CareFirst

MediGap-65 Maryland

Why Medicare Supplement Coverage is Important

Welcome

Did you know Medicare was never designed to pay all of your health care expenses? More importantly, the gaps in Medicare could cost you thousands of dollars out of your own pocket each year. A serious illness or lengthy hospital stay could make a big dent in your retirement savings.

Are you prepared to pay:

- The $1,184 Part A deductible[1] for hospitalization? It comes out of your pocket before Medicare pays anything.
- The $296 a day Part A copayment[1] for days 61-90 in the hospital? That's $8,880 if you're in the hospital for that length of time.
- The $592 a day Part A copayment[1] for days 91-150 in the hospital? That works out to over $35,520 in 60 days.

There's more. Even at a doctor's office, you'll pay:

- $147 for the Part B deductible[1] in 2013 — before Medicare pays anything, and 20% of most medical services — with no out-of-pocket maximum.

That's why it's so important to protect yourself and your hard-earned money with MediGap-65, CareFirst's Medicare Supplement plan. We offer eight plans to choose from and reliable coverage you can count on. With one of CareFirst's Medicare Supplement plans, you'll receive coverage for:

- Medicare's Part A deductible and copayments (including skilled nursing copayments)
- Medicare's Part B deductible and copayments

You can also choose a MediGap-65 plan that offers coverage for emergency care when you're traveling in a foreign country — something that Medicare never covers[2].

Enclosed in this booklet are CareFirst's Outline of Coverage and MediGap-65 plan brochure, which feature the MediGap-65 family of plans we offer. You'll find all the information you will need to help you choose the plan that's right for you. To apply for coverage, simply fill out the enclosed application and mail it to us in the enclosed postage-paid envelope.

You owe it to yourself to get your coverage from the company you can trust: CareFirst BlueCross BlueShield.

Sincerely,

Vickie S. Cosby

Vickie S. Cosby
Senior Director, Consumer Direct Sales

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[1] Medicare Part A and Part B amounts are established by Medicare.

[2] Medigap plans pay up to 80% of billed charges for Medicare-eligible expenses for emergency care received during the first 60 consecutive days of each trip outside the United States. The plan payment is subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000.

What's Covered

Plan Options

Having Medicare alone could cost you thousands of dollars in health costs each year; costs that Medicare was never designed to cover. Purchasing a MediGap-65 plan will cover the gaps in your Medicare coverage. You can pick from any of the eight plans listed below. See the Comparison Chart on pages 4-5 to compare plan options.

MediGap-65 Plan A

Plan A delivers basic coverage to protect against the financial strain caused by serious illness and lengthy hospital stays. After you've satisfied your Medicare deductible, this plan pays your Part A hospital copayments, your Part B[1] coinsurance, and protects you for a full 365 days of hospital care after your Medicare benefits end.

MediGap-65 Plan B

Plan B is a moderately priced plan that pays your $1,184 Part A hospital deductible in addition to the same benefits featured in Plan A. This plan protects against the high cost of hospitalization.

MediGap-65 Plan F*

Plan F offers the broadest protection against high medical expenses and is our most popular plan. In addition to covering your Medicare Part A and Part B deductibles, copayments and coinsurances, Plan F also provides emergency coverage for care you receive in a foreign country[2], as well as coverage for balance billing.

MediGap-65 High-Deductible Plan F*

High-Deductible Plan F is our lowest premium Medigap Plan. If you like to share in more of your health care costs, in exchange for a lower monthly premium, consider High-Deductible Plan F. This plan offers the same benefits as regular Plan F, after you have met a $2,110 annual deductible for 2013.

MediGap-65 Plan G*

Plan G offers the same coverage as Plan F, at a lower monthly premium—you are just responsible for the Medicare Part B deductible.

*** Coverage for Balance Billing**

If you see a doctor who does not accept Medicare's reimbursement as payment in full for services (some doctors charge you up to 15% more than Medicare allows!), Plans F, High-Deductible F, and G will cover these extra charges.

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[1] *Medicare Part A and Part B amounts are established by Medicare.*

[2] *Medigap plans pay up to 80% of billed charges for Medicare-eligible expenses for emergency care received during the first 60 consecutive days of each trip outside the United States. The plan payment is subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000.*

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Plan Options

MediGap-65 Plan L

With Plan L, you share in the costs for Medicare-covered services in exchange for a lower premium—but are rewarded with the added protection of an out-of-pocket limit that caps your costs at $2,400 during the calendar year. Most basic benefits are covered at 75%, including the Part A deductible. After the Part A deductible is met, your hospitalization is covered at 100%.

MediGap-65 Plan M

Plan M is a moderately-priced plan that starts with the benefits of Plan A and adds coverage for half of your $1,184 Part A hospital deductible. Plus, it covers skilled nursing copayments and emergency care received in a foreign country[2].

MediGap-65 Plan N

Plan N offers the broad coverage of Plan F at a lower premium by incorporating cost-sharing features to help you manage your costs. Just like Plan F, Plan N covers 100% of your Part A deductible and copayments, your skilled nursing facility copays and emergency care received in a foreign country[2]. It costs less because you are responsible for the $147 Part B deductible and a small co-pay for office and emergency room visits. Plan N does not cover part B excess charges* that are covered under Plan F.

What is not covered.

MediGap-65 policies are designed to work hand-in-hand with the federal Medicare program. They are not intended to be classified as long-term care policies, and do not pay for most custodial care. MediGap-65 plans do not cover expenses for services and items excluded from coverage under Medicare, or expenses for services and items that would duplicate Medicare payments.

** Part B excess charges are the difference between the doctor's actual charge and Medicare's approved amount. This would apply if you go to a doctor who does not accept assignment and bills you more than Medicare's approved amount.*

Coverage is available on a guaranteed issue basis.

If you are within six months of your Medicare Part B Effective Date (Open Enrollment) or during a Guaranteed Issue Period (please refer to the Additional Information section located in the back of this booklet), your acceptance into your choice of CareFirst's eight MediGap-65 plans is guaranteed! There is no health screening or medical exam.

During your Open Enrollment or Guaranteed Issue Period, you will automatically receive our lowest, Level 1 premiums.

What's more, as long as you've had continuous health coverage for the past six months, with no more than a 63-day break, you will have no waiting period for pre-existing conditions. That means all medical conditions will be covered the day your policy goes into effect!*

Coverage is available on an underwritten basis.

If you are over six months from your Medicare Part B Effective Date (Open Enrollment) and are NOT applying during a Guaranteed Issue Period, you will need to answer questions regarding your medical history on the enclosed application. This assessment will determine your acceptance and the premium you will receive. Please refer to the Outline of Coverage for current pricing.

You risk nothing by applying today. If accepted, we'll send you a Certificate of Coverage. Please read it carefully.

If you're not satisfied with the coverage described, do not pay your bill. Your coverage will not go into effect, and you'll be under no further obligation.

Switching plans.

- If you're switching your coverage we'll give you full credit for every dollar you've already spent toward your Medicare Part B deductible.
- We'll also give you full credit for time you've already spent on your previous policy toward the waiting period for pre-existing health conditions on your new CareFirst policy.*
- You may be subject to a review of your medical history through Medical Underwriting if you are outside of your Open Enrollment or Guaranteed Issue period.

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* *If you have had more than a 63-day break in health insurance coverage and are applying for Plans **A, B, F, High-Deductible F**, or **N**, you may be subject to a waiting period of up to 90 days for any condition for which medical advice or treatment was recommended by or received from a physician within six months before the effective date of the policy for which you are applying.*

*If you are applying for Plans **G, L** or **M**, there is NO pre-existing condition waiting period for any condition for which medical advice or treatment was recommended by or received from a physician within six months before the effective date of the policy for which you are applying.*

Plan Options

Comparison Chart

What You Pay with Original Medicare vs. What You Pay with CareFirst Medigap plans					
	With Original Medicare alone, You Pay:	Choose Medigap Plan A and You Pay:	Choose Medigap Plan B and You Pay:	Choose Medigap Plan F and You Pay:	Choose Medigap High Deductible Plan F* and You Pay:
Inpatient hospital deductible	$1,184	$1,184	$0	$0	$0 after plan deductible
Hospital days 61-90	$296/day	$0	$0	$0	$0 after plan deductible
Hospital days 91-150 (lifetime reserve)	$592/day	$0	$0	$0	$0 after plan deductible
365 days after hospital benefits stop	All Costs	$0	$0	$0	$0 after plan deductible
Skilled nursing facility days 21-100	$148/day	$148/day	$148/day	$0	$0 after plan deductible
Medical expense deductible	$147	$147	$147	$0	$0 after plan deductible
Medical expenses after deductible	20%	0%	0%	0%	0% after plan deductible
Excess charges above Medicare approved amounts	100%	100%	100%	$0	0% after plan deductible
Foreign country emergency care (up to $50,000 lifetime max)	100%	100%	100%	$250 deductible, then 20%	$250 deductible after plan deductible, then 20%

Dollar amounts shown are the 2013 deductibles, copayment and coinsurance. These amounts may change on January 1, 2014.

**With High-Deductible Plan F, there is an annual plan deductible of $2,110 ; after you meet the $2,110 annual plan deductible, you pay $0.*

***With Plan L, there is an Out-of-Pocket limit of $2,400; After you meet $2,400 in out-of-pocket expenses, you pay $0.*

What You Pay with Original Medicare vs. What You Pay with CareFirst Medigap plans				
	Choose Medigap Plan G and You Pay:	**Choose Medigap Plan L** and You Pay:**	**Choose Medigap Plan M and You Pay:**	**Choose Medigap Plan N and You Pay:**
Inpatient hospital deductible	$0	$296	$592	$0
Hospital days 61-90	$0	$0	$0	$0
Hospital days 91-150 (lifetime reserve)	$0	$0	$0	$0
365 days after hospital benefits stop	$0	$0	$0	$0
Skilled nursing facility days 21-100	$0	$37/day	$0	$0
Medical expense deductible	$147	$147	$147	$147
Medical expenses after deductible	0%	5%	0%	Office visit: up to $20; ER visit: up to $50
Excess charges above Medicare approved amounts	0%	100%	100%	100%
Foreign country emergency care (up to $50,000 lifetime max)	$250 deductible, then 20%	100%	$250 deductible, then 20%	$250 deductible, then 20%

The CareFirst Advantage

Your health and your money are important. Make sure you entrust them to a worthy company: CareFirst BlueCross BlueShield.

Consider the advantages

Carry the card that's recognized nationwide

Once enrolled, you'll experience the security of knowing that your CareFirst BlueCross BlueShield card is accepted for medical treatment by health care providers throughout the state of Maryland and beyond. It's your assurance of the care you need...where and when you need it.

Get local service from a local company

CareFirst BlueCross BlueShield is a local company. That means you'll talk to local customer service representatives over the phone. Or, use our walk-in neighborhood service offices throughout Maryland. Either way, you'll receive courteous, friendly service from dedicated, experienced representatives—they may even be your neighbors!

Call (410) 581-3411 or toll-free (800) 843-4280 to locate a service office near you.

Get rid of claim forms

As a CareFirst member, you'll rarely, if ever, have to file a claim to receive benefits. In fact, once Medicare processes your claim, it's automatically sent to us for payment. It couldn't be easier.

24-Hour Health Care Advice Line

Anytime, day or night, you can speak with a FirstHelp™ nurse directly, or e-mail a question if the medical issue is less urgent*. Registered nurses are available to answer your health care questions and help guide you to the most appropriate care.

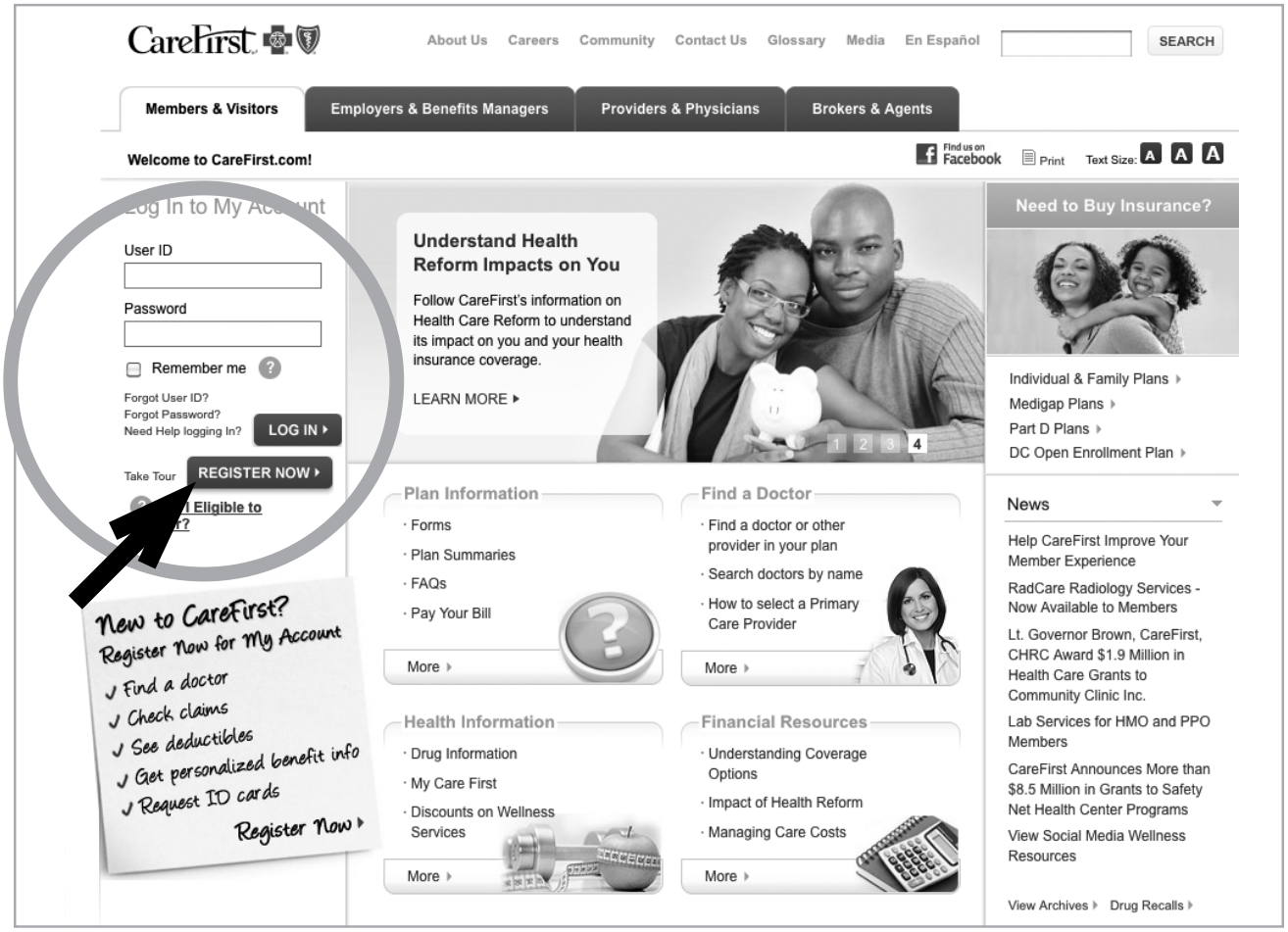
**If you believe a situation is a medical emergency, call 911 immediately or go to the nearest emergency facility.*

In an urgent situation, contact your doctor for advice. If your doctor isn't available, you have symptoms and don't know exactly what they mean or how serious they are, CareFirst provides you with FirstHelp™.

Have online access to claims and out-of-pocket costs

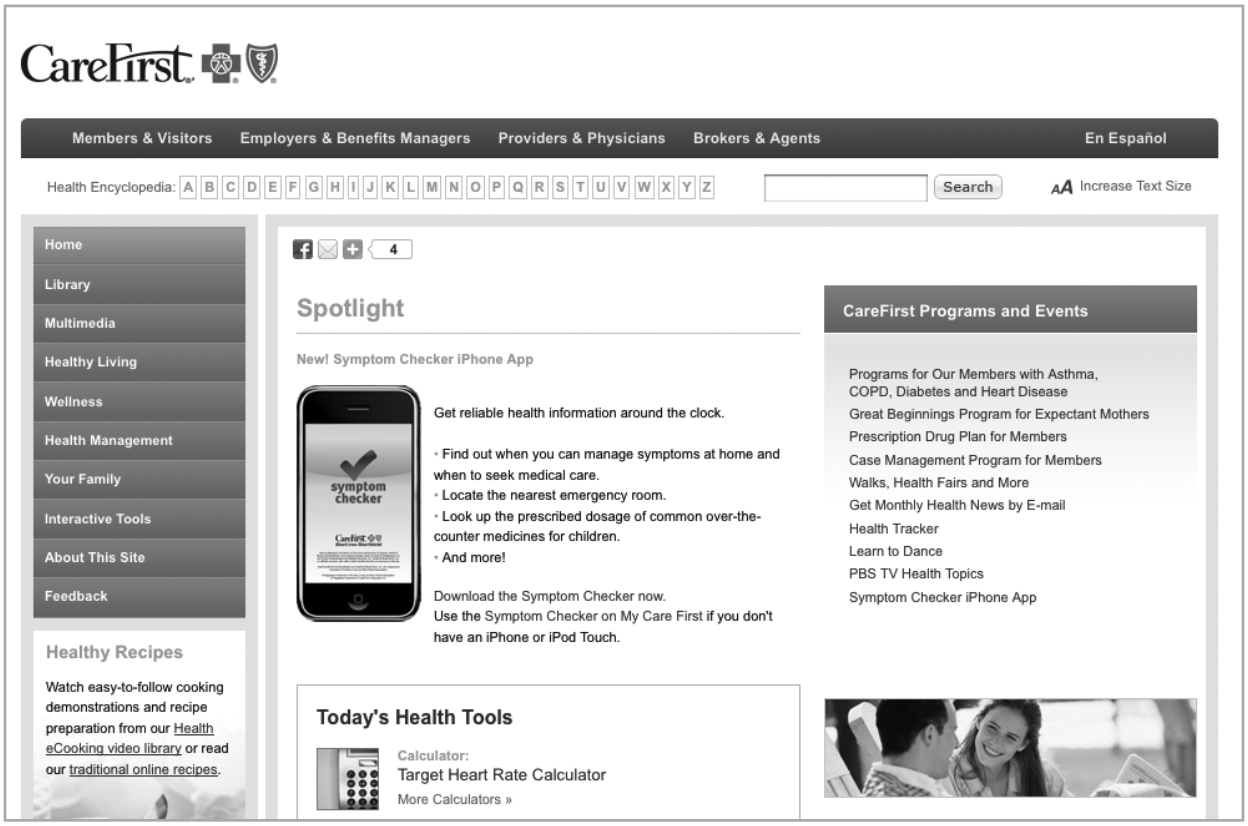
You can view real-time information on your claims and out-of-pocket costs online, whenever you need to with My Account. With My Account, you can:

- Find out the effective date of your coverage.
- Check your deductible and out-of-pocket costs for your current and previous plan year.
- View claims status and review up to one year of medical claims — total charges, benefits paid and costs for a specific date range.
- Check the average retail cost of a drug, as well as find out if a generic equivalent is available.
- Request a replacement medical ID card and/or Print Verification of Coverage.
- Update information about other health care coverage you may have.



Visit **www.mycarefirst.com** to access these health tools that are fun and easy to use:

- Interactive quizzes, assessments and calculators
- Personalized features that let you record your health goals, reminders and medical history on our secure server
- Healthy cooking videos and recipes divided by category, including low-sodium, heart-healthy and diabetes-friendly
- A library of articles about diseases, health conditions, wellness tips, tests and procedures
- A mutimedia section with more than 400 videos, podcasts and tutorials about a variety of health topics
- CareFirst's preventive guidelines and a list of classes and health events in the area
- Sections on back care, blood pressure, cholesterol, fitness, mental health, nutrition, pregnancy, smoking cessation, stress and weight management
- Sections on chronic illnesses, including asthma, diabetes and heart disease
- Sections for men, women, children and older adults



Health + Wellness

Our discount programs offer the health and wellness information, support and services you need — while providing you with special savings.

For details on the health and wellness discounts available to you, visit **www.carefirst.com/options.**

Health and Wellness Service	Discount/Special Offer	Provider	
Alternative Therapies and Wellness	Up to 30% off chiropractic care, acupuncture, massage therapy, nutritional counseling, personal training, yoga, guided imagery, spa services, and more.	**Healthways WholeHealth Networks, Inc.** (800) 514-6502 http://options.wholehealthmd.com	
Eldercare Services	Free service to find referrals and information for elders and their families.	**ElderCarelink** www.eldercarelink.com/carefirst **SeniorLink Care** (866) 797-2341	
Fitness Apparel and Gear	Exclusive discounts on fitness apparel, workout gear and equipment.	**Sportline** (866) 324-4438 **Fitness Gear and Equipment** **Polar**	**Leisure Fitness** (866) 324-4438 **Balance Walking** **Gaiam**
Fitness Centers	Discounts on membership fees, initiation fees and more depending on the fitness network and location you choose.	**Healthways Fitness Your Way** (888)242-2060 **Snap Fitness** (877) 474-5422	
Hearing Care	Free screenings, discounts on hearing aids and more.	**Beltone** (888) 896-2365	**TruHearing** (877) 343-0745

Health and Wellness Service	Discount/Special Offer	Provider	
Laser Vision Correction and Contact Lenses	Discounts on mail-order contact lenses, laser vision correction and 100% patient financing with approved credit.	**QualSight LASIK** (877) 285-2010 or www.qualsight.com/–carefirst **LasikPlus** (866) 713-2044 **TruVision** (800) 398-7075 www.truvision.com/carefirst/LASIK.htm	
Medical IDs	22% discount on personalized medical ID bracelets and necklaces.	American Medical ID (800) 363-5985 www.americanmedical-id.com/extras/carefirst.php	
Nutritional Foods	Discounts on organic and specialty foods.	**Frontier** **Simply Organic**	**Shari's Berries** **Cherry Moon Farms**
Weight Loss and Management	Nationally recognized weight loss plan discounts.	**Jenny Craig®** (800) 96-JENNY	**Medifast** (800) 209-0878

The Options and Blue365 programs are not offered as an inducement to purchase a policy of insurance from CareFirst. CareFirst does not underwrite these programs because they are not insurance products. No benefits are paid by CareFirst under these programs. The discount programs listed above are not guaranteed by CareFirst BlueCross BlueShield and may be discontinued at any time.

Dental Coverage *(Optional)*

You've already turned to us for MediGap-65 coverage, which provides security for the gaps in Medicare coverage. Now you can look to CareFirst for your dental needs. You have the option of purchasing a separate dental plan through our network administrator, The Dental Network.*

** An independent licensee of the Blue Cross and Blue Shield Association.*

Choices for Your Dental Health

Regular preventive dental care is an important part of staying healthy. We offer three dental options in the Individual Select family of products:

- Individual Select Preferred Dental Plus
- Individual Select Dental HMO
- Individual Select Preferred Dental

Individual Select Preferred Dental Plus offers a large provider network of over 3,600 in-network general dentists and specialists. Plus you have access to a national dental network which includes 60,000 dental providers across the country. And, you can see any provider you want – no referrals are necessary.

With Individual Select Preferred Dental Plus, you receive coverage for an extensive range of basic and major dental services, including no charge oral exams, cleanings and X-rays when you visit in-network providers.

Individual Select Dental HMO offers you dental care with lower, predictable copayments for routine and major dental services such as preventive and diagnostic dental care, surgical extractions, root canal therapy and orthodontic treatment.

As a member of our Dental Health Maintenance Organization (Dental HMO) plan, you'll select a general dentist from a network of 580+ participating providers to coordinate all of your dental care needs. When specialized care is needed, your general dentist will recommend a specialist within the Dental HMO network.

Individual Select Preferred Dental also offers a larger dental network of over 3,600 participating providers, 100% coverage for preventive and diagnostic dental care, and potential in-network savings for major procedures. And, there are no deductibles to meet.

Guaranteed acceptance – no claim forms!

All of our Individual Select dental plans are guaranteed acceptance and require no claim forms when you stay in-network.

It's easy to apply for CareFirst's dental coverage!

To request an application for Individual Select Preferred Dental Plus, Individual Select Dental HMO, or Individual Select Preferred Dental, please contact one of our Product Consultants at (410) 356-8123 or toll-free at (800) 275-3802.

Note: *The dental plans referenced are not part of your MediGap-65 policy. In order to receive coverage for dental services, you must apply separately for this plan. The plans are not offered as an inducement to purchase a Medigap policy from CareFirst BlueCross BlueShield.*

BlueVision *(Optional)*

You have the option of purchasing a separate vision plan through our network administrator, Davis Vision, Inc.* Benefits include annual eye examinations with dilation at participating providers for a $10 copay at the time of service plus discounts of about 30% on eyeglass frames and lenses or contact lenses. For medical eye care, please follow your normal medical procedures.

To locate a vision provider, contact Davis Vision, Inc. at (800) 783-5602 or visit **www.carefirst.com**.

Guaranteed acceptance – no claim forms!

You cannot be turned down for CareFirst's vision plans. If you have questions or would like to apply for a vision plan, please contact a Product Consultant at (410) 356-8123 or toll-free at (800) 275-3802.

Note: *The vision plans referenced are not part of your MediGap-65 policy. In order to receive coverage for vision services, you must apply separately for this plan. The plans are not offered as an inducement to purchase a Medigap policy from CareFirst BlueCross BlueShield.*

**An independent company that does not provide CareFirst BlueCross BlueShield products or services. The company is solely responsible for its products or services mentioned herein.*

The benefits described are issued under policies:
CFMI/MG PLAN A (6/10) • CFMI/MG PLAN B (6/10) • CFMI/MG PLAN F (6/10)
CFMI/MG PLAN G (2/12) • CFMI/MG PLAN L (2/12) • CFMI/MG PLAN M (2/12)
CFMI/MG PLAN N (6/10) • CFMI/MG PLAN HI DED F (6/10) • MD/CF/MG PLAN G (2/12)
MD/CF/MG PLAN L (2/12) • MD/CF/MG PLAN M (2/12) • CFMI/2010 PLAN HI F SOB (6/10)
MDSUPPAPP (8/12) • MD/CF/MG PLAN A (6/10) • MD/CF/MG PLAN B (6/10) • MD/CF/MG PLAN F (6/10) • MD/CF/MG PLAN N (6/10) • MD/CF/MG PLAN HI DED F (6/10)
MD/CF/2010 PLAN HI F SOB (6/10) MDSUPPAPP (8/12) as amended

Legal entity CareFirst of Maryland, Inc.; policy #: CFMI/BLUEVISION (R. 1/06)
and any amendments

Legal entity Group Hospitalization and Medical Services, Inc.; policy #: GHMSI BlueVision (R. 1/06)
and any amendments

FORM DN001C (R. 1/10) • FORM DN4001 (R. 1/10) • MD/TDN/DB/DEPENDENT AGE (9/10)
TDN – DISCLOSURE 10/12 • MD/TDN/DOL APPEAL (R. 9/11)
and any amendments

MD GHMSI/DB/ISPP DOCS (10/11) • MD GHMSI/DB/ISPP IEA (10/11)
MD/GHMSI/DB/DENT/ES (10/11) • MD/GHMSI/ISPP/AMEND (2/12)
and any amendments

CFMI/DB/ISPP DOCS (10/11) • CFMI/DB/ISPP IEA (10/11)
MD/CFMI/DB/DENT/ES (2/12) • MD/CFMI/ISPP/AMEND (2/12)
and any amendments

MD/GHMSI/DB/IEA-DENTAL (2/08) • MD/GHMSI/DB/DOCS-DENTAL (2/08)
MD/GHMSI/DB/ES-DENTAL (2/08) • MD/GHMSI/DOL APPEAL (R. 9/11)
MD/GHMSI/DB/PARTNER (12/08) • MD/CF/DB/DEPENDENT AGE (9/10)
GHMSI-DISCLOSURE (10/12) • MD NCA – HEALTH GUARANTY (10/12)
and any amendments

Not all services and procedures are covered by your benefits contract. This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.

Neither CareFirst BlueCross BlueShield nor its agents represent, work for or receive compensation from any federal, state or local government agency.

We're here to answer your questions.

If you have any questions about the plans described in this booklet, or if you'd like assistance, just call 1-800-275-3802 (in the Baltimore area call (410) 356-8123). You'll receive courteous, knowledgeable assistance from one of our dedicated Product Consultants.

CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, Maryland 21117

A not-for-profit health service plan incorporated under the laws of the State of Maryland.

Group Hospitalization and Medical Services, Inc.
840 First Street, NE
Washington, DC 20065

www.carefirst.com

If you reside in either Prince George's or Montgomery County, then a Group Hospitalization and Medical Services, Inc. policy will be issued. For Baltimore City and all other counties in the state of Maryland, a CareFirst of Maryland, Inc. policy will be issued.

Outline of Coverage

Medicare Supplemental Coverage Outline

MediGap-65 Maryland

Plans A, B, F, High-Deductible F, G, L, M and N

Offered by CareFirst of Maryland, Inc.*, d/b/a CareFirst BlueCross BlueShield, 10455 Mill Run Circle, Owings Mills, Maryland 21117-5559. Offered by Group Hospitalization and Medical Services, Inc.*, d/b/a CareFirst BlueCross BlueShield, 840 First Street, NE, Washington, DC 20065. A not-for-profit health service plan.

*An independent licensee of the Blue Cross and Blue Shield Association

CareFirst BlueCross BlueShield

Outline of Medicare Supplement Coverage

- 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.
- CareFirst offers plans A, B, F, High-Deductible F, G, L, M and N.

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.

A	B	C	D	F	F*
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	
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	
		Part B Deductible		Part B Deductible	
				Part B Excess (100%)	
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	

** 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 $2,110 deductible. Benefits from High Deductible Plans F will not begin until out-of-pocket expenses exceed $2,110. 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.*

G	K	L	M	N
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% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
Part B Excess (100%)				
Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
	Out-of-pocket limit $4,800; paid at 100% after limit reached	Out-of-pocket limit $2,400; paid at 100% after limit reached		

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What Will My Premium Be?

The premium you pay will be based on:

- Your gender
- Your age when coverage becomes effective
- When you enrolled in Medicare Part B
- Whether you are in a Guaranteed Issue Period
- The plan you select
- Your tobacco usage (ONLY if you are applying more than 6 months past your Medicare Part B effective date and are not applying during a Guaranteed Issue Period)
- A review of your Medical History through Medical Underwriting (ONLY if you are applying more than 6 months past your Medicare Part B effective date and are not applying during a Guaranteed Issue Period)

Please Note

- If you are applying within 6 months of your Medicare Part B Effective Date (Open Enrollment) or during a Guaranteed Issue Period, the Level 1 Rate applies and is dependent on the plan you selected, your age and gender. You are not required to answer any health or tobacco use questions found in Section 4 of the application. Therefore, the tobacco use and health screening questions will not be used in determining your rate.
- If you are applying more than 6 months past your Medicare Part B effective date and are not applying during a Guaranteed Issue Period, your medical history will be reviewed (Medical Underwriting). If you pass medical underwriting, you will receive a Level 2 or Level 3 rate, depending upon the review of your medical history information. Your rate also will be based on the plan you selected, your age, gender, and tobacco usage.

	Guaranteed Issue Period
If you apply within 6 months of your Medicare Part B effective date, or during a Guaranteed Issue Period, you will receive:	**Level 1 Rate**

Example: Mary is 67 years old. Her Medicare Part B effective date is October 1, 2013, as found on her red, white and blue Medicare identification card. She is applying for MediGap-65 Plan F coverage on November 1, 2013, which is within 6 months of her Medicare Part B effective date. Because this is in her Open Enrollment Period, Mary gets a Level 1 Rate of $157.00, and tobacco use and health screening questions are not used in determining her rate.

	Rates Based on Tobacco Use and Review of Medical History
If you apply over 6 months past your Medicare Part B effective date, and are not applying during a Guaranteed Issue Period, you will receive:	**Level 2 Tobacco or Non-Tobacco Rate** **Level 3 Tobacco or Non-Tobacco Rate**

MediGap-65 Maryland: Level 1 Rates

- If you are applying within 6 months of your Medicare Part B Effective Date (Open Enrollment) or during a Guaranteed Issue Period, the Level 1 Rate applies and is dependent on the plan you selected, your age and gender. You are not required to answer any health or tobacco use questions found in Section 4 of the application. Therefore, tobacco use and health screening questions will not be used in determining your rate.

Monthly Premium Rates Effective January 1, 2013

Level 1 Female Rates								
	Plan A	**Plan B**	**Plan F**	**High-Ded F**	**Plan G**	**Plan L**	**Plan M**	**Plan N**
Under 65	$171	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	$123	$133	$157	$39	$135	$104	$123	$110
66					$140	$109	$129	
67					$146	$113	$134	
68					$151	$117	$138	
69					$157	$122	$144	
70	$145	$157	$185	$46	$163	$127	$150	$130
71					$170	$132	$155	
72					$175	$136	$161	
73					$181	$140	$166	
74					$187	$145	$171	
75	$171	$185	$219	$54	$192	$149	$176	$153
76					$197	$153	$181	
77					$203	$157	$186	
78					$208	$161	$191	
79					$214	$166	$196	
80	$202	$219	$258	$64	$218	$169	$199	$181
81					$221	$172	$203	
82					$225	$175	$206	
83					$229	$178	$210	
84					$233	$181	$214	
85	$232	$252	$297	$73	$237	$184	$217	$208
86					$240	$186	$220	
87					$243	$188	$223	
88					$246	$191	$225	
89					$249	$193	$228	
90 and Older					$252	$195	$231	

MediGap-65 Maryland: Level 1 Rates

- If you are applying within 6 months of your Medicare Part B Effective Date (Open Enrollment) or during a Guaranteed Issue Period, the Level 1 Rate applies and is dependent on the plan you selected, your age and gender. You are not required to answer any health or tobacco use questions found in Section 4 of the application. Therefore, tobacco use and health screening questions will not be used in determining your rate.

Monthly Premium Rates Effective January 1, 2013

Level 1 Male Rates								
	Plan A	**Plan B**	**Plan F**	**High-Ded F**	**Plan G**	**Plan L**	**Plan M**	**Plan N**
Under 65	$177	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	$127	$137	$162	$40	$141	$110	$129	$113
66					$148	$114	$135	
67					$154	$120	$141	
68					$161	$125	$148	
69					$168	$131	$154	
70	$157	$170	$201	$50	$175	$136	$161	$141
71					$182	$141	$167	
72					$189	$147	$174	
73					$197	$153	$181	
74					$205	$159	$188	
75	$192	$208	$245	$61	$212	$164	$194	$172
76					$219	$170	$201	
77					$227	$176	$208	
78					$235	$182	$215	
79					$243	$189	$223	
80	$232	$251	$296	$73	$249	$193	$229	$207
81					$256	$198	$234	
82					$262	$203	$240	
83					$269	$208	$246	
84					$275	$214	$252	
85	$248	$269	$317	$78	$282	$219	$259	$222
86					$286	$221	$262	
87					$289	$224	$265	
88					$292	$227	$268	
89					$296	$230	$271	
90 and Older					$299	$232	$275	

MediGap-65 Maryland: Level 2, Non-Tobacco Rates

- If you are applying more than 6 months past your Medicare Part B effective date and are not applying during a Guaranteed Issue Period, your medical history will be reviewed (Medical Underwriting). If you pass medical underwriting, you will receive a Level 2 or Level 3 rate, depending upon the review of your medical history information. Your rate also will be based on the plan you selected, your age, gender and tobacco usage.

Monthly Premium Rates Effective January 1, 2013

Level 2 Non-Tobacco Female Rates								
	Plan A	**Plan B**	**Plan F**	**High-Ded F**	**Plan G**	**Plan L**	**Plan M**	**Plan N**
Under 65	$189	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	$148	$160	$189	$47	$168	$130	$154	$132
66					$173	$134	$158	
67					$176	$137	$162	
68					$180	$139	$165	
69					$184	$143	$169	
70	$167	$181	$213	$53	$190	$147	$174	$149
71					$195	$151	$179	
72					$200	$155	$183	
73					$204	$158	$187	
74					$209	$162	$192	
75	$188	$204	$241	$59	$211	$164	$193	$169
76					$217	$168	$199	
77					$223	$173	$204	
78					$229	$178	$210	
79					$235	$182	$216	
80	$222	$241	$284	$70	$239	$186	$219	$199
81					$243	$189	$223	
82					$248	$192	$227	
83					$252	$195	$231	
84					$256	$199	$235	
85	$256	$277	$327	$81	$261	$202	$239	$229
86					$264	$205	$242	
87					$267	$207	$245	
88					$270	$210	$248	
89					$273	$212	$251	
90 and Older					$277	$215	$254	

MediGap-65 Maryland: Level 2, Non-Tobacco Rates

- If you are applying more than 6 months past your Medicare Part B effective date and are not applying during a Guaranteed Issue Period, your medical history will be reviewed (Medical Underwriting). If you pass medical underwriting, you will receive a Level 2 or Level 3 rate, depending upon the review of your medical history information. Your rate also will be based on the plan you selected, your age, gender and tobacco usage.

Monthly Premium Rates Effective January 1, 2013

Level 2 Non-Tobacco Male Rates								
	Plan A	**Plan B**	**Plan F**	**High-Ded F**	**Plan G**	**Plan L**	**Plan M**	**Plan N**
Under 65	$195	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	$152	$165	$194	$48	$176	$137	$162	$136
66					$181	$141	$166	
67					$187	$145	$171	
68					$192	$149	$176	
69					$197	$153	$181	
70	$181	$196	$231	$57	$203	$158	$186	$162
71					$209	$162	$192	
72					$216	$167	$198	
73					$223	$173	$204	
74					$229	$178	$210	
75	$211	$229	$270	$67	$233	$181	$214	$189
76					$241	$187	$221	
77					$250	$194	$229	
78					$259	$201	$237	
79					$268	$208	$245	
80	$255	$276	$326	$81	$274	$213	$251	$228
81					$281	$218	$258	
82					$288	$224	$264	
83					$295	$229	$271	
84					$303	$235	$278	
85	$273	$296	$349	$86	$310	$241	$284	$244
86					$314	$244	$288	
87					$318	$247	$291	
88					$322	$249	$295	
89					$326	$252	$298	
90 and Older					$329	$256	$302	

MediGap-65 Maryland: Level 2, Tobacco Rates

- If you are applying more than 6 months past your Medicare Part B effective date and are not applying during a Guaranteed Issue Period, your medical history will be reviewed (Medical Underwriting). If you pass medical underwriting, you will receive a Level 2 or Level 3 rate, depending upon the review of your medical history information. Your rate also will be based on the plan you selected, your age, gender and tobacco usage.

Monthly Premium Rates Effective January 1, 2013

Level 2 Tobacco Female Rates								
	Plan A	**Plan B**	**Plan F**	**High-Ded F**	**Plan G**	**Plan L**	**Plan M**	**Plan N**
Under 65	$236	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	$184	$200	$236	$58	$210	$163	$193	$165
66					$216	$167	$198	
67					$221	$171	$202	
68					$224	$174	$206	
69					$230	$179	$211	
70	$209	$226	$267	$66	$237	$184	$217	$187
71					$244	$189	$223	
72					$249	$193	$229	
73					$255	$198	$234	
74					$261	$203	$240	
75	$235	$255	$301	$74	$264	$205	$242	$211
76					$271	$210	$248	
77					$278	$216	$255	
78					$286	$222	$262	
79					$294	$228	$269	
80	$278	$301	$355	$88	$299	$232	$274	$248
81					$304	$236	$279	
82					$310	$240	$284	
83					$315	$244	$289	
84					$320	$248	$294	
85	$319	$346	$408	$101	$326	$253	$299	$286
86					$330	$256	$302	
87					$334	$259	$306	
88					$338	$262	$310	
89					$342	$265	$313	
90 and Older					$346	$268	$317	

MediGap-65 Maryland: Level 2, Tobacco Rates

- If you are applying more than 6 months past your Medicare Part B effective date and are not applying during a Guaranteed Issue Period, your medical history will be reviewed (Medical Underwriting). If you pass medical underwriting, you will receive a Level 2 or Level 3 rate, depending upon the review of your medical history information. Your rate also will be based on the plan you selected, your age, gender and tobacco usage.

Monthly Premium Rates Effective January 1, 2013

Level 2 Tobacco Male Rates								
	Plan A	**Plan B**	**Plan F**	**High-Ded F**	**Plan G**	**Plan L**	**Plan M**	**Plan N**
Under 65	$244	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	$190	$206	$243	$60	$221	$171	$202	$170
66					$227	$176	$208	
67					$233	$181	$214	
68					$240	$186	$220	
69					$246	$191	$226	
70	$226	$245	$289	$71	$254	$197	$233	$202
71					$262	$203	$240	
72					$270	$209	$247	
73					$278	$216	$255	
74					$287	$222	$263	
75	$264	$286	$337	$83	$291	$226	$267	$236
76					$302	$234	$277	
77					$312	$242	$286	
78					$323	$251	$296	
79					$334	$259	$307	
80	$319	$345	$407	$101	$343	$266	$314	$285
81					$351	$273	$322	
82					$360	$279	$330	
83					$369	$286	$338	
84					$378	$293	$347	
85	$341	$370	$436	$108	$388	$301	$356	$305
86					$393	$304	$360	
87					$397	$308	$364	
88					$402	$312	$368	
89					$407	$316	$373	
90 and Older					$412	$319	$377	

MediGap-65 Maryland: Level 3, Non-Tobacco Rates

- If you are applying more than 6 months past your Medicare Part B effective date and are not applying during a Guaranteed Issue Period, your medical history will be reviewed (Medical Underwriting). If you pass medical underwriting, you will receive a Level 2 or Level 3 rate, depending upon the review of your medical history information. Your rate also will be based on the plan you selected, your age, gender and tobacco usage.

Monthly Premium Rates Effective January 1, 2013

Level 3 Non-Tobacco Female Rates								
	Plan A	**Plan B**	**Plan F**	**High-Ded F**	**Plan G**	**Plan L**	**Plan M**	**Plan N**
Under 65	$274	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	$239	$258	$305	$75	$269	$209	$247	$213
66					$278	$216	$255	
67					$284	$221	$261	
68					$287	$222	$263	
69					$291	$226	$267	
70	$247	$267	$315	$78	$294	$228	$270	$221
71					$297	$230	$272	
72					$298	$231	$273	
73					$298	$231	$273	
74					$302	$235	$277	
75	$274	$297	$350	$87	$307	$238	$281	$245
76					$315	$245	$289	
77					$324	$251	$297	
78					$333	$258	$305	
79					$342	$265	$314	
80	$323	$350	$413	$102	$348	$270	$319	$289
81					$354	$275	$325	
82					$360	$279	$330	
83					$367	$284	$336	
84					$373	$289	$342	
85	$372	$402	$475	$117	$379	$294	$348	$333
86					$384	$298	$352	
87					$388	$301	$356	
88					$393	$305	$360	
89					$398	$309	$365	
90 and Older					$403	$312	$369	

MediGap-65 Maryland: Level 3, Non-Tobacco Rates

- If you are applying more than 6 months past your Medicare Part B effective date and are not applying during a Guaranteed Issue Period, your medical history will be reviewed (Medical Underwriting). If you pass medical underwriting, you will receive a Level 2 or Level 3 rate, depending upon the review of your medical history information. Your rate also will be based on the plan you selected, your age, gender and tobacco usage.

Monthly Premium Rates Effective January 1, 2013

Level 3 Non-Tobacco Male Rates								
	Plan A	**Plan B**	**Plan F**	**High-Ded F**	**Plan G**	**Plan L**	**Plan M**	**Plan N**
Under 65	$284	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	$246	$266	$314	$78	$282	$219	$259	$220
66					$292	$227	$268	
67					$301	$233	$276	
68					$306	$237	$281	
69					$311	$242	$286	
70	$267	$289	$341	$84	$315	$244	$289	$239
71					$319	$247	$292	
72					$322	$250	$295	
73					$325	$252	$298	
74					$332	$257	$304	
75	$307	$333	$393	$97	$339	$263	$311	$275
76					$351	$272	$322	
77					$363	$282	$333	
78					$376	$292	$345	
79					$389	$302	$357	
80	$371	$401	$474	$117	$399	$309	$366	$332
81					$409	$317	$375	
82					$419	$325	$384	
83					$430	$333	$394	
84					$440	$342	$404	
85	$397	$430	$508	$125	$451	$350	$414	$355
86					$457	$354	$419	
87					$462	$359	$424	
88					$468	$363	$429	
89					$473	$367	$434	
90 and Older					$479	$372	$439	

MediGap-65 Maryland: Level 3, Tobacco Rates

- If you are applying more than 6 months past your Medicare Part B effective date and are not applying during a Guaranteed Issue Period, your medical history will be reviewed (Medical Underwriting). If you pass medical underwriting, you will receive a Level 2 or Level 3 rate, depending upon the review of your medical history information. Your rate also will be based on the plan you selected, your age, gender and tobacco usage.

Monthly Premium Rates Effective January 1, 2013

Level 3 Tobacco Female Rates								
	Plan A	**Plan B**	**Plan F**	**High-Ded F**	**Plan G**	**Plan L**	**Plan M**	**Plan N**
Under 65	$343	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	$298	$323	$381	$94	$336	$261	$308	$267
66					$348	$270	$319	
67					$355	$276	$326	
68					$358	$278	$329	
69					$364	$282	$334	
70	$308	$334	$394	$97	$368	$285	$337	$276
71					$371	$288	$340	
72					$372	$289	$341	
73					$373	$289	$342	
74					$378	$293	$346	
75	$342	$371	$438	$108	$384	$298	$352	$306
76					$394	$306	$361	
77					$405	$314	$371	
78					$416	$323	$381	
79					$428	$332	$392	
80	$404	$437	$516	$128	$435	$337	$399	$361
81					$443	$343	$406	
82					$450	$349	$413	
83					$458	$355	$420	
84					$466	$361	$427	
85	$465	$503	$594	$147	$474	$368	$434	$416
86					$480	$372	$440	
87					$485	$376	$445	
88					$491	$381	$450	
89					$497	$386	$456	
90 and Older					$503	$390	$461	

MediGap-65 Maryland: Level 3, Tobacco Rates

- If you are applying more than 6 months past your Medicare Part B effective date and are not applying during a Guaranteed Issue Period, your medical history will be reviewed (Medical Underwriting). If you pass medical underwriting, you will receive a Level 2 or Level 3 rate, depending upon the review of your medical history information. Your rate also will be based on the plan you selected, your age, gender and tobacco usage.

Monthly Premium Rates Effective January 1, 2013

Level 3 Tobacco Male Rates								
	Plan A	**Plan B**	**Plan F**	**High-Ded F**	**Plan G**	**Plan L**	**Plan M**	**Plan N**
Under 65	$355	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	$307	$332	$392	$97	$353	$274	$323	$275
66					$365	$283	$335	
67					$376	$291	$344	
68					$383	$297	$351	
69					$389	$302	$357	
70	$334	$361	$427	$105	$394	$306	$361	$299
71					$398	$309	$365	
72					$402	$312	$369	
73					$406	$315	$372	
74					$415	$322	$380	
75	$384	$416	$491	$121	$424	$329	$389	$344
76					$439	$340	$402	
77					$454	$352	$416	
78					$470	$365	$431	
79					$486	$377	$446	
80	$463	$502	$592	$146	$499	$387	$457	$415
81					$511	$396	$469	
82					$524	$406	$480	
83					$537	$416	$492	
84					$550	$427	$505	
85	$496	$538	$635	$157	$564	$438	$517	$444
86					$571	$443	$523	
87					$578	$448	$530	
88					$585	$454	$536	
89					$592	$459	$542	
90 and Older					$599	$464	$549	

Premium Information

CareFirst BlueCross BlueShield can only raise your premiums if we raise the premiums for all policies like yours in the state.

There may be a rate increase when approved by the Maryland Insurance Administration or (if you have enrolled in Plans A, B, F, High-Deductible F or N) when you change from one age group to another, as shown below:

1) age 65 through 69
2) age 70 through 74
3) age 75 through 79
4) age 80 through 84
5) age 85 or older

Under Medicare supplement policies **G, L and M**, which use attained age rating, premiums automatically increase as you get older. You can expect your premiums to increase **each** year due to changes in age. We reserve the right to adjust premiums on your renewal.

The rate increase will be effective on the first of the policy renewal month. The policy renewal month means the month in which the policy becomes effective and each subsequent anniversary of that month. If the change from one age group to another occurs prior to the policy renewal month, the rate increase will not be effective until the first of the policy renewal month. You will be notified of any rate increase at least 45 days prior to the date that a premium increase becomes effective.

Disclosures

Use this outline to compare benefits and premiums among policies.

This outline shows benefits and premiums of policies sold for effective dates on or after January 1, 2013. Policies sold for effective dates prior to January 1, 2013 have the same benefits.

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 your insurance company.

Right to Return Policy

If you find that you are not satisfied with your policy, you may return it to:

CareFirst of Maryland, Inc.
d/b/a CareFirst BlueCross BlueShield
Individual Market Division
10455 Mill Run Circle, 4th Floor
Owings Mills, Maryland 21117

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 CareFirst BlueCross BlueShield 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 your 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.

MediGap-65: PLAN A

Medicare Part A Hospital Services Per Benefit Period[1]

Services	Medicare Pays	**Plan A Pays**	You Pay
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,184	$0	$1,184 (Part A Deductible)
61st thru 90th day	All but $296 a day	$296 a day	$0
91st day and after:			
■ While using 60 lifetime reserve days	All but $592 a day	$592 a day	$0
Once lifetime reserve days are used:			
■ Additional 365 days	$0	100% of Medicare Eligible Expenses	$0[2]
■ Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] 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 $148 a day	$0	Up to $148 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

[1] *A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

[2] *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.*

MediGap-65: PLAN A

Medicare Part B Medical Services Per Calendar Year

Services	Medicare Pays	**Plan A Pays**	You Pay
Medical Expenses-In or Out of 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[1]	$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[1]	$0	$0	$147 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services			
Tests for diagnostic services	100%	$0	$0
Medicare Parts A and B			
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[1]	$0	$0	$147 (Part B Deductible)
• Remainder of Medicare-approved amounts	80%	20%	$0

[1] Once you have been billed $147 of Medicare-approved amounts for covered services (which are noted with a footnote), your Part B deductible will have been met for the calendar year.

MediGap-65: PLAN B

Medicare Part A Hospital Services Per Benefit Period[1]

Services	Medicare Pays	**Plan B Pays**	You Pay
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,184	$1,184 (Part A Deductible)	$0
61st thru 90th day	All but $296 a day	$296 a day	$0
91st day and after:			
■ While using 60 lifetime reserve days	All but $592 a day	$592 a day	$0
Once lifetime reserve days are used:			
■ Additional 365 days	$0	100% of Medicare Eligible Expenses	$0[2]
■ Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] 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 $148 a day	$0	Up to $148 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

[1] *A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

[2] *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.*

MediGap-65: PLAN B

Medicare Part B Medical Services Per Calendar Year

Services	Medicare Pays	**Plan B Pays**	You Pay
Medical Expenses-In or Out of 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[1]	$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[1]	$0	$0	$147 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services			
Tests for diagnostic services	100%	$0	$0
Medicare Parts A and B			
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[1]	$0	$0	$147 (Part B Deductible)
■ Remainder of Medicare-approved amounts	80%	20%	$0

[1] *Once you have been billed $147 of Medicare-approved amounts for covered services (which are noted with a footnote), your Part B Deductible will have been met for the calendar year.*

MediGap-65: PLAN F

Medicare Part A Hospital Services Per Benefit Period[1]

Services	Medicare Pays	**Plan F Pays**	You Pay
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,184	$1,184 (Part A Deductible)	$0
61st thru 90th day	All but $296 a day	$296 a day	$0
91st day and after:			
■ While using 60 lifetime reserve days	All but $592 a day	$592 a day	$0
Once lifetime reserve days are used:			
■ Additional 365 days	$0	100% of Medicare Eligible Expenses	$0[2]
■ Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] 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 $148 a day	Up to $148 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

[1] *A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

[2] *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.*

MediGap-65: PLAN F

Medicare Part B Medical Services Per Calendar Year

Services	Medicare Pays	**Plan F Pays**	You Pay
Medical Expenses-In or Out of 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[1]	$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[1]	$0	$147 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services			
Tests for diagnostic services	100%	$0	$0
Medicare Parts A and B			
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[1]	$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

[1] *Once you have been billed $147 of Medicare-approved amounts for covered services (which are noted with a footnote), your Part B Deductible will have been met for the calendar year.*

MediGap-65: High-Deductible PLAN F

Medicare Part A Hospital Services Per Benefit Period[1]

Services	Medicare Pays	**High-Deductible Plan F Pays**	You Pay
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies		**After you pay $2,110 deductible[2], High-Deductible Plan F pays**	**In addition to $2,110 deductible[2], you pay**
First 60 days	All but $1,184	$1,184 (Part A Deductible)	$0
61st thru 90th day	All but $296 a day	$296 a day	$0
91st day and after:			
■ While using 60 lifetime reserve days	All but $592 a day	$592 a day	$0
Once lifetime reserve days are used:			
■ Additional 365 days	$0	100% of Medicare Eligible Expenses	$0[3]
■ Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] 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 $148 a day	Up to $148 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

[1] *A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

[2] *This High-Deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,110 deductible. Benefits from the High-Deductible Plan F will not begin until out-of-pocket expenses are $2,110. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.*

[3] *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.*

MediGap-65: High-Deductible PLAN F

Medicare Part B Medical Services Per Calendar Year

Services	Medicare Pays	**High-Deductible Plan F Pays**	You Pay
Medical Expenses-In or Out of 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:		**After you pay $2,110 deductible[2], High-Deductible Plan F pays**	**In addition to $2,110 deductible[2], you pay**
First $147 of Medicare-approved amounts[1]	$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[1]	$0	$147 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services			
Tests for diagnostic services	100%	$0	$0
Medicare Parts A and B			
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[1]	$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

[1] *Once you have been billed $147 of Medicare-approved amounts for covered services (which are noted with a footnote), your Part B Deductible will have been met for the calendar year.*

[2] *This High-Deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,110 deductible. Benefits from the High-Deductible Plan F will not begin until out-of-pocket expenses are $2,110. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.*

MediGap-65: PLAN G

Medicare Part A Hospital Services Per Benefit Period[1]

Services	Medicare Pays	**Plan G Pays**	You Pay
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,184	$1,184 (Part A Deductible)	$0
61st thru 90th day	All but $296 a day	$296 a day	$0
91st day and after:			
■ While using 60 lifetime reserve days	All but $592 a day	$592 a day	$0
Once lifetime reserve days are used:			
■ Additional 365 days	$0	100% of Medicare Eligible Expenses	$0[2]
■ Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] 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 $148 a day	Up to $148 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

[1] *A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

[2] *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.*

MediGap-65: PLAN G

Medicare Part B Medical Services Per Calendar Year

Services	Medicare Pays	**Plan G Pays**	You Pay
Medical Expenses-In or Out of 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[1]	$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	100%	$0
Blood			
First 3 pints	$0	All costs	$0
First $147 of Medicare-approved amounts[1]	$0	$0	$147 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services			
Tests for diagnostic services	100%	$0	$0
Medicare Parts A and B			
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[1]	$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

[1] *Once you have been billed $147 of Medicare-approved amounts for covered services (which are noted with a footnote), your Part B Deductible will have been met for the calendar year.*

MediGap-65: PLAN L

Medicare Part A Hospital Services Per Benefit Period[2]

Services	Medicare Pays	**Plan L Pays**	You Pay[1]
Hospitalization[2] Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,184	$888 (75% of Part A Deductible)	$296♦ (25% of Part A Deductible)
61st thru 90th day	All but $296 a day	$296 a day	$0
91st day and after:			
■ While using 60 lifetime reserve days	All but $592 a day	$592 a day	$0
Once lifetime reserve days are used:			
■ Additional 365 days	$0	100% of Medicare Eligible Expenses	$0[3]
■ Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[2] 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 $148 a day	Up to $111 a day (75% of Part A Coinsurance)♦	Up to $37 a day♦ (25% of Part A Coinsurance)♦
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	75%	25%♦
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	75% of copayment/ coinsurance	25% of copayment/ coinsurance♦

[1] *You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $2,400 each calendar year. The amounts that count toward your annual limit are noted with diamonds "♦" in the chart above. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year.* ***However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.***

[2] *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.*

[3] *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.*

MediGap-65: PLAN L

Medicare Part B Medical Services Per Calendar Year

Services	Medicare Pays	**Plan L Pays**	You Pay[1]
Medical Expenses-In or Out of 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[2]	$0	$0	$147[2] (Part B Deductible)♦
Preventive benefits for Medicare-covered services	Generally 80% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5%♦
Part B Excess Charges			
(Above Medicare-approved amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket[3] limit of $2,400[1]
Blood			
First 3 pints	$0	75%	25%♦
Next $147 of Medicare-approved amounts[2]	$0	$0	$147♦ (Part B Deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5%♦
Clinical Laboratory Services			
Tests for diagnostic services	100%	$0	$0
Medicare Parts A and B			
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[3]	$0	$0	$147♦ (Part B Deductible)
■ Remainder of Medicare-approved amounts	80%	15%	5%♦

[1] *This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $2,400 per year.* ***However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.***

[2] *Once you have been billed $147 of Medicare-approved amounts for covered services (which are noted with a footnote), your Part B Deductible will have been met for the calendar year.*

[3] *Medicare Benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.*

MediGap-65: PLAN M

Medicare Part A Hospital Services Per Benefit Period[1]

Services	Medicare Pays	**Plan M Pays**	You Pay
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,184	$592 (50% of Part A Deductible)	$592 (50% of Part A Deductible)
61st thru 90th day	All but $296 a day	$296 a day	$0
91st day and after:			
■ While using 60 lifetime reserve days	All but $592 a day	$592 a day	$0
Once lifetime reserve days are used:			
■ Additional 365 days	$0	100% of Medicare Eligible Expenses	$0[2]
■ Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] 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 $148 a day	Up to $148 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

[1] *A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

[2] *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.*

MediGap-65: PLAN M

Medicare Part B Medical Services Per Calendar Year

Services	Medicare Pays	**Plan M Pays**	You Pay
Medical Expenses-In or Out of 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[1]	$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[1]	$0	$0	$147 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services			
Tests for diagnostic services	100%	$0	$0
Medicare Parts A and B			
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[1]	$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 6o 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

[1] *Once you have been billed $147 of Medicare-approved amounts for covered services (which are noted with a footnote), your Part B Deductible will have been met for the calendar year.*

MediGap-65: PLAN N

Medicare Part A Hospital Services Per Benefit Period[1]

Services	Medicare Pays	**Plan N Pays**	You Pay
Hospitalization[1] Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,184	$1,184 (Part A Deductible)	$0
61st thru 90th day	All but $296 a day	$296 a day	$0
91st day and after:			
■ While using 60 lifetime reserve days	All but $592 a day	$592 a day	$0
Once lifetime reserve days are used:			
■ Additional 365 days	$0	100% of Medicare Eligible Expenses	$0[2]
■ Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[1] 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 $148 a day	Up to $148 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

[1] *A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

[2] *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.*

MediGap-65: PLAN N

Medicare Part B Medical Services Per Calendar Year

Services	Medicare Pays	**Plan N Pays**	You Pay
Medical Expenses-In or Out of 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[1]	$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[1]	$0	$0	$147 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services			
Tests for diagnostic services	100%	$0	$0
Medicare Parts A and B			
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[1]	$0	$0	$147 (Part B Deductible)
■ Remainder of Medicare-approved amounts	80%	20%	$0

[1] *Once you have been billed $147 of Medicare-approved amounts for covered services (which are noted with a footnote), your Part B Deductible will have been met for the calendar year.*

MediGap-65: PLAN N

Medicare Part B Medical Services Per Benefit Period

Services	Medicare Pays	**Plan N Pays**	You Pay
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

These benefits described are issued under Policy
Form Numbers:
CFMI/MG PLAN A (6/10)
CFMI/MG PLAN B (6/10)
CFMI/MG PLAN F (6/10)
CFMI/MG PLAN G (2/12)
CFMI/MG PLAN L (2/12)
CFMI/MG PLAN M (2/12)
CFMI/MG PLAN N (6/10)
CFMI/MG PLAN HI DED F (6/10)
CFMI/2010 PLAN HI F SOB (6/10)
as amended

MD/CF/MG PLAN A (6/10)
MD/CF/MG PLAN B (6/10)
MD/CF/MG PLAN F (6/10)
MD/CF/MG PLAN G (2/12)
MD/CF/MG PLAN L (2/12)
MD/CF/MG PLAN M (2/12)
MD/CF/MG PLAN N (6/10)
MD/CF/MG PLAN HI DED F (6/10)
MD/CF/2010 PLAN HI F SOB (6/10)
as amended

CareFirst of Maryland, Inc.
10455 Mill Run Circle
Owings Mills, Maryland 21117

A not-for-profit health service plan incorporated under the laws of the State of Maryland.

Group Hospitalization and Medical Services, Inc.
840 First Street, NE
Washington, DC 20065

www.carefirst.com

If you reside in either Prince George's or Montgomery County, then a Group Hospitalization and Medical Services, Inc. policy will be issued. For Baltimore City and all other counties in the state of Maryland, a CareFirst of Maryland, Inc. policy will be issued.

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Apply Today

Three Ways to Apply!

Applying for a MediGap-65 plan is easy. Select one of the three ways to apply from the list below.

1. Apply online and be approved in as little as 24 hours at **www.carefirst.com**. Click on *Medigap Plans* under "Need to Buy Insurance?" Take a look at the picture below of our website, to see where you can apply online.

2. Fill out and mail the enclosed application. Send no money when you apply. We'll begin processing your application right away.

   Please Note: We recommend folding the application into thirds before placing it into the enclosed envelope.

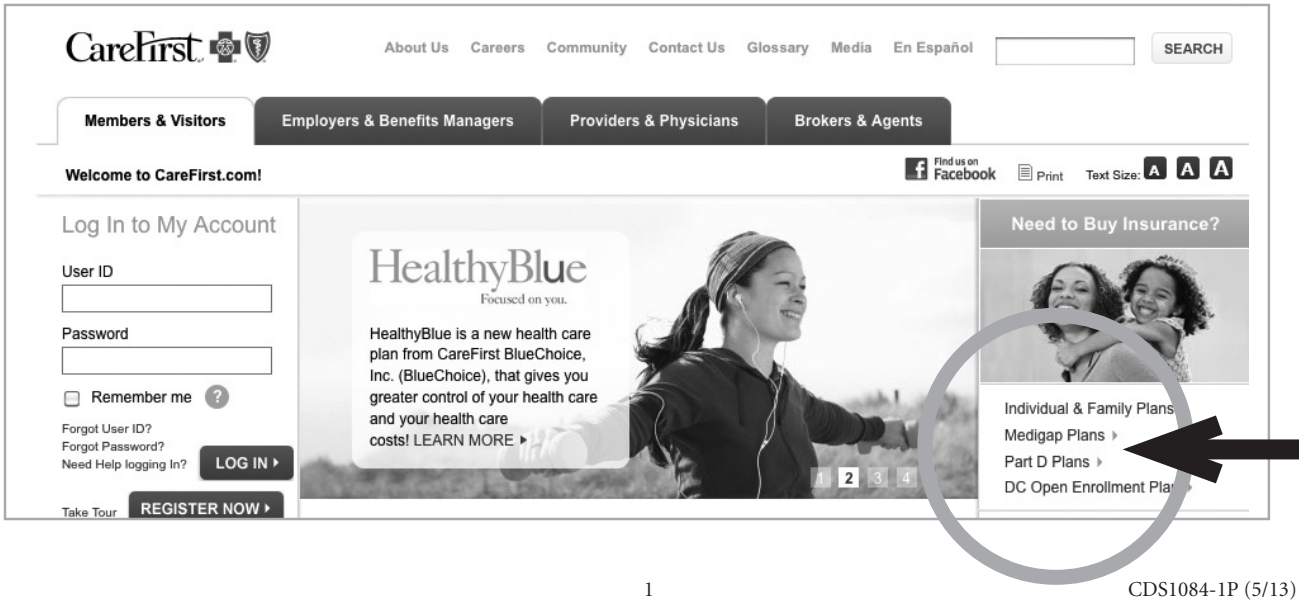
Steps to Apply:

- Review the plan options and premiums in the Outline of Coverage.
- Complete your application. Don't forget to:
  - Indicate the MediGap-65 plan of your choice.
  - Read Section 3 of your application to see if you automatically qualify for Guaranteed Acceptance and our lowest rates.
  - Sign your application.
- Mail your application in the enclosed, postage-paid envelope.

3. Apply through your broker.

Once you have submitted your application, you can call the Application Status Hotline at (877) 746-7515 with questions. Your coverage will become effective the first of the month following the month in which we approve your application.

If you have questions, please call our Product Consultant at (410) 356-8123 or toll-free at (800) 275-3802, Monday-Friday 8 a.m. – 8 p.m. Or, visit the CareFirst web site at **www.carefirst.com**.

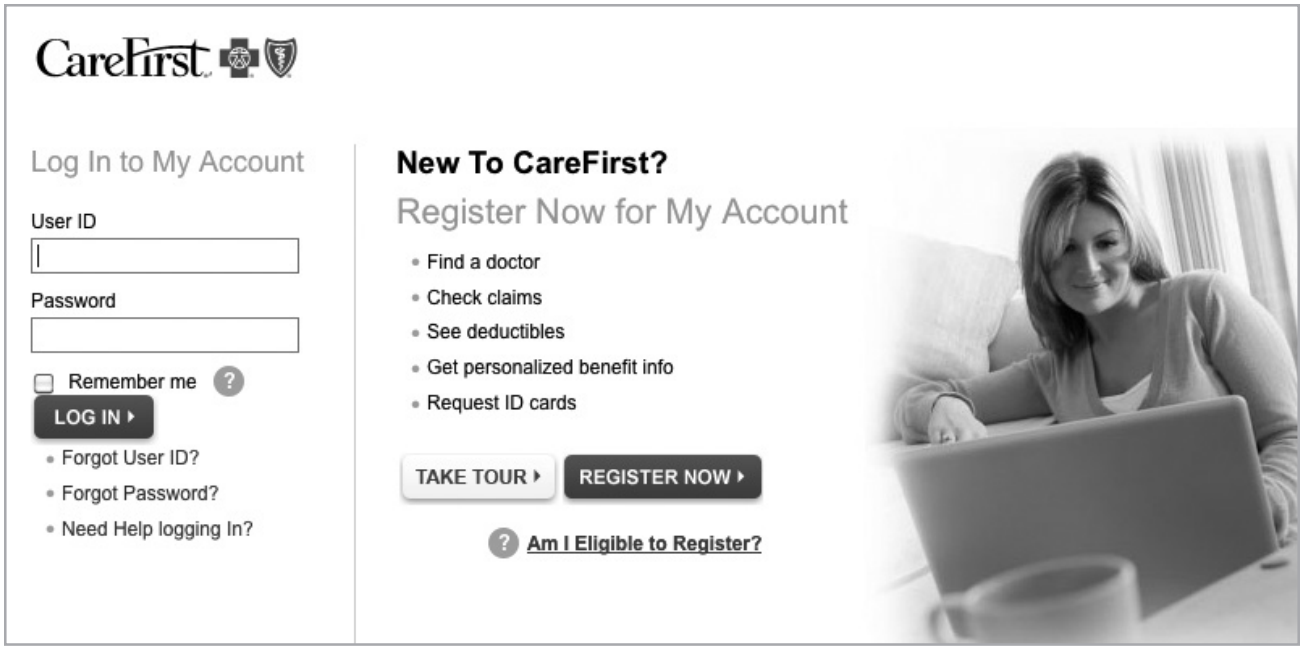


Pay Your Premium Online with eBilling!

As a member, you can save time and take advantage of our online billing system called eBilling.

With eBilling you can:

1. Set up recurring monthly payments in two ways:
   - Fill out Section 6 on the enclosed application with your checking account information, OR
2. After you're a member, sign up for eBilling through My Account, which can be found at **www.carefirst.com/myaccount**. You'll just need your member ID card in order to register for My Account the first time you visit.
   - View and pay your monthly bill online 24 hours a day, 7 days a week.
   - Check the status of your payment and any outstanding balances.
   - End the hassle of buying stamps and the worry of getting your payment in the mail on time.



Additional Information

Open Enrollment/ Guaranteed Issue Guidelines

I. During an Open Enrollment period, acceptance is guaranteed if the individual:

- Is age 65 or older and enrolled in Medicare Part B within the last 6 months;
- Turned age 65 in the last 6 months (member must have Medicare Parts A and B);
- Is under age 65, eligible for Medicare due to a disability, and enrolled in Medicare Part B within the last 6 months;
- Is under age 65, eligible for Medicare due to a disability, AND has been terminated from the Maryland Health Insurance Plan as a result of enrollment in Medicare Part B within the last 6 months; or
- At the time of application is within 6 months from the first day of the month in which he or she first enrolled or will enroll in Medicare Part B.

II. Acceptance may also be guaranteed through other special Guaranteed Issue Enrollment Provisions. If health insurance coverage is lost, the individual may be considered an "Eligible Person" entitled to guaranteed acceptance and may have a guaranteed right to enroll in CareFirst Medicare Supplement Plans under the following circumstances:

A. Supplemental Plan Termination, meaning:

- The individual was enrolled under an employer group health plan or union coverage that pays after Medicare pays (Medicare Supplemental Plan) and the plan is ending or will no longer provide the individual with supplemental health benefits and the coverage was terminated or ceased within the last 63 days;
- The individual got a notice that supplemental health benefits were terminated or ceased within the past 63 days; or
- The individual did NOT get a notice that supplemental health benefits terminated or ceased, BUT within the past 63 days received a notice that a claim was denied because supplemental benefits terminated or ceased.

B. Medicare Health Plan* termination, movement out of service area, violation of contract terms or marketing violations, meaning:

Within the past 63 day period the individual was enrolled under: A Medicare Health Plan* (such as a Medicare Advantage Plan), or was 65 years of age or older and enrolled with a PACE provider (Program of All Inclusive Care for the Elderly), and one of the following occurs:

i. The Plan was terminated, no longer provides or has discontinued to offer coverage in the service area where the individual lives;

ii. The individual lost coverage because of a move out of the plan's service area or experienced other change in circumstances specified by Health and Human Services (NOTE: This does not include failure to pay premiums on a timely basis.);

iii. The individual terminated because he or she can show that the Plan violated the terms of the Plan's contract such as failing to provide timely medically necessary care or in accordance with medical standards;

iv. The individual can show that the Plan or its agent misled them in marketing the Plan; or

v. The certificate of the organization was terminated.

***A Medicare Health Plan Includes:**

a) Any Medicare Advantage plan;

b) Any eligible organization under a contract under Section 1876 (Medicare cost);

c) Any similar organization operating under demonstration pro authority;

d) Any PACE provider, under section 1894 of the Social Security Act;

e) Any organization under an agreement under Section 1833(a)(1)(A) (health care prepayment plan); or

f) A Medicare Select policy

C. Medicare Supplemental Plan involuntary termination, or termination due to a violation of contract terms, or marketing violations, meaning:

Within the past 63 day period the individual was enrolled under: A Medicare supplemental policy and the individual's enrollment ended because:

i. Of any involuntary termination of coverage or enrollment under the policy, including plan bankruptcy;

ii. The plan violated the terms of the Plan's contract; or

iii. The individual can show that the company or its agent misled them in marketing the Plan.

D. Enrollment change from a Medicare Health Plan* to Medicare Supplemental Plan (enrolled in MA less than 12 months), meaning:

- Within the past 63 day period the individual was enrolled under: A Medicare Health Plan* (such as Medicare Advantage or PACE plan), when the individual first enrolled under Medicare Part B at age 65 or older, and within 12 months of enrollment in the Medicare Health Plan* decided to switch back to a Medicare Supplement policy; or
- Within the past 63 day period the individual was enrolled under: A Medicare Supplemental plan that the individual dropped and subsequently enrolled for

the first time with a Medicare Health Plan* (such as Medicare Advantage or PACE); and was with the plan less than 12 months and wants to return to a Medicare Supplemental plan.

E. Enrollment termination from Medicare Supplemental plan WITH drug (like Plan I or Plan J) when Part D purchased, meaning:

- Within the past 63 day period the individual was enrolled under: A Medicare Part D plan, and ALSO enrolled under a Medicare Supplement policy that covers outpatient prescription drugs. When the individual enrolled in Medicare Part D, he or she terminated enrollment in the Medicare supplement policy that covered outpatient prescription drug coverage (NOTE: Evidence of enrollment in Medicare Part D must be submitted with this application).

F. Loss of employer group or union coverage due to termination of employer group or union plan, and ineligibility for insurance tax credits or MHIP enrollment solely because of Medicare eligibility, meaning:

- Within the past 63 day period the individual was enrolled under: An employer group health plan or union coverage that provides health benefits and the plan terminated; and solely because of your Medicare eligibility, the individual is not eligible for the tax credit for health insurance costs and enrollment in the Maryland Health Insurance Plan.

IMPORTANT NOTES

- Individuals are required to:
  - o Apply within the required time period following the termination of prior health insurance plan.
  - o Provide a copy of the termination notice received from the prior insurer with the application. This notice must verify the circumstance of the Plan's termination and describe the individual's right to guaranteed issue of Medicare Supplement Insurance.
- Questions on the guaranteed right to insurance should be directed to the Administrator of the individual's prior health insurance plan or to the local state Department on Aging.

CareFirst's Privacy Practices

Our Commitment to Our Members

The following statement applies to CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. doing business as CareFirst BlueCross BlueShield, and their affiliates (collectively, CareFirst).

When you apply for any type of insurance, you disclose information about yourself and/or members of your family. The collection, use and disclosure of this information are regulated by law. Safeguarding your personal information is something that we take very seriously at CareFirst. CareFirst is providing this notice to inform you of what we do with the information you provide to us.

Categories of Personal Information We May Collect

We may collect personal, financial and medical information about you from various sources, including:

- Information you provide on applications or other forms, such as your name, address, social security number, salary, age and gender.
- Information pertaining to your relationship with CareFirst, its affiliates or others, such as your policy coverage, premiums and claims payment history.
- Information (as described in preceding paragraphs) that we obtain from any of our affiliates.
- Information we receive about you from other sources, such as your employer, your provider and other third parties.

How Your Information Is Used

We use the information we collect about you in connection with underwriting or administration of an insurance policy or claim or for other purposes allowed by law. At no time do we disclose your personal, financial and medical information to anyone outside of CareFirst unless we have proper authorization from you or we are permitted or required to do so by law. We maintain physical, electronic and procedural safeguards in accordance with federal and state standards that protect your information.

In addition, we limit access to your personal, financial and medical information to those CareFirst employees, brokers, benefit plan administrators, consultants, business partners, providers and agents who need to know this information to conduct CareFirst business or to provide products or services to you.

Disclosure of Your Information

In order to protect your privacy, affiliated and nonaffiliated third parties of CareFirst are subject to strict confidentiality laws. Affiliated entities are companies that are a part of the CareFirst corporate family and include health maintenance organizations, third party administrators, health insurers, long-term care insurers and insurance agencies. In certain situations related to our insurance transactions involving you, we disclose your personal, financial and medical information to a nonaffiliated third party that assists us in providing services to you. When we disclose

information to these critical business partners, we require these business partners to agree to safeguard your personal, financial and medical information and to use the information only for the intended purpose, and to abide by the applicable law. The information CareFirst provides to these business partners can only be used to provide services we have asked them to perform for us or for you and/or your benefit plan.

Changes in Our Privacy Policy

CareFirst periodically reviews its policies and reserves the right to change them. If we change the substance of our privacy policy, we will continue our commitment to keep your personal, financial and medical information secure – it is our highest priority. Even if you are no longer a CareFirst customer, our privacy policy will continue to apply to your records. You can always review our current privacy policy online at **www.carefirst.com.**

Rights and Responsibilities

Notice of Privacy Practices

CareFirst BlueCross BlueShield (CareFirst) is committed to keeping the confidential information of members private. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to send our Notice of Privacy Practices to members. The notice (pages 20-21) outlines the uses and disclosures of protected health information, the individual's rights and CareFirst's responsibility for protecting the member's health information.

To obtain an additional copy of our Notice of Privacy Practices, go to **www.carefirst.com** and click on *"Privacy Statement"* at the bottom of the page, click on *"Health Information"* then click on *"Notice of Privacy Practices."* Or call the Member Services telephone number on your member ID card.

Member Satisfaction

CareFirst wants to hear your concerns and/or complaints so that they may be resolved. We have procedures that address medical and non-medical issues. If a situation should occur for which there is any question or difficulty, here's what you can do:

- If your comment or concern is regarding the quality of service received from a CareFirst representative or related to administrative problems (e.g., enrollment, claims, bills, etc.) you should contact Member Services. If you send your comments to us in writing, please include your member ID number and provide us with as much detail as possible regarding any events. Please include your daytime telephone number so that we may contact you directly if we need additional information.
- If your concern or complaint is about the quality of care or quality of service received from a specific provider, contact Member Services. A representative will record your concerns and may request a written summary of the issues. To write to us directly with a quality of care or service concern, you can:
  - Send an email to:
    quality.care.complaints@carefirst.com
  - Fax a written complaint to:
    (301) 470-5866
  - Write to:
    CareFirst BlueCross BlueShield
    Quality of Care Department,
    P.O. Box 17636
    Baltimore, MD 21297

If you send your comments to us in writing, please include your identification number and provide us with as much detail as possible regarding the event or incident. Please include your daytime telephone number so that we may contact you directly if we need additional information. Our Quality of Care Department will investigate your concerns, share those issues with the provider involved and request a response. We will then provide you with a summary of our findings. CareFirst member complaints are retained in our provider files and are reviewed when providers are considered for continuing participation with CareFirst.

If you wish, you may also contact the appropriate jurisdiction's regulatory department regarding your concern:

Maryland
Maryland Insurance Administration, Inquiry and Investigation, Life and Health, 200 St. Paul Place, Suite 2700, Baltimore, MD 21202 Phone: (800) 492-6116 or (410) 468-2244 Office of Health Care Quality, Spring Grove Center, Bland-Bryant Building, 55 Wade Avenue, Catonsville, MD 21228 Phone: (410) 402-8016 or (877) 402-8218

For assistance in resolving a billing or payment dispute with the health plan or a health care provider, contact the Health Education and Advocacy Unit of the Consumer Protection Division of the Office of the Attorney General at:

Health Education and Advocacy Unit, Consumer Protection Division, Office of the Attorney General, 200 St. Paul Place, 16th Floor, Baltimore, MD 21202 Phone: (410) 528-1840 or (877) 261-8807 Fax: (410) 576-6571 / web site: **www.oag.state.md.us**

Hearing Impaired

To contact a Member Services representative, please choose the appropriate hearing impaired assistance number below, based on the region in which your coverage originates.

Maryland Relay Program: (800) 735-2258
National Capital Area TTY: (202) 479-3546.
Please have your Member Services number ready.

Language Assistance

Interpreter services are available through Member Services. When calling Member Services, inform the representative that you need language assistance.

Note: CareFirst appreciates the opportunity to improve the level of quality of care and services available for you. As a member, you will not be subject to disenrollment or otherwise penalized as a result of filing a complaint or appeal.

Confidentiality of Subscriber/ Member Information

All health plans and providers must provide information to members and patients regarding how their information is protected. You will receive a Notice of Privacy Practices from CareFirst or your health plan, and from your providers as well, when you visit their office.

CareFirst has policies and procedures in place to protect the confidentiality of member information. Your confidential information includes Protected Health Information (PHI), whether oral, written or electronic, and other nonpublic financial information. Because we are responsible for your insurance coverage, making sure your claims are paid, and that you can obtain any important services related to your health care, we are permitted to use and disclose (give out) your information for these

purposes. Sometimes we are even required by law to disclose your information in certain situations. You also have certain rights to your own protected health information on your behalf.

Our Responsibilities

We are required by law to maintain the privacy of your PHI, and to have appropriate procedures in place to do so. In accordance with the federal and state Privacy laws, we have the right to use and disclose your PHI for treatment, payment activities and health care operations as explained in the Notice of Privacy Practices. We may disclose your protected health information to the plan sponsor/employer to perform plan administration function. The Notice is sent to all policy holders upon enrollment.

Your Rights

You have the following rights regarding your own Protected Health Information. You have the right to:

- Request that we restrict the PHI we use or disclose about you for payment or health care operations.
- Request that we communicate with you regarding your information in an alternative manner or at an alternative location if you believe that a disclosure of all or part of your PHI may endanger you.
- Inspect and copy your PHI that is contained in a designated record set including your medical record.
- Request that we amend your information if you believe that your PHI is incorrect or incomplete.
- An accounting of certain disclosures of your PHI that are for some reasons other than treatment, payment, or health care operations.
- Give us written authorization to use your protected health information or to disclose it to anyone for any purpose not listed in this notice.

Inquiries and Complaints

If you have a privacy-related inquiry, please contact the CareFirst Privacy Office at (800) 853-9236 or send an email to: **privacy.office@carefirst.com**.

Members' Rights and Responsibilities Statement

Members have the right to:

- Be treated with respect and recognition of their dignity and right to privacy.
- Receive information about the health plan, its services, its practitioners and providers, and members' rights and responsibilities.
- Participate with practitioners in decision-making regarding their health care.
- Participate in a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.

- Make recommendations regarding the organization's members' rights and responsibilities.
- Voice complaints or appeals about the health plan or the care provided.

Members have a responsibility to:

- Provide, to the extent possible, information that the health plan and its practitioners and providers need in order to care for them.
- Understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
- Follow the plans and instructions for care that they have agreed on with their practitioners.
- Pay copayments or coinsurance at the time of service.
- Be on time for appointments and to notify practitioners/providers when an appointment must be canceled.

Eligible Individuals' Rights Statement Wellness and Health Promotion Services

Eligible individuals have a right to:

- Receive information about the organization, including wellness and health promotion services provided on behalf of the employer or plan sponsors; organization staff and staff qualifications; and any contractual relationships.
- Decline participation or disenroll from wellness and health promotion services offered by the organization.
- Be treated courteously and respectfully by the organization's staff.
- Communicate complaints to the organization and receive instructions on how to use the complaint process that includes the organization's standards of timeliness for responding to and resolving complaints and quality issues.

We're here to answer your questions.

If you have any questions about the plans described in this booklet, or if you'd like assistance, just call 1-800-275-3802 (in the Baltimore area call (410) 356-8123). You'll receive courteous, knowledgeable assistance from one of our dedicated Product Consultants.

Policy Form Numbers

The benefits described are issued under policies:
CFMI/MG PLAN A (6/10) • CFMI/MG PLAN B (6/10) • CFMI/MG PLAN F (6/10)
CFMI/MG PLAN G (2/12) • CFMI/MG PLAN L (2/12) • CFMI/MG PLAN M (2/12)
CFMI/MG PLAN N (6/10) • CFMI/MG PLAN HI DED F (6/10) • MD/CF/MG PLAN G (2/12)
MD/CF/MG PLAN L (2/12) • MD/CF/MG PLAN M (2/12) • CFMI/2010 PLAN HI F SOB (6/10)
MDSUPPAPP (8/12) • MD/CF/MG PLAN A (6/10) • MD/CF/MG PLAN B (6/10)
MD/CF/MG PLAN F (6/10) • MD/CF/MG PLAN N (6/10) • MD/CF/MG PLAN HI DED F (6/10)
MD/CF/2010 PLAN HI F SOB (6/10) • MDSUPPAPP (8/12) as amended

Legal entity CareFirst of Maryland, Inc.; policy #: CFMI/BLUEVISION (R. 1/06)
and any amendments

Legal entity Group Hospitalization and Medical Services, Inc.; policy #: GHMSI BlueVision (R. 1/06)
and any amendments

FORM DN001C (R. 1/10) • FORM DN4001 (R. 1/10) • MD/TDN/DB/DEPENDENT AGE (9/10)
TDN – DISCLOSURE 10/12 • MD/TDN/DOL APPEAL (R. 9/11)
and any amendments

MD GHMSI/DB/ISPP DOCS (10/11) • MD GHMSI/DB/ISPP IEA (10/11)
MD/GHMSI/DB/DENT/ES (10/11) • MD/GHMSI/ISPP/AMEND (2/12)
and any amendments

CFMI/DB/ISPP DOCS (10/11) • CFMI/DB/ISPP IEA (10/11)
MD/CFMI/DB/DENT/ES (2/12) • MD/CFMI/ISPP/AMEND (2/12)
and any amendments

MD/GHMSI/DB/IEA-DENTAL (2/08) • MD/GHMSI/DB/DOCS-DENTAL (2/08)
MD/GHMSI/DB/ES-DENTAL (2/08) • MD/GHMSI/DOL APPEAL (R. 9/11)
MD/GHMSI/DB/PARTNER (12/08) • MD/CF/DB/DEPENDENT AGE (9/10)
GHMSI-DISCLOSURE (10/12) • MD NCA – HEALTH GUARANTY (10/12)
and any amendments

Not all services and procedures are covered by your benefits contract. This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.

Neither CareFirst BlueCross BlueShield nor its agents represent, work for or receive compensation from any federal, state or local government agency.

Offered by CareFirst of Maryland, Inc.*, d/b/a CareFirst BlueCross BlueShield, 10455 Mill Run Circle, Owings Mills, Maryland 21117-5559. Offered by Group Hospitalization and Medical Services, Inc.*, d/b/a CareFirst BlueCross BlueShield, 840 First Street, NE, Washington, DC 20065. A not-for-profit health service plan.
*An independent licensee of the Blue Cross and Blue Shield Association

CareFirst of Maryland, Inc.
10455 Mill Run Circle
Owings Mills, Maryland 21117

A not-for-profit health service plan incorporated under the laws of the State of Maryland.

Group Hospitalization and Medical Services, Inc.
840 First Street, NE
Washington, DC 20065

www.carefirst.com

If you reside in either Prince George's or Montgomery County, then a Group Hospitalization and Medical Services, Inc. policy will be issued. For Baltimore City and all other counties in the state of Maryland, a CareFirst of Maryland, Inc. policy will be issued.

CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, Maryland 21117

www.carefirst.com

MDO65POD13 (5/13) CDS1007-1P (5/13)