Medicare Medical Plan Options

Medical Plans Insured by Transamerica Premier Life Insurance Company			
	HIGH PLAN	**MID PLAN**	**LOW PLAN** (4)
Deductibles & Coinsurance / Copays			
	You Pay ǂ	**You Pay ǂ**	**You Pay ǂ**
Part A Deductible	$0.00	$0.00	$0.00
Part B Deductible	$185.00	$185.00	$2,180.00
Part B Coinsurance Amount	20%	20%	20%
Annual Maximum Coinsurance	$1,000.00	$1,500.00	$2,180.00
Office Visit Copay (Part B) (3)	$20.00	$30.00	N/A
Emergency Visit Copay (Part B) (3)	$100.00	$100.00	N/A
Medicare (Part A) - Hospital Services - Per Benefit Period (1) In general, Medicare Part A covers hospital care, skilled nursing care (even if received in a nursing home) and some health services.			
	You Pay ǂ	**You Pay ǂ**	**In addition to the $2,180 Deductible You Pay ǂ**
First 60 days	$0	$0	$0
61st through 90th day	$0	$0	$0
91st through 150th day (Reserve days)	$0	$0	$0
Additional 365 days	All costs	All costs	All costs
SKILLED NURSING FACILITY CARE(1)			
First 20 days	$0	$0	$0
21st through 100th day	$0	$0	$0
101st day and after	All costs	All costs	All costs
BLOOD			
First 3 pints	$0	$0	$0
Additional amounts	$0	$0	$0

Medicare Medical Plan Options

	HIGH PLAN	MID PLAN	LOW PLAN [4]
Medicare (Part B) - Medical Services - Per Calendar Year In general, Medicare Part B covers services such as lab tests, surgeries, doctor visits and medical supplies considered medically necessary to diagnose or treat a disease or condition.			
	You Pay ǂ	**You Pay ǂ**	**In addition to the $2,180 Deductible You Pay ǂ**
First $185 of Medicare-approved amounts [2]	$185.00	$185.00	$0
Next Medicare-approved amounts	20% up to $1,000[3]	20% up to $1,500[3]	20% up to $2,180
Part B Excess Charges	$0	$0	$0
BLOOD			
First 3 pints	$0	$0	$0
Next $185 of Medicare-approved amounts [2]	$185.00	$185.00	$0
Next Medicare-approved amounts	20% up to $1,000[3]	20% up to $1,500[3]	20% up to $2,180
CLINICAL LABORATORY SERVICES			
Blood tests for Diagnostic Services	$0	$0	$0
Medicare Parts A & B			
	You Pay ǂ	**You Pay ǂ**	**In addition to the $2,180 Deductible You Pay ǂ**
HOME HEALTH CARE			
Medically necessary skilled care services and medical supplies	$0	$0	$0
DURABLE MEDICAL SERVICES			
First $185 Medicare-approved amounts [2]	$185.00	$185.00	$0
Next Medicare-approved amounts	20% up to $1,000[3]	20% up to $1,500[3]	20% up to $2,180

Medicare Medical Plan Options

	HIGH PLAN	MID PLAN	LOW PLAN (4)
Preventative Services			
	You Pay ǂ	You Pay ǂ	In addition to the $2,180 Deductible You Pay ǂ
Annual Wellness Exam	$0	$0	$0
Other Preventative Services (per Medicare schedule) including cardiovascular screenings, cancer screenings, flu shots, etc.	$0	$0	$0
Other Services – Not Covered by Medicare			
Foreign Travel Emergency (5)			
Foreign Emergency outside of USA	$250 Deductible, then 20% up to $50,000	$250 Deductible, then 20% up to $50,000	$250 Deductible, then 20% up to $50,000

ǂ The plan options chart represents the amount you pay when the Plans and Medicare are integrated to provide your coverage.

(1) 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.

(2) Once you have been billed $185 of Medicare approved amounts for covered services, your Medicare Part B deductible will have been satisfied for the calendar year.

(3) Part B Expenses may also include Office Visit Copays or Emergency Room Visit Copays if applicable. These copays do not apply to the deductible.

(4) This high deductible plan pays the same benefits as a Plan F after one has paid a calendar-year $2,180 deductible. Benefits from the high Deductible Plan F will not begin until out-of-pocket expenses are $2,180. 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.

(5) Foreign Travel coverage deductible is a separate deductible and does not apply to the Part A or B deductible amounts.

**The summary of benefits described herein is for illustrative purposes only.
In case of differences or errors, the Group Policy governs.**

The Medicare Parts A and B deductibles and co-insurance amounts shown are the 2019 amounts. Your plan will automatically adjust to the changes to Medicare Parts A and B amounts for 2020.

Retiree Medical Insurance Plan Summary of Benefits (Plan N)

Underwritten by: Transamerica Premier Life Insurance Company **(FL Residents)**

Part B Deductible:	**$198.00**
Lifetime Maximum:	**Unlimited**
Office Visit Copay:	**$20.00**
ER Visit Copay:	**$50.00**

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

Services	Medicare Pays	Plan Pays	You Pay
HOSPITAL CONFINEMENT BENEFIT* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but $1,408	$1,408 (Part A Deductible)	**$0**
61st through 90th day	All but $352 per day	$352 per day	**$0**
91st through 150th day (While using 60 lifetime reserve days)	All but $704 per day	$704 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 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 $176.00 a day	Up to $176.00 a day	**$0**
101st day and after	$0	$0	**All costs**
BLOOD DEDUCTIBLE – Hospital Confinement and Out-Patient Medical Expense When furnished by a hospital or skilled nursing facility during a covered stay.			
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**

Retiree Medical Insurance Plan Summary of Benefits (Plan N)

Underwritten by: Transamerica Premier Life Insurance Company **(FL Residents)**

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

Services	Medicare Pays	Plan Pays	You Pay
OUT-PATIENT MEDICAL EXPENSES - - In or Out of the Hospital and Out-Patient 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:			
Medicare Part B Deductible: First $198 of Medicare-approved amounts**	$0	$0	**$198 (Part B Deductible)**
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	**0%*** **
Part B Excess Charges (Above Medicare Approve Amounts)	$0	100%	**0%**
BLOOD			
First 3 pints	$0	All costs	**$0**
Next $198 of Medicare Approved Amounts**	$0	$0	**$198 (Part B Deductible)**
Remainder of Medicare Approved Amounts	80%	20%	**$0*** **
CLINICAL LABORATORY SERVICES			
Blood tests for Diagnostic Services	100%	$0	**$0**

MEDICARE 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 $198 of Medicare Approved Amounts**	$0	$0	**$198 (Part B Deductible)**
Remainder of Medicare Approved Amounts	80%	20%	**$0*** **

Retiree Medical Insurance Plan Summary of Benefits (Plan N)

Underwritten by: Transamerica Premier Life Insurance Company **(FL Residents)**

OTHER BENEFITS NOT COVERED BY MEDICARE

Services	Medicare Pays	Plan Pays	You Pay
FOREIGN TRAVEL - 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	80% to a lifetime maximum of $50,000	20% and amounts over the $50,000 lifetime max

*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.

**Once you have been billed the first dollars of Medicare-Approved amounts for covered services (which are noted with two asterisks), your Medicare Part B Deductible will have been met for the calendar year.

*****May be subject to an additional $20 Office Visit Copay or $50 for Emergency Room Visit Copay for Part B Services. The copayment for the Emergency Room Visit may be waived if the insured is admitted to any hospital and the emergency is covered as a Medicare Part A expense**

Benefits are paid only for those expenses which have been approved as eligible by the federal Medicare program.

Benefits will not be paid for any expenses which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

This policy's renewability, cancellability and termination provisions are at the option of the group policy holder except in cases of non-payment of premium

The summary of program benefits described herein is for illustrative purposes only. In case of differences or errors, the Group Policy governs.