Plan L *Medicare (Part A)*

Hospital services – per benefit period

Services	*Medicare pays*	*Plan pays*	*You pay*[1]
Hospitalization[2] Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,340	$1,005 (75% of Part A deductible)	$335 (25% of Part A deductible)◆
61st through 90th day	All but $335 a day	$335 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $670 a day	$670 a day	$0
Once lifetime reserve days are used:			
• Additional 365 days	$0	100% of Medicare-eligible expenses	$0[3]
• Beyond the additional 365 days	$0	$0	All costs

[1]You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $2,620 each calendar year. The amounts that count toward your annual limit are noted with diamonds (◆) in these charts. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges"), and you will be responsible for paying this difference between the amount charged by your provider and the amount paid by Medicare for the item or service.**

[2]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.

[3]**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*	*Plan pays*	*You pay*[1]
Skilled nursing facility care[2] 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 $167.50 a day	Up to $125.63 a day	Up to $41.85 a day◆
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	75%	25%◆
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	75% of Medicare copayment/ coinsurance	25% of Medicare copayment/ coinsurance◆

[2]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.

Plan L *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 $183 of Medicare-approved amounts*	$0	$0	$183 (Part B deductible)◆
Preventive benefits for Medicare-covered services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5%◆
Part B Excess Charges (above Medicare-approved amounts)	$0	$0	All costs (and they do not count toward out-of-pocket limit of $2,560)**
Blood			
First 3 pints	$0	75%	25%◆
Next $183 of Medicare-approved amounts*	$0	$0	$183 (Part B deductible)◆
Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5%◆
Clinical laboratory services			
Tests for diagnostic services	100%	$0	$0

*Once you have been billed $183 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $2,620 per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges"), and you will be responsible for paying this difference between the amount charged by your provider and the amount paid by Medicare for the item or service.

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 $183 of Medicare-approved amounts*	$0	$0	$183 (Part B deductible)◆
Remainder of Medicare-approved amounts	80%	15%	5%◆

*Once you have been billed $183 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.