Anthem BlueCross BlueShield

Anthem Blue Cross and Blue Shield – Colorado

Administrative Office: P.O. Box 9063, Oxnard, CA 93031-9063
Toll Free Telephone Number: 1-877-831-3000

2015 Outline of Medicare Supplement Coverage

Cover Page (1 of 2)
Plans A, F & N

Benefit Chart of Medicare Supplement Plans Sold for Effective Dates On or After June 1, 2010

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state. Plans shown in gray are available for purchase.

These same Plans are available to those who are under 65 and qualify for Medicare due to disability.

Basic Benefits:

- **Hospitalization –** Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses –** Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.
- **Blood –** First three pints of blood each year.
- **Hospice –** Part A coinsurance.

PLAN	A	B	C	D	F | F*[1]	G	K	L	M	N
Basic coverage	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance*	Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
Skilled Nursing Facility coinsurance			✓	✓	✓	✓	50%	75%	✓	✓

[1] High Deductible Plan F is not available.

(continued on next page)

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2015 Outline of Medicare Supplement Coverage

Cover Page (2 of 2)
Plans A, F & N

PLAN	A	B	C	D	F | F*[1]	G	K	L	M	N
Part A Deductible		✓	✓	✓	✓	✓	50%	75%	50%	✓
Part B Deductible			✓		✓					
Part B Excess (100%)					✓	✓				
Foreign Travel Emergency			✓	✓	✓	✓			✓	✓
Out-of-pocket limit							$4,940; paid at 100% after limit reached	$2,470; paid at 100% after limit reached		

* Plan F also has an option called a High Deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,180 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses exceed $2,180. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

[1] High Deductible Plan F is not available.

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Premium Information

Plans A, F & N
Effective February 1, 2015

Premiums are subject to change.

About Your Premium

Here's some important information, before we get started:

Premiums are subject to change on or after the Renewal Date in accordance with the terms of the Policy. Renewal Date is defined as generally February 1, subject to state approval. Your Premium Billing Preference does not guarantee your premium for any specific time period. Any state-approved premium changes will be applied starting on your next Renewal Date following your Coverage Effective Date, regardless of your Premium Billing Preference. The selected Premium Billing Preference will take effect on the first day of payment period which immediately follows your Coverage Effective Date. For example, if your Coverage Effective Date is September 1 and you pick the Quarterly Premium Billing Preference, Quarterly premium billing will start on October 1; if you select the Annual Premium Billing Preference, Annual premium billing will start on February 1. Any premiums billed for the period of time from your Coverage Effective Date to the start of your selected Premium Billing Preference will be prorated to reflect the Premium Billing Preference selected.

We, Anthem, can only raise your premium if we raise the premium for all plans like yours in this State. We will recalculate your age each year to determine your new attained age. Your premium may increase annually at your plan renewal based upon your new attained age.

Don't miss out on a chance to SAVE!

These optional discounts are offered.

Save $2 on your monthly premium! Enroll in our Automatic Bank Draft or Electronic Fund Transfer (EFT) program and you will save $2 on your monthly premium. (To enroll, simply complete the Premium Payment Form.)

OR

Save $48 by paying your premium for the entire year! (Note: Based on the policy effective date, the discount may be pro-rated the first year.)

Save 5% when more than one member in the household enrolls in a Medicare Supplement plan with us. The discount is for policies with effective dates of June 1, 2010 or after and available to those members who occupy the same housing unit.

LET'S BEGIN

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Premium Information

Plans A, F & N
Effective February 1, 2015

Premiums are subject to change.

Find Your Monthly Premium

We're here to help you make choices to match your coverage needs.
First, you'll need to locate your premium. Premiums (and future changes to premiums) are determined by several factors, including the zip code where you live, tobacco use, age, gender, plan, and the costs of medical services and supplies. After locating your monthly premium, you'll refer to individual plan pages. These pages will provide details of coverage and benefits, for comparison purposes.

Here's how to find your premium, step-by-step:

Step 1.

Determine your Rating Area.

First, you will use the **Zip Code Area Guide** to determine your **Rating Area**.

Record your area below:

_____

Step 2.

Determine which Premium Table applies to you.

Refer to the appropriate **Premium Table**, according to your tobacco use:

If you did not use any tobacco products in the past 12 months:

> see Table 1

or

If you did use any tobacco products in the past 12 months:

> see Table 2

✓

Find your premium.

Now you're ready to compare premiums for each plan available to you.

We sort this information by gender and age.

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Monthly Premium

Plans A, F & N
Effective February 1, 2015

Premiums are subject to change.

Step 1: Determine Your Rating Area **5-Digit Zip Code Area Guide**

- **Go to Column 1** and locate the Prefix (first 3 digits of your Zip Code) (P.O. Box addresses are not acceptable.)
- **Next, move to Column 2** and locate the last two digits of your Zip Code.
- **Column 3** is your Rating Area. (note: Some zip codes are assigned Multiple Rating Areas.*)
- ✓ **Got it?** Now refer to your Premium Table.

1 Prefix	2 (Last two digits of Zip Code)	3 Area
800	01-07, 10-19, 21, 22, 24, 30, 31, 33, 34-37, 40-42, 44-47	1
800	25-28, 38	2
800	20, 23	1, 2, 3*
801	03, 04, 08, 09, 10-13, 16, 18, 20-31, 35-37, 50, 51, 55, 60-63, 65, 66	1
801	01, 07, 17, 32, 33	3
801	02, 05, 06, 34, 38	1, 3*
802	01-12, 14-39, 41, 43, 44, 46-52, 56, 57, 59-66, 71, 73, 74, 79-81, 90, 91, 93-95, 99	1
803	01-10, 14, 21-23, 28, 29	2
804	01, 02, 19, 25, 33, 37, 53, 54, 57, 65	1
804	55, 66, 71, 81	2
804	20, 21, 23, 24, 26-30, 32, 34-36, 38, 40, 42-44, 46, 47-49, 51, 52, 56, 59, 61, 63, 67-69, 73-80, 82, 83, 87, 88, 97, 98	3
804	03, 22, 39, 70	1, 2, 3*
805	02, 03, 10-12, 15, 17, 21-23, 25-28, 32, 33, 35, 36, 38-41, 44, 45, 47, 53	2
805	14, 20, 30, 42, 43, 46, 51	3
805	01, 04, 13, 16, 24, 34, 37, 49, 50	2, 3*
806	01, 02, 14, 40	1
806	10, 11, 15, 20-24, 31-34, 38, 39, 44-46, 48-53	03
806	03, 12, 42, 43, 54	1, 2, 3*
807	05, 20-23, 26-29, 31-37, 40-47, 49-51, 54, 55, 57-59	3
807	01	1, 3*
808	01, 02, 04, 05, 07-10, 12-36, 40, 41, 60-64, 66	3
809	01-47, 49-51, 60, 62, 70, 77, 95, 97	3
810	01-12, 19, 22, 23, 25, 69	2
810	20, 21, 24, 27, 29, 30, 33, 34, 36, 38, 40, 41, 43-47, 49, 50, 52, 54, 55, 57-59, 63, 64, 67, 71, 73, 76, 77, 81, 82, 84, 87, 89-92	3

* **Counties With Multiple Rating Areas:**

- **Area 1** Adams, Arapahoe, Broomfield, Douglas, and Jefferson.
- **Area 2** Boulder, Larimer, and Pueblo.
- **Area 3** Clear Creek, Crowley, Custer, El Paso, Elbert, Fremont, Gilpin, Morgan, Otero, Park, and Weld.

(see next page for more zips)

Step 1: Determine Your Rating Area **5-Digit Zip Code Area Guide** *(continued)*

> **Go to Column 1** and locate the Prefix (first 3 digits of your Zip Code) (P.O. Box addresses are not acceptable.)

> **Next, move to Column 2** and locate the last two digits of your Zip Code.

> **Column 3** is your Rating Area. (note: Some zip codes are assigned Multiple Rating Areas.*)

✓ **Got it?** Now refer to your Premium Table.

1 Prefix	2 (Last two digits of Zip Code)	3 Area
810	08, 39, 62	2, 3*
811	01, 02, 20-33, 35-38, 40, 41, 43, 44, 46-49, 51-55, 57	3
812	01, 10-12, 15, 20-28, 30-33, 35-37, 39-44, 47, 48, 51, 52, 90	3
812	53	2, 3*
813	01-03, 20, 21, 23-32, 34, 35	3
814	01-03, 10, 11, 13-16, 18-20, 22-35	3
815	01-07, 20-27	3
816	01, 02, 10-12, 15, 20, 21, 23, 24-26, 30-33, 35-43, 45-50, 52-58	3

* **Counties With Multiple Rating Areas:**

- **Area 1** Adams, Arapahoe, Broomfield, Douglas, and Jefferson.
- **Area 2** Boulder, Larimer, and Pueblo.
- **Area 3** Clear Creek, Crowley, Custer, El Paso, Elbert, Fremont, Gilpin, Morgan, Otero, Park, and Weld.

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Monthly Premium

Plans A, F & N
Effective February 1, 2015

Premiums are subject to change.

Step 2: Find your Premium **Table 1 | For Non-Tobacco Users**

*If you have not used tobacco products in the past 12 months, use this table —**or**— if you are a tobacco user, see Table 2.*
Premium is based upon your age, gender and plan.

Area 1

Age*	Male			Female		
	Plan A	Plan F	Plan N	Plan A	Plan F	Plan N
<65	$316.40	$505.37	$328.97	$272.67	$435.56	$283.54
65	$107.95	$172.53	$118.30	$ 97.91	$156.07	$107.31
66	111.75	178.61	122.47	101.26	161.39	110.97
67	117.18	187.30	128.42	106.14	169.18	116.33
68	121.14	193.60	132.76	110.15	175.56	120.72
69	126.49	202.17	138.63	115.05	183.36	126.08
70	131.21	209.71	143.80	119.18	189.98	130.62
71	136.56	218.29	149.67	124.08	197.77	136.00
72	142.84	228.32	156.54	128.98	205.58	141.36
73	151.45	242.07	165.97	136.31	217.27	149.40
74	159.91	255.59	175.24	144.47	230.27	158.33
75	169.21	270.46	185.43	153.44	244.56	168.17
76	178.59	285.45	195.72	162.39	258.85	178.00
77	189.37	302.69	207.54	171.37	273.15	187.83
78	194.82	311.36	213.49	177.15	282.37	194.17
79	201.08	321.39	220.36	182.04	290.16	199.52
80+	207.29	331.31	227.16	187.75	299.27	205.78

Area 2

Age*	Male			Female		
	Plan A	Plan F	Plan N	Plan A	Plan F	Plan N
<65	$286.65	$457.85	$298.03	$247.02	$394.60	$256.88
65	$ 97.80	$156.30	$107.17	$ 88.70	$141.39	$ 97.22
66	101.24	161.81	110.95	91.73	146.21	100.53
67	106.16	169.68	116.35	96.15	153.27	105.39
68	109.75	175.40	120.27	99.79	159.05	109.37
69	114.59	183.15	125.59	104.23	166.11	114.23
70	118.87	189.99	130.28	107.97	172.12	118.34
71	123.72	197.76	135.59	112.41	179.17	123.21
72	129.41	206.85	141.82	116.85	186.24	128.06
73	137.21	219.30	150.36	123.49	196.84	135.35
74	144.87	231.55	158.76	130.88	208.62	143.44
75	153.30	245.02	168.00	139.01	221.56	152.35
76	161.80	258.61	177.31	147.12	234.51	161.26
77	171.56	274.22	188.02	155.26	247.47	170.17
78	176.49	282.08	193.42	160.49	255.81	175.91
79	182.17	291.16	199.64	164.92	262.87	180.76
80+	187.79	300.15	205.80	170.09	271.12	186.43

* Attained age at the time of enrollment.

(see next page for more rating areas)

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Step 2: Find your Premium **Table 1 | For Non-Tobacco Users** *(continued)*

*If you have not used tobacco products in the past 12 months, use this table —**or**— if you are a tobacco user, see Table 2.*
Premium is based upon your age, gender and plan.

Area 3

Age*	Male			Female		
	Plan A	Plan F	Plan N	Plan A	Plan F	Plan N
<65	$283.89	$453.44	$295.16	$244.65	$390.80	$254.40
65	$ 96.86	$154.80	$106.14	$ 87.85	$140.03	$ 96.28
66	100.26	160.25	109.89	90.85	144.80	99.56
67	105.14	168.05	115.23	95.23	151.80	104.38
68	108.69	173.71	119.11	98.83	157.52	108.32
69	113.49	181.39	124.38	103.22	164.51	113.13
70	117.73	188.16	129.02	106.93	170.46	117.20
71	122.53	195.85	134.29	111.33	177.44	122.02
72	128.16	204.85	140.45	115.72	184.45	126.83
73	135.89	217.19	148.91	122.30	194.94	134.05
74	143.48	229.32	157.24	129.62	206.61	142.06
75	151.82	242.66	166.38	137.67	219.43	150.88
76	160.24	256.12	175.60	145.71	232.25	159.71
77	169.91	271.58	186.21	153.76	245.08	168.53
78	174.79	279.36	191.55	158.95	253.35	174.21
79	180.42	288.36	197.72	163.33	260.34	179.02
80+	185.99	297.26	203.82	168.45	268.51	184.64

* Attained age at the time of enrollment.

(see next page for Table 2)

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Monthly Premium

Plans A, F & N
Effective February 1, 2015

Premiums are subject to change.

Step 2: Find your Premium **Table 2** | **For Tobacco Users**

*If you have used tobacco products in the past 12 months, use this table —**or**— if you are not a tobacco user, see Table 1.*
Premium is based upon your age, gender and plan.

Area 1

Age*	Male			Female		
	Plan A	Plan F	Plan N	Plan A	Plan F	Plan N
<65	$354.37	$566.02	$368.45	$305.39	$487.83	$317.57
65	$120.90	$193.23	$132.49	$109.66	$174.80	$120.19
66	125.16	200.04	137.17	113.41	180.76	124.28
67	131.24	209.77	143.83	118.87	189.48	130.29
68	135.67	216.83	148.69	123.37	196.63	135.21
69	141.66	226.43	155.27	128.85	205.36	141.21
70	146.96	234.88	161.06	133.48	212.78	146.30
71	152.95	244.48	167.63	138.97	221.50	152.32
72	159.98	255.71	175.32	144.45	230.25	158.32
73	169.63	271.12	185.88	152.67	243.34	167.33
74	179.10	286.26	196.27	161.80	257.90	177.33
75	189.51	302.91	207.69	171.85	273.91	188.35
76	200.02	319.70	219.20	181.88	289.91	199.36
77	212.10	339.01	232.45	191.94	305.93	210.37
78	218.19	348.72	239.11	198.41	316.25	217.47
79	225.21	359.95	246.81	203.89	324.98	223.47
80+	232.16	371.07	254.42	210.28	335.18	230.48

Area 2

Age*	Male			Female		
	Plan A	Plan F	Plan N	Plan A	Plan F	Plan N
<65	$321.05	$512.79	$333.80	$276.67	$441.95	$287.70
65	$109.53	$175.06	$120.03	$ 99.35	$158.36	$108.88
66	113.39	181.23	124.27	102.74	163.76	112.60
67	118.90	190.04	130.31	107.69	171.66	118.04
68	122.92	196.44	134.70	111.77	178.14	122.50
69	128.34	205.13	140.67	116.73	186.05	127.93
70	133.14	212.79	145.91	120.93	192.77	132.54
71	138.57	221.49	151.86	125.90	200.67	137.99
72	144.94	231.67	158.83	130.87	208.59	143.43
73	153.67	245.62	168.40	138.31	220.46	151.60
74	162.26	259.34	177.82	146.59	233.65	160.66
75	171.69	274.43	188.15	155.69	248.15	170.63
76	181.21	289.64	198.59	164.78	262.65	180.61
77	192.15	307.13	210.59	173.89	277.16	190.59
78	197.67	315.92	216.63	179.75	286.51	197.02
79	204.04	326.10	223.60	184.71	294.42	202.45
80+	210.33	336.17	230.49	190.50	303.66	208.80

* Attained age at the time of enrollment.

(see next page for more rating areas)

Monthly Premium

Plans A, F & N
Effective February 1, 2015

Premiums are subject to change.

Step 2: Find your Premium **Table 2 | For Tobacco Users** *(continued)*

*If you have used tobacco products in the past 12 months, use this table —**or**— if you are not a tobacco user, see Table 1.*
Premium is based upon your age, gender and plan.

Area 3

Age*	Male			Female		
	Plan A	Plan F	Plan N	Plan A	Plan F	Plan N
‹65	$317.96	$507.85	$330.58	$274.00	$437.69	$284.93
65	$108.48	$173.37	$118.88	$ 98.39	$156.83	$107.84
66	112.29	179.48	123.07	101.75	162.18	111.51
67	117.75	188.21	129.05	106.66	170.01	116.90
68	121.73	194.55	133.41	110.69	176.42	121.32
69	127.11	203.16	139.31	115.61	184.26	126.70
70	131.86	210.74	144.51	119.77	190.91	131.26
71	137.23	219.36	150.40	124.69	198.74	136.67
72	143.54	229.44	157.31	129.61	206.59	142.05
73	152.20	243.26	166.78	136.98	218.34	150.14
74	160.70	256.84	176.10	145.18	231.40	159.11
75	170.04	271.78	186.34	154.19	245.76	168.99
76	179.47	286.85	196.68	163.19	260.12	178.87
77	190.30	304.17	208.56	172.21	274.49	188.75
78	195.77	312.88	214.54	178.02	283.75	195.12
79	202.07	322.96	221.44	182.93	291.58	200.50
80+	208.30	332.94	228.27	188.67	300.73	206.79

* Attained age at the time of enrollment.

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Disclosure Page

Plans A, F & N

Retain this outline for your records.

Disclosures

Use this outline to compare benefits and premiums among policies.

Medicare deductibles and coinsurance amounts are effective as of January 1, 2015. Medicare may change their amounts annually.

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 Anthem.

Right to Return Policy

If you find that you are not satisfied with your policy, you may return it to us at our Administrative Office: P.O. Box 9063, Oxnard, CA 93031-9063. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

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

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

Neither Anthem 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

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

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

Retain this outline for your records.

PLAN A
MEDICARE (PART A) HOSPITAL SERVICES — PER BENEFIT PERIOD

PART A Services

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,260	$0	$1,260 (Part A deductible)
61st thru 90th day	All but $315 a day	$315 a day	$0
91st day and after: · While using 60 lifetime reserve days	All but $630 a day	$630 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

(continued on next page)

* 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.

** 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.

PLAN A
MEDICARE (PART A) HOSPITAL SERVICES — PER BENEFIT PERIOD

PART **A** Services

Services	Medicare Pays	Plan Pays	You Pay
Skilled Nursing Facility Care* 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 $157.50 a day	$0	Up to $157.50 a day
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 copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

* 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.

PLAN A
MEDICARE (PART B) MEDICAL SERVICES — PER CALENDAR YEAR

PART B Services

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 $147 of Medicare Approved Amounts*	$0	$0	$147 (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 $147 of Medicare Approved Amounts*	$0	$0	$147 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Clinical Laboratory Services			
Tests for Diagnostic Services	100%	$0	$0

* Once you have been billed $147 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.

PLAN A
MEDICARE (PART A) HOSPITAL & (PART B) MEDICAL SERVICES

PARTS **A+B** Services

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 $147 of Medicare approved amounts*	$0	$0	$147 (Part B deductible)
— Remainder of Medicare approved amounts	80%	20%	$0

* Once you have been billed $147 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.

PLAN F

MEDICARE (PART A) HOSPITAL SERVICES — PER BENEFIT PERIOD

PART A Services

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,260	$1,260 (Part A deductible)	$0
61st thru 90th day	All but $315 a day	$315 a day	$0
91st day and after: · While using 60 lifetime reserve days	All but $630 a day	$630 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

(continued on next page)

* 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.

** 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.

PLAN F
MEDICARE (PART A) HOSPITAL SERVICES — PER BENEFIT PERIOD

PART A Services

Services	Medicare Pays	Plan Pays	You Pay
Skilled Nursing Facility Care* 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 $157.50 a day	Up to $157.50 a 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 copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

* 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.

PLAN F

MEDICARE (PART B) MEDICAL SERVICES — PER CALENDAR YEAR

PART **B** Services

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 $147 of Medicare Approved Amounts*	$0	$147 (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 $147 of Medicare Approved Amounts*	$0	$147 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
Clinical Laboratory Services			
Tests for Diagnostic Services	100%	$0	$0

* Once you have been billed $147 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.

PLAN F
MEDICARE (PART A) HOSPITAL & (PART B) MEDICAL SERVICES
OTHER BENEFITS — NOT COVERED BY MEDICARE

PARTS A+B Services

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 $147 of Medicare approved amounts*	$0	$147 (Part B deductible)	$0
— Remainder of Medicare approved amounts	80%	20%	$0

OTHER BENEFITS

Not Covered by Medicare

Foreign Travel — Not Covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

* Once you have been billed $147 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.

PLAN N

MEDICARE (PART A) HOSPITAL SERVICES — PER BENEFIT PERIOD

PART A Services

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,260	$1,260 (Part A deductible)	$0
61st thru 90th day	All but $315 a day	$315 a day	$0
91st day and after: · While using 60 lifetime reserve days	All but $630 a day	$630 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

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* 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.

** 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.

PLAN N

MEDICARE (PART A) HOSPITAL SERVICES — PER BENEFIT PERIOD

PART A Services

Services	Medicare Pays	Plan Pays	You Pay
Skilled Nursing Facility Care* 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 $157.50 a day	Up to $157.50 a 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 copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

* 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.

PLAN N

MEDICARE (PART B) MEDICAL SERVICES — PER CALENDAR YEAR

PART **B** Services

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 $147 of Medicare Approved Amounts*	$0	$0	$147 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	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.	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	$0	All costs	$0
Next $147 of Medicare Approved Amounts*	$0	$0	$147 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

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* Once you have been billed $147 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.

PLAN N

MEDICARE (PART B) MEDICAL SERVICES — PER CALENDAR YEAR
MEDICARE (PART A) HOSPITAL & (PART B) MEDICAL SERVICES
OTHER BENEFITS — NOT COVERED BY MEDICARE

PART B Services

Services	Medicare Pays	Plan Pays	You Pay
Clinical Laboratory Services			
Tests for Diagnostic Services	100%	$0	$0

PARTS A+B Services

Home Health Care — Medicare Approved Services			
· Medically necessary skilled care services and medical supplies	100%	$0	$0
· Durable medical equipment:			
— First $147 of Medicare approved amounts*	$0	$0	$147 (Part B deductible)
— Remainder of Medicare approved amounts	80%	20%	$0

OTHER BENEFITS

Not Covered by Medicare

Foreign Travel — Not Covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

* Once you have been billed $147 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.