

## OSAGE NATION MEDICARE SUPPLEMENT PLAN F OUTLINE OF COVERAGE

### MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD – 2026

- \* 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                                                                                                                                                                     | All but \$1736                                                                              | \$1736 (Part A Deductible)         | \$0       |
| 61st thru 90th day                                                                                                                                                                | All but \$434 a day                                                                         | \$434 a day                        | \$0       |
| 91st day and after:                                                                                                                                                               |                                                                                             |                                    |           |
| – While using 60 lifetime reserve days                                                                                                                                            | All but \$868 a day                                                                         | \$868 a 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 |
| <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                                                                                                                                                                     | All approved amounts                                                                        | \$0                                | \$0       |
| 21st thru 100th day                                                                                                                                                               | All but \$217 a day                                                                         | Up to \$217 a day                  | \$0       |
| 101st day and after                                                                                                                                                               | \$0                                                                                         | \$0                                | All Costs |
| <b>BLOOD</b>                                                                                                                                                                      |                                                                                             |                                    |           |
| First 3 pints                                                                                                                                                                     | \$0                                                                                         | 3 pints                            | \$0       |
| Additional Amounts                                                                                                                                                                | 100%                                                                                        | \$0                                | \$0       |
| <b>HOSPICE CARE</b>                                                                                                                                                               |                                                                                             |                                    |           |
| You must meet Medicare's requirements, including a doctor's certification of terminal illness                                                                                     | All but very limited copayment/ 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 the balance based on any difference between its billed charges and the amount Medicare would have paid.

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### MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR – 2026

- \* Once you have been billed \$283 of Medicare-Approved amounts for covered services (which are noted with an asterisk), Medicare 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<br>Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment<br>First \$283 of Medicare Approved Amounts*<br>Remainder of Medicare Approved Amounts<br>Part B Excess Charges (Above Medicare Approved Amounts) | \$0<br>Generally 80%<br>\$0 | 100% of the amount not paid by Medicare              | \$0<br>\$0<br>\$0 |
| BLOOD<br>First 3 pints<br>Next \$283 of Medicare Approved Amounts*<br>Remainder of Medicare Approved Amounts                                                                                                                                                                                                                                                                                                     | \$0<br>\$0<br>80%           | All Costs<br>100% of the amount not paid by Medicare | \$0<br>\$0<br>\$0 |
| CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES                                                                                                                                                                                                                                                                                                                                                     | 100%                        | \$0                                                  | \$0               |

### PARTS A & B

|                                                                                                                                                                                                                                       |                            |                                                    |                       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------------------------------|-----------------------|
| HOME HEALTH CARE MEDICARE APPROVED SERVICES<br>– Medically necessary skilled care services and medical supplies<br>– Durable medical equipment<br>First \$283 of Medicare Approved Amounts*<br>Remainder of Medicare Approved Amounts | 100%<br><br><br>\$0<br>80% | \$0<br><br>100% of the amount not paid by Medicare | \$0<br><br>\$0<br>\$0 |
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### OTHER BENEFITS – NOT COVERED BY MEDICARE

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