



# Medicare Supplement Outline of Coverage

Plans A, F, Innovative F, G & N

**Anthem Blue Cross  
California 2018**

This booklet includes premium rates, Medicare deductibles,  
copays and maximum out-of-pocket costs.

Questions call 1-916-682-1117

## Benefit Chart of Medicare Supplement Plans Sold 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 (except for those that qualify due to ESRD).

### 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.

Benefits	A	B	C	D	F	Innovative	G	K	L	M	N
					F* <sup>1</sup>	F <sup>+</sup>					
Basic Coverage, Including 100% Part B Coinsurance	✓	✓	✓	✓	✓*	✓ <sup>+</sup>	✓			✓	✓ <sup>▲</sup>
Hospitalization & Preventative Care /Other Basic Benefits								100% /50%	100% /75%		
Skilled Nursing Facility Coinsurance			✓	✓	✓	✓	✓	50%	75%	✓	✓
Part A Deductible		✓	✓	✓	✓	✓	✓	50%	75%	50%	✓
Part B Deductible			✓		✓	✓					
Part B Excess (100%)					✓	✓	✓				
Foreign Travel Emergency			✓	✓	✓	✓	✓			✓	✓
Out-of-pocket Limit; Paid at 100% after Limit is Reached								\$5,120	\$2,560		

\* 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 \$2,200 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses exceed \$2,200. 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.

<sup>1</sup> High Deductible Plan F is not available.

<sup>+</sup> **Innovative F** includes additional benefits not contained in other standardized Medicare Supplement Plans as outlined in the following pages.

<sup>▲</sup> Basic benefits, EXCEPT up to \$20 copayment for office visit, and up to \$50 copayment for emergency room visit.

## Premium Information

Plans A, F, G & N | Effective March 1, 2017  
Innovative F | Effective January 1, 2018  
Premiums are subject to change.

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

We, Anthem Blue Cross, 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 and adjust your premium based on the new age band in March of each year up to the age cap.

Premiums are subject to change on or after the Renewal Date in accordance with the terms of the Policy. Renewal Date is defined as March 1, subject to state approval. The selected billing preference does not guarantee your premium for any specific period. Approved premium changes are effective as of the Renewal Date.

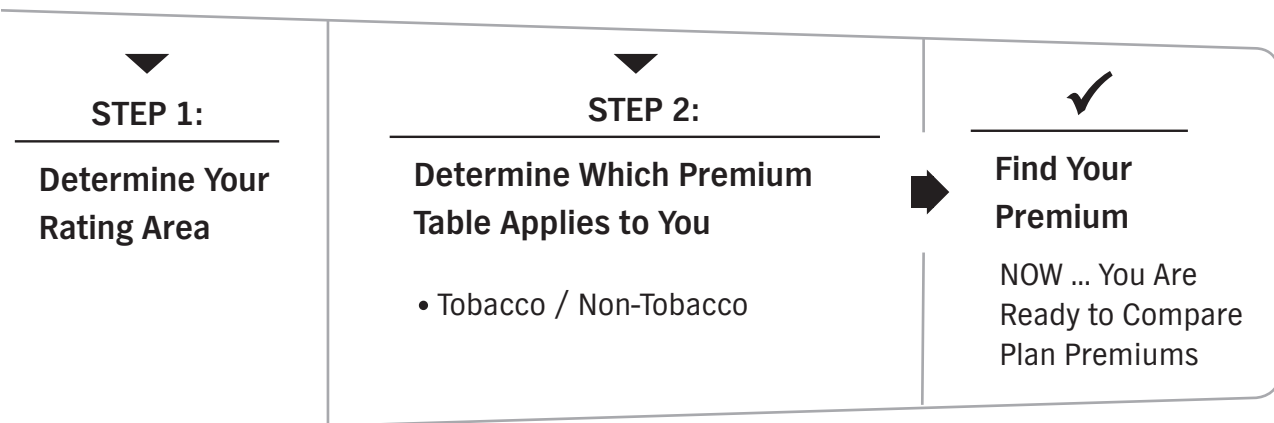
If you select a billing method other than Monthly EFT (Electronic Fund Transfer), the billing frequency takes effect on the first day of the payment period that immediately follows your coverage effective date. Based on your selected billing method and your coverage effective date, we will prorate the initial premium to align you with the quarterly or annual billing. For example, if you select quarterly billing and your coverage effective date is September 1, your quarterly billing will start on October 1. We base annual billing on a calendar year (January-December).

### Find Your Premium

Premiums (and future changes to premiums) are determined by several factors, including whether you are applying during your **Open Enrollment Period**, are eligible for **Guaranteed Issue** coverage, the county and/or zip code where you live, tobacco use, age, plan, and the costs of medical services and supplies.

- Your **Open Enrollment period** is the best time to buy a Medicare Supplement plan. The Open Enrollment period automatically starts the month you turn age 65 and enroll in Medicare Part B — this period only occurs once and allows you to enroll in any plan offered. During this period, you do not go through medical underwriting and are **guaranteed** acceptance into the Plan of your choice!
- When outside your Open Enrollment period you may experience a **Guaranteed Issue** right. These rights generally occur when you have other health coverage that changes. In California, you have this period annually based on your birthday. During this period, your Medicare Supplement plan options may be limited.

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



## Finding the Right Plan for You

Plans A, F, G & N | Effective March 1, 2017  
Innovative F | Effective January 1, 2018  
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### Compare Plans

After locating the monthly premium, you are ready to review the individual plan pages. These pages provide details of the covered services and what each plan pays. Based on your individual needs, these pages will help you determine the plan that is best for you. You are now ready to **ENROLL!**

### 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.)

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**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.

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#### **New to Medicare** – Enroll in Plan F and **SAVE \$240!**

If you are age 65 or older, and within six months of your Part B effective date you will receive \$20 off your monthly premium for the first 12 months of your policy. This discount is applicable to Plan F policies with an effective date of March 1, 2016 or after.

# Finding Your Monthly Premium

Plans A, F, G & N | Effective March 1, 2017  
 Innovative F | Effective January 1, 2018  
 Premiums are subject to change.

## Step 1: Determine Your Rating Area **County Area Guide**

➤ Find the county you live in from the list below.

✓ Got Your Rating Area?  
 Now you are ready to go to Step #2.

County	Area	County	Area	County	Area	County	Area
Alameda	3	Los Angeles <sup>◇</sup> (For this county, use your zip code to find your area.)	5	90260-90267	5	90650-90652	5
Alpine	1			90270		90659-90662	
Amador	1			90272		90670	
Butte	1			90274		90671	
Calaveras	1			90001-90084		90701-90704	
Colusa	1			90086-90089		90706	
Contra Costa	3			90091		90707	
Del Norte	1			90093-90096		90280	
El Dorado	1			90099		90290-90296	
Fresno	2			90101-90103		90301-90313	
Glenn	1			90189		90397	
Humboldt	1			90201		90398	
Imperial	2			90202		90401-90411	
Inyo	1			90209-90213		90501-90510	
Kern	2			90220-90224		90601-90610	
Kings	1			90230-90233		90612	
Lake	1			90239-90242		90623	
Lassen	1	90245		90630			
		90247-90251		90631			
		90254		90637-90640			
		90255					

◇ This county spans multiple rating areas.

# Finding Your Monthly Premium

Plans A, F, G & N | Effective March 1, 2017  
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## Step 1: Determine Your Rating Area

## County Area Guide

(continued)

► Find the county you live in from the list below.



Got Your Rating Area?  
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County	Area	County	Area	County	Area	County	Area	
<b>Los Angeles</b> <sup>◇</sup> (Continued – For this county, use your zip code to find your area.)	5	91101-91110	5	91322	5	91436	5	
		91114-91118		91324-91331		91470		
		91121		91333-91335		91482		
		91123-91126		91337		91495-91497		
		91129		91340-91346		91499		
		91131		91350-91357		91501-91508		
		91182		91361		91510		
		91184		91362		91521-91523		
		91185		91363-91365		91526		
		91188		91367		91601-91612		
		91189		91371		91614-91618		
		91191		91372		91702		6
		91199		91376		91706		
		91201-91210		91380-91388		91709		5
		91214		91390		91711		
		91221		91392-91396		91714-91716		6
		91222		91399		91722-91724		
		91224-91226		91401-91413		91731-91735		
		91301-91311		91416		91740		
		91313		91423		91741		5
		91316		91426		91744-91749		6
		91321						

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# Finding Your Monthly Premium

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## Step 1: Determine Your Rating Area

## County Area Guide

(continued)

► Find the county you live in from the list below.



Got Your Rating Area?  
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County	Area	County	Area	County	Area	County	Area	
<b>Los Angeles</b> <sup>◇</sup> (Continued – For this county, use your zip code to find your area.)		91801-91804	5	Madera	2	Placer	1	
		91841		Marin	3	Plumas	1	
		91896		Mariposa	2	Riverside	6	
		91899		Mendocino	1	Sacramento	2	
	91750	5	93243		Merced	2	San Benito	1
	91754-91756	6	93510	6	Modoc	1	San Bernardino	6
	91759	5	93532		Mono	1	San Diego	6
	91765	6	93534-93536		Monterey	1	San Francisco	3
	91766	5	93539		Napa	2	San Joaquin	2
	91767-91769		93543		Nevada	1	San Luis Obispo	2
	91770-91772	6	93544		Orange	4	San Mateo	3
	91773	5	93550-93553					
	91775	6	93560	5				
	91776		93563	6				
	91778		93584					
	91780		93586					
	91788-91793		93590					
	91795		93591					
	91797	5	93599	5				
91799	6							

◇ This county spans multiple rating areas.

## Finding Your Monthly Premium

Plans A, F, G & N | Effective March 1, 2017  
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### Step 1: Determine Your Rating Area

### County Area Guide

(continued)

► Find the county you live in from the list below.



Got Your Rating Area?  
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County	Area	County	Area	County	Area	
Santa Barbara <sup>◇</sup> (For this county, use your zip code to find your area.)		93190	2	Santa Clara	3	
		93199		Santa Cruz	2	
		93252	3	Shasta	1	
	93013	3	93254	2	Sierra	1
	93014	2	93427		Siskiyou	1
	93067		93429		Solano	2
	93101-93103		93434		Sonoma	2
	93105-93111		93436-93438		Stanislaus	2
	93116-93118		93440		Sutter	1
	93120		93441		Tehama	1
	93121		93454-93458		Trinity	1
	93130		93460		Tulare	1
	93140		93463		Tuolumne	1
	93150		93464		Ventura	6
93160				Yolo	1	
				Yuba	1	

◇ This county spans multiple rating areas.



# Finding Your Monthly Premium

Plans A, F, G & N | Effective March 1, 2017

Innovative F | Effective January 1, 2018

Premiums are subject to change. Premium is based upon your tobacco usage, age, area and plan.

## Step 2: Find Your Premium

**Table 1 | Non-Tobacco Users and/or Open Enrollment or Guaranteed Issue**

*Use this table if: you are in your Open Enrollment Period, or are eligible for Guaranteed Issue; —or— you do not use tobacco products. (Tobacco users should use Table 2.)*

### Areas 1, 2 and 3

Age*	Plan A	Plan F	Innovative F	Plan G	Plan N
<65	\$221.59	\$426.60	\$426.60	N/A	\$259.11
65	99.76	156.62	142.62	119.52	108.65
66	103.81	162.99	148.99	124.37	113.06
67	107.99	169.57	155.57	129.39	117.63
68	112.34	176.39	162.39	134.59	122.35
69	116.84	183.45	169.45	140.00	127.27
70	121.51	190.80	176.80	145.59	132.35
71	126.36	198.40	184.40	151.39	137.63
72	131.38	206.29	192.29	157.39	143.08
73	136.59	214.47	200.47	163.65	148.77
74	141.99	222.95	208.95	170.12	154.65
75	147.58	231.73	217.73	176.81	160.74
76	153.40	240.85	226.85	183.78	167.07
77	159.41	250.29	236.29	190.98	173.62
78	165.65	260.10	246.10	198.47	180.43
79	172.13	270.27	256.27	206.22	187.47
80	178.83	280.79	266.79	214.26	194.78
81+	185.99	292.03	278.03	222.83	202.57

\* Attained age at the time of enrollment.

Questions call: 1-916-682-1117

# Finding Your Monthly Premium

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Premiums are subject to change. Premium is based upon your tobacco usage, age, area and plan.

## Step 2: Find Your Premium

**Table 1 | Non-Tobacco Users and/or Open Enrollment or Guaranteed Issue**

*Use this table if: you are in your Open Enrollment Period, or are eligible for Guaranteed Issue; —or— you do not use tobacco products. (Tobacco users should use Table 2.)*

### Areas 4 and 5

Age*	Plan A	Plan F	Innovative F	Plan G	Plan N
<65	\$307.98	\$556.76	\$556.76	N/A	\$360.12
65	126.17	190.14	172.14	144.41	131.28
66	131.29	197.87	179.87	150.27	136.61
67	136.58	205.86	187.86	156.34	142.13
68	142.08	214.14	196.14	162.62	147.84
69	147.77	222.71	204.71	169.16	153.78
70	153.68	231.63	213.63	175.91	159.92
71	159.81	240.86	222.86	182.93	166.30
72	166.16	250.44	232.44	190.18	172.89
73	172.75	260.37	242.37	197.74	179.76
74	179.58	270.66	252.66	205.56	186.87
75	186.65	281.32	263.32	213.65	194.23
76	194.01	292.39	274.39	222.06	201.87
77	201.61	303.85	285.85	230.77	209.79
78	209.50	315.76	297.76	239.82	218.02
79	217.69	328.11	310.11	249.17	226.52
80	226.17	340.88	322.88	258.89	235.35
81+	235.22	354.52	336.52	269.25	244.77

Questions: 1-916-682-1117

\* Attained age at the time of enrollment.

## Finding Your Monthly Premium

Plans A, F, G & N | Effective March 1, 2017

Innovative F | Effective January 1, 2018

Premiums are subject to change. Premium is based upon your tobacco usage, age, area and plan.

### Step 2: Find Your Premium

#### Table 1 | Non-Tobacco Users and/or Open Enrollment or Guaranteed Issue

*Use this table if: you are in your Open Enrollment Period, or are eligible for Guaranteed Issue; —or— you do not use tobacco products. (Tobacco users should use Table 2.)*

#### Area 6

Age*	Plan A	Plan F	Innovative F	Plan G	Plan N
<65	\$291.07	\$469.99	\$469.99	N/A	\$276.72
65	119.24	168.54	154.54	127.64	116.04
66	124.08	175.39	161.39	132.83	120.75
67	129.08	182.47	168.47	138.19	125.63
68	134.28	189.81	175.81	143.75	130.68
69	139.66	197.41	183.41	149.52	135.93
70	145.24	205.32	191.32	155.49	141.35
71	151.04	213.50	199.50	161.69	146.99
72	157.04	221.99	207.99	168.10	152.82
73	163.27	230.79	216.79	174.78	158.89
74	169.72	239.92	225.92	181.69	165.17
75	176.40	249.36	235.36	188.85	171.68
76	183.36	259.18	245.18	196.27	178.43
77	190.54	269.34	255.34	203.97	185.43
78	198.00	279.89	265.89	211.98	192.71
79	205.74	290.84	276.84	220.24	200.22
80	213.75	302.16	288.16	228.83	208.03
81+	222.31	314.25	300.25	237.99	216.35

\* Attained age at the time of enrollment.

# Important Plan Disclosures

**Plans A, F, Innovative F, G & 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, 2018. 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 Blue Cross.

## 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 659816, San Antonio, TX 78265-9116. 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 Blue Cross 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.

## Innovative F

### Medicare (Part A) – Hospital Services – Per Benefit Period

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 \$1,316	\$1,316 (Part A deductible)	\$0
61 <sup>st</sup> thru 90 <sup>th</sup> day	All but \$329 a day	\$329 a day	\$0
91 <sup>st</sup> day and after:			
• While using 60 lifetime reserve days	All but \$658 a day	\$658 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
21 <sup>st</sup> thru 100 <sup>th</sup> day	All but \$164.50 a day	Up to \$164.50 a day	\$0
101 <sup>st</sup> 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

\* 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.

**Medicare (Part B) – Medical Services – Per 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 \$183 of Medicare Approved Amounts*	\$0	\$183 (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
<b>▼ Part B Excess Charges</b>			
Above Medicare Approved Amounts	\$0	100%	\$0
<b>▼ Blood</b>			
First 3 pints	\$0	All costs	\$0
Next \$183 of Medicare Approved Amounts*	\$0	\$183 (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>▼ Clinical Laboratory Services</b>			
Tests for Diagnostic Services	100%	\$0	\$0

**Parts A & B Services**

<b>▼ Home Health Care – Medicare Approved Services</b>			
• Medically necessary skilled care services and medical supplies	100%	\$0	\$0
• Durable medical equipment:			
– First \$183 of Medicare Approved Amounts*	\$0	\$183 (Part B deductible)	\$0
– Remainder of Medicare approved amounts	80%	20%	\$0
<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	\$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 \$183 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.

**Innovative Benefits – Not Covered by Medicare or Standardized Medicare Supplement Plans**

Services	Medicare Pays	Plan Pays	You Pay
<p><b>▼ Routine Vision Benefit</b>                      Through Blue View Vision Insight network you can maximize your benefits. You may receive covered benefits outside of the Blue View Vision Insight network. You will need to pay the provider at the time of service and submit a claim for reimbursement.</p>			
A. Routine Eye Exam (with dilation as needed) once every 12 months	\$0	In Network: 100% after the Copayment Out of Network: Up to \$35 allowance	In Network: \$25 copay Out of Network: Any amounts remaining after the Plan pays
B. Eyeglass Frames – Allowance toward new frames once every 24 months	\$0	In-Network: \$100 allowance Out-of-Network: Up to \$45 allowance	Any amounts remaining after the Plan pays
C. Lenses: Standard Plastic (CR39) – up to 55 mm in: Single Vision, Bifocal, Trifocal (FT 25-28), Lenticular (once every 12 months)	\$0	In Network: 100% after the Copayment Out of Network: Single Vision: Up to \$25 Bifocal: Up to \$40 Trifocal or Lenticular: Up to \$55	In Network: \$25 copay Out of Network: Any amounts remaining after the Plan pays
<ul style="list-style-type: none"> <li>• Contact Lenses (in place of eyeglass lenses) – once every 12 months                             <ul style="list-style-type: none"> <li>– Elective (conventional/disposable)</li> <li>– Non-Elective</li> </ul> </li> </ul>	\$0	In Network: \$100 allowance Out of Network: Up to \$80 allowance	Any amounts remaining after the Plan pays
	\$0	In Network: All Costs Out of Network: Up to \$210 allowance	
<p><b>▼ Routine Hearing Benefit</b>                      Through Hearing Care Solutions network of providers, coverage is provided for an annual hearing exam and hearing aid(s). This is separate from diagnostic hearing examinations and related charges as covered by Medicare.</p>			
Hearing Exam – Coverage for up to (1) routine hearing exam every 12 months.	\$0	100%	\$0
Hearing Aid(s) – Includes fitting evaluation for a hearing aid(s).	\$0	Coverage allowance up to \$750 toward a hearing device(s) every year. Includes 1-year supply of batteries (up to 64 cells per hearing aid).	Amounts in excess of Allowance

## Plan G

### Medicare (Part A) – Hospital Services – Per Benefit Period

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 \$1,316	\$1,316 (Part A deductible)	\$0
61 <sup>st</sup> thru 90 <sup>th</sup> day	All but \$329 a day	\$329 a day	\$0
91 <sup>st</sup> day and after:			
• While using 60 lifetime reserve days	All but \$658 a day	\$658 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
21 <sup>st</sup> thru 100 <sup>th</sup> day	All but \$164.50 a day	Up to \$164.50 a day	\$0
101 <sup>st</sup> 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

\* 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.



**Medicare (Part B) – Medical Services – Per 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 \$183 of Medicare Approved Amounts*	\$0	\$0	\$183 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
<b>▼ Part B Excess Charges</b>			
Above Medicare Approved Amounts	\$0	100%	\$0
<b>▼ Blood</b>			
First 3 pints	\$0	All costs	\$0
Next \$183 of Medicare Approved Amounts*	\$0	\$0	\$183 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>▼ Clinical Laboratory Services</b>			
Tests for Diagnostic Services	100%	\$0	\$0

**Parts A & B Services**

Services	Medicare Pays	Plan Pays	You Pay
<b>▼ Home Health Care – Medicare Approved Services</b>			
• Medically necessary skilled care services and medical supplies	100%	\$0	\$0
• Durable medical equipment:			
– First \$183 of Medicare Approved Amounts*	\$0	\$0	\$183 (Part B deductible)
– Remainder of Medicare approved amounts	80%	20%	\$0

\* Once you have been billed \$183 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.

**Other Benefits – Not Covered by Medicare**

Services	Medicare Pays	Plan Pays	You Pay
<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	\$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

## Plan N

### Medicare (Part A) – Hospital Services – Per Benefit Period

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 \$1,316	\$1,316 (Part A deductible)	\$0
61 <sup>st</sup> thru 90 <sup>th</sup> day	All but \$329 a day	\$329 a day	\$0
91 <sup>st</sup> day and after:			
• While using 60 lifetime reserve days	All but \$658 a day	\$658 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
21 <sup>st</sup> thru 100 <sup>th</sup> day	All but \$164.50 a day	Up to \$164.50 a day	\$0
101 <sup>st</sup> 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

\* 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.

**Medicare (Part B) – Medical Services – Per 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 \$183 of Medicare Approved Amounts*	\$0	\$0	\$183 (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 co-payment 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 co-payment 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.
<b>▼ Part B Excess Charges</b>			
Above Medicare Approved Amounts	\$0	\$0	All costs
<b>▼ Blood</b>			
First 3 pints	\$0	All costs	\$0
Next \$183 of Medicare Approved Amounts*	\$0	\$0	\$183 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>▼ Clinical Laboratory Services</b>			
Tests for Diagnostic Services	100%	\$0	\$0

\* Once you have been billed \$183 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.

**Parts A & B Services**

Services	Medicare Pays	Plan Pays	You Pay
<b>▼ Home Health Care – Medicare Approved Services</b>			
• Medically necessary skilled care services and medical supplies	100%	\$0	\$0
• Durable medical equipment:			
– First \$183 of Medicare approved amounts*	\$0	\$0	\$183 (Part B deductible)
– Remainder of Medicare approved amounts	80%	20%	\$0

**Other Benefits – Not Covered by Medicare**

Services	Medicare Pays	Plan Pays	You Pay
<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	\$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 \$183 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.