Anthem Blue Cross and Blue Shield – Wisconsin

Administrative Office: PO Box 9063, Oxnard, CA 93031-9063
Toll Free Telephone Number: 1-888-211-9815

2012 Outline of Medicare Supplement Coverage

Outline of Medicare Supplement Insurance Plans — Basic Plan, High Deductible Plan and Basic Plan Rider Options

Cover Page

The Wisconsin Insurance Commissioner has set standards for Medicare Supplement Insurance. This policy meets these standards. It, along with Medicare, may not cover all of your medical costs. You should review carefully all policy limitations. For an explanation of these standards and other important information, see the "Wisconsin Guide to Health Insurance for People with Medicare" included in this package. Do not buy this policy if you did not get this guide.

Note: You may purchase optional benefit riders for additional premium. With the Basic Plan, you may choose riders for Part A Deductible, Part B Copayment/Coinsurance, Part B Deductible, Medicare Part B Excess Charges, Foreign Travel Emergency, and Home Health Care.

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2012 Outline of Medicare Supplement Coverage

Disclosure Page (1 of 3)

Retain this outline for your records.

Premium Information

We, Anthem Blue Cross and Blue Shield, can only raise your premium if we raise the premium for all policies like yours in this state. If you change age categories, your premium will increase to that rate at the beginning of the policy term following your birthday. Also, if your residence changes such that you move into a new rating area, your rates may be adjusted. Finally, if your coverage begins prior to age 65, you will remain in the same age category for the duration of your policy.

Disclosures

Use this outline to compare benefits and premiums among policies.

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 and Blue Shield.

Right to Return Policy

If you find you are not satisfied with your policy, you may return it to our Administrative Office: PO 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 directly to you.

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.

(continued on next page)

NOTE: Neither Anthem Blue Cross and Blue Shield nor its agents are connected with Medicare.

2012 Outline of Medicare Supplement Coverage

Disclosure Page (2 of 3)

Retain this outline for your records.

Limitations and Exclusions

The policy does not cover expenses for:

1. Nursing Home Care costs beyond what is covered by Medicare and the Wisconsin 30 day Skilled Nursing benefit mandated by s. 632.895(3), Stats.
2. Physician's charges above Medicare's approved charge (unless the optional Medicare Part B Excess Charges Rider is chosen and the additional premium is paid.)
3. Outpatient prescription drugs.
4. Most care received outside of the U.S.A. (unless the optional Foreign Travel Emergency Rider is chosen and the additional premium is paid.)
5. Dental care, dentures, checkups, routine immunizations, cosmetic surgery, routine foot care, examinations for and the cost of eyeglasses or hearing aids, unless eligible under Medicare.
6. Coverage for emergency care anywhere or for care received outside the service area if this care is treated differently than other covered benefits.
7. Waiting period for pre-existing conditions.
8. Amounts in excess of what we determine to be above the usual, customary, and reasonable rate, fee, or cost.

Notice

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.

Guaranteed Renewable for Life — How You Can Renew Your Policy

Pay your premiums by the due date, or within the 31 day grace period and your policy will automatically renew. We may change the premium rates only if we change them for all policies like this in your state. If your premium rates increase, we will give you at least 60 days notice.

Our Guarantee for Changes in Medicare

If Medicare changes the fixed deductibles or co-payments as defined in the policy, which you must pay, we will also change the benefits of this policy. In that way, you will be covered at all times for the Medicare deductibles and co-payments. Premiums may be changed to correspond with the increased benefits. If you have any questions concerning this policy, please write or call our Administrative Office. Our telephone number is 1-888-211-9815. Our address is PO Box 9063, Oxnard, CA 93031-9063.

Grievance and Appeals

If you have any dissatisfaction with the provision of services or our claim practices or administration, you have the right to file a written grievance. Your grievance must be in writing, and it should be identified as a grievance.

We will acknowledge receipt of your grievance within 5 days. Our Grievance Committee will conduct a complete review of your case. You will have an opportunity to appear before the committee to present written or oral information and ask questions. We will inform you of the time

and place of the committee meeting at least 7 days in advance. In general, the resolution of your grievance will occur within 30 days after receiving your grievance. However, we may extend this period by an additional 30 days. If an extension is required, we will notify you in writing prior to the expiration of the first 30-day period. You must complete this grievance process before you start any legal action against us or before requesting external review (except in limited circumstances explained in the policy).

External Review

If you are not satisfied with the decision of the Review Committee and your grievance qualifies, you may request an external review. A neutral third party then reviews your case and makes a decision. We will inform you if your grievance qualifies for external review.

Anthem Health. Join In.

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Toll Free Telephone Number: 1-888-211-9815

Monthly Rates
Basic and High Deductible Plan
Effective January 1, 2012

Rates are subject to change

Basic and High Deductible Plan — Area 1, Female Rates

To determine your premium, select your age as of your requested policy effective date. Refer to the Zip Code Area Guide on pages 11 and 12 to determine which area you live in. Some zip codes may fall in two or more rating areas.

	BASIC PLAN							HIGH DEDUCTIBLE PLAN
		Optional Riders						
Attained Age	Base Rate	Part A Deductible	Part B Deductible*	Medicare Part B Copayment/ Coinsurance*	Part B Excess Charges	Home Health	Foreign Travel Emergency	Base Rate
< 65	$326.38	$63.80	$12.69	-$109.17	$15.13	$5.08	$7.56	$137.15
65	101.23	20.82	12.69	-28.23	4.92	1.78	2.48	45.84
66	109.53	21.80	12.69	-31.05	5.18	1.86	2.59	48.93
67	114.70	22.80	12.69	-32.89	5.42	1.92	2.71	51.04
68	119.87	23.80	12.69	-34.73	5.67	1.99	2.82	53.14
69	125.04	24.79	12.69	-36.57	5.91	2.06	2.93	55.23
70	130.22	25.78	12.69	-38.42	6.17	2.12	3.06	57.34
71	135.39	26.78	12.69	-40.26	6.41	2.19	3.15	59.43
72	140.56	27.77	12.69	-42.11	6.66	2.26	3.28	61.54
73	146.85	28.97	12.69	-44.36	6.96	2.35	3.42	64.09
74	153.16	30.17	12.69	-46.61	7.24	2.44	3.54	66.64
75	159.45	31.37	12.69	-48.86	7.54	2.53	3.68	69.19
76	165.76	32.56	12.69	-51.13	7.84	2.63	3.82	71.75
77	172.05	33.76	12.69	-53.37	8.13	2.71	3.95	74.30
78	179.80	35.28	12.69	-56.19	8.47	2.85	4.13	77.46
79	187.54	36.77	12.69	-59.02	8.80	2.98	4.31	80.61
80+	210.79	41.32	12.69	-67.51	9.83	3.38	4.86	90.09

* You may select either Part B Deductible or Part B Copayment/Coinsurance rider option.

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Monthly Rates
Basic and High Deductible Plan
Effective January 1, 2012

Rates are subject to change

Basic and High Deductible Plan — Area 1, Male Rates

To determine your premium, select your age as of your requested policy effective date. Refer to the Zip Code Area Guide on pages 11 and 12 to determine which area you live in. Some zip codes may fall in two or more rating areas.

	BASIC PLAN							HIGH DEDUCTIBLE PLAN
		Optional Riders						
Attained Age	Base Rate	Part A Deductible	Part B Deductible*	Medicare Part B Copayment/ Coinsurance*	Part B Excess Charges	Home Health	Foreign Travel Emergency	Base Rate
< 65	$351.63	$68.72	$12.69	-$118.31	$16.30	$5.47	$8.15	$147.44
65	109.06	22.43	12.69	-31.10	5.30	1.92	2.68	49.07
66	118.00	23.50	12.69	-34.11	5.57	1.99	2.79	52.40
67	123.57	24.57	12.69	-36.11	5.84	2.07	2.92	54.67
68	129.14	25.64	12.69	-38.10	6.10	2.14	3.04	56.93
69	134.72	26.72	12.69	-40.07	6.37	2.21	3.15	59.19
70	140.29	27.78	12.69	-42.07	6.64	2.29	3.29	61.46
71	145.85	28.86	12.69	-44.05	6.91	2.36	3.41	63.72
72	151.43	29.91	12.69	-46.04	7.18	2.44	3.53	65.98
73	158.21	31.21	12.69	-48.45	7.50	2.53	3.67	68.73
74	165.00	32.50	12.69	-50.91	7.80	2.64	3.82	71.48
75	171.78	33.78	12.69	-53.31	8.12	2.73	3.96	74.22
76	178.58	35.08	12.69	-55.74	8.45	2.82	4.11	76.99
77	185.36	36.37	12.69	-58.17	8.76	2.92	4.25	79.73
78	193.71	38.00	12.69	-61.23	9.12	3.07	4.45	83.14
79	202.05	39.63	12.69	-64.28	9.48	3.22	4.65	86.54
80+	227.09	44.51	12.69	-73.41	10.57	3.65	5.23	96.73

* You may select either Part B Deductible or Part B Copayment/Coinsurance rider option.

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Monthly Rates
Basic and High Deductible Plan
Effective January 1, 2012

Rates are subject to change

Basic and High Deductible Plan — Area 2, Female Rates

To determine your premium, select your age as of your requested policy effective date. Refer to the Zip Code Area Guide on pages 11 and 12 to determine which area you live in. Some zip codes may fall in two or more rating areas.

	BASIC PLAN							HIGH DEDUCTIBLE PLAN
		Optional Riders						
Attained Age	Base Rate	Part A Deductible	Part B Deductible*	Medicare Part B Copayment/ Coinsurance*	Part B Excess Charges	Home Health	Foreign Travel Emergency	Base Rate
< 65	$277.42	$54.23	$10.79	-$92.79	$12.86	$4.32	$6.43	$116.58
65	86.05	17.70	10.79	-24.00	4.18	1.51	2.11	38.96
66	93.10	18.53	10.79	-26.39	4.40	1.58	2.20	41.59
67	97.50	19.38	10.79	-27.96	4.61	1.63	2.30	43.38
68	101.89	20.23	10.79	-29.52	4.82	1.69	2.40	45.17
69	106.28	21.07	10.79	-31.08	5.02	1.75	2.49	46.95
70	110.69	21.91	10.79	-32.66	5.24	1.80	2.60	48.74
71	115.08	22.76	10.79	-34.22	5.45	1.86	2.68	50.52
72	119.48	23.60	10.79	-35.79	5.66	1.92	2.79	52.31
73	124.82	24.62	10.79	-37.71	5.92	2.00	2.91	54.48
74	130.19	25.64	10.79	-39.62	6.15	2.07	3.01	56.64
75	135.53	26.66	10.79	-41.53	6.41	2.15	3.13	58.81
76	140.90	27.68	10.79	-43.46	6.66	2.24	3.25	60.99
77	146.24	28.70	10.79	-45.36	6.91	2.30	3.36	63.16
78	152.83	29.99	10.79	-47.76	7.20	2.42	3.51	65.84
79	159.41	31.25	10.79	-50.17	7.48	2.53	3.66	68.52
80+	179.17	35.12	10.79	-57.38	8.36	2.87	4.13	76.58

* You may select either Part B Deductible or Part B Copayment/Coinsurance rider option.

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Basic and High Deductible Plan
Effective January 1, 2012

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Basic and High Deductible Plan — Area 2, Male Rates

To determine your premium, select your age as of your requested policy effective date. Refer to the Zip Code Area Guide on pages 11 and 12 to determine which area you live in. Some zip codes may fall in two or more rating areas.

	BASIC PLAN							HIGH DEDUCTIBLE PLAN
		Optional Riders						
Attained Age	Base Rate	Part A Deductible	Part B Deductible*	Medicare Part B Copayment/ Coinsurance*	Part B Excess Charges	Home Health	Foreign Travel Emergency	Base Rate
< 65	$298.89	$58.41	$10.79	-$100.56	$13.86	$4.65	$6.93	$125.32
65	92.70	19.07	10.79	-26.44	4.51	1.63	2.28	41.71
66	100.30	19.98	10.79	-28.99	4.73	1.69	2.37	44.54
67	105.03	20.88	10.79	-30.69	4.96	1.76	2.48	46.47
68	109.77	21.79	10.79	-32.39	5.19	1.82	2.58	48.39
69	114.51	22.71	10.79	-34.06	5.41	1.88	2.68	50.31
70	119.25	23.61	10.79	-35.76	5.64	1.95	2.80	52.24
71	123.97	24.53	10.79	-37.44	5.87	2.01	2.90	54.16
72	128.72	25.42	10.79	-39.13	6.10	2.07	3.00	56.08
73	134.48	26.53	10.79	-41.18	6.38	2.15	3.12	58.42
74	140.25	27.63	10.79	-43.27	6.63	2.24	3.25	60.76
75	146.01	28.71	10.79	-45.31	6.90	2.32	3.37	63.09
76	151.79	29.82	10.79	-47.38	7.18	2.40	3.49	65.44
77	157.56	30.91	10.79	-49.44	7.45	2.48	3.61	67.77
78	164.65	32.30	10.79	-52.05	7.75	2.61	3.78	70.67
79	171.74	33.69	10.79	-54.64	8.06	2.74	3.95	73.56
80+	193.03	37.83	10.79	-62.40	8.98	3.10	4.45	82.22

* You may select either Part B Deductible or Part B Copayment/Coinsurance rider option.

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Monthly Rates
Basic and High Deductible Plan
Effective January 1, 2012

Rates are subject to change

Basic and High Deductible Plan — Area 3, Female Rates

To determine your premium, select your age as of your requested policy effective date. Refer to the Zip Code Area Guide on pages 11 and 12 to determine which area you live in. Some zip codes may fall in two or more rating areas.

	BASIC PLAN							HIGH DEDUCTIBLE PLAN
		Optional Riders						
Attained Age	Base Rate	Part A Deductible	Part B Deductible*	Medicare Part B Copayment/ Coinsurance*	Part B Excess Charges	Home Health	Foreign Travel Emergency	Base Rate
< 65	$293.74	$57.42	$11.42	-$98.25	$13.62	$4.57	$6.80	$123.44
65	91.11	18.74	11.42	-25.41	4.43	1.60	2.23	41.26
66	98.58	19.62	11.42	-27.95	4.66	1.67	2.33	44.04
67	103.23	20.52	11.42	-29.60	4.88	1.73	2.44	45.94
68	107.88	21.42	11.42	-31.26	5.10	1.79	2.54	47.83
69	112.54	22.31	11.42	-32.91	5.32	1.85	2.64	49.71
70	117.20	23.20	11.42	-34.58	5.55	1.91	2.75	51.61
71	121.85	24.10	11.42	-36.23	5.77	1.97	2.84	53.49
72	126.50	24.99	11.42	-37.90	5.99	2.03	2.95	55.39
73	132.17	26.07	11.42	-39.92	6.26	2.12	3.08	57.68
74	137.84	27.15	11.42	-41.95	6.52	2.20	3.19	59.98
75	143.51	28.23	11.42	-43.97	6.79	2.28	3.31	62.27
76	149.18	29.30	11.42	-46.02	7.06	2.37	3.44	64.58
77	154.85	30.38	11.42	-48.03	7.32	2.44	3.56	66.87
78	161.82	31.75	11.42	-50.57	7.62	2.57	3.72	69.71
79	168.79	33.09	11.42	-53.12	7.92	2.68	3.88	72.55
80+	189.71	37.19	11.42	-60.76	8.85	3.04	4.37	81.08

* You may select either Part B Deductible or Part B Copayment/Coinsurance rider option.

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Basic and High Deductible Plan
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Rates are subject to change

Basic and High Deductible Plan — Area 3, Male Rates

To determine your premium, select your age as of your requested policy effective date. Refer to the Zip Code Area Guide on pages 11 and 12 to determine which area you live in. Some zip codes may fall in two or more rating areas.

	BASIC PLAN							HIGH DEDUCTIBLE PLAN
		Optional Riders						
Attained Age	Base Rate	Part A Deductible	Part B Deductible*	Medicare Part B Copayment/ Coinsurance*	Part B Excess Charges	Home Health	Foreign Travel Emergency	Base Rate
< 65	$316.47	$61.85	$11.42	-$106.48	$14.67	$4.92	$7.34	$132.70
65	98.15	20.19	11.42	-27.99	4.77	1.73	2.41	44.16
66	106.20	21.15	11.42	-30.70	5.01	1.79	2.51	47.16
67	111.21	22.11	11.42	-32.50	5.26	1.86	2.63	49.20
68	116.23	23.08	11.42	-34.29	5.49	1.93	2.74	51.24
69	121.25	24.05	11.42	-36.06	5.73	1.99	2.84	53.27
70	126.26	25.00	11.42	-37.86	5.98	2.06	2.96	55.31
71	131.27	25.97	11.42	-39.65	6.22	2.12	3.07	57.35
72	136.29	26.92	11.42	-41.44	6.46	2.20	3.18	59.38
73	142.39	28.09	11.42	-43.61	6.75	2.28	3.30	61.86
74	148.50	29.25	11.42	-45.82	7.02	2.38	3.44	64.33
75	154.60	30.40	11.42	-47.98	7.31	2.46	3.56	66.80
76	160.72	31.57	11.42	-50.17	7.61	2.54	3.70	69.29
77	166.82	32.73	11.42	-52.35	7.88	2.63	3.83	71.76
78	174.34	34.20	11.42	-55.11	8.21	2.76	4.01	74.83
79	181.85	35.67	11.42	-57.85	8.53	2.90	4.19	77.89
80+	204.38	40.06	11.42	-66.07	9.51	3.29	4.71	87.06

* You may select either Part B Deductible or Part B Copayment/Coinsurance rider option.

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Basic and High Deductible Plan
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Rates are subject to change

5-Digit Zip Code Area Guide

To determine your premium, refer to the zip code listing to determine which area you live in, then select your age as of your requested policy effective date from the prior pages.

1. Go to **Column 1** and locate the Prefix (first 3 digits of your Zip Code) (P.O. Box addresses are not acceptable.)
2. Then move to **Column 2** and locate the last two digits of your Zip Code.
3. **Column 3** is your Rating Area. (note: Some zip codes are assigned Multiple Rating Areas.*)
4. See Premium Chart for your area.

1 Prefix	2 (Last two digits of Zip Code)	3 Area
530	05, 07, 08, 12, 17, 18, 22, 24, 29, 33, 37, 45, 46, 51, 52, 56, 58, 60, 64, 69, 72, 74, 76, 80, 86, 89, 90, 92, 95, 97	1
530	01, 03, 06, 11, 14-16, 19, 20, 23, 26, 31, 32, 34, 35, 38, 39, 42, 44, 47, 48-50, 57, 59, 61-63, 65, 70, 73, 78, 79, 81, 82, 83, 85, 88, 93, 94, 98, 99	3
530	02, 04, 10, 13, 21, 27, 36, 40, 66, 75, 91	1, 3*
531	01-04, 08-10, 22, 26, 27, 29, 30, 32, 39, 40-44, 46, 50-54, 58, 59, 67, 68, 70-72, 77, 79, 81-83, 85-89, 92, 94, 99	1
531	14, 15, 21, 25, 37, 38, 47, 48, 57, 76, 84, 90, 91, 95	3
531	05, 18, 19, 20, 28, 49, 56, 78	1, 3*
532	1-28, 33-35, 37, 44, 59, 63, 67, 68, 74, 78, 88, 90, 93, 95	1
534	01-08	1
535	27-29, 31, 58, 62, 71, 75, 90, 93, 96-98	2
535	01-06, 10-12, 18, 20, 22, 25, 26, 30, 33, 35-38, 40-43, 45-51, 53, 54, 56, 57, 61, 63, 65, 66, 69, 70, 73, 76-78, 79-82, 84-88, 95, 99	3
535	07, 08, 15- 17, 21, 23, 32, 34, 44, 55, 59, 60, 72, 74, 83, 89, 94	2, 3*
537	01-08, 11, 13-19, 25, 26, 44, 74, 77-79, 82-86, 88-94	2
538	01-13, 16-18, 20, 21, 24-27	3
539	01, 10, 13, 16, 19, 20, 22-24, 26-37, 39-44, 46-59, 61-65, 68, 69	3
539	11, 25, 60	2, 3*
540	01-07, 09-11, 13-17, 20-28, 82	3
541	13, 31, 36, 40, 52, 55, 73, 80	2
541	01-04, 11, 12, 14, 19-21, 23-25, 27-29, 35, 37-39, 41, 43, 49-51, 53, 54, 56, 57, 59-61, 66, 69, 71, 74, 75, 77, 82	3
541	06, 07, 10, 15, 26, 30, 62, 65, 70	2, 3*
542	29	2
542	01, 02, 04, 05, 07, 09-16, 20, 21, 26, 28, 32, 34, 35, 40, 41, 45-47	3

*** Counties With Zip Codes That Cross Rating Area Boundaries:**

- **Area 1** Includes Kenosha, Ozaukee, Racine, Washington, and Waukesha Counties.
- **Area 2** Includes Brown, Dane, and Outagamie Counties.
- **Area 3** Includes Calumet, Columbia, Dodge, Door, Fond du Lac, Green, Iowa, Jefferson, Kewaunee, Lafayette, Manitowoc, Oconto, Rock, Sauk, Shawano, Sheboygan, Walworth, Waupaca, Waushara, and Winnebago Counties.

5-Digit Zip Code Area Guide (Continued)

To determine your premium, refer to the zip code listing to determine which area you live in, then select your age as of your requested policy effective date from the prior pages.

1. Go to **Column 1** and locate the Prefix (first 3 digits of your Zip Code) (P.O. Box addresses are not acceptable.)
2. Then move to **Column 2** and locate the last two digits of your Zip Code.
3. **Column 3** is your Rating Area. (note: Some zip codes are assigned Multiple Rating Areas.*)
4. See Premium Chart for your area.

1 Prefix	2 (Last two digits of Zip Code)	3 Area
542	08, 17, 27, 30	2, 3*
543	01-08, 11, 13, 24, 44	2
544	01-18, 20-30, 32-37, 39-43, 46-52, 54-60, 62-67, 69-76, 79-81, 84-95, 98, 99	3
545	01, 11-15, 17, 19-21, 24-27, 29-32, 34, 36-43, 45-48, 50, 52, 54-66, 68	3
546	01-03, 10-16, 18-32, 34-46, 48-62, 64-67, 69, 70	3
547	01-03, 20-43, 45-51, 54-74	3
548	01, 05, 06, 10, 12-14, 16-22, 24, 26-30, 32, 34-50, 53-59, 61, 62, 64, 65, 67, 68, 70-76, 80, 88-91, 93, 95, 96	3
549	11, 12, 19, 31, 42	2
549	01-04, 06, 09, 21, 23, 26-28, 30, 32-37, 41, 43, 45, 46, 48-50, 52, 57, 60, 62-71, 74, 76-86, 90	3
549	13, 14, 15, 22, 29, 40, 44, 47, 56, 61	2, 3*

*** Counties With Zip Codes That Cross Rating Area Boundaries:**

- **Area 1** Includes Kenosha, Ozaukee, Racine, Washington, and Waukesha Counties.
- **Area 2** Includes Brown, Dane, and Outagamie Counties.
- **Area 3** Includes Calumet, Columbia, Dodge, Door, Fond du Lac, Green, Iowa, Jefferson, Kewaunee, Lafayette, Manitowoc, Oconto, Rock, Sauk, Shawano, Sheboygan, Walworth, Waupaca, Waushara, and Winnebago Counties.

Anthem Health. Join In.

Anthem Blue Cross and Blue Shield – Wisconsin

Administrative Office: PO Box 9063, Oxnard, CA 93031-9063
Toll Free Telephone Number: 1-888-211-9815

Monthly Rates
Basic and High Deductible Plan
Effective January 1, 2012

Rates are subject to change

Basic and High Deductible Plan: Premium Information

Save $2 on your monthly premium! Enroll in our monthly 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.

Anthem Health. Join In.

Anthem Blue Cross and Blue Shield – Wisconsin

Administrative Office: PO Box 9063, Oxnard, CA 93031-9063
Toll Free Telephone Number: 1-888-211-9815

Premium Calculator

Medicare Supplement Premium Information

To Determine Your Total Initial Premium

Once you have determined the premium for each benefit you have chosen by referring to the schedule of premiums, fill in the premium amounts below to determine your Total Initial Premium.

$ _____ **Base Medicare Supplement Coverage**

Optional Benefits for Medicare Supplement Policy

Each of these riders may be purchased separately with the Basic Plan.

$ _____ 1. **Medicare Part A Deductible Rider —** 100% of Part A deductible.

$ _____ 2. **Medicare Part B Deductible Rider —** 100% of Part B deductible.

$ _____ 3. **Medicare Part B Copayment or Coinsurance Rider —** Copayment or coinsurance will be the lesser of $20 per office visit or the Medicare Part B coinsurance and the lesser of $50 per emergency room visit or the Medicare Part B coinsurance that is in addition to the Medicare Part B medical deductible.

$ _____ 4. **Medicare Part B Excess Charges Rider —** Difference between the Medicare eligible charge and the amount charged by the provider which shall be no greater than the actual charge or the limiting charge allowed by Medicare, whichever is less.

$ _____ 5. **Additional Home Health Care Rider —** An aggregate of 365 visits per year including those covered by Medicare.

$ _____ 6. **Foreign Travel Emergency Rider —** After a deductible not greater than $250, covers at least 80% of expenses associated with emergency medical care received outside the U.S.A. during the first 60 days of a trip with a maximum of at least $50,000.

$ _____ **TOTAL Monthly Premium for Basic Policy and Selected Optional Benefits**

In addition to this Outline of Coverage, Anthem Blue Cross and Blue Shield will send an annual notice to you 30 days prior to the effective date of Medicare changes which will describe these changes and the changes in your Medicare supplement coverage.

Basic Plan

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

PART A Services

For for details on the Basic Plan, refer to the Policy or contact Anthem Blue Cross and Blue Shield.

SERVICES	MEDICARE PAYS	THIS POLICY PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but $1,156	$0 or **Optional Part A Deductible Rider** ♦	$1,156 or **$0** ♦
61st thru 90th day	All but $289 per day	$289 per day	$0
91st day and after: · **While using 60 lifetime reserve days**	All but $578 per day	$578 per 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.

♦ These are optional riders. You may purchase these benefits if you pay an additional premium.

Basic Plan

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

PART **A** Services

SERVICES	MEDICARE PAYS	THIS POLICY 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 $144.50 a day	Up to $144.50 a day	$0
101st day and after	$0	$0	All costs for 101st day and after per benefit period*
INPATIENT PSYCHIATRIC CARE			
Inpatient psychiatric care in a participating psychiatric hospital	190 days per lifetime	175 additional days per lifetime	Beyond 365 days
BLOOD			
First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services.			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	$0 or 100% of 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.

Basic Plan

MEDICARE (PART B) MEDICAL SERVICES — PER CALENDAR YEAR

PART **B** Services

SERVICES	MEDICARE PAYS	THIS POLICY 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 and durable medical equipment			
First $140 of Medicare-approved amounts*	$0	$0 or **Optional Part B Deductible Rider** ♦ or **Optional Part B Copayment or Coinsurance Rider**♦♦	$140 (Part B deductible or **$0**♦ or $140 (Part B Deductible) and no more than $20 per office visit and no more than $50 per emergency room visit
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20% or **Optional Part B Excess Charges Rider** ♦	$Charges in excess of Medicare approved charges or **charges not paid by Medicare or $0**▲
BLOOD			
First 3 pints	$0	All costs	$0
Next $140 of Medicare Approved Amounts*	$0	$0 or **Optional Part B Deductible Rider** ♦ or **Optional Part B Copayment or Coinsurance Rider**♦♦	$140 (Part B deductible) or **$0**♦
Remainder of Medicare Approved Amounts	80%	20% or **Optional Part B Excess Charges Rider** ♦	$0

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* Once you have been billed $140 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.

♦ These are optional riders. You may purchase these benefits if you pay an additional premium.

♦♦ This is an optional rider that may decrease your premium when you pay copayments for medical and emergency room visits.

▲ For doctors who do not accept assignment, Anthem Blue Cross Blue Shield pays the difference between what Medicare pays and the amount charged by the provider, up to the limiting charge allowed by Medicare.

Basic Plan

MEDICARE (PART B) MEDICAL SERVICES — PER CALENDAR YEAR

PART **B** Services

SERVICES	MEDICARE PAYS	THIS POLICY PAYS	YOU PAY
CLINICAL LABORATORY SERVICES			
Tests for Diagnostic Services	100%	$0	$0
HOME HEALTH CARE — Medicare Approved Services			
Medically necessary skilled care services and medical supplies	100% of charges for visits considered medically necessary by Medicare	40 visits in addition to those paid by Medicare or **Optional Additional Home Health Rider ♦**	Beyond 40 visits per calendar year or **Beyond 365 visits ♦**
PREVENTIVE MEDICAL CARE BENEFIT — Not Covered by Medicare			
Coverage for preventive health care services not covered by Medicare and as determined to be medically appropriate by an attending physician.	$0	Reimbursement shall be for the actual charges up to 100% of the Medicare approved amount for each service, as if Medicare were to cover the service, as identified in the American Medical Association Current Procedural Terminology codes, up to $120.	Charges in excess of $120 per year

♦ These are optional riders. You may purchase these benefits if you pay an additional premium.

ADDITIONAL BENEFITS

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
DIABETIC EQUIPMENT & SUPPLIES			
Self-education programs and infusion pump (provided you use it for 30 days before buying it)	Medicare generally does not cover diabetic supplies	The full usual, customary and reasonable charge, less what Medicare paid	Charges in excess of the full usual, customary and reasonable charge
LICENSED SKILLED NURSING FACILITY CARE			
The facility does not have to be certified by Medicare, no prior hospitalization is required and the stay does not have to meet Medicare's definition of skilled care.	$0 for services beyond those covered under Part A	Up to 30 days per admission for medically necessary care	Charges for care beyond 30 days per admission
CHIROPRACTIC SERVICES			
	80% for manual manipulations of the spine to correct a subluxation that can be demonstrated by X-ray	The full usual, customary and reasonable charge, less what Medicare pays for Medicare-eligible expenses	Charges in excess of the full, usual, customary and reasonable charge
KIDNEY DISEASE CARE			
Inpatient and outpatient expenses for dialysis, transplantation or donor-related services	80%	Up to $30,000 per year	Charges in excess of $30,000 per year

Basic Plan

OPTIONAL BENEFITS FOR MEDICARE SUPPLEMENT PLAN

Optional Benefits for Medicare Supplement Plan

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
Part A Deductible ♦	$0	100% of Part A Deductible	$0
365 Home Health Care Visits ♦	100% of charges for visits considered medically necessary by Medicare	An aggregate of 365 visits per year including those covered by Medicare	Charges for visits beyond 365 per year
Part B Deductible*♦	$0	100% of Part B Deductible	$0
Part B Copayment/ Coinsurance*♦♦	Generally 80%, after the Part B Deductible has been met.	Coverage of the Medicare Part B medical coinsurance, subject to a copayment or coinsurance of no more than $20 per office visit and no more than $50 per emergency room visit. If admitted, the $50 is waived and the emergency visit is covered as a Medicare Part A expense.	$140 (Part B Deductible) and no more than $20 per office visit and no more than $50 per emergency room visit. If admitted, the $50 is waived and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges ♦	$0	Difference between what Medicare pays and the amount charged by the provider, up to the limiting charge allowed by Medicare	$0
Foreign Travel Emergency Rider♦	$0	After a separate Foreign Travel Emergency Rider deductible of $250, covers 80% of expenses associated with emergency medical care received outside the U.S.A. during the first 60 days of a trip with a lifetime maximum of $50,000 in covered expenses	$250, Then 20% of charges for the first 60 Days up to the $50,000 Lifetime maximum; 100% beyond 60 Days or over $50,000 maximum

* You may select either Part B Deductible or Part B Copayment/Coinsurance rider option.
♦ These are optional riders. You may purchase these benefits if you pay an additional premium.
♦♦ This is an optional rider that may decrease your premium when you pay copayments for medical and emergency room visits.

High Deductible Plan**

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

PART A Services

For for details on the High Deductible Plan, refer to the Policy or contact Anthem Blue Cross and Blue Shield.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,070 DEDUCTIBLE,** THIS POLICY PAYS	IN ADDITION TO $2,070 DEDUCTIBLE,** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but $1,156	100% of Part A Deductible	$0
61st thru 90th day	All but $289 per day	$289 per day	$0
91st day and after: · **While using 60 lifetime reserve days**	All but $578 per day	$578 per 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.

** **This High Deductible Plan offers benefits after one has paid a calendar year $2,070 deductible. This deductible consists of expenses that would ordinarily be paid by the policy. This includes the Medicare deductible for Part A and Part B, but does not include the plan's separate Foreign Travel Emergency Rider deductible.**

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and willpay 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.

High Deductible Plan**

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

PART **A** Services

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,070 DEDUCTIBLE,** THIS POLICY PAYS	IN ADDITION TO $2,070 DEDUCTIBLE,** 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 $144.50 a day	Up to $144.50 a day	$0
101st day and after	$0	$0	All costs for 101st day and after per benefit period*
INPATIENT PSYCHIATRIC CARE			
Inpatient psychiatric care in a participating psychiatric hospital	190 days per lifetime	175 additional days per lifetime	Beyond 365 days
BLOOD			
First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0

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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.

** **This High Deductible Plan offers benefits after one has paid a calendar year $2,070 deductible. This deductible consists of expenses that would ordinarily be paid by the policy. This includes the Medicare deductible for Part A and Part B, but does not include the plan's separate Foreign Travel Emergency Rider deductible.**

High Deductible Plan**

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

PART **A** Services

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,070 DEDUCTIBLE,** THIS POLICY PAYS	IN ADDITION TO $2,070 DEDUCTIBLE,** YOU PAY
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services.			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	$0 or 100% of copayment/ coinsurance	$0

** **This High Deductible Plan offers benefits after one has paid a calendar year $2,070 deductible. This deductible consists of expenses that would ordinarily be paid by the policy. This includes the Medicare deductible for Part A and Part B, but does not include the plan's separate Foreign Travel Emergency Rider deductible.**

High Deductible Plan**

MEDICARE (PART B) MEDICAL SERVICES — PER CALENDAR YEAR

PART **B** Services

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,070 DEDUCTIBLE,** THIS POLICY PAYS	IN ADDITION TO $2,070 DEDUCTIBLE,** 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 and durable medical equipment			
First $140 of Medicare-approved amounts*	$0	100% of Part B Deductible	$0
Remainder of Medicare Approved Amounts	$0	Difference between what Medicare pays and the amount charged by the provider, up to the limiting charge allowed by Medicare	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $140 of Medicare Approved Amounts*	$0	100% of Part B Deductible	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

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* Once you have been billed $140 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.

** **This High Deductible Plan offers benefits after one has paid a calendar year $2,070 deductible. This deductible consists of expenses that would ordinarily be paid by the policy. This includes the Medicare deductible for Part A and Part B, but does not include the plan's separate Foreign Travel Emergency Rider deductible.**

High Deductible Plan**

MEDICARE (PART B) MEDICAL SERVICES — PER CALENDAR YEAR

PART **B** Services

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,070 DEDUCTIBLE,** THIS POLICY PAYS	IN ADDITION TO $2,070 DEDUCTIBLE,** YOU PAY
CLINICAL LABORATORY SERVICES			
Tests for Diagnostic Services	100%	$0	$0
HOME HEALTH CARE – Medicare Approved Services			
Medically necessary skilled care services and medical supplies	100% of charges for visits considered medically necessary by Medicare	An aggregate of 365 visits per year including those covered by Medicare	Charges for visits beyond 365 per year
PREVENTIVE MEDICAL CARE BENEFIT — Not Covered by Medicare			
Coverage for preventive health care services not covered by Medicare and as determined to be medically appropriate by an attending physician.	$0	Reimbursement shall be for the actual charges up to 100% of the Medicare approved amount for each service, as if Medicare were to cover the service, as identified in the American Medical Association Current Procedural Terminology codes, up to $120.	Charges in excess of $120 per year

** **This High Deductible Plan offers benefits after one has paid a calendar year $2,070 deductible. This deductible consists of expenses that would ordinarily be paid by the policy. This includes the Medicare deductible for Part A and Part B, but does not include the plan's separate Foreign Travel Emergency Rider deductible.**

High Deductible Plan**
ADDITIONAL BENEFITS

ADDITIONAL BENEFITS	SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,070 DEDUCTIBLE,** THIS POLICY PAYS	IN ADDITION TO $2,070 DEDUCTIBLE,** YOU PAY
FOREIGN TRAVEL EMERGENCY				
		$0	After a separate Foreign Travel Emergency Rider deductible of $250, covers 80% of expenses associated with emergency medical care received outside the U.S.A. during the first 60 days of a trip with a lifetime maximum of $50,000 in covered expenses	$250, Then 20% of charges for the first 60 Days up to the $50,000 Lifetime maximum; 100% beyond 60 Days or over $50,000 maximum
DIABETIC EQUIPMENT & SUPPLIES				
	Self-education programs and infusion pump (provided you use it for 30 days before buying it)	Medicare generally does not cover diabetic supplies	The full usual, customary and reasonable charge, less what Medicare paid	Charges in excess of the full usual, customary and reasonable charge
LICENSED SKILLED NURSING FACILITY CARE				
	The facility does not have to be certified by Medicare, no prior hospitalization is required and the stay does not have to meet Medicare's definition of skilled care.	$0 for services beyond those covered under Part A	Up to 30 days per admission for medically necessary care	Charges for care beyond 30 days per admission

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** **This High Deductible Plan offers benefits after one has paid a calendar year $2,070 deductible. This deductible consists of expenses that would ordinarily be paid by the policy. This includes the Medicare deductible for Part A and Part B, but does not include the plan's separate Foreign Travel Emergency Rider deductible.**

High Deductible Plan**
ADDITIONAL BENEFITS

ADDITIONAL BENEFITS	SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,070 DEDUCTIBLE,** THIS POLICY PAYS	IN ADDITION TO $2,070 DEDUCTIBLE,** YOU PAY
	CHIROPRACTIC SERVICES			
		80% for manual manipulations of the spine to correct a subluxation that can be demonstrated by X-ray	The full usual, customary and reasonable charge, less what Medicare pays for Medicare-eligible expenses	Charges in excess of the full, usual, customary and reasonable charge
	KIDNEY DISEASE CARE			
	Inpatient and outpatient expenses for dialysis, transplantation or donor-related services	80%	Up to $30,000 per year	Charges in excess of $30,000 per year

** **This High Deductible Plan offers benefits after one has paid a calendar year $2,070 deductible. This deductible consists of expenses that would ordinarily be paid by the policy. This includes the Medicare deductible for Part A and Part B, but does not include the plan's separate Foreign Travel Emergency Rider deductible.**

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