OUTLINE OF COVERAGE AND RATES FOR MINNESOTA RESIDENTS

Medicare Supplement benefit plans: Basic Plan, Extended Basic Plan, 2020 Extended Basic Plan, High-Deductible Coverage Plan, and $20/$50 Copayment Plan

Together, all the way.®

Cigna®

Cigna Medicare Supplement Insurance
Cigna Health and Life Insurance Company

CIGNA HEALTH AND LIFE INSURANCE COMPANY
PO Box 5700, Scranton, PA 18505 • 866-459-4272

Chart of Standardized Medicare Supplement Policies – Minnesota

MINIMUM 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	**The Extended Basic Plan 2024 does not provide coverage for the Medicare Part B Deductible and is available to all Applicants who are first eligible for Medicare on or after January 1, 2020. The Extended Basic Plan that provides coverage for the Medicare Part B Deductible is available only if you are first eligible for Medicare before January 1, 2020[2]**				**Coverage for the Part B Deductible is available only if you are first eligible for Medicare before January 1, 2020[4]**
	Basic Plan	**Extended Basic Plan 2022[1, 2]**	**High-Deductible Coverage Plan[3]**	**$20/$50 Copayment Plan**	**Extended Basic Plan[4]**
Minimum benefits	√	√	√	√ (100% Part B coinsurance except up to $20 copayment 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%)		√			√
Foreign Travel Emergency	80%	80%	100%	80%	80%
Additional benefits (not covered by Medicare)		80%			80%
Coverage while in a foreign country		80%			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: • Medicare Part A Deductible (CHLIC-MS-PTAD.v2-MN) • Medicare Part B Deductible (CHLIC-MS-PTBD.v2-MN) (available only if you are first eligible for Medicare before January 1, 2020) • Medicare Part B Excess Charges (100%) CHLIC-MS-PTBEXC.v2-MN) • Preventive Medical Care Benefit (CHLIC-MS-PC.v2-MN)

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

[2]The Extended Basic Plan 2023 does not provide coverage for the Medicare Part B Deductible and is available to all Applicants who are first eligible for Medicare on or after January 1, 2020. The Extended Basic Plan that provides coverage for the Medicare Part B Deductible is available only if you are first eligible for Medicare before January 1, 2020.

[3]Benefits from the High-Deductible Coverage Plan will not begin until out-of-pocket expenses exceed $2,800. 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.

[4]The Extended Basic Plan is available to both pre-MACRA and post-MACRA Applicants; however, the coverage for the Part B Deductible does not apply to a newly-eligible individual as defined in Minnesota law.

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.

Notice: This disclosure is required by Minnesota law. This policy is expected to return on average 77.3% of your premium dollar for health care. The lowest percentage permitted by state law for this policy is 65%.

Cigna Health and Life Insurance Company

MEDICARE SUPPLEMENT

MINNESOTA

Community Rated Rates -- All Ages -- Effective 5/1/2023 -- 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
1874.63	974.81	496.78	156.16	**Copayment Plan CHLIC-MS-Copayment-MN**	2062.09	1072.29	546.45	171.77
2995.63	1557.73	793.84	249.54	**MN Extended 2020 Plan CHLIC-MS-EXTENDED-2020-MN**	3314.40	1723.49	878.32	276.09
3187.73	1657.62	844.75	265.54	**MN Extended Plan CHLIC-MS-Extended-MN**	3506.50	1823.38	929.22	292.09
2449.56	1273.77	649.13	204.05	**MN Basic Plan CHLIC-MS-Basic-MN**	2694.51	1401.14	714.04	224.45
294.53	153.15	78.05	24.53	**Part A Deductible Rider CHLIC-MS-PTAD-MN**	323.98	168.47	85.85	26.99
23.56	12.25	6.24	1.96	**Part B Excess Charge Rider CHLIC-MS-PTBEXC-MN**	25.92	13.48	6.87	2.16
226.00	117.52	59.89	18.83	**Part B Deductible Rider CHLIC-MS-PTBD-MN**	226.00	117.52	59.89	18.83
58.91	30.63	15.61	4.91	**Preventive Care Rider CHLIC-MS-PC-MN**	64.80	33.69	17.17	5.40
741.40	385.53	196.47	61.76	**High Deductible Plan CHLIC-MS-HDED-MN**	815.54	424.08	216.12	67.93

*Optional riders only available for MN Basic Plan

Cigna Health and Life Insurance Company

MEDICARE SUPPLEMENT

MINNESOTA

Community Rated Rates -- All Ages -- Effective 5/1/2023 -- 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
1940.79	1009.21	514.31	161.67	**Copayment Plan CHLIC-MS-Copayment-MN**	2134.87	1110.13	565.74	177.83
3101.36	1612.71	821.86	258.34	**MN Extended 2020 Plan CHLIC-MS-EXTENDED-2020-MN**	3431.38	1784.32	909.32	285.83
3300.24	1716.12	874.56	274.91	**MN Extended Plan CHLIC-MS-Extended-MN**	3630.26	1887.74	962.02	302.40
2536.01	1318.73	672.04	211.25	**MN Basic Plan CHLIC-MS-Basic-MN**	2789.61	1450.60	739.25	232.37
304.92	158.56	80.80	25.40	**Part A Deductible Rider CHLIC-MS-PTAD-MN**	335.41	174.41	88.88	27.94
24.39	12.68	6.46	2.03	**Part B Excess Charge Rider CHLIC-MS-PTBEXC-MN**	26.83	13.95	7.11	2.24
226.00	117.52	59.89	18.83	**Part B Deductible Rider CHLIC-MS-PTBD-MN**	226.00	117.52	59.89	18.83
60.98	31.71	16.16	5.08	**Preventive Care Rider CHLIC-MS-PC-MN**	67.08	34.88	17.78	5.59
767.57	399.13	203.41	63.94	**High Deductible Plan CHLIC-MS-HDED-MN**	844.32	439.05	223.75	70.33

*Optional riders only available for MN Basic Plan

DISCLOSURES
Use this Outline to compare benefits and premiums among policies.

PREMIUM INFORMATION
Premium changes are subject to filing and prior approval by the Minnesota Department of Commerce. We will send you a written notice at least thirty (30) days in advance when we change the premium rates 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 5700, Scranton, PA 18505. 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
The 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.

GUARANTEED ACCEPTANCE AND RENEWAL
Your acceptance into our Medicare Supplemental policy is guaranteed if you apply for coverage during your Open Enrollment period. The Medicare initial Open Enrollment period for persons turning age 65 and enrolled in Medicare Part B is the seven (7) month period that begins three (3) months before the month the consumer turns 65, includes the month the person turns 65, and ends three (3) months after the person turns 65. 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 equal $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.

EXCLUSIONS AND LIMITATIONS
The benefits of a policy will not duplicate any benefits paid by Medicare. The combined benefits of a policy and the benefits paid by Medicare may not exceed 100% of the Medicare Eligible Expenses incurred. A policy will not pay benefits for the following:

1. any expense which you are not legally obligated to pay or services for which no charge is normally made in the absence of insurance; or
2. any type of expense not a Medicare Eligible Expense except as provided previously in the policy.

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 $1,632	$0 **OR** +$1,632 **with Optional Benefit Rider**	$1,632 (Part A deductible) **OR** $0
61st through 90th day	All but $408 per day	$408 per day	$0
91st day and after:			
– while using 60 lifetime reserve days	All but $816 per day	$816 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 $204 per day	Up to $204 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."

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

Medicare Part B Deductible Rider available only if you are **first** eligible for Medicare before January 1, 2020.

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

*Once you have been billed $240 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 $240 of Medicare-approved amounts*	$0	$0 **OR** +$240 **with Optional Benefit Rider**	$240 (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 $240 of Medicare-approved amounts*	$0	$0 **OR** +$240 **with Optional Benefit Rider**	$240 (Part B deductible) **OR** $0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Tests for diagnostic services	100%	$0	$0

**The Basic Medicare Supplement plan offers a benefit rider that covers 100% of the Medicare Part B excess charges coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

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

Medicare Part B Deductible Rider available only if you are **first** eligible for Medicare before January 1, 2020.

BASIC PLAN

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

*Once you have been billed $240 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			
Medically-necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $240 of Medicare-approved amounts*	$0	$0 **OR** +$240 **with Optional Benefit Rider**	$240 (Part B deductible) **OR** $0
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 **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.

Medicare Part B Deductible Rider available only if you are **first** eligible for Medicare before January 1, 2020.

OPTIONAL COVERAGE AVAILABLE FOR BASIC PLAN (Policy form no. CHLIC-MS-BASIC.v2-MN)

- CHLIC-MS-PTAD.v2-MN – We will provide 100% coverage of the Medicare Part A inpatient hospital deductible amount.
- CHLIC-MS-PTBEXC.v2-MN – We will provide 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.v2-MN – We will provide 100% coverage of the Medicare Part B annual deductible amount. Medicare Part B Deductible Rider is available only if you are first eligible for Medicare before January 1, 2020.
- CHLIC-MS-PC.v2-MN – We will provide coverage for Preventive Medical Care not to exceed $120 per year.

EXTENDED BASIC PLAN

(available only if you are **first** eligible for Medicare before January 1, 2020)

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 $1,632	$1,632 (Part A deductible)	$0
61st through 90th day	All but $408 per day	$408 per day	$0
91st day and after:			
– while using 60 lifetime reserve days	All but $816 per day	$816 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 $204 per day	Up to $204 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

(available only if you are **first** eligible for Medicare before January 1, 2020)

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

***Once you have been billed $240 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 $240 of Medicare-approved amounts*	$0	$240 (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 $240 of Medicare-approved amounts*	$0	$240 (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 $240 of Medicare-approved amounts*	$0	$240 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

**The Extended Basic Medicare Supplement plan pays 100% of the Medicare Part B excess charges coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved amount for any Medicare-covered services provided.

EXTENDED BASIC PLAN

(available only if you are **first** eligible for Medicare before January 1, 2020)

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 services beginning during travel outside the United States (for Hospital, Physician, medical care, and supplies; prescription drug expenses not covered by Medicare)	$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

2020 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 $1,632	$1,632 (Part A deductible)	$0
61st through 90th day	All but $408 per day	$408 per day	$0
91st day and after:			
– while using 60 lifetime reserve days	All but $816 per day	$816 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 $204 per day	Up to $204 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."

2020 EXTENDED BASIC PLAN
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 physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-approved amounts*	$0	$0	$240 (Part B deductible)
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 $240 of Medicare-approved amounts*	$0	$0	$240 (Part B deductible)
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 $240 of Medicare-approved amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

**The Extended Basic Medicare Supplement plan pays 100% of the Medicare Part B excess charges coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved amount for any Medicare-covered services provided.

2020 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 services beginning during travel outside the United States (for Hospital, Physician, medical care, and supplies; prescription drug expenses not covered by Medicare)	$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

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, including outpatient medical and surgical services;
3. dental coverage;
4. podiatric coverage;
5. services of a nursing home for not more than 120 days each year; such services must qualify as reimbursable under Medicare;
6. services of a home health agency; such services must qualify as reimbursable under Medicare;
7. use of radium or other radioactive materials;
8. oxygen;
9. anesthetics;
10. prosthetic devices;
11. rental or purchase, as appropriate, of durable medical equipment other than eyeglasses and hearing aids;
12. diagnostic X-rays and lab tests;
13. 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;
14. services of a physical therapist;
15. 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;
16. services of an Occupational Therapist;
17. 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) cosmetic surgery except for repair of an injury or a birth defect or state-mandated reconstructive surgery; (b) care which is primarily for custodial or for domiciliary purposes which would not qualify as eligible services under Medicare; (c) 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 (d) 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.

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 $2,800. 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. The High-Deductible Plan will not provide coverage for 100% or any portion of the Medicare Part B deductible to a newly-eligible individual that is first eligible for Medicare on or after January 1, 2020.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE**, YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A deductible)	$0
61st through 90th day	All but $408 per day	$408 per day	$0
91st day and after:			
– while using 60 lifetime reserve days	All but $816 per day	$816 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 $204 per day	Up to $204 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 $240 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 $2,800. 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. The High-Deductible Plan will not provide coverage for 100% or any portion of the Medicare Part B deductible to a newly-eligible individual that is first eligible for Medicare on or after January 1, 2020.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO $2,800 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 $240 of Medicare-approved amounts*	$0	$0	$240 (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 $240 of Medicare-approved amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Tests for diagnostic services	100%	$0	$0

***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 $240 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 $2,800. 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. The High-Deductible Plan will not provide coverage for 100% or any portion of the Medicare Part B deductible to a newly-eligible individual that is first eligible for Medicare on or after January 1, 2020.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE**, YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically-necessary skilled care services and medical supplies – Durable medical equipment First $240 of Medicare-approved amounts* Remainder of Medicare-approved amounts	 100% $0 80%	 $0 $0 20%	 $0 $240 (Part B deductible) $0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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 $1,632	$1,632 (Part A deductible)	$0
61st through 90th day	All but $408 per day	$408 per day	$0
91st day and after:			
– while using 60 lifetime reserve days	All but $816 per day	$816 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 $204 per day	Up to $204 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 $240 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 $240 of Medicare-approved amounts* Remainder of Medicare-approved amounts	$0 Generally 80%	$0 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	$240 (Part B deductible) 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 Next $240 of Medicare-approved amounts* Remainder of Medicare-approved amounts	$0 $0 80%	All costs $0 20%	$0 $240 (Part B deductible) $0
CLINICAL LABORATORY SERVICES Tests for diagnostic services	100%	$0	$0

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 $240 of Medicare-approved amounts*	$0	$0	$240 (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 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 equipment and supplies used in the management and treatment of diabetes and diabetes outpatient self-management training and education, including medical nutrition therapy, that is provided by a certified, registered, or licensed health care professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association. Coverage must include persons with gestational, Type I, or Type II diabetes. The coverage required is subject to the same deductible or coinsurance provisions applicable to the plan's hospital, medical expense, medical equipment, or prescription drug benefits. The Extended Basic plan covers the Medicare deductibles with the exception of coverage for the Medicare Part B Deductible sold or issued after January 1, 2020, to a newly-eligible individual. 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:
   a. help restore or maintain your health; or
   b. 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: (a) at least one screening per year for any insured male 50 years of age or older; and (b) 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: (a) a prostate-specific antigen blood test; and (b) 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 and the office or facility visit, including mammograms, surveillance tests for ovarian cancer for women who are at risk for ovarian cancer, pap smears, and colorectal screening tests for men and women when ordered or provided by a licensed medical professional in accordance with the standard practice of medicine. Benefits are not payable for that portion of expense that is paid by Medicare or paid under any other part of this policy.
    Coverage will be provided for the Usual and Customary Charge for a preventive mammogram screening which includes (a) digital breast tomosynthesis for insureds at risk for breast cancer and (b) is covered as a preventive item or service. "Digital breast tomosynthesis" means a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional, digital, three-dimensional images of the breast.
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.
    a. At risk for ovarian cancer means:
        i. having a family history
            1. with one or more first- or second-degree relatives with ovarian cancer;
            2. of clusters of women relatives with breast cancer; or
            3. of nonpolyposis colorectal cancer; or
            4. testing positive for BRCA1 or BRCA2 mutations.
    b. Surveillance tests for ovarian cancer means annual screening using:
        i. CA-125 serum tumor marker testing;
        ii. transvaginal ultrasound;
        iii. pelvic examination; or
        iv. other proven ovarian cancer screening tests currently being evaluated by the federal Food and Drug Administration or by the National Cancer Institute.

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.

You may contact the **Minnesota Department of Commerce** with any complaints at the following:

Minnesota Department of Commerce
Main Office, Golden Rule Building
85 7th Place East, Suite 280
St. Paul, MN 55101

website: https://mn.gov/commerce/about/contact/

651-539-1500 (local)
1-800-657-3602 (greater Minnesota only)

Mail written complaints to:
Minnesota Department of Commerce
ATTN: Consumer Services Center
85 7th Place East, Suite 280
St. Paul, MN 55101

online complaints: https://mn.gov/commerce/consumers/file-a-complaint/