Gerber Life
Insurance Company

KENTUCKY—Medicare Supplement Comparison Statement

Current Insurance (Policy being replaced) ______________________ Insurer Name   Annual Premium ______________

Proposed Insurance ______________________ Insurer Name   Annual Premium ______________

Medicare (Part A): Hospital Insurance – Covered Services Per Benefit Period (1)				Private Insurance Checklist	
Services	**Benefit**	**Medicare Pays***	**You Pay***	**Current Insurance Pays (Plan__)****	**Proposed Insurance Pays (Plan__)**
Hospitalization Semiprivate room and board, general nursing and miscellaneous hospital services and supplies	First 60 days	All but $1,184.00	$1,184.00		
	61st to 90th day	All but $296.00 a day	$296.00 a day		
	91st to 150th day While using 60 lifetime reserve days***	All but $592.00 a day	$592.00 a day		
	Beyond 150 days	Nothing	All costs		
Posthospital Skilled Nursing Facility Care. In a facility approved by Medicare. You must have been in a hospital for at least 3 days and enter the facility within 30 days after hospital discharge (2)	First 20 days	100% of approved amounts	Nothing		
	Additional 80 days	All but $148.00 a day	$148.00 a day		
	Beyond 100 days	Nothing	All costs		
Home Health Care	Visits limited to medically necessary skilled care	Full cost of services; 80% of Medicare Approved Amounts for durable medical equipment	Nothing for services; 20% of Medicare Approved Amounts for durable medical equipment		
Hospice Care	Available with Doctor certification of terminal illness and services are requested.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Limited cost sharing for outpatient drugs and inpatient respite care		
Blood	Blood	All but first 3 pints	For first 3 pints ****		
Foreign Travel Benefits are payable for health care you need because of a covered injury or illness	Medically necessary emergency care in a foreign country	Emergency hospital services in qualified Mexican or Canadian hospitals*****	All costs not covered by Medicare		

* These figures are for 2013 and are subject to change each year.
** If the policy being replaced is not a standardized policy, insert "N/A" after "Plan" and complete this column.
*** 60 reserve days may be used only once; days used are not renewable.
**** To the extent the blood deductible is met under one part of Medicare during the calendar year, it does not have to be met under the other part.
***** Please refer to your Medicare Handbook for more information.
(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 or skilled nursing facility for 60 days in a row.
(2) Medicare and private Medicare supplement insurance will not pay for most nursing home care. You pay for custodial care and most care in a nursing home.

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KENTUCKY—Medicare Supplement Comparison Statement (continued)

Medicare (Part B): Physician Services and Supplies – Covered Services Per Benefit Period				Private Insurance Checklist	
Services	**Benefit**	**Medicare Pays**	**You Pay***	**Current Insurance Pays (Plan__)***	**Proposed Insurance Pays (Plan__)**
Medical Expense Physician's services, inpatient and outpatient and outpatient medical services and supplies, physical and speech therapy, ambulance, etc.	Medicare pays for medical services in or out of the hospital	80% of approved amount (after $147.00 deductible)	$147.00 deductible** plus 20% of balance of approved amount (plus up to 15% above approved charge)***		
Home Health Care Medicare Approved Services	Visits limited to medically necessary skilled care	Full cost of services and 80% of Medicare approved amounts for durable medical equipment (after $147.00 deductible)	Nothing for services; 20% of approved amount for durable medical equipment (after $147.00 deductible).		
At-Home Recovery Benefit	Short-term at-home assistance with activities of daily living****	Nothing	All costs		
Outpatient Hospital Treatment	Unlimited of medically necessary	80% of approved amounts (after $147.00 deductible)	Subject to deductible plus 20% of approved amount.		
Blood	Blood	80% of approved amount (after $147.00 deductible and starting with 4th pint)	First 3 pints plus 20% of approved amount (after $147.00 deductible)*****		
Preventive Care– Patient Education	Annual physical exam, preventive testing, influenza vaccines	Screening Pap smears once every 24 months; screening mammograms every 12 months	All costs not covered by Medicare		
Outpatient Prescription Drugs*****	Outpatient prescription drugs	Nothing	All costs		
Foreign Travel	Medically necessary emergency care in a foreign country	Doctor and ambulance service in Canada and Mexico if in connection with covered inpatient	All costs not covered by Medicare		
Other****					

* If the policy being replaced is not a standardized policy, insert "N/A."
** Once you have had $147.00 of expense for covered services in 2013, the Part B deductible does not apply to any further covered services you received for the rest of the year.
*** YOU PAY FOR charges higher than the amount approved by Medicare unless the doctor or supplier agrees to accept Medicare's approved amount as the total charge for services rendered.
**** At-home recovery benefits must be received in conjunction with Medicare approved home health care benefits.
***** To the extent the blood deductible is met under one part of Medicare during the calendar year, it does not have to be met under the other part.
****** Use this area to compare pre-standardization and/or innovative benefits
******* Medicare supplement insurers cannot offer prescription drug coverage after January 1, 2006. Prescription drug coverage will be offered through Medicare.

NOTE: Plan F pays 100% and Plan G pays 100% of Part B Excess Charges (charges above Medicare approved amounts).

Notice to Applicant: (Not applicable if sold through the mail)
Do not sign this form unless it has been explained to you.

Applicant ____________ Date ________ Agent ____________ Date ________

Notice to Agent/Insurer: (if applicable)
This form is to be retained by the replacing insurer and attached to the replacement policy.

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