

# KPS HEALTH PLANS

## Outline of Medicare Supplement Coverage - Cover Page Benefit Plans A, E and F

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A". Some plans may not be available in your state. KPS Health Plans is providing Plans A, E and F which are shaded below.

<b>Basic Benefits for Plans A-J</b> <b>Hospitalization:</b> Part A coinsurance plus coverage for 365 additional days after Medicare benefits end. <b>Medical Expenses:</b> Part B coinsurance (generally 20% of Medicare-approved expenses) or copayment for hospital outpatient services. <b>Blood:</b> First three pints of blood each year.									
A	B	C	D	E	F/F*	G	H	I	J/J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
				Preventive Care NOT covered by Medicare					Preventive Care NOT covered by Medicare

\*Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same benefits as Plans F and J after one has paid a calendar year \$1,900 deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses exceed \$1,900. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the contract. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

KPS Health Plans does not offer the high deductible plan F or J.

# KPS HEALTH PLANS

## Outline of Medicare Supplement Coverage - Cover Page 2

Basic Benefits for Plans K and L include similar services as Plans A-J, but cost-sharing for the basic benefits is at different levels.

J	K**	L**
Basic Benefits	100% of Part A Hospitalization Coinsurance plus coverage for 365 days after Medicare benefits end	100% of Part A Hospitalization Coinsurance plus coverage for 365 days after Medicare benefits end
	50% Hospice cost-sharing	75% Hospice cost-sharing
	50% of Medicare-eligible expenses for the first three pints of blood	75% of Medicare-eligible expenses for the first three pints of blood
	50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services
Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT covered by Medicare		
	\$4,440 Out-of-Pocket Annual Limit***	\$2,220 Out-of-Pocket Annual Limit***

\*\*Plans K and L provide for different cost-sharing for items and services A-J. Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges". You will be responsible for paying excess charges.

\*\*\*The out-of-pocket annual limit will increase each year for inflation.

See Outlines of Coverage for details and exceptions.

**EFFECTIVE 4/01/2008 MONTHLY RATES PER PERSON ARE AS FOLLOWS:**

PLAN A: \$106.00

PLAN E: \$164.00

PLAN F: \$198.00

Should the Subscriber elect to make monthly payments in advance of the current monthly rate due date and the revised rate is to become effective at the beginning of a month for which the Subscriber has already paid, the next billing will include a retroactive adjustment for the revised rate.

## **PREMIUM INFORMATION**

We, KPS Health Plans, can only raise your monthly premium if we raise the premium for all contracts like yours in this state.

## **DISCLOSURES**

Use this outline to compare benefits and premiums among contracts.

### **READ YOUR CONTRACT VERY CAREFULLY**

This is only an outline describing your contract's most important features. The contract is your health care coverage contract. You must read the contract itself to understand all of the rights and duties of both you and KPS Health Plans.

### **RIGHT TO RETURN CONTRACT**

If you find that you are not satisfied with your contract, you may return it to KPS Health Plans, P.O. Box 339, 400 Warren Avenue, Bremerton, Washington, 98337, Attn: Marketing. If you send the contract back to us within thirty days after you receive it, we will treat the contract as if it had never been issued and return all of your payments.

### **CONTRACT REPLACEMENT**

If you are replacing another health insurance contract, do NOT cancel it until you have actually received your new contract and are sure you want to keep it.

## **NOTICE**

This contract may not fully cover all of your medical costs.

Neither KPS Health Plans 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 *Medicare and You* for more details.

### **COMPLETE ANSWERS ARE VERY IMPORTANT**

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

## PLAN A

### 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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: - While using 60 lifetime reserve days Once lifetime reserve days are used: - Additional 365 days  - Beyond the Additional 365 days	All but \$1,024 All but \$256 a day  All but \$512 a day  \$0  \$0	\$0 \$256 a day  \$512 a day  100% of Medicare Eligible Expenses \$0	\$1,024 (Part A Deductible) \$0  \$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 21st thru 100th day 101st day and after	All approved amounts All but \$128 a day \$0	\$0 \$0 \$0	\$0 Up to \$128 a day All Costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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

**\*\*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 contract'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.

## PLAN A

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

\* Once you have been billed \$135 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
<b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$135 of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (Above Medicare approved amounts)	\$0 Generally 80% \$0	\$0 Generally 20% \$0	\$135 (Part B Deductible) \$0 All Costs
<b>BLOOD</b> First 3 pints Next \$135 of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$135 (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

## PLAN A PARTS A & B

<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First \$135 of Medicare approved amounts* Remainder of Medicare approved amounts	100%   \$0 80%	\$0   \$0 20%	\$0   \$135 (Part B Deductible) \$0
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## PLAN E

### 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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: - While using 60 lifetime reserve days Once lifetime reserve days are used: - Additional 365 days  - Beyond the Additional 365 days	All but \$1,024 All but \$256 a day  All but \$512 a day  \$0  \$0	\$1,024 (Part A Deductible) \$256 a day  \$512 a day  100% of Medicare Eligible Expenses \$0	\$0 \$0  \$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 21st thru 100th day 101st day and after	All approved amounts All but \$128 a day \$0	\$0 Up to \$128 a day \$0	\$0 \$0 All Costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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

**\*\*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 contract'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.

## PLAN E

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

\* Once you have been billed \$135 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
<b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$135 of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (Above Medicare approved amounts)	\$0 Generally 80% \$0	\$0 Generally 20% \$0	\$135 (Part B Deductible) \$0 All Costs
<b>BLOOD</b> First 3 pints Next \$135 of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$135 (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

## PLAN E PARTS A & B

<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First \$135 of Medicare approved amounts* Remainder of Medicare approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$135 (Part B Deductible) \$0
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## PLAN E (Continued)

### OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p><b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b>                      Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA</p> <p>First \$250 each calendar year                      Remainder of Charges</p>	<p>\$0                      \$0</p>	<p>\$0                      80% to a lifetime maximum benefit of \$50,000</p>	<p>\$250                      20% and amounts over the \$50,000 lifetime maximum</p>
<p><b>***PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE</b>                      Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare</p> <p>First \$120 each calendar year                      Additional charges</p>	<p>\$0                      \$0</p>	<p>\$120                      \$0</p>	<p>\$0                      All Costs</p>

\*\*\*Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

## PLAN F

### 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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days  61st thru 90th day 91st day and after: - While using 60 lifetime reserve days Once lifetime reserve days are used: - Additional 365 days  - Beyond the Additional 365 days	All but \$1,024 (Part A Deductible)  All but \$256 a day  All but \$512 a day  \$0  \$0	\$1,024 (Part A Deductible)  \$256 a day  \$512 a day  100% of Medicare Eligible Expenses \$0	\$0  \$0  \$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 21st thru 100th day 101st day and after	All approved amounts All but \$128 a day \$0	\$0 Up to \$128 a day \$0	\$0 \$0 All Costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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

\*\*\***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 contract'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.

## PLAN F

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

\* Once you have been billed \$135 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
<b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$135 of Medicare approved amounts* Remainder of Medicare approved Amounts Part B excess charges (Above Medicare approved amounts)	\$0 Generally 80% \$0	\$135 (Part B Deductible) Generally 20% 100%	\$0 \$0 \$0
<b>BLOOD</b> First 3 pints Next \$135 of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All Costs \$135 (Part B Deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

### PLAN F PARTS A & B

<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100%  \$0 80%	\$0  \$135 (Part B Deductible) 20%	\$0  \$0 \$0
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### OTHER BENEFITS - NOT COVERED BY MEDICARE

<b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
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# KPS

health plans

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