



Underwritten by **United American Insurance Company**

**Benefit Period: 1/1/2019 through 12/31/2019**

**MEDICARE PART A - 2019**

Services	Medicare Pays	Plan Pays	You Pay
<b>HOSPITALIZATION**</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 Days	All but \$1,364	\$1,364 - Part A Deductible	\$0
61st thru 90th day	All but \$341 a day	\$341 a day	\$0
91st day and after:			
While using 60 lifetime reserve days	All but \$682 a day	\$682 a day	\$0
Once Lifetime reserve days are used:			
Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
Beyond the Additional 365 days	\$0	\$0	All Costs
<b>SKILLED NURSING FACILITY CARE**</b>			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$170.50 a day	Up to \$170.50 a day	\$0
101st day and after	\$0	\$0	All Costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

\*\*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.



**Health Insurance Services, Inc.**  
reliable resources  
you can count on

Underwritten by **United American Insurance Company**

**Benefit Period: 1/1/2019 through 12/31/2019**

<b>Your Plan Annual Deductible</b>	<b>\$0</b>	<b>\$100</b>	<b>\$500</b>	<b>\$1000</b>	<b>\$1500</b>
------------------------------------	------------	--------------	--------------	---------------	---------------

**MEDICARE PART B - 2019**

Plan Deductible (Part B Out of Pocket Expenses)			
Services	Medicare Pays	Plan Pays	You Pay
<b>Medicare Part B Deductible 2019</b>			Chosen Annual Plan Deductible applies, then: Plan Options: \$0 Copay OR \$10 office visit copay & \$50 (ER) visit copay (ER copay is waived if admitted)
First \$185 of Medicare Approved Amounts	\$0	Part B Deductible	
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	100%	
<b>BLOOD</b>			
While using 60 lifetime reserve days			
First 3 pints	\$0	All Costs	\$0
Remainder of Medicare Approved Amounts	80%	20%	Chosen Annual Plan Deductible
<b>CLINICAL LABORATORY SERVICES</b>			
Blood tests for Diagnostic Services	100%	\$0	\$0

**MEDICARE PARTS A & B**

<b>HOME HEALTH CARE</b>			
Medically necessary skilled care services ( <b>must be homebound</b> ) and medical supplies	100%	\$0	\$0
Durable Medical Equipment			
First \$185 of Medicare Approved Amounts	\$0	Part B Deductible	Chosen Annual Plan Deductible
Remainder of Medicare Approved Amounts	80%	20%	

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

<b>FOREIGN TRAVEL</b>			
Medically necessary emergency care services during the first 60 days of each trip outside of the USA:			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges - Up to \$50,000 Lifetime Maximum benefit	\$0	80%	20%



**Health Insurance Services, Inc.**  
reliable resources  
you can count on

**Part D with Generic Only Coverage in the Gap**

**Benefit Period: 1/1/2019 through 12/31/2019**

<b>Deductible State</b>	You pay a \$0 yearly deductible.			
<b>Initial Coverage Stage</b>	You will pay the following until your total yearly drug costs (what you and the plan pay) reach \$3,820:			
	<b>Tier</b>	<b>Plan 1</b>	<b>Plan 2</b>	<b>Plan 3</b>
<b>Retail One-Month (31-day) Supply</b>	<b>Preferred Generic/Generic</b>	\$0/\$15	\$5.00	\$0.00
	<b>Preferred Brand</b>	\$60.00	\$40.00	\$30.00
	<b>Non-Preferred Brand</b>	\$100.00	\$75.00	\$60.00
	<b>Specialty</b>	33% coinsurance	33% coinsurance	33% coinsurance
	Not all drugs are available at a 90-day supply, and not all retail pharmacies offer a 90-day supply. You may receive up to a 90-day supply of certain maintenance drugs (medications taken on a long-term basis) through home delivery from Express Scripts PharmacySM. There is no charge for standard shipping.			
<b>Coverage Gap stage</b>	After your total yearly drug costs reach \$3,820, you will continue to pay the same cost-sharing amount as in the Initial Coverage stage, until you qualify for the Catastrophic Coverage stage. <ul style="list-style-type: none"> <li>• Brand-name drugs: You pay 25% of the total cost (plus a portion of the dispensing fee).</li> <li>• Generic drugs: You will continue to pay the same cost-sharing amount as in the Initial Coverage stage.</li> </ul>			
<b>Non Part D Drugs</b>	Covered; Excluding Lifestyle Drugs			
<b>Catastrophic Coverage stage</b>	After your yearly out-of-pocket drug costs reach \$5,100, you will pay <b>the greater of 5% coinsurance or:</b> <ul style="list-style-type: none"> <li>• a \$3.40 copayment for covered generic drugs (including brand drugs treated as generics) with a maximum of the above copays</li> <li>• a \$8.50 copayment for all other covered drugs</li> </ul>			



**Health Insurance Services, Inc.**  
reliable resources  
you can count on

**Part D with Full Coverage in the Gap**

**Benefit Period: 1/1/2019 through 12/31/2019**

<b>Deductible State</b>	You pay a \$0 yearly deductible.			
<b>Initial Coverage Stage</b>	You will pay the following until your total yearly drug costs (what you and the plan pay) reach \$3,820:			
	<b>Tier</b>	<b>Plan 1</b>	<b>Plan 2</b>	<b>Plan 3</b>
<b>Retail One-Month (31-day) Supply</b>	<b>Preferred Pharmacy Copays. If you use a Non-Preferred Pharmacy you will pay \$5.00 more per prescription</b>			
	<b>Preferred Generic</b>	\$0.00	\$5.00	\$0.00
	<b>Generic</b>	\$15.00	\$5.00	\$0.00
	<b>Preferred Brand</b>	\$60.00	\$40.00	\$30.00
	<b>Non-Preferred Brand</b>	\$100.00	\$75.00	\$60.00
	<b>Specialty</b>	33% coinsurance	33% coinsurance	33% coinsurance
	Not all drugs are available at a 90-day supply, and not all retail pharmacies offer a 90-day supply. You may receive up to a 90-day supply of certain maintenance drugs (medications taken on a long-term basis) through home delivery from Express Scripts Pharmacy <sup>SM</sup> . There is no charge for standard shipping.			
<b>Coverage Gap stage</b>	After your total yearly drug costs reach \$3,820, you will continue to pay the same cost-sharing amount as in the Initial Coverage stage, until you qualify for the Catastrophic Coverage stage.			
<b>Non Part D Drugs</b>	Covered; Excluding Lifestyle Drugs			
<b>Catastrophic Coverage stage</b>	After your yearly out-of-pocket drug costs reach \$5,100, you will pay <b>the greater of 5% coinsurance or:</b> <ul style="list-style-type: none"> <li>a \$3.40 copayment for covered generic drugs (including brand drugs treated as generics) with a maximum of the above copays</li> <li>a \$8.50 copayment for all other covered drugs, with a maximum of the above copays</li> </ul>			