

Medicare Supplement: Plan "A"

2006 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.

** \$0 indicates your liability for covered charges. You are responsible for all other no covered charges.

Services	Medicare Pays	Plan "A" Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies • First 60 days	All but \$952	\$0	\$952 (Part A Deductible)
• 61st thru 90th day	All but \$238 a day	\$238 a day	\$0**
• 91st day and after: - While using 60 lifetime reserve days	All but \$476 a day	\$476 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 thru 100th day	All but \$119 a day	\$0	Up to \$119 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 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

2006 Medicare (Part B) -- 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.

** \$0 indicates your liability for covered charges. You are responsible for all other noncovered charges.

Services	Medicare Pays	Plan "A" 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, and durable medical equipment • First \$124 of Medicare-approved amounts*	\$0	\$0	\$124 (Part B Deductible)
• Remainder of Medicare-approved amounts, Generally 80%	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 \$124 of Medicare-approved amounts* (Deductible)	\$0	\$0	\$124 (Part B Deductible)
• Remainder of Medicare-approved amounts	80%	20%	\$0**
Clinical Laboratory Services -- Tests for Diagnostic Services	100%	\$0	\$0**

Medicare -- Parts A & B

Services	Medicare Pays	Plan "A" Pays	You Pay
Home Health Care -- Medicare-approved services • Medically necessary skilled care services and medical supplies	100%	\$0	\$0**
• Durable medical equipment: – First \$124 of Medicare-approved amounts*	\$0	\$0	\$124 (Part B Deductible)
– Remainder of Medicare-approved amounts	80%	20%	\$0**
Home Health Care -- At-home recovery services -- not covered by Medicare	\$0	\$0	All Costs

Home care certified by your doctor for personal care during recovery from an injury or sickness for which Medicare-approved a Home Care Treatment Plan • Benefit for each visit			
• Number of visits covered (must be received within 8 weeks of last Medicare-approved visit)	0	0	
• Calendar-year maximum	\$0	\$0	

Other Benefits -- Not Covered by Medicare

Services	Medicare Pays	Plan "A" 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 USA • First \$250 each calendar year	\$0	\$0	\$250
• Remainder of Charges	\$0	\$0	All Costs