Medical Plan Description	Medicare	ELITE			PREMIUM		CHOICE	
		Hartford	You		Hartford	You	Hartford	You
Preventive Care Screening [i]								
Pap Test & Pelvic Exam (1 every 2 years)	100%	$0	$0		$0	$0	$0	$0
Prostate Cancer Screening (PSA Test once a year	100%	$0	$0		$0	$0	$0	$0
Mammogram Screening (once a year)	100%	$0	$0		$0	$0	$0	$0
Hospital Confinement Benefit [ii]								
1 – 60th Day	All but Part A Deductible	Part A Deductible	$0		Part A Deductible	$0	Part A Deductible	$0
61st – 90th Day	All but 25% of the Medicare Part A Deductible per day	25% of the Medicare Part A Deductible per day	$0		25% of the Medicare Part A Deductible per day	$0	25% of the Medicare Part A Deductible per day	$0
91st – 150th Day (60 Day Lifetime Reserve Period)	All but 50% of the Medicare Part A Deductible per day	50% of the Medicare Part A Deductible per day	$0		50% of the Medicare Part A Deductible per day	$0	50% of the Medicare Part A Deductible per day	$0
Once Lifetime Reserve Days are Used (or Ended) Add'l 365 Days per Person per Lifetime	$0	100%	$0		100%	$0	100%	0
Out-Patient Medical Expenses								
Medicare Part B Deductible of Medicare-Approved Amounts	$0	Part B Deductible	$0		$0	Part B Deductible	$0	Part B Deductible
Remainder of Medicare-Approved Amounts	80%	20%	$0		20% after $500 in out-of-pocket expenses	20% until $500 in out-of-pocket expenses	20% after $1,000 in out-of-pocket expenses	20% until $1,000 in out-of-pocket expenses
Clinical Laboratory Services	100%	$0	$0		$0	$0	$0	$0
Part B Excess Charges	$0	100%	$0		100%	$0	100%	$0
Blood Deductible								
1 – 3 Pints	$0	100%	$0		100%	$0	100%	$0
Additional Amounts	100%	$0	$0		$0	$0	$0	$0
Skilled Nursing Facilities								
1 – 20th Day	All Approved Amounts	$0	$0		$0	$0	$0	$0
21st – 100th Day	All but 12.5% of the Medicare Part A Deductible per day	Up to 12.5% of the Part A Deductible per day	$0		Up to 12.5% of the Part A Deductible per day	$0	Up to 12.5% of the Part A Deductible per day	$0
101st – 365th Day	$0	$0	All Costs		$0	All Costs	$0	All Costs
Hospice Care	All Costs (limited to costs for out-patient drug & in-patient respite care)	Co-insurance charges (in-patient respite care, drugs & biological approved by Medicare)	All other charges		Co-insurance charges (in-patient respite care, drugs & biological approved by Medicare)	All other charges	Co-insurance charges (in-patient respite care, drugs & biological approved by Medicare)	All other charges
Foreign Travel Emergency	$0	80% after $250 Deductible (up to $50,000)	$250 Deductible 20% (to a lifetime maximum of $50,000 then 100% thereafter)		80% after $250 Deductible (up to $50,000)	$250 Deductible 20% (to a lifetime maximum of $50,000 then 100% thereafter)	80% after $250 Deductible (up to $50,000)	$250 Deductible 20% (to a lifetime maximum of $50,000 then 100% thereafter)