# OUTLINE OF COVERAGE AND RATES FOR MINNESOTA RESIDENTS

**Medicare Supplement benefit plans:** **Basic, Extended Basic, High-Deductible Coverage, and $20/$50 Copayment**

Together, all the way.®

**Cigna Medicare Supplement Insurance**
Cigna Health and Life Insurance Company

CHLIC-MS-OC-MN

902464 01/18

**CIGNA HEALTH AND LIFE INSURANCE COMPANY**

PO Box 26700, Austin, TX 78755-0580 • 866-459-4272

**Chart of Standardized Medicare Supplement Policies (MN)**

**BASIC BENEFITS included in Medicare Supplement policies:**

- **Inpatient Hospital Care:** Covers the Medicare Part A coinsurance.
- **Medical Costs:** Covers the Medicare Part B coinsurance (generally 20% of the Medicare-approved payment amount).
- **Blood:** Covers the first three pints of blood each year.
- **Hospice:** Covers Part A coinsurance.
- **Home Health Care and Medical Supplies:** Covers Medicare Part A or B cost sharing.

| Medicare Supplement Benefits | Basic Plan | Extended Basic Plan* | High-Deductible Coverage Plan** | $20/$50 Copayment Plan |
|---|---|---|---|---|
| Basic benefits | √ | √ | √ | √ (100% Part B coinsurance except up to $20 co-payment for office visit and up to $50 for ER) |
| Medicare Part A: Skilled nursing facility coinsurance | √ | √ | √ | √ |
| Medicare Part A Deductible | | √ | √ | √ |
| Medicare Part B Deductible | | √ | | |
| Medicare Part B Excess Charges (100%) | | √ | | |
| Preventive Care (not covered by Medicare) | | √ | √ | |
| Foreign Travel Emergency | 80% | 80% | 100% | 80% |
| Additional benefits (not covered by Medicare) | | 80%* | | |
| Coverage while in a foreign country | | 80%* | | |
| State-mandated benefits (diabetic equipment and supplies, routine cancer screening, reconstructive surgery, and immunizations) | √ | √ | √ | √ |

| **Optional Riders for the Basic Plan only** | You may add any of the following four riders to the Basic Plan:<br>• Medicare Part A Deductible (CHLIC-MS-PTAD-MN)<br>• Medicare Part B Deductible (CHLIC-MS-PTBD-MN)<br>• Medicare Part B Excess Charges (100%) CHLIC-MS-PTBEXC-MN)<br>• Preventive Medical Care Benefit (CHLIC-MS-PC-MN) |
|---|---|

*100% after you spend $1,000 of out-of-pocket costs for a Calendar Year

**Benefits from the High-Deductible Coverage Plan will not begin until out-of-pocket expenses exceed $2,240. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductible for Part A.

Note: The check marks in this chart mean the benefit is covered.

**NOTE TO BUYER**: THE CONTRACTS DO NOT COVER PRESCRIPTION DRUGS. PRESCRIPTION DRUGS CAN BE A VERY HIGH PERCENTAGE OF YOUR MEDICAL EXPENSES. COVERAGE FOR PRESCRIPTION DRUGS MAY BE AVAILABLE TO YOU BY RETAINING EXISTING COVERAGE YOU MAY HAVE OR BY ENROLLING IN MEDICARE PART D. PLEASE ASK FOR FURTHER DETAILS.

THE POLICY DOES NOT COVER ALL MEDICAL EXPENSES BEYOND THOSE COVERED BY MEDICARE. THE POLICY DOES NOT COVER ALL SKILLED NURSING HOME CARE EXPENSES AND DOES NOT COVER CUSTODIAL OR RESIDENTIAL NURSING CARE. READ YOUR POLICY CAREFULLY TO DETERMINE WHICH NURSING HOME FACILITIES AND EXPENSES ARE COVERED BY YOUR POLICY.

We will not pay for services for which a charge is normally not made where there is no insurance. In addition, no benefits are payable for expenses incurred before the Coverage Effective Date.

*Cigna Health and Life Insurance Company*

**MEDICARE SUPPLEMENT**

## MINNESOTA

**Community Rated Rates -- Effective 10/1/2017 -- Area I (555-567)**

| NON-TOBACCO | | | | | TOBACCO | | | |
|---|---|---|---|---|---|---|---|---|
| Annual Direct Bill | Semi-Annual Direct Bill | Quarterly Direct Bill | Monthly Bank Draft | | Annual Direct Bill | Semi-Annual Direct Bill | Quarterly Direct Bill | Monthly Bank Draft |
| 2295.00 | 1193.40 | 608.18 | 191.17 | **MN Extended Plan<br>LOYAL-MS-Extended-MN** | 2524.50 | 1312.74 | 668.99 | 210.29 |
| 1552.22 | 807.15 | 411.34 | 129.30 | **MN Basic Plan<br>LOYAL-MS-Basic-MN** | 1707.44 | 887.87 | 452.47 | 142.23 |
| 255.00 | 132.60 | 67.58 | 21.24 | **Part A Deductible Rider*<br>LOYAL-MS-PTAD-MN** | 280.50 | 145.86 | 74.33 | 23.37 |
| 20.40 | 10.61 | 5.41 | 1.70 | **Part B Excess Charge Rider*<br>LOYAL-MS-PTBEXC-MN** | 22.44 | 11.67 | 5.95 | 1.87 |
| 183.00 | 95.16 | 48.50 | 15.24 | **Part B Deductible Rider*<br>LOYAL-MS-PTBD-MN** | 183.00 | 95.16 | 48.50 | 15.24 |
| 51.00 | 26.52 | 13.52 | 4.25 | **Preventive Care Rider*<br>LOYAL-MS-PC-MN** | 56.10 | 29.17 | 14.87 | 4.67 |

*Optional riders only available for MN Basic Plan

*Cigna Health and Life Insurance Company*

**MEDICARE SUPPLEMENT**

## MINNESOTA

### Community Rated Rates -- Effective 10/1/2017 -- Area II (550-551, 553-554)

| NON-TOBACCO | | | | | TOBACCO | | | |
|---|---|---|---|---|---|---|---|---|
| Annual Direct Bill | Semi-Annual Direct Bill | Quarterly Direct Bill | Monthly Bank Draft | | Annual Direct Bill | Semi-Annual Direct Bill | Quarterly Direct Bill | Monthly Bank Draft |
| 2511.00 | 1305.72 | 665.42 | 209.17 | **MN Extended Plan LOYAL-MS-Extended-MN** | 2762.10 | 1436.29 | 731.96 | 230.08 |
| 1698.31 | 883.12 | 450.05 | 141.47 | **MN Basic Plan LOYAL-MS-Basic-MN** | 1868.14 | 971.43 | 495.06 | 155.62 |
| 279.00 | 145.08 | 73.94 | 23.24 | **Part A Deductible Rider* LOYAL-MS-PTAD-MN** | 306.90 | 159.59 | 81.33 | 25.56 |
| 22.32 | 11.61 | 5.91 | 1.86 | **Part B Excess Charge Rider* LOYAL-MS-PTBEXC-MN** | 24.55 | 12.77 | 6.51 | 2.05 |
| 183.00 | 95.16 | 48.50 | 15.24 | **Part B Deductible Rider* LOYAL-MS-PTBD-MN** | 183.00 | 95.16 | 48.50 | 15.24 |
| 55.80 | 29.02 | 14.79 | 4.65 | **Preventive Care Rider* LOYAL-MS-PC-MN** | 61.38 | 31.92 | 16.27 | 5.11 |

*Optional riders only available for MN Basic Plan

*Cigna Health and Life Insurance Company*

**MEDICARE SUPPLEMENT**

## MINNESOTA

### Community Rated Rates -- Effective 10/1/2017 -- Area I (555-567)

| NON-TOBACCO | | | | | TOBACCO | | | |
|---|---|---|---|---|---|---|---|---|
| Annual Direct Bill | Semi-Annual Direct Bill | Quarterly Direct Bill | Monthly Bank Draft | | Annual Direct Bill | Semi-Annual Direct Bill | Quarterly Direct Bill | Monthly Bank Draft |
| 1552.22 | 807.15 | 411.34 | 129.30 | **Copayment Plan LOYAL-MS-Copayment-MN** | 1707.44 | 887.87 | 452.47 | 142.23 |

*Cigna Health and Life Insurance Company*

**MEDICARE SUPPLEMENT**

## MINNESOTA

### Community Rated Rates -- Effective 10/1/2017 -- Area II (550-551, 553-554)

| NON-TOBACCO | | | | | TOBACCO | | | |
|---|---|---|---|---|---|---|---|---|
| Annual Direct Bill | Semi-Annual Direct Bill | Quarterly Direct Bill | Monthly Bank Draft | | Annual Direct Bill | Semi-Annual Direct Bill | Quarterly Direct Bill | Monthly Bank Draft |
| 1698.31 | 883.12 | 450.05 | 141.47 | **Copayment Plan LOYAL-MS-Copayment-MN** | 1868.14 | 971.43 | 495.06 | 155.62 |

*Cigna Health and Life Insurance Company*

**MEDICARE SUPPLEMENT**

## MINNESOTA

**Community Rated Rates -- Effective 10/1/2017 -- Area I (555-567)**

| NON-TOBACCO | | | | | TOBACCO | | | |
|---|---|---|---|---|---|---|---|---|
| Annual Direct Bill | Semi-Annual Direct Bill | Quarterly Direct Bill | Monthly Bank Draft | | Annual Direct Bill | Semi-Annual Direct Bill | Quarterly Direct Bill | Monthly Bank Draft |
| 663.00 | 344.76 | 175.70 | 55.23 | **High Deductible Plan CHLIC-MS-HDED-MN** | 729.30 | 379.24 | 193.26 | 60.75 |

*Cigna Health and Life Insurance Company*

**MEDICARE SUPPLEMENT**

## MINNESOTA

**Community Rated Rates -- Effective 10/1/2017 -- Area II (550-551, 553-554)**

| NON-TOBACCO | | | | | TOBACCO | | | |
|---|---|---|---|---|---|---|---|---|
| Annual Direct Bill | Semi-Annual Direct Bill | Quarterly Direct Bill | Monthly Bank Draft | | Annual Direct Bill | Semi-Annual Direct Bill | Quarterly Direct Bill | Monthly Bank Draft |
| 725.40 | 377.21 | 192.23 | 60.43 | **High Deductible Plan CHLIC-MS-HDED-MN** | 797.94 | 414.93 | 211.45 | 66.47 |

**Locate appropriate Area according to the Applicant's ZIP Code in the ZIP Code chart below.**

**MINNESOTA ZIP CODES:**

| Area | 3-digit ZIP Codes |
|---|---|
| Area I | 555–567 |
| Area II | 550–551, 553–554 |

## DISCLOSURES

Use this Outline to compare benefits and premiums among policies.

## PREMIUM INFORMATION

We, Cigna Health and Life Insurance Company, can also raise Your premium if (a) We change the rates or discounts which apply to all policies of this form issued by Us and in force in the state where Your policy was issued; or (b) coverage under Medicare changes. We will send You a written notice at least thirty (30) days in advance when We change the premium rates or discounts for all policies of this form issued by Us and in force in the state where Your policy was issued.

## READ YOUR POLICY VERY CAREFULLY

This is only an Outline describing Your policy's most important features. The policy is Your insurance contract. You must read the policy itself to understand all of the rights and duties of both You and Cigna Health and Life Insurance Company.

## 30-DAY RIGHT TO RETURN POLICY

If You find that You are not satisfied with Your policy, You may return it to Cigna Health and Life Insurance Company, PO Box 26580, Austin, TX 78755-0580. If You send the policy back to Us within thirty (30) days after You receive it, We will treat the policy as if it had never been issued and return all of Your premiums.

## POLICY REPLACEMENT

If You are replacing another health insurance policy, do NOT cancel it until You have actually received Your new policy and are sure You want to keep it.

## NOTICE

This policy may not fully cover all of Your medical costs. Neither Cigna Health and Life Insurance Company nor its agents are connected with Medicare. This Outline of Coverage does not give all the details of Medicare coverage. Contact Your local Social Security Office or consult the *Medicare and You* for more details.

## COMPLETE ANSWERS ARE VERY IMPORTANT

When You fill out the application for the new policy, be sure to answer truthfully and completely all questions about Your medical and health history. We may cancel Your policy and refuse to pay any claims if You leave out or falsify important medical information.

Review the application carefully before You sign it. Be certain that all information has been properly recorded.

THE POLICY DOES NOT COVER ALL MEDICAL EXPENSES BEYOND THOSE COVERED BY MEDICARE. THE POLICY DOES NOT COVER ALL SKILLED NURSING HOME CARE EXPENSES AND DOES NOT COVER CUSTODIAL OR RESIDENTIAL NURSING CARE. READ YOUR POLICY CAREFULLY TO DETERMINE WHICH NURSING HOME FACILITIES AND EXPENSES ARE COVERED BY YOUR POLICY.

We will not pay for services for which a charge is normally not made where there is no insurance. In addition, no benefits are payable for expenses incurred before the coverage effective date.

## GUARANTEED ACCEPTANCE AND RENEWAL

Your acceptance into Our Medicare Supplemental policy is guaranteed if You apply for coverage during Your Open Enrollment period. This period lasts for six (6) months and begins on the first day of the month in which You are both age 65 and enrolled in Medicare Part B. During this period, We will waive any medical underwriting requirements. Certain circumstances may provide further opportunity for guaranteed acceptance. For details, consult "*A Guide to Health Insurance for People with Medicare*."

Our Medicare Supplement policies are Guaranteed Renewable.

## LIMITATION ON OUT-OF-POCKET EXPENSES

*When Your out-of-pocket expenses equals $1,000 per person in a Calendar Year, we will pay 100% of additional covered expense You incur during the remainder of such Calendar Year (**only applies to CHLIC-MS-EXTENDED-MN**).

**BASIC PLAN**

**MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** | | | |
| Semi-private room and board, general nursing, and miscellaneous services and supplies | | | |
| First 60 days | All but $1,340 | $0 **OR +$1,340 with Optional Benefit Rider** | $1,340 (Part A deductible) **OR $0** |
| 61st through 90th day | All but $335 per day | $335 per day | $0 |
| 91st day and after: | | | |
| – while using 60 lifetime reserve days | All but $670 per day | $670 per day | $0 |
| – once lifetime reserve days are used, additional 365 days | $0 | 100% of Medicare eligible expenses | $0** |
| – beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** | | | |
| You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entering 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 per day | Up to $167.50 per 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 coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance | $0 |

****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.

+These are Optional Benefit Riders. You purchased this benefit if the box is checked and You paid the premium.

## BASIC PLAN
## MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT** such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $183 of Medicare-approved amounts* | $0 | $0 **OR +$183 with Optional Benefit Rider** | $183 (Part B deductible) **OR $0** |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 20%** | $0 |
| **PART B EXCESS CHARGES** (above Medicare-approved amounts)** | $0 | $0 **OR +100% with Optional Benefit Rider** | All costs **OR $0** |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $183 of Medicare-approved amounts* | $0 | $0 **OR +$183 with Optional Benefit Rider** | $183 (Part B deductible) **OR $0** |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES** | | | |
| Tests for diagnostic services | 100% | $0 | $0 |

**Except for ambulance services and medical supplies and equipment, all health care providers in Minnesota shall not charge any person with Medicare in Minnesota any amount in excess of the Medicare-approved amount for any Medicare-covered services provided.

+ These are Optional Benefit Riders. You purchased this benefit if the box is checked and You paid the premium.

## BASIC PLAN

## MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

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

### PARTS A & B

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE MEDICARE-APPROVED SERVICES**<br>Medically-necessary skilled care services and medical supplies<br>– Durable medical equipment<br>First $183 of Medicare-approved amounts*<br><br>Remainder of Medicare-approved amounts | <br><br>100%<br><br>$0<br><br>80% | <br><br>$0<br><br>$0 **OR +$183 with Optional Benefit Rider**<br>20% | <br><br>$0<br><br>$183 (Part B deductible) **OR $0**<br><br>$0 |

### OTHER BENEFITS – NOT COVERED BY MEDICARE

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **FOREIGN TRAVEL – NOT COVERED BY MEDICARE**<br>Medically-necessary emergency care services beginning during travel outside the United States (for Hospital, Physician, medical care, and supplies | $0 | 80% of covered expenses | Expenses not paid by Medicare or the policy |
| **PREVENTIVE MEDICAL CARE BENEFIT NOT COVERED BY MEDICARE**<br>Annual physical and preventive tests and services administered or ordered by a Physician when not covered by Medicare. Routine annual medical exam, including diagnostic X-rays and laboratory services. | $0 | $0 **OR +up to $120 with Optional Benefit Rider** | All costs or balance |
| **Immunizations** not otherwise covered under Part D of the Medicare program and routine screening procedures for cancer including mammograms, Pap smears, surveillance tests for ovarian cancer, prostate cancer screening (including antigen blood test and digital rectal examination), and colorectal cancer screening test | $0 | 100% | $0 |

**+**These are Optional Benefit Riders. You purchased this benefit if the box is checked and You paid the premium.

## EXTENDED BASIC PLAN
## MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** | | | |
| Semi-private room and board, general nursing, and miscellaneous services and supplies | | | |
| First 60 days | All but $1,340 | $1,340 (Part A deductible) | $0 |
| 61st through 90th day | All but $335 per day | $335 per day | $0 |
| 91st day and after: | | | |
| – while using 60 lifetime reserve days | All but $670 per day | $670 per day | $0 |
| – once lifetime reserve days are used, additional 365 days | $0 | 100% of Medicare eligible expenses | $0** |
| – beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** | | | |
| You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entering 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 per day | Up to $167.50 per 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 coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance | $0 |

****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."

**EXTENDED BASIC PLAN**
**MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT** such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $183 of Medicare-approved amounts* | $0 | $183 (Part B deductible) | $0 |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 20%** | $0 |
| **PART B EXCESS CHARGES** (above Medicare-approved amounts) | $0 | 100% | $0 |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $183 of Medicare-approved amounts* | $0 | $183 (Part B deductible) | $0 |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES** | | | |
| Tests for diagnostic services | 100% | $0 | $0 |

**PARTS A & B**

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE MEDICARE-APPROVED SERVICES** | | | |
| Medically-necessary skilled care services and medical supplies | 100% | $0 | $0 |
| – Durable medical equipment | | | |
| First $183 of Medicare-approved amounts* | $0 | $183 (Part B deductible) | $0 |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |

**except for ambulance services and medical supplies and equipment, all health care providers in Minnesota shall not charge any person with Medicare in Minnesota any amount in excess of the Medicare-approved amount for any Medicare covered services provided

## EXTENDED BASIC PLAN
## MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR (CONT'D.)

### 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 travel outside the United States (for Hospital, Physician, medical care, and supplies) | $0 | 80% of covered expenses | Expenses not paid by Medicare or the policy |
| **PREVENTIVE MEDICAL CARE BENEFIT – NOT COVERED BY MEDICARE** Annual physical and preventive tests and services administered or ordered by a Physician when not covered by Medicare. Up to $120 each Calendar Year for routine annual medical exam including diagnostic X-rays and laboratory services | $0 | $120 | Balance |
| **Immunizations** not otherwise covered under Part D of the Medicare program and routine screening procedures for cancer including mammograms, Pap smears, surveillance tests for ovarian cancer, prostate cancer screening (including antigen blood test and digital rectal examination), and colorectal cancer screening test | $0 | 100% | $0 |

## HIGH-DEDUCTIBLE COVERAGE PLAN
## MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

** Benefits from the High-Deductible Coverage Plan will not begin until out-of-pocket expenses exceed $2,240. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductible for Part A.

| SERVICES | MEDICARE PAYS | AFTER YOU PAY $2,240 DEDUCTIBLE**, PLAN PAYS | IN ADDITION TO $2,240 DEDUCTIBLE**, YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** | | | |
| Semi-private room and board, general nursing, and miscellaneous services and supplies | | | |
| First 60 days | All but $1,340 | $1,340 (Part A deductible) | $0 |
| 61st through 90th day | All but $335 per day | $335 per day | $0 |
| 91st day and after: | | | |
| – while using 60 lifetime reserve days | All but $670 per day | $670 per day | $0 |
| – once lifetime reserve days are used, additional 365 days | $0 | 100% of Medicare eligible expenses | $0*** |
| – beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** | | | |
| You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entering 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 per day | Up to $167.50 per 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 coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance | $0 |

***__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."

**HIGH-DEDUCTIBLE COVERAGE PLAN**
**MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

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

**Benefits from the High-Deductible Coverage Plan will not begin until out-of-pocket expenses exceed $2,240. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductible for Part A.

| SERVICES | MEDICARE PAYS | AFTER YOU PAY $2,240 DEDUCTIBLE**, PLAN PAYS | IN ADDITION TO $2,240 DEDUCTIBLE**, YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT** such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $183 of Medicare-approved amounts* | $0 | $0 | $183 (Part B deductible) |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 20% | $0 |
| **PART B EXCESS CHARGES** | | | |
| (above Medicare-approved amounts)*** | $0 | 0% | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $183 of Medicare-approved amounts* | $0 | $0 | $183 (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES** | | | |
| Tests for diagnostic services | 100% | $0 | $0 |

***except for ambulance services and medical supplies and equipment, all health care providers in Minnesota shall not charge any person with Medicare in Minnesota any amount in excess of the Medicare-approved amount for any Medicare-covered services provided

## HIGH-DEDUCTIBLE COVERAGE PLAN
## PARTS A & B

*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.

**Benefits from the High-Deductible Coverage Plan will not begin until out-of-pocket expenses exceed $2,240. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductible for Part A.

| SERVICES | MEDICARE PAYS | AFTER YOU PAY $2,240 DEDUCTIBLE**, PLAN PAYS | IN ADDITION TO $2,240 DEDUCTIBLE**, YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE MEDICARE-APPROVED SERVICES** | | | |
| Medically-necessary skilled care services and medical supplies | 100% | $0 | $0 |
| – Durable medical equipment | | | |
| First $183 of Medicare-approved amounts* | $0 | $0 | $183 (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |

## OTHER BENEFITS – NOT COVERED BY MEDICARE

| SERVICES | MEDICARE PAYS | AFTER YOU PAY $2,240 DEDUCTIBLE**, PLAN PAYS | IN ADDITION TO $2,240 DEDUCTIBLE**, YOU PAY |
|---|---|---|---|
| **FOREIGN TRAVEL – NOT COVERED BY MEDICARE** Medically-necessary emergency care services beginning during travel outside the United States (for hospital, Physician, medical care, and supplies) | $0 | 100% of covered expenses | Expenses not paid by Medicare or the policy |
| **PREVENTIVE MEDICAL CARE BENEFIT – NOT COVERED BY MEDICARE** Annual physical and preventive tests and services administered or ordered by a Physician when not covered by Medicare. Routine annual medical exam including diagnostic X-rays and laboratory services | $0 | $0 | All costs |
| **Immunizations** not otherwise covered under Part D of the Medicare program and routine screening procedures for cancer including mammograms, Pap smears, surveillance tests for ovarian cancer, prostate cancer screening (including antigen blood test and digital rectal examination), and colorectal cancer screening test | $0 | 100% | $0 |

**MEDICARE SUPPLEMENT WITH $20 AND $50 COPAYMENT MEDICARE PART B COVERAGE**

**MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** | | | |
| Semi-private room and board, general nursing, and miscellaneous services and supplies | | | |
| First 60 days | All but $1,340 | $1,340 (Part A deductible) | $0 |
| 61st through 90th day | All but $335 per day | $335 per day | $0 |
| 91st day and after: | | | |
| – while using 60 lifetime reserve days | All but $670 per day | $670 per day | $0 |
| – once lifetime reserve days are used, additional 365 days | $0 | 100% of Medicare eligible expenses | $0** |
| – beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** | | | |
| You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entering 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 per day | Up to $167.50 per 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 coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance | $0 |

****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.

**MEDICARE SUPPLEMENT WITH $20 AND $50 COPAYMENT MEDICARE PART B COVERAGE**
**MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT** such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $183 of Medicare-approved amounts* | $0 | $0 | $183 (Part B deductible) |
| Remainder of Medicare-approved amounts | Generally 80% | Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if 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 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 |
| **PART B EXCESS CHARGES** (above Medicare-approved amounts) | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $183 of Medicare-approved amounts* | $0 | $0 | $183 (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES** | | | |
| Tests for diagnostic services | 100% | $0 | $0 |

## MEDICARE SUPPLEMENT WITH $20 AND $50 COPAYMENT MEDICARE PART B COVERAGE
## MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR (CONT'D.)

### PARTS A & B

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE MEDICARE-APPROVED SERVICES** | | | |
| Medically-necessary skilled care services and medical supplies | 100% | $0 | $0 |
| – Durable medical equipment | | | |
| First $183 of Medicare-approved amounts* | $0 | $0 | $183 (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |

### OTHER BENEFITS – NOT COVERED BY MEDICARE

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **FOREIGN TRAVEL – NOT COVERED BY MEDICARE** Medically-necessary emergency care services beginning during travel outside the United States (for Hospital, Physician, medical care, and supplies) | $0 | 80% of covered expenses | Expenses not paid by Medicare or the policy |
| **PREVENTIVE MEDICAL CARE BENEFIT – NOT COVERED BY MEDICARE** Annual physical and preventive tests and services administered or ordered by a Physician when not covered by Medicare. Routine annual medical exam including diagnostic X-rays and laboratory services | $0 | $0 | All costs |
| **Immunizations** not otherwise covered under Part D of the Medicare program and routine screening procedures for cancer including mammograms, Pap smears, surveillance tests for ovarian cancer, prostate cancer screening (including antigen blood test and digital rectal examination), and colorectal cancer screening test | $0 | 100% | $0 |

## DESCRIPTION OF BENEFITS

The charts summarizing Medicare benefits only briefly described the benefits. The Centers for Medicare and Medicaid Services or its Medicare publications should be consulted for further details and limitations.

Your Policy provides the following benefits:

1. **Alcoholism, Chemical Dependency, Drug Addiction**: We will pay the Usual and Customary charge for the treatment of alcoholism and chemical dependency on the same basis as coverage for any other condition when treatment is provided for: (1) outpatient chemical dependency and alcoholism services that must not place a greater financial burden on the Insured or be more restrictive than those requirements and limitations for outpatient medical services; (2) inpatient hospital and residential chemical dependency and alcoholism services that must not place a greater financial burden on the Insured or be more restrictive than those requirements and limitations for inpatient hospital medical services. Benefits are not payable for that portion of expense that is paid by Medicare or paid under any other part of Your policy.
2. **Ambulatory Surgical Center Services Benefits**: We will pay the Usual and Customary charge for surgical center services for health care treatment or service rendered by a freestanding ambulatory surgical center or facilities offering ambulatory medical service 24 hours a day, 7 days a week, which are not part of a hospital but have been reviewed and approved by the State Commissioner of Health to provide the treatment or service on the same basis as coverage provided for the same health care treatment or service rendered by a hospital. Benefits are not payable for that portion of expenses for which benefits were paid by Medicare or under any other provisions of this policy.
3. **Court-ordered Mental Health Services Benefit**: We will pay the Usual and Customary Charge, when ordered by a court of competent jurisdiction, for mental health services issued on the basis of a behavioral care evaluation performed by a licensed psychiatrist which includes the diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment. Coverage is contingent on the evaluation and court-ordered treatment plan being performed by a participating provider or another provider as required by law.
4. **Diabetes Equipment and Supplies**: We will pay 80% for all Physician-prescribed, medically appropriate, and necessary diabetic equipment and supplies (includes oral and injectable insulin) for diabetes self-management training and self-education classes, medical nutrition therapy, and treatment of diabetes not otherwise covered under Part D of the Medicare program. Coverage must include persons with gestational, Type I, or Type II diabetes, subject to the Medicare Part B deductible. Benefits are not payable for that portion of expense for which benefits were paid by Medicare or under any other provisions of this policy.
5. **Immunization Benefits**: We will pay the Usual and Customary Charge of the cost of immunizations received by You, not otherwise covered under Part D of the Medicare program. Benefits are not payable for that portion of expense for which benefits were paid by Medicare or under any other portion of the policy.
6. **Lyme Disease Benefit**: If You are diagnosed with Lyme Disease, We will pay for treatment to the same extent that We pay for treatment of any other sickness under the policy. Benefits are not payable for that portion of expense for which benefits were paid by Medicare or under any other provision of this policy.
7. **Mental Health Services Benefit**: We will pay 100% of the cost sharing of Medicare eligible expenses for inpatient hospital and outpatient mental health covered services that are intended to treat or ameliorate an emotional, behavioral, or psychiatric condition if they are medically necessary. "Medically necessary care" means health care services appropriate, in terms of type, frequency, level, setting, and duration, to the enrollee's diagnosis or condition and diagnostic testing and preventive services. Medically necessary care must be consistent with generally-accepted practice parameters as determined by health care providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue and must:
   (1) help restore or maintain Your health; or
   (2) prevent deterioration of Your condition.
   Benefits are not payable for that portion of expense for which benefits were paid by Medicare or under any other provision of this policy.

8. **Phenylketonuria Treatment**: Benefits are payable for special dietary treatment for phenylketonuria when recommended by a Physician.
9. **Reconstructive Surgery**: We will pay for the Usual and Customary Charge for reconstructive surgery on the same basis as that for any other surgery if the Reconstructive Surgery is incidental to or follows surgery resulting from injury, sickness, or other diseases of the involved part. The coverage limitations on Reconstructive Surgery do not apply to reconstructive breast surgery following mastectomies. In these cases, coverage for Reconstructive Surgery must be provided if the mastectomy is medically necessary as determined by the attending Physician. Reconstructive surgery benefits include all stages of reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prosthesis and physical complications at all stages of a mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and patient. Benefits are not payable for that portion of expense for which benefits were paid by Medicare or under any other provision of this policy.
10. **Routine Prostate Cancer Screening**: We will pay the expense incurred for Prostate Cancer Screening. Benefits are limited to: (1) at least one screening per year for any insured male 50 years of age or older; and (2) at least one screening per year shall be covered for any insured male 40 years of age or older who are symptomatic or at a high risk of developing prostate cancer as determined by the insured male's Physician. Prostate Cancer screening shall consist (at a minimum) of: (1) a prostate-specific antigen blood test; and (2) a digital rectal examination.
11. **Routine Screening Procedures for Cancer**: We will pay the Usual and Customary Charge, not otherwise covered under Part B of the Medicare Program, for the expense incurred for routine screening procedures for cancer, including colorectal, mammograms, and pap smears. Benefits are not payable for that portion of expense that is paid by Medicare or paid under any other part of this policy.
12. **Scalp Hair Prosthesis**: When you incur expense for a scalp hair prosthesis needed because of hair loss suffered as a result of alopecia areata, We will pay the expense incurred on the same basis as any other sickness or injury and as if Medicare paid benefits. We will pay for one (1) scalp hair prosthesis per Calendar Year under this part of Your policy. Amounts in excess of the Usual and Customary Charges in the geographical area involved (as determined by Us) are not considered expense. Benefits are not payable for that portion of expense that is paid by Medicare or paid under any other part of this policy.
13. **Testing for Ovarian Cancer Benefits**: Coverage will be provided for the Usual and Customary Charge for Surveillance Tests for women at risk for ovarian cancer when ordered or provided by a Physician in accordance with the standard practice of medicine.
14. **Temporomandibular Joint Disorder and Craniomandibular Disorder**: We will pay the Usual and Customary Charge for the surgical and nonsurgical treatment of temporomandibular joint disorder and craniomandibular disorder on the same basis as that for treatment to any other joint in the body. Such treatment must be administered or prescribed by a Physician or dentist. Benefits are not payable under this part of your policy for an expense payable under another part of this policy.
15. **Ventilator Dependent Benefit**: We will pay the Usual and Customary Charge for services by a private-duty Nurse or personal care assistant to a ventilator-dependent person in the person's home. We will pay the Usual and Customary Charge for services provided by a private-duty Nurse or personal care assistant to the ventilator-dependent person during the time the ventilator-dependent person is in a licensed hospital, not to exceed 120 hours. The personal care assistant or private-duty Nurse shall perform only the services of communicator or interpreter for the ventilator-dependent patient during a transition period of up to 120 hours to assure adequate training of the hospital staff to communicate with the patient and to understand the unique comfort, safety, and personal care needs of the ventilator-dependent patient. Benefits are not payable for that portion of expense for which benefits were paid by Medicare or under any other provisions of this policy.

## ADDITIONAL BENEFITS UNDER THE EXTENDED BASIC POLICY

We will pay eighty percent (80%) of the charges, not to exceed any charge limitation established by the Medicare program or state law, for the following services and articles that are prescribed by a Physician and are not paid by Medicare or payable under any other provision of this policy. Payments will be based on the Medicare fee schedule.

1. hospital services;
2. professional services for the diagnosis or treatment of injuries, sickness, or conditions when such services are given by a Physician or are under a Physician's direction; outpatient mental or dental services are not covered;
3. services of a nursing home for not more than 120 days each year; such services must qualify as reimbursable under Medicare;
4. services of a home health agency; such services must qualify as reimbursable under Medicare;
5. use of radium or other radioactive materials;
6. oxygen;
7. anesthetics;
8. prosthetic devices other than dental;
9. rental or purchase, as appropriate, of durable medical equipment other than eyeglasses and hearing aids;
10. diagnostic X-rays and lab tests;
11. oral surgery for: (a) partially or completely unerupted, impacted teeth, (b) a tooth root without the extraction of the entire tooth, or (c) the gums or tissues of the mouth when not performed in connection with the extraction or repair of teeth;
12. services of a physical therapist;
13. professional ambulance for service to the nearest facility qualified to treat the condition, or a reasonable mileage rate for transportation to a kidney dialysis center for treatment;
14. services of an Occupational Therapist;
15. a second opinion from a Physician on all surgical procedures expected to cost at least $500; cost includes Physicians, laboratory, and hospital fees; not included is the repetition of diagnostic tests.

Benefits will be considered under this part of Your policy for charges incurred within or outside of the United States.

The additional Benefits are not payable for (a) injuries or sickness for which any benefits are provided by Workers' Compensation or Employers' Liability Laws, (b) cosmetic surgery except for repair of an injury or a birth defect, (c) care which is primarily for custodial or for domiciliary purposes which would not qualify as eligible services under Medicare, (d) any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless the private room is prescribed as medically necessary by a Physician, or (e) any charges for services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles.

## OPTIONAL COVERAGE AVAILABLE FOR BASIC PLAN (Policy Form No. CHLIC-MS-BASIC-MN)

- CHLIC-MS-PTAD-MN: We will provide one hundred percent (100%) coverage of the Medicare Part A inpatient Hospital deductible amount.
- CHLIC-MS-PTBEXC-MN: We will provide one hundred percent (100%) coverage of the Medicare Part B Excess Charges, not to exceed any charge limitation established by the Medicare program or state law and the Medicare-approved Part B charge.
- CHLIC-MS-PTBD-MN: We will provide one hundred percent (100%) coverage for the Medicare Part B annual deductible amount.
- CHLIC-MS-PC-MN: We will provide coverage for Preventive Medical Care not to exceed $120 per year.