or after January 1, 2020, or the individual became eligible for Medicare benefits on or after January 1, 2020, by reason of disability, as specified.



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



Blood: First three pints of blood each year.



Hospice: Part A coinsurance.



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.

A	B	C	D	F, High Deductible F,¹ Innovative Plan F²
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

G, High Deductible G¹, Innovative Plan G²	K	L	M	N
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 \$7,060; paid at 100% after limit reached	Out-of-pocket limit \$3,530; paid at 100% after limit reached		

¹Plans 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 \$2,800 deductible. Benefits from High Deductible Plan F or High Deductible Plan G will not begin until out-of-pocket expenses exceed \$2,800. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by this policy.

²Innovative 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.

New to Part B discount
Members who apply within six months of their Part B effective date qualify for \$30 off their monthly premium for the first 12 months.

This applies to any policies with an effective date of February 1, 2020.

Note: Any qualifying individual will forfeit their discount if canceled due to non-payment during the first 12 months of enrollment.

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.

Once you choose the plan that works best for your needs, you are ready to enroll!



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	\$165	\$72	\$170	\$144
67-68	\$184	\$81	\$189	\$160
69-70	\$204	\$89	\$207	\$176
71-72	\$224	\$98	\$226	\$193
73-74	\$243	\$106	\$245	\$210
75-76	\$263	\$114	\$264	\$227
77-78	\$283	\$125	\$284	\$245
79-80	\$301	\$131	\$301	\$260
81-82	\$321	\$141	\$321	\$278
83-84	\$341	\$149	\$338	\$294
85-86	\$360	\$158	\$357	\$311
87-88	\$376	\$164	\$374	\$326
89-90	\$391	\$171	\$389	\$338
91-92	\$407	\$177	\$403	\$352
93-94	\$420	\$184	\$417	\$364
95+	\$446	\$195	\$441	\$384
Disabled under 65	\$446	\$195	\$441	\$384

Age range	Smoking ¹			
	Plan D	High Ded. G	Innovative Plan G	Plan N
65-66	\$192	\$85	\$196	\$167
67-68	\$217	\$95	\$218	\$188
69-70	\$238	\$104	\$239	\$205
71-72	\$259	\$113	\$261	\$225
73-74	\$283	\$125	\$284	\$245
75-76	\$305	\$133	\$306	\$265
77-78	\$332	\$146	\$330	\$287
79-80	\$352	\$154	\$350	\$305
81-82	\$373	\$164	\$372	\$323
83-84	\$396	\$173	\$394	\$343
85-86	\$419	\$184	\$416	\$362
87-88	\$437	\$192	\$434	\$379
89-90	\$457	\$200	\$450	\$395
91-92	\$474	\$207	\$468	\$410
93-94	\$492	\$215	\$485	\$424
95+	\$519	\$227	\$511	\$447
Disabled under 65	\$519	\$227	\$511	\$447

¹A 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	\$156	\$68	\$161	\$135
67-68	\$176	\$78	\$180	\$152
69-70	\$192	\$85	\$196	\$167
71-72	\$212	\$92	\$214	\$183
73-74	\$230	\$101	\$232	\$198
75-76	\$248	\$108	\$249	\$214
77-78	\$268	\$118	\$269	\$232
79-80	\$286	\$125	\$286	\$247
81-82	\$304	\$133	\$303	\$263
83-84	\$322	\$141	\$321	\$279
85-86	\$341	\$149	\$338	\$294
87-88	\$356	\$155	\$354	\$308
89-90	\$370	\$162	\$368	\$320
91-92	\$385	\$169	\$382	\$333
93-94	\$399	\$174	\$395	\$344
95+	\$420	\$184	\$417	\$364
Disabled under 65	\$420	\$184	\$417	\$364

Age range	Smoking ¹			
	Plan D	High Ded. G	Innovative Plan G	Plan N
65-66	\$183	\$81	\$186	\$158
67-68	\$204	\$89	\$207	\$176
69-70	\$226	\$100	\$227	\$195
71-72	\$247	\$108	\$248	\$214
73-74	\$268	\$118	\$269	\$232
75-76	\$290	\$127	\$290	\$250
77-78	\$314	\$137	\$312	\$270
79-80	\$333	\$146	\$331	\$288
81-82	\$355	\$155	\$353	\$307
83-84	\$376	\$164	\$374	\$326
85-86	\$397	\$174	\$395	\$344
87-88	\$414	\$182	\$412	\$358
89-90	\$432	\$190	\$427	\$374
91-92	\$448	\$196	\$443	\$387
93-94	\$465	\$204	\$460	\$402
95+	\$492	\$215	\$485	\$424
Disabled under 65	\$492	\$215	\$485	\$424

¹A 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	\$151	\$214	\$92	\$220	\$191
67-68	\$166	\$237	\$102	\$243	\$211
69-70	\$180	\$257	\$112	\$264	\$229
71-72	\$195	\$278	\$119	\$283	\$247
73-74	\$209	\$299	\$129	\$305	\$267
75-76	\$225	\$320	\$138	\$326	\$286
77-78	\$238	\$341	\$148	\$346	\$303
79-80	\$252	\$359	\$155	\$365	\$320
81-84	\$271	\$387	\$167	\$393	\$345
85+	\$304	\$434	\$188	\$439	\$387
Disabled under 65	\$304	\$434	\$188	\$439	\$387

Age range	Smoking ¹				
	Plan A	Plan F	High Ded. F	Innovative Plan F	Plan G
65-66	\$175	\$250	\$107	\$255	\$222
67-68	\$192	\$276	\$119	\$281	\$246
69-70	\$210	\$301	\$130	\$306	\$268
71-72	\$227	\$323	\$140	\$329	\$288
73-74	\$245	\$349	\$151	\$356	\$311
75-76	\$260	\$372	\$161	\$379	\$332
77-78	\$278	\$397	\$173	\$404	\$354
79-80	\$294	\$419	\$181	\$425	\$374
81-84	\$317	\$452	\$195	\$458	\$402
85+	\$355	\$506	\$218	\$511	\$449
Disabled under 65	\$355	\$506	\$218	\$511	\$449

Los Angeles County (Region 3)

Age range	Nonsmoking			
	Plan D	High Ded. G	Innovative Plan G	Plan N
65-66	\$183	\$81	\$186	\$158
67-68	\$204	\$89	\$207	\$176
69-70	\$225	\$98	\$227	\$194
71-72	\$246	\$108	\$247	\$213
73-74	\$268	\$118	\$269	\$232
75-76	\$290	\$127	\$290	\$250
77-78	\$314	\$137	\$312	\$270
79-80	\$333	\$146	\$331	\$288
81-82	\$354	\$154	\$352	\$306
83-84	\$374	\$164	\$373	\$324
85-86	\$397	\$174	\$395	\$344
87-88	\$414	\$182	\$412	\$358
89-90	\$431	\$189	\$426	\$373
91-92	\$448	\$196	\$443	\$387
93-94	\$464	\$203	\$460	\$401
95+	\$492	\$215	\$485	\$424
Disabled under 65	\$492	\$215	\$485	\$424

Age range	Smoking ¹			
	Plan D	High Ded. G	Innovative Plan G	Plan N
65-66	\$212	\$92	\$215	\$184
67-68	\$240	\$105	\$240	\$206
69-70	\$263	\$114	\$264	\$227
71-72	\$288	\$126	\$288	\$249
73-74	\$312	\$137	\$311	\$270
75-76	\$337	\$148	\$336	\$292
77-78	\$365	\$160	\$362	\$315
79-80	\$387	\$170	\$384	\$335
81-82	\$412	\$181	\$410	\$357
83-84	\$437	\$192	\$434	\$379
85-86	\$462	\$203	\$458	\$400
87-88	\$483	\$212	\$478	\$418
89-90	\$503	\$221	\$498	\$436
91-92	\$522	\$228	\$516	\$453
93-94	\$541	\$237	\$534	\$468
95+	\$572	\$250	\$564	\$495
Disabled under 65	\$572	\$250	\$564	\$495

¹A 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	\$151	\$214	\$92	\$220	\$191
67-68	\$166	\$237	\$102	\$243	\$211
69-70	\$180	\$257	\$112	\$264	\$229
71-72	\$195	\$278	\$119	\$283	\$247
73-74	\$209	\$299	\$129	\$305	\$267
75-76	\$225	\$320	\$138	\$326	\$286
77-78	\$238	\$341	\$148	\$346	\$303
79-80	\$252	\$359	\$155	\$365	\$320
81-84	\$271	\$387	\$167	\$393	\$345
85+	\$304	\$434	\$188	\$439	\$387
Disabled under 65	\$304	\$434	\$188	\$439	\$387

Age range	Smoking ¹				
	Plan A	Plan F	High Ded. F	Innovative Plan F	Plan G
65-66	\$175	\$250	\$107	\$255	\$222
67-68	\$192	\$276	\$119	\$281	\$246
69-70	\$210	\$301	\$130	\$306	\$268
71-72	\$227	\$323	\$140	\$329	\$288
73-74	\$245	\$349	\$151	\$356	\$311
75-76	\$260	\$372	\$161	\$379	\$332
77-78	\$278	\$397	\$173	\$404	\$354
79-80	\$294	\$419	\$181	\$425	\$374
81-84	\$317	\$452	\$195	\$458	\$402
85+	\$355	\$506	\$218	\$511	\$449
Disabled under 65	\$355	\$506	\$218	\$511	\$449

¹A 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	\$183	\$81	\$186	\$158
67-68	\$204	\$89	\$207	\$176
69-70	\$225	\$98	\$227	\$194
71-72	\$246	\$108	\$247	\$213
73-74	\$268	\$118	\$269	\$232
75-76	\$290	\$127	\$290	\$250
77-78	\$314	\$137	\$312	\$270
79-80	\$333	\$146	\$331	\$288
81-82	\$354	\$154	\$352	\$306
83-84	\$374	\$164	\$373	\$324
85-86	\$397	\$174	\$395	\$344
87-88	\$414	\$182	\$412	\$358
89-90	\$431	\$189	\$426	\$373
91-92	\$448	\$196	\$443	\$387
93-94	\$464	\$203	\$460	\$401
95+	\$492	\$215	\$485	\$424
Disabled under 65	\$492	\$215	\$485	\$424

Age range	Smoking ¹			
	Plan D	High Ded. G	Innovative Plan G	Plan N
65-66	\$212	\$92	\$215	\$184
67-68	\$240	\$105	\$240	\$206
69-70	\$263	\$114	\$264	\$227
71-72	\$288	\$126	\$288	\$249
73-74	\$312	\$137	\$311	\$270
75-76	\$337	\$148	\$336	\$292
77-78	\$365	\$160	\$362	\$315
79-80	\$387	\$170	\$384	\$335
81-82	\$412	\$181	\$410	\$357
83-84	\$437	\$192	\$434	\$379
85-86	\$462	\$203	\$458	\$400
87-88	\$483	\$212	\$478	\$418
89-90	\$503	\$221	\$498	\$436
91-92	\$522	\$228	\$516	\$453
93-94	\$541	\$237	\$534	\$468
95+	\$572	\$250	\$564	\$495
Disabled under 65	\$572	\$250	\$564	\$495

¹A 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.

Region 1 Zip Codes (Within San Diego County)	
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	\$165	\$72	\$170	\$144
67-68	\$184	\$81	\$189	\$160
69-70	\$204	\$89	\$207	\$176
71-72	\$224	\$98	\$226	\$193
73-74	\$243	\$106	\$245	\$210
75-76	\$263	\$114	\$264	\$227
77-78	\$283	\$125	\$284	\$245
79-80	\$301	\$131	\$301	\$260
81-82	\$321	\$141	\$321	\$278
83-84	\$341	\$149	\$338	\$294
85-86	\$360	\$158	\$357	\$311
87-88	\$376	\$164	\$374	\$326
89-90	\$391	\$171	\$389	\$338
91-92	\$407	\$177	\$403	\$352
93-94	\$420	\$184	\$417	\$364
95+	\$446	\$195	\$441	\$384
Disabled under 65	\$446	\$195	\$441	\$384

Age range	Smoking ¹			
	Plan D	High Ded. G	Innovative Plan G	Plan N
65-66	\$192	\$85	\$196	\$167
67-68	\$217	\$95	\$218	\$188
69-70	\$238	\$104	\$239	\$205
71-72	\$259	\$113	\$261	\$225
73-74	\$283	\$125	\$284	\$245
75-76	\$305	\$133	\$306	\$265
77-78	\$332	\$146	\$330	\$287
79-80	\$352	\$154	\$350	\$305
81-82	\$373	\$164	\$372	\$323
83-84	\$396	\$173	\$394	\$343
85-86	\$419	\$184	\$416	\$362
87-88	\$437	\$192	\$434	\$379
89-90	\$457	\$200	\$450	\$395
91-92	\$474	\$207	\$468	\$410
93-94	\$492	\$215	\$485	\$424
95+	\$519	\$227	\$511	\$447
Disabled under 65	\$519	\$227	\$511	\$447

¹A 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	\$133	\$190	\$82	\$196	\$170
67-68	\$149	\$210	\$91	\$217	\$188
69-70	\$161	\$229	\$99	\$234	\$204
71-72	\$174	\$247	\$106	\$253	\$221
73-74	\$187	\$267	\$115	\$272	\$237
75-76	\$200	\$285	\$123	\$291	\$254
77-78	\$212	\$303	\$131	\$309	\$270
79-80	\$225	\$320	\$138	\$326	\$286
81-84	\$242	\$345	\$149	\$350	\$308
85+	\$270	\$386	\$166	\$392	\$344
Disabled under 65	\$270	\$386	\$166	\$392	\$344

Age range	Smoking ¹				
	Plan A	Plan F	High Ded. F	Innovative Plan F	Plan G
65-66	\$156	\$222	\$97	\$228	\$197
67-68	\$173	\$246	\$106	\$252	\$219
69-70	\$188	\$268	\$116	\$273	\$238
71-72	\$202	\$289	\$124	\$294	\$257
73-74	\$218	\$311	\$135	\$317	\$277
75-76	\$232	\$332	\$143	\$337	\$295
77-78	\$248	\$355	\$153	\$360	\$315
79-80	\$260	\$372	\$161	\$379	\$332
81-84	\$281	\$403	\$174	\$408	\$358
85+	\$316	\$450	\$194	\$456	\$400
Disabled under 65	\$316	\$450	\$194	\$456	\$400

San Diego County (Region 2)

Age range	Nonsmoking			
	Plan D	High Ded. G	Innovative Plan G	Plan N
65-66	\$156	\$68	\$161	\$135
67-68	\$176	\$78	\$180	\$152
69-70	\$192	\$85	\$196	\$167
71-72	\$212	\$92	\$214	\$183
73-74	\$230	\$101	\$232	\$198
75-76	\$248	\$108	\$249	\$214
77-78	\$268	\$118	\$269	\$232
79-80	\$286	\$125	\$286	\$247
81-82	\$304	\$133	\$303	\$263
83-84	\$322	\$141	\$321	\$279
85-86	\$341	\$149	\$338	\$294
87-88	\$356	\$155	\$354	\$308
89-90	\$370	\$162	\$368	\$320
91-92	\$385	\$169	\$382	\$333
93-94	\$399	\$174	\$395	\$344
95+	\$420	\$184	\$417	\$364
Disabled under 65	\$420	\$184	\$417	\$364

Age range	Smoking ¹			
	Plan D	High Ded. G	Innovative Plan G	Plan N
65-66	\$183	\$81	\$186	\$158
67-68	\$204	\$89	\$207	\$176
69-70	\$226	\$100	\$227	\$195
71-72	\$247	\$108	\$248	\$214
73-74	\$268	\$118	\$269	\$232
75-76	\$290	\$127	\$290	\$250
77-78	\$314	\$137	\$312	\$270
79-80	\$333	\$146	\$331	\$288
81-82	\$355	\$155	\$353	\$307
83-84	\$376	\$164	\$374	\$326
85-86	\$397	\$174	\$395	\$344
87-88	\$414	\$182	\$412	\$358
89-90	\$432	\$190	\$427	\$374
91-92	\$448	\$196	\$443	\$387
93-94	\$465	\$204	\$460	\$402
95+	\$492	\$215	\$485	\$424
Disabled under 65	\$492	\$215	\$485	\$424

¹A 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	\$137	\$196	\$85	\$202	\$174
67-68	\$151	\$215	\$92	\$221	\$192
69-70	\$164	\$234	\$102	\$241	\$210
71-72	\$177	\$253	\$109	\$258	\$225
73-74	\$191	\$273	\$118	\$279	\$244
75-76	\$204	\$292	\$127	\$297	\$260
77-78	\$218	\$311	\$135	\$317	\$277
79-80	\$230	\$328	\$142	\$334	\$292
81-84	\$247	\$354	\$152	\$359	\$314
85+	\$277	\$395	\$171	\$401	\$352
Disabled under 65	\$277	\$395	\$171	\$401	\$352

Age range	Smoking ¹				
	Plan A	Plan F	High Ded. F	Innovative Plan F	Plan G
65-66	\$159	\$228	\$99	\$233	\$203
67-68	\$177	\$252	\$109	\$257	\$224
69-70	\$192	\$275	\$118	\$280	\$245
71-72	\$206	\$295	\$128	\$301	\$263
73-74	\$224	\$319	\$138	\$324	\$285
75-76	\$238	\$341	\$148	\$346	\$303
77-78	\$254	\$362	\$157	\$368	\$323
79-80	\$268	\$383	\$165	\$388	\$340
81-84	\$289	\$412	\$178	\$418	\$368
85+	\$323	\$461	\$200	\$468	\$412
Disabled under 65	\$323	\$461	\$200	\$468	\$412

¹A 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	\$165	\$72	\$170	\$144
67-68	\$184	\$81	\$189	\$160
69-70	\$204	\$89	\$207	\$176
71-72	\$224	\$98	\$226	\$193
73-74	\$243	\$106	\$245	\$210
75-76	\$263	\$114	\$264	\$227
77-78	\$283	\$125	\$284	\$245
79-80	\$301	\$131	\$301	\$260
81-82	\$321	\$141	\$321	\$278
83-84	\$341	\$149	\$338	\$294
85-86	\$360	\$158	\$357	\$311
87-88	\$376	\$164	\$374	\$326
89-90	\$391	\$171	\$389	\$338
91-92	\$407	\$177	\$403	\$352
93-94	\$420	\$184	\$417	\$364
95+	\$446	\$195	\$441	\$384
Disabled under 65	\$446	\$195	\$441	\$384

Age range	Smoking ¹			
	Plan D	High Ded. G	Innovative Plan G	Plan N
65-66	\$192	\$85	\$196	\$167
67-68	\$217	\$95	\$218	\$188
69-70	\$238	\$104	\$239	\$205
71-72	\$259	\$113	\$261	\$225
73-74	\$283	\$125	\$284	\$245
75-76	\$305	\$133	\$306	\$265
77-78	\$332	\$146	\$330	\$287
79-80	\$352	\$154	\$350	\$305
81-82	\$373	\$164	\$372	\$323
83-84	\$396	\$173	\$394	\$343
85-86	\$419	\$184	\$416	\$362
87-88	\$437	\$192	\$434	\$379
89-90	\$457	\$200	\$450	\$395
91-92	\$474	\$207	\$468	\$410
93-94	\$492	\$215	\$485	\$424
95+	\$519	\$227	\$511	\$447
Disabled under 65	\$519	\$227	\$511	\$447

¹A 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	\$133	\$190	\$82	\$196	\$170
67-68	\$149	\$210	\$91	\$217	\$188
69-70	\$161	\$229	\$99	\$234	\$204
71-72	\$174	\$247	\$106	\$253	\$221
73-74	\$187	\$267	\$115	\$272	\$237
75-76	\$200	\$285	\$123	\$291	\$254
77-78	\$212	\$303	\$131	\$309	\$270
79-80	\$225	\$320	\$138	\$326	\$286
81-84	\$242	\$345	\$149	\$350	\$308
85+	\$270	\$386	\$166	\$392	\$344
Disabled under 65	\$270	\$386	\$166	\$392	\$344

Age range	Smoking ¹				
	Plan A	Plan F	High Ded. F	Innovative Plan F	Plan G
65-66	\$156	\$222	\$97	\$228	\$197
67-68	\$173	\$246	\$106	\$252	\$219
69-70	\$188	\$268	\$116	\$273	\$238
71-72	\$202	\$289	\$124	\$294	\$257
73-74	\$218	\$311	\$135	\$317	\$277
75-76	\$232	\$332	\$143	\$337	\$295
77-78	\$248	\$355	\$153	\$360	\$315
79-80	\$260	\$372	\$161	\$379	\$332
81-84	\$281	\$403	\$174	\$408	\$358
85+	\$316	\$450	\$194	\$456	\$400
Disabled under 65	\$316	\$450	\$194	\$456	\$400

¹A 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	\$156	\$68	\$161	\$135
67-68	\$176	\$78	\$180	\$152
69-70	\$192	\$85	\$196	\$167
71-72	\$212	\$92	\$214	\$183
73-74	\$230	\$101	\$232	\$198
75-76	\$248	\$108	\$249	\$214
77-78	\$268	\$118	\$269	\$232
79-80	\$286	\$125	\$286	\$247
81-82	\$304	\$133	\$303	\$263
83-84	\$322	\$141	\$321	\$279
85-86	\$341	\$149	\$338	\$294
87-88	\$356	\$155	\$354	\$308
89-90	\$370	\$162	\$368	\$320
91-92	\$385	\$169	\$382	\$333
93-94	\$399	\$174	\$395	\$344
95+	\$420	\$184	\$417	\$364
Disabled under 65	\$420	\$184	\$417	\$364

Age range	Smoking ¹			
	Plan D	High Ded. G	Innovative Plan G	Plan N
65-66	\$183	\$81	\$186	\$158
67-68	\$204	\$89	\$207	\$176
69-70	\$226	\$100	\$227	\$195
71-72	\$247	\$108	\$248	\$214
73-74	\$268	\$118	\$269	\$232
75-76	\$290	\$127	\$290	\$250
77-78	\$314	\$137	\$312	\$270
79-80	\$333	\$146	\$331	\$288
81-82	\$355	\$155	\$353	\$307
83-84	\$376	\$164	\$374	\$326
85-86	\$397	\$174	\$395	\$344
87-88	\$414	\$182	\$412	\$358
89-90	\$432	\$190	\$427	\$374
91-92	\$448	\$196	\$443	\$387
93-94	\$465	\$204	\$460	\$402
95+	\$492	\$215	\$485	\$424
Disabled under 65	\$492	\$215	\$485	\$424

¹A 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	\$146	\$209	\$90	\$215	\$186
67-68	\$162	\$231	\$100	\$237	\$206
69-70	\$177	\$253	\$109	\$258	\$225
71-72	\$190	\$272	\$117	\$278	\$243
73-74	\$206	\$294	\$127	\$299	\$261
75-76	\$220	\$314	\$136	\$319	\$279
77-78	\$233	\$334	\$144	\$340	\$298
79-80	\$246	\$352	\$152	\$358	\$313
81-84	\$266	\$380	\$164	\$385	\$337
85+	\$297	\$425	\$184	\$431	\$378
Disabled under 65	\$297	\$425	\$184	\$431	\$378

Age range	Smoking ¹				
	Plan A	Plan F	High Ded. F	Innovative Plan F	Plan G
65-66	\$173	\$245	\$105	\$251	\$218
67-68	\$189	\$270	\$117	\$276	\$240
69-70	\$206	\$294	\$127	\$299	\$261
71-72	\$222	\$318	\$137	\$323	\$284
73-74	\$240	\$342	\$148	\$347	\$305
75-76	\$256	\$366	\$158	\$371	\$326
77-78	\$272	\$390	\$169	\$395	\$348
79-80	\$288	\$410	\$177	\$416	\$365
81-84	\$310	\$443	\$191	\$449	\$395
85+	\$347	\$496	\$215	\$501	\$441
Disabled under 65	\$347	\$496	\$215	\$501	\$441

¹A 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	\$174	\$76	\$176	\$149
67-68	\$192	\$85	\$196	\$167
69-70	\$213	\$93	\$216	\$184
71-72	\$233	\$103	\$236	\$202
73-74	\$253	\$110	\$255	\$218
75-76	\$273	\$120	\$273	\$236
77-78	\$296	\$129	\$295	\$256
79-80	\$315	\$138	\$313	\$271
81-82	\$335	\$147	\$334	\$290
83-84	\$356	\$155	\$354	\$308
85-86	\$376	\$164	\$374	\$326
87-88	\$392	\$172	\$390	\$339
89-90	\$409	\$179	\$404	\$353
91-92	\$424	\$185	\$420	\$366
93-94	\$439	\$193	\$436	\$380
95+	\$464	\$203	\$460	\$401
Disabled under 65	\$464	\$203	\$460	\$401

Age range	Smoking ¹			
	Plan D	High Ded. G	Innovative Plan G	Plan N
65-66	\$202	\$88	\$204	\$174
67-68	\$226	\$100	\$227	\$195
69-70	\$250	\$109	\$250	\$215
71-72	\$272	\$119	\$273	\$236
73-74	\$296	\$129	\$295	\$256
75-76	\$319	\$140	\$318	\$276
77-78	\$345	\$151	\$344	\$299
79-80	\$367	\$161	\$365	\$317
81-82	\$391	\$171	\$387	\$337
83-84	\$414	\$182	\$412	\$358
85-86	\$437	\$192	\$434	\$379
87-88	\$457	\$201	\$453	\$396
89-90	\$476	\$208	\$470	\$413
91-92	\$495	\$217	\$488	\$427
93-94	\$513	\$224	\$506	\$443
95+	\$541	\$237	\$534	\$468
Disabled under 65	\$541	\$237	\$534	\$468

¹A 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	\$122	\$175	\$75	\$180	\$155
67-68	\$135	\$192	\$84	\$199	\$171
69-70	\$146	\$209	\$90	\$215	\$186
71-72	\$158	\$227	\$99	\$232	\$202
73-74	\$171	\$244	\$105	\$250	\$217
75-76	\$182	\$260	\$113	\$267	\$233
77-78	\$195	\$278	\$119	\$283	\$247
79-80	\$205	\$293	\$127	\$298	\$260
81-84	\$221	\$316	\$136	\$321	\$281
85+	\$247	\$354	\$152	\$359	\$314
Disabled under 65	\$247	\$354	\$152	\$359	\$314

Age range	Smoking ¹				
	Plan A	Plan F	High Ded. F	Innovative Plan F	Plan G
65-66	\$142	\$204	\$88	\$209	\$182
67-68	\$158	\$226	\$98	\$231	\$201
69-70	\$173	\$245	\$105	\$251	\$218
71-72	\$184	\$265	\$114	\$270	\$235
73-74	\$200	\$285	\$123	\$291	\$254
75-76	\$213	\$304	\$131	\$310	\$271
77-78	\$228	\$324	\$141	\$331	\$289
79-80	\$240	\$342	\$148	\$347	\$305
81-84	\$258	\$369	\$159	\$374	\$329
85+	\$289	\$412	\$178	\$418	\$368
Disabled under 65	\$289	\$412	\$178	\$418	\$368

¹A 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	\$143	\$63	\$148	\$124
67-68	\$162	\$70	\$166	\$140
69-70	\$177	\$78	\$181	\$153
71-72	\$194	\$85	\$197	\$168
73-74	\$212	\$92	\$214	\$183
75-76	\$228	\$100	\$229	\$197
77-78	\$247	\$108	\$248	\$214
79-80	\$263	\$114	\$264	\$227
81-82	\$278	\$123	\$279	\$240
83-84	\$296	\$129	\$295	\$256
85-86	\$314	\$137	\$312	\$270
87-88	\$326	\$144	\$326	\$282
89-90	\$340	\$149	\$338	\$293
91-92	\$354	\$154	\$351	\$306
93-94	\$366	\$160	\$364	\$316
95+	\$386	\$169	\$383	\$334
Disabled under 65	\$386	\$169	\$383	\$334

Age range	Smoking ¹			
	Plan D	High Ded. G	Innovative Plan G	Plan N
65-66	\$167	\$74	\$172	\$146
67-68	\$188	\$83	\$191	\$162
69-70	\$207	\$90	\$210	\$180
71-72	\$227	\$100	\$228	\$196
73-74	\$246	\$108	\$247	\$213
75-76	\$267	\$117	\$267	\$230
77-78	\$288	\$126	\$288	\$249
79-80	\$305	\$133	\$305	\$264
81-82	\$324	\$142	\$324	\$281
83-84	\$344	\$151	\$343	\$298
85-86	\$365	\$160	\$362	\$315
87-88	\$382	\$167	\$378	\$330
89-90	\$396	\$173	\$394	\$343
91-92	\$411	\$180	\$408	\$356
93-94	\$427	\$186	\$422	\$370
95+	\$451	\$197	\$446	\$391
Disabled under 65	\$451	\$197	\$446	\$391

¹A 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.

Medicare Supplement Plan Policy replacement

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new Medicare Supplement Plan Policy and are sure you want to keep it.

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.

Complete answers are very important

You do not need to answer questions about your medical and health history if you are applying for coverage during an open enrollment or guaranteed issue period.

When you fill out the application for an HNL Medicare Supplement plan, be sure to truthfully and completely answer all questions about your medical and health history. HNL may have the right to cancel your Medicare Supplement Plan 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.



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 \$240 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
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$1632	\$0	\$1632 (Part A ded.)
61st through 90th day	All but \$408 a day	\$408 a day	\$0
91st day and after:			
• While using 60 lifetime reserve days	All but \$816 a day	\$816 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 \$204 a day	\$0	Up to \$204 a day
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.

Plan **A** 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 \$240 of Medicare-approved amounts*	\$0	\$0	\$240 (Part B ded.)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B excess charges (above Medicare-approved amounts)	\$0	\$0	All costs
Blood First 3 pints	\$0	All costs	\$0
Next \$240 of Medicare-approved amounts*	\$0	\$0	\$240 (Part B ded.)
Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical laboratory services Tests for diagnostic services	100%	\$0	\$0

*Once you have been billed \$240 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 \$240 of Medicare-approved amounts*	\$0	\$0	\$240 (Part B ded.)
Remainder of Medicare-approved amounts	80%	20%	\$0

*Once you have been billed \$240 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
Hospitalization*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1632	\$1632 (Part A ded.)	\$0
61st through 90th day	All but \$408 a day	\$408 a day	\$0
91st day and after:			
• While using 60 lifetime reserve days	All but \$816 a day	\$816 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 \$204 a day	Up to \$204 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.

Plan **D** 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 \$240 of Medicare-approved amounts*	\$0	\$0	\$240 (Part B ded.)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B excess charges (above Medicare-approved amounts)	\$0	\$0	All costs
Blood First 3 pints	\$0	All costs	\$0
Next \$240 of Medicare-approved amounts*	\$0	\$0	\$240 (Part B ded.)
Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical laboratory services Tests for diagnostic services	100%	\$0	\$0

*Once you have been billed \$240 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 \$240 of Medicare-approved amounts*	\$0	\$0	\$240 (Part B ded.)
Reminder 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 \$240 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
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1632	\$1632 (Part A ded.)	\$0
61st through 90th day	All but \$408 a day	\$408 a day	\$0
91st day and after:			
• While using 60 lifetime reserve days	All but \$816 a day	\$816 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 \$204 a day	Up to \$204 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.

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 \$240 of Medicare-approved amounts*	\$0	\$240 (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 \$240 of Medicare-approved amounts*	\$0	\$240 (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 \$240 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 \$240 of Medicare-approved amounts*	\$0	\$240 (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 \$240 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 \$2,800 calendar year deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses exceed \$2,800. 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 \$2,800 ded., plan pays	In addition to \$2,800 ded., you pay
Hospitalization*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1632	\$1632 (Part A ded.)	\$0
61st through 90th day	All but \$408 a day	\$408 a day	\$0
91st day and after:			
• While using 60 lifetime reserve days	All but \$816 a day	\$816 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 \$204 a day	Up to \$204 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 \$2,800 ded., plan pays	In addition to \$2,800 ded., you pay
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.

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 \$2,800 calendar year deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses exceed \$2,800. 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 \$2,800 ded., plan pays	In addition to \$2,800 ded., 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 \$240 of Medicare-approved amounts*	\$0	\$240 (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 \$240 of Medicare-approved amounts*	\$0	\$240 (Part B ded.)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0

*Once you have been billed \$240 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 \$2,800 ded., plan pays	In addition to \$2,800 ded., you pay
Clinical laboratory services Tests for diagnostic services	100%	\$0	\$0
Home health care – Medicare-approved services Medically necessary skilled care services and medical supplies such as durable medical equipment	100%	\$0	\$0
First \$240 of Medicare-approved amounts*	\$0	\$240 (Part B ded.)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

Services	Medicare pays	After you pay \$2,800 ded., plan pays	In addition to \$2,800 ded., 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 \$240 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
Hospitalization*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1632	\$1632 (Part A ded.)	\$0
61st through 90th day	All but \$408 a day	\$408 a day	\$0
91st day and after:			
• While using 60 lifetime reserve days	All but \$816 a day	\$816 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 \$204 a day	Up to \$204 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 \$240 of Medicare-approved amounts*	\$0	\$240 (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 \$240 of Medicare-approved amounts*	\$0	\$240 (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 \$240 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 \$240 of Medicare-approved amounts*	\$0	\$240 (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 \$240 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
<ul style="list-style-type: none"> • Contact lenses – Includes materials only, once every 24 months <ul style="list-style-type: none"> – Conventional 	\$0	Up to \$250 allowance	85% of the remaining balance
<ul style="list-style-type: none"> – Disposable 	\$0	Up to \$250 allowance	100% of the remaining balance
<ul style="list-style-type: none"> – 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 <ul style="list-style-type: none"> • 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

Plan **G** 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 \$1632	\$1632 (Part A ded.)	\$0
61st through 90th day	All but \$408 a day	\$408 a day	\$0
91st day and after:			
• While using 60 lifetime reserve days	All but \$816 a day	\$816 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 \$204 a day	Up to \$204 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.

Plan **G** 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 \$240 of Medicare-approved amounts*	\$0	\$0	\$240 (Part B ded.)
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 \$240 of Medicare-approved amounts*	\$0	\$0	\$240 (Part B ded.)
Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical laboratory services Tests for diagnostic services	100%	\$0	\$0

*Once you have been billed \$240 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 \$240 of Medicare-approved amounts*	\$0	\$0	\$240 (Part B ded.)
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 \$240 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 \$2,800 calendar year deductible. Benefits from High Deductible Plan G will not begin until out-of-pocket expenses exceed \$2,800. 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 \$2,800 ded., plan pays	In addition to \$2,800 ded., you pay
Hospitalization*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1632	\$1632 (Part A ded.)	\$0
61st through 90th day	All but \$408 a day	\$408 a day	\$0
91st day and after:			
• While using 60 lifetime reserve days	All but \$816 a day	\$816 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 \$204 a day	Up to \$204 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 \$2,800 ded., plan pays	In addition to \$2,800 ded., you pay
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

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 \$2,800 calendar year deductible. Benefits from High Deductible Plan G will not begin until out-of-pocket expenses exceed \$2,800. 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 \$2,800 ded., plan pays	In addition to \$2,800 ded., 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 \$240 of Medicare-approved amounts*	\$0	\$0	\$240 (Part B ded.)
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 \$240 of Medicare-approved amounts*	\$0	\$0	\$240 (Part B ded.)
Remainder of Medicare-approved amounts	80%	20%	\$0

*Once you have been billed \$240 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 \$2,800 ded., plan pays	In addition to \$2,800 ded., you pay
Clinical laboratory services Tests for diagnostic services	100%	\$0	\$0
Home health care – Medicare-approved services Medically necessary skilled care services and medical supplies such as durable medical equipment	100%	\$0	\$0
First \$240 of Medicare-approved amounts*	\$0	\$0	\$240 (Part B ded.)
Remainder of Medicare-approved amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

Services	Medicare pays	After you pay \$2,800 ded., plan pays	In addition to \$2,800 ded., 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 \$240 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
Hospitalization*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1632	\$1632 (Part A ded.)	\$0
61st through 90th day	All but \$408 a day	\$408 a day	\$0
91st day and after:			
• While using 60 lifetime reserve days	All but \$816 a day	\$816 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 \$204 a day	Up to \$204 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 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 \$240 of Medicare-approved amounts*	\$0	\$0	\$240 (Part B ded.)
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 \$240 of Medicare-approved amounts*	\$0	\$0	\$240 (Part B ded.)
Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical laboratory services Tests for diagnostic services	100%	\$0	\$0

*Once you have been billed \$240 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 \$240 of Medicare-approved amounts*	\$0	\$0	\$240 (Part B ded.)
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 \$240 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
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
<ul style="list-style-type: none"> Contact lenses – Includes materials only, once every 24 months <ul style="list-style-type: none"> – Conventional 	\$0	Up to \$250 allowance	85% of the remaining balance
<ul style="list-style-type: none"> – Disposable 	\$0	Up to \$250 allowance	100% of the remaining balance
<ul style="list-style-type: none"> – 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 <ul style="list-style-type: none"> • 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
Routine Chiropractic and Acupuncture benefit 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
Hospitalization¹ Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$1632	\$1632 (Part A ded.)	\$0
61st through 90th day	All but \$408 a day	\$408 a day	\$0
91st day and after:			
• While using 60 lifetime reserve days	All but \$816 a day	\$816 a day	\$0
• Once lifetime reserve days are used:	\$0	100% of Medicare-eligible expenses	\$0 ²
– Additional 365 days	\$0	\$0	All costs
– Beyond the additional 365 days	\$0	\$0	All costs
Skilled nursing facility care¹ 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 \$204 a day	Up to \$204 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

¹A 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.

²**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
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 \$240 of Medicare-approved amounts*	\$0	\$0	\$240 (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.
Part B Excess Charges (above Medicare-approved amounts)	\$0	\$0	All costs
Blood First 3 pints	\$0	All costs	\$0
Next \$240 of Medicare-approved amounts*	\$0	\$0	\$240 (Part B ded.)
Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical laboratory services Tests for diagnostic services	100%	\$0	\$0

*Once you have been billed \$240 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 \$240 of Medicare-approved amounts*	\$0	\$0	\$240 (Part B ded.)
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 \$240 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

You are eligible for enrollment in one of HNL's Medicare Supplement plans if you are 65 or older and entitled to Medicare on the basis of Social Security disability benefits and do not have end-stage renal disease (ESRD), are enrolled in Medicare Parts A and B, and reside within the State of California. Your continued eligibility to participate in this health plan depends on your continued Medicare enrollment. You may be eligible for guaranteed issuance of a Medicare Supplement Plan Policy with HNL. Please call Health Net Life Medicare Inside Sales for more details at **1-800-944-7287**.

IF YOU ARE 64 OR YOUNGER

You may be able to enroll in one of HNL's Medicare Supplement plans, under the following conditions:

- You are a resident of California.
- You are enrolled in Medicare Parts A and B at the time you apply.
- You qualify for guaranteed acceptance in an HNL plan according to HNL's guidelines.
- You do not have end-stage renal disease.

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.

How to apply

You may apply by completing the application and returning it in the enclosed envelope. You may enroll in your choice of plans A, D, F, High Deductible Plan F, Innovative Plan F, G, High Deductible Plan G, Innovative Plan G, and N. You may be eligible for guaranteed issuance of a Medicare Supplement Plan Policy with HNL. Please call Health Net Life Medicare Inside Sales for more details at **1-800-944-7287**.

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.

Health Net Life Inside Sales

Once you have had a chance to review the information presented here, please feel free to call Health Net Life Medicare Inside Sales at **1-800-944-7287**. We'll be glad to talk to you about this plan and all the benefits it offers you.

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

HEALTH NET LIFE INSIDE SALES

1-800-944-7287

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.



Underwritten by Health Net Life Insurance Company. Health Net Life Insurance Company is a subsidiary of Health Net, LLC. Health Net is a registered service mark of Health Net, LLC. All rights reserved.

BKT060793ED00 (11/22)