Anthem Blue Cross – California

Administrative Office: PO Box 9063, Oxnard, CA 93031-9063
Toll Free Telephone Number: 1-888-211-9813

2012 Outline of Medicare Supplement Coverage

Cover Page (1 of 2)

Plans A, F, High Ded F, G & N

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

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

Plans A, F, High Deductible F & N are available to those who are under age 65 and qualify for Medicare due to disability (noted with a diamond '✦').

Basic Benefits:

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

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

(continued on next page)

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2012 Outline of Medicare Supplement Coverage

Cover Page (2 of 2)

Plans A, F, High Ded F, G & N

PLAN	A✦	B	C	D	F✦ | F*✦	G	K	L	M	N✦
Part A Deductible		✓	✓	✓	✓	✓	50%	75%	50%	✓
Part B Deductible			✓		✓					
Part B Excess					✓	✓				
Foreign Travel Emergency			✓	✓	✓	✓			✓	✓
Out-of-pocket limit							$4,660; paid at 100% after limit reached	$2,330; paid at 100% after limit reached		

* Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,070 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed $2,070. 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.

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Monthly Rates

Plans A, F, High Ded F, G & N
Effective March 1, 2012

Rates are subject to change.

Premium Information — Age 65 and Over

We, Anthem Blue Cross, can only raise your premium if we raise the premium for all plans like yours in this State. Your premium rate increases based upon your attained age. We will recalculate your age each year. Your premium rate will increase annually based upon your new attained age. Premium changes due to your attained age occur at the beginning of your policy term. To determine your premium, select your age as of your requested policy effective date, then refer to the zip code listing on pages 7-10 to determine which area you live in. Some zip codes may fall in two or more rating areas.

Attained Age	Plan A						Plan F					
	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6
65	$ 90.78	$ 90.78	$ 90.78	$ 126.17	$ 126.17	$ 119.24	$ 129.68	$ 129.68	$ 129.68	$ 169.25	$ 169.25	$ 142.87
66	94.46	94.46	94.46	131.29	131.29	124.08	134.94	134.94	134.94	176.11	176.11	148.66
67	98.27	98.27	98.27	136.58	136.58	129.08	140.39	140.39	140.39	183.22	183.22	154.67
68	102.23	102.23	102.23	142.08	142.08	134.28	146.04	146.04	146.04	190.60	190.60	160.89
69	106.32	106.32	106.32	147.77	147.77	139.66	151.89	151.89	151.89	198.23	198.23	167.34
70	110.57	110.57	110.57	153.68	153.68	145.24	157.97	157.97	157.97	206.17	206.17	174.04
71	114.98	114.98	114.98	159.81	159.81	151.04	164.26	164.26	164.26	214.38	214.38	180.97
72	119.55	119.55	119.55	166.16	166.16	157.04	170.80	170.80	170.80	222.91	222.91	188.17
73	124.29	124.29	124.29	172.75	172.75	163.27	177.57	177.57	177.57	231.75	231.75	195.63
74	129.21	129.21	129.21	179.58	179.58	169.72	184.59	184.59	184.59	240.91	240.91	203.36
75	134.29	134.29	134.29	186.65	186.65	176.40	191.86	191.86	191.86	250.40	250.40	211.37
76	139.59	139.59	139.59	194.01	194.01	183.36	199.41	199.41	199.41	260.25	260.25	219.69
77	145.06	145.06	145.06	201.61	201.61	190.54	207.23	207.23	207.23	270.46	270.46	228.31
78	150.74	150.74	150.74	209.50	209.50	198.00	215.34	215.34	215.34	281.04	281.04	237.24
79	156.63	156.63	156.63	217.69	217.69	205.74	223.76	223.76	223.76	292.03	292.03	246.52
80+	162.73	162.73	162.73	226.17	226.17	213.75	232.48	232.48	232.48	303.41	303.41	256.12

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Premium Information — Age 65 and Over (Continued)

Attained Age	Plan High Ded F						Plan G					
	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6
65	$ 41.30	$ 41.30	$ 41.30	$ 57.40	$ 57.40	$ 54.25	$ 121.25	$ 121.25	$ 121.25	$ 168.52	$ 168.52	$ 142.79
66	42.98	42.98	42.98	59.73	59.73	56.45	126.17	126.17	126.17	175.36	175.36	148.58
67	44.71	44.71	44.71	62.14	62.14	58.73	131.26	131.26	131.26	182.43	182.43	154.57
68	46.51	46.51	46.51	64.64	64.64	61.09	136.55	136.55	136.55	189.78	189.78	160.80
69	48.37	48.37	48.37	67.23	67.23	63.54	142.01	142.01	142.01	197.38	197.38	167.24
70	50.31	50.31	50.31	69.92	69.92	66.08	147.69	147.69	147.69	205.27	205.27	173.93
71	52.31	52.31	52.31	72.71	72.71	68.72	153.58	153.58	153.58	213.46	213.46	180.86
72	54.39	54.39	54.39	75.60	75.60	71.45	159.69	159.69	159.69	221.94	221.94	188.05
73	56.55	56.55	56.55	78.59	78.59	74.28	166.02	166.02	166.02	230.74	230.74	195.51
74	58.78	58.78	58.78	81.70	81.70	77.21	172.59	172.59	172.59	239.87	239.87	203.24
75	61.10	61.10	61.10	84.92	84.92	80.26	179.39	179.39	179.39	249.32	249.32	211.25
76	63.50	63.50	63.50	88.26	88.26	83.41	186.44	186.44	186.44	259.13	259.13	219.56
77	65.99	65.99	65.99	91.72	91.72	86.68	193.76	193.76	193.76	269.30	269.30	228.18
78	68.58	68.58	68.58	95.32	95.32	90.09	201.34	201.34	201.34	279.84	279.84	237.11
79	71.26	71.26	71.26	99.04	99.04	93.60	209.21	209.21	209.21	290.77	290.77	246.37
80+	74.04	74.04	74.04	102.90	102.90	97.25	217.36	217.36	217.36	302.10	302.10	255.97

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Effective March 1, 2012

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Premium Information — Age 65 and Over (Continued)

Attained Age	Plan N					
	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6
65	$ 81.42	$ 81.42	$ 81.42	$ 113.16	$ 113.16	$ 86.95
66	84.72	84.72	84.72	117.75	117.75	90.48
67	88.14	88.14	88.14	122.50	122.50	94.13
68	91.69	91.69	91.69	127.43	127.43	97.92
69	95.36	95.36	95.36	132.54	132.54	101.84
70	99.18	99.18	99.18	137.84	137.84	105.92
71	103.13	103.13	103.13	143.33	143.33	110.13
72	107.23	107.23	107.23	149.03	149.03	114.51
73	111.48	111.48	111.48	154.94	154.94	119.06
74	115.89	115.89	115.89	161.07	161.07	123.77
75	120.45	120.45	120.45	167.41	167.41	128.64
76	125.19	125.19	125.19	174.00	174.00	133.70
77	130.11	130.11	130.11	180.83	180.83	138.95
78	135.20	135.20	135.20	187.91	187.91	144.39
79	140.48	140.48	140.48	195.25	195.25	150.03
80+	145.96	145.96	145.96	202.86	202.86	155.88

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

—OR—

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

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

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Premium Information — Under Age 65

We, Anthem Blue Cross, can only raise your premium if we raise the premium for all plans like yours in this State. To determine your premium, select your age as of your requested policy effective date, then refer to the zip code listing on pages 7-10 to determine which area you live in. Some zip codes may fall in two or more rating areas.

Age	A						F					
	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6
< 65	$ 185.43	$ 185.43	$ 185.43	$ 257.72	$ 257.72	$ 243.57	$ 264.90	$ 264.90	$ 264.90	$ 345.72	$ 345.72	$ 291.84

Age	Plan High Ded F						Plan N					
	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6
< 65	$ 84.36	$ 84.36	$ 84.36	$ 117.25	$ 117.25	$ 110.81	$ 166.31	$ 166.31	$ 166.31	$ 231.15	$ 231.15	$ 177.62

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5-Digit Zip Code Area Guide

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

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

1 Prefix	2 (Last two digits of Zip Code)	3 Area
900	01-91, 93-96, 99	5
901	01-03, 89	5
902	01, 02, 09-13, 20-24, 30-33, 39-42, 45, 47-51, 54, 55, 60-64, 66, 67, 70, 72, 74, 75, 77, 78, 80, 90, 91-96	5
902	65	5, 6*
903	01-13, 97, 98	5
904	01-11	5
905	01-10	5
906	20-22, 24, 32, 33, 80	4
906	01-10, 12, 37, 39, 40, 50-52, 59-62, 70, 71	5
906	23, 30, 31, 38	4, 5*
907	20, 21, 40, 42, 43	4
907	01-04, 06, 07, 10-17, 23, 31-34, 44-49, 55	5
908	01-10, 13-15, 22, 31-35, 40, 42, 44-48, 53, 88, 95, 99	5
910	01, 03, 06-12, 16, 17, 20, 21, 23-25, 30, 31, 40-43, 46, 66, 77	5
911	01-10, 14-18, 21, 23-26, 29, 31, 82, 84, 85, 88, 89, 91, 99	5
912	01-10, 14, 21, 22, 24-26	5
913	01-03, 05, 06, 08-10, 13, 16, 21, 22, 24-35, 37, 40-46, 50-57, 63-65, 67, 71, 72, 76, 80-88, 90, 92-96, 99	5
913	19, 20, 58-60, 77	6
913	04, 07, 11, 61, 62	5, 6*
914	01-13, 16, 23, 26, 36, 70, 82, 95-97, 99	5
915	01-08, 10, 21-23, 26	5
916	01-12, 14-18	5
917	11, 41, 50, 59, 67-69, 73, 97	5
917	01, 02, 06, 08, 10, 14-16, 22-24, 29-40, 43-49, 52, 54-56, 58, 61-65, 70-72, 75, 76, 78, 80, 84-86, 88-93, 95, 98, 99	6
917	09, 66	5, 6*
918	01-04, 41, 96, 99	5
919	01-03, 05, 06, 08-17, 21, 31-35, 41-48, 50, 51, 62, 63, 76-80, 87, 90	6
920	03, 07-11, 13, 14, 18-30, 33, 36-40, 46, 49, 51, 52, 54-61, 64-72, 74, 75, 78, 79, 81-86, 88, 90-93, 96	6
920	04	2, 6*
921	01-24, 26-40, 42, 43, 45, 47, 49, 50, 52-55, 58-79, 82, 84, 86, 87, 90-99	6

* **Counties With Zip Codes That Cross Rating Area Boundaries:** ▌ **Area 1** Includes Calaveras, Inyo, Kings, Mendocino, Monterey, Placer, San Benito, Sutter, Tulare, Tuolumne, and Yolo. ▌ **Area 2** Includes Fresno, Imperial, Kern, Mariposa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, and Stanislaus. ▌ **Area 3** Includes Alameda, Contra Costa, Santa Barbara, and Santa Clara. ▌ **Area 4** Includes Orange. ▌ **Area 5** Includes Los Angeles. ▌ **Area 6** Includes Riverside, San Bernardino, San Diego, and Ventura.

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5-Digit Zip Code Area Guide (Continued)

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4. See Premium Chart for your area.

1 Prefix	2 (Last two digits of Zip Code)	3 Area
922	22, 27, 31-33, 43, 44, 49-51, 57, 59, 66, 73, 75, 81, 83	2
922	01-03, 10, 11, 20, 23, 26, 30, 34-36, 39-42, 47, 48, 52-56, 58, 60-64, 67, 68, 70, 76-78, 80, 82, 84-86, 92	6
922	25, 74	2, 6*
923	28, 84, 89	1
923	01, 04, 05, 07-18, 20-27, 29, 31-42, 44-47, 50, 52, 54, 56-59, 63-66, 68, 69, 71-78, 82, 85, 86, 91-95, 97-99	6
924	01-08, 10-15, 18, 23, 24, 27	6
925	01-09, 13-19, 21, 22, 30-32, 36, 39, 43-46, 48, 49, 51-57, 61-64, 67, 70-72, 81-87, 89-93, 95, 96, 99	6
926	02-07, 09, 10, 12, 14-20, 23-30, 37, 46-63, 72-79, 83-85, 88, 90-94, 97, 98	4
927	01-12, 25, 28, 35, 80-82, 99	4
928	01-09, 11, 12, 14-17, 21-23, 25, 31-, 38, 40-46, 50, 56, 57, 59, 61-71, 85-87, 99	4
928	60, 77-83	6
930	14, 67	2
930	01-07, 09-12, 15, 16, 20-24, 30-36, 40-44, 60-66, 93, 94, 99	6
930	13	3, 6*
931	01-03, 05-11, 16-18, 20, 21, 30, 40, 50, 60, 90, 99	2
932	01, 02, 04, 07, 08, 12, 18, 19, 21, 23, 27, 30, 32, 35, 37, 39, 44, 46, 47, 56-58, 60-62, 65-67, 70-72, 74, 75, 77-79, 82, 86, 90-92	1
932	03, 05, 06, 16, 20, 22, 24-26, 34, 40, 41, 49-51, 54, 55, 63, 68, 76, 80, 83, 85, 87	2
932	10, 15, 38, 42, 43, 45, 52	1-3, 5, 6*
933	01-09, 11-14, 80-90	2
934	50	1
934	01-03, 05-10, 12, 20-24, 27-30, 32-38, 40-49, 52-58, 60, 61, 63-65, 75, 83	2
934	26, 51	1, 2*
935	12-15, 17, 22, 26, 29, 30, 41, 42, 45, 46, 49	1
935	01, 02, 04, 05, 18, 19, 23, 24, 28, 31, 54, 56, 61, 81, 96	2
935	99	5
935	10, 32, 34-36, 39, 43, 44, 50-53, 58, 62, 63, 84, 86, 90-92	6
935	16, 27, 55, 60	1, 2, 5, 6*

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5-Digit Zip Code Area Guide (Continued)

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1 Prefix	2 (Last two digits of Zip Code)	3 Area
936	03, 15, 33, 47, 66, 70, 73	1
936	01, 02, 04-14, 16, 19-28, 30, 34-40, 42-45, 48-53, 57, 60-62, 64, 65, 67-69, 75	2
936	18, 31, 41, 46, 54, 56	1, 2*
937	01-12, 14-18, 20-30, 37, 40, 41, 44, 45, 47, 50, 55, 60, 61, 64, 65, 71-80, 84, 86, 90-94	2
938	44, 88	2
939	01, 02, 05-08, 12, 15, 20-28, 30, 32, 33, 40, 42-44, 50, 53-55, 60, 62	1
940	02, 05, 10, 11, 13-28, 30, 35, 37-44, 60-66, 70, 74, 80, 83, 85-89	3
941	01-12, 14-47, 50-56, 58-64, 71, 72, 75, 77, 88, 99	3
942	03-09, 11, 29, 30, 32, 34-37, 39, 40, 44-50, 52, 54, 56-59, 61-63, 67-69, 71, 73, 74, 77- 80, 82-91, 93-99	2
943	01-06, 09	3
944	01-04, 97	3
945	03, 08, 10, 12, 15, 33-35, 58, 59, 62, 67, 71, 73, 74, 76, 81, 85, 89-92, 99	2
945	01, 02, 06, 07, 09, 11, 13, 16-31, 36-53, 55-57, 60, 61, 63-66, 68-70, 72, 75, 77-80, 82, 83, 86-88, 95-98	3
945	05, 14	2, 3*
946	01-15, 17-25, 49, 59-62, 66	3
947	01-10, 12, 20	3
948	01-08, 20, 50	3
949	22, 23, 26-28, 31, 51-55, 72, 75, 99	2
949	01, 03, 04, 12-15, 20, 24, 25, 29, 30, 33, 37-42, 45-50, 56, 57, 60, 63-66, 70, 71, 73, 74, 76-79, 98	3
950	04, 12, 24, 39, 43, 45, 75	1
950	01, 03, 05-07, 10, 17-19, 41, 60-67, 73, 77	2
950	02, 08, 09, 11, 13-15, 20, 21, 26, 30-32, 35-38, 42, 44, 46, 50-56, 70, 71	3
950	23, 33, 76	1, 2, 3*
951	01, 03, 06, 08-13, 15-36, 38-41, 48, 50-61, 64, 70, 72, 73, 90-94, 96	3
952	21-26, 28, 29, 32, 33, 45-52, 54, 55, 57	1
952	01-13, 15, 19, 20, 27, 31, 34, 37, 40-42, 53, 58, 67, 69, 96, 97	2
952	30, 36	1, 2*
953	05, 09, 10, 14, 27, 35, 46, 47, 64, 70, 72, 73, 75, 79, 83	1

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5-Digit Zip Code Area Guide (Continued)

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3. **Column 3** is your Rating Area. (note: Some zip codes are assigned Multiple Rating Areas.*)
4. See Premium Chart for your area.

1 Prefix	2 (Last two digits of Zip Code)	3 Area
953	01, 03, 04, 06, 07, 12, 13, 15-20, 22-26, 28, 30, 33, 34, 36-38, 40, 41, 43-45, 48, 50-58, 60, 61, 63, 65-69, 74, 76, 78, 80-82, 85-89, 97	2
953	11, 21, 29, 77, 91	1, 2, 3*
954	10, 15, 17, 18, 20, 22-24, 26-29, 32, 35, 37, 43, 45, 49, 51, 53, 54, 56-61, 63, 64, 66-70, 81, 82, 85, 88, 90, 93, 94	1
954	01-07, 09, 12, 16, 19, 21, 30, 31, 33, 36, 39, 41, 42, 44, 46, 48, 50, 52, 62, 65, 71-73, 76, 80, 86, 87, 92, 97	2
954	25	1, 2*
955	01-03, 11, 14, 18, 19, 21, 24-28, 31, 32, 34, 36-38, 40, 42, 43, 45-56, 58, 59, 60, 62-71, 73, 85, 87, 89, 95	1
956	01-07, 12-14, 17, 19, 23, 27, 29, 31, 33-37, 40, 42, 44-46, 48, 50, 51, 53, 54, 56, 58, 59, 61, 63-69, 72, 74-79, 81, 82, 84, 85, 89, 91, 92, 95, 97-99	1
956	08-11, 15, 20, 21, 24, 25, 28, 30, 32, 38, 39, 41, 52, 55, 60, 62, 70, 71, 73, 80, 83, 86-88, 90, 93, 96	2
956	16, 18, 26, 94	1, 2*
957	01, 03, 09, 12-15, 17, 20-22, 24, 26, 28, 35, 36, 46, 47, 62, 65, 76, 98, 99	1
957	41, 42, 57-59, 63	2
958	11-35, 38, 40-43, 51-53, 60, 64-67, 87, 94, 99	2
958	36, 37	1, 2*
959	01, 03, 10, 12-20, 22-30, 32, 34-51, 53-63, 65-84, 86-88, 91-93	1
960	01-03, 06-11, 13-17, 19-25, 27-29, 31-35, 37-41, 44, 46-52, 54-59, 61-65, 67-71, 73-76, 78-80, 84-97, 99	1
961	01, 03-30, 32-37, 40-43, 45, 46, 48, 50-52, 54-58, 60-62	1
976	35	1

*** Counties With Zip Codes That Cross Rating Area Boundaries:** ▌ **Area 1** Includes Calaveras, Inyo, Kings, Mendocino, Monterey, Placer, San Benito, Sutter, Tulare, Tuolumne, and Yolo. ▌ **Area 2** Includes Fresno, Imperial, Kern, Mariposa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, and Stanislaus. ▌ **Area 3** Includes Alameda, Contra Costa, Santa Barbara, and Santa Clara. ▌ **Area 4** Includes Orange. ▌ **Area 5** Includes Los Angeles. ▌ **Area 6** Includes Riverside, San Bernardino, San Diego, and Ventura.

Anthem Blue Cross – California

Administrative Office: PO Box 9063, Oxnard, CA 93031-9063
Toll Free Telephone Number: 1-888-211-9813

Disclosure Page

Plans A, F, High Ded F, G & N

Disclosures

Use this outline to compare benefits and premiums among policies.

Medicare deductibles and coinsurance amounts are effective as of January 1, 2012. Medicare may change their amounts annually.

Read Your Policy Very Carefully

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and Anthem Blue Cross.

Right to Return Policy

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

Policy Replacement

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

Notice

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

Neither Anthem Blue Cross nor its agents are connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

Complete Answers are Very Important

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

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

Retain this outline for your records.

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

PART **A** Services

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,156	$0	$1,156 (Part A deductible)
61st thru 90th day	All but $289 a day	$289 a day	$0
91st day and after: · While using 60 lifetime reserve days	All but $578 a day	$578 a day	$0
· Once lifetime reserve days are used: — Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs

(continued on next page)

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

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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

PART **A** Services

Services	Medicare Pays	Plan Pays	You Pay
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $144.50 a day	$0	Up to $144.50 a day
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

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

PART B Services

Services	Medicare Pays	Plan Pays	You Pay
Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment Such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $140 of Medicare Approved Amounts*	$0	$0	$140 (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 $140 of Medicare Approved Amounts*	$0	$0	$140 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Clinical Laboratory Services			
Tests for Diagnostic Services	100%	$0	$0

* Once you have been billed $140 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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

PARTS **A+B** Services

Services	Medicare Pays	Plan Pays	You Pay
Home Health Care — Medicare Approved Services			
· Medically necessary skilled care services and medical supplies	100%	$0	$0
· Durable medical equipment:			
— First $140 of Medicare approved amounts*	$0	$0	$140 (Part B deductible)
— Remainder of Medicare approved amounts	80%	20%	$0

* Once you have been billed $140 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

PLAN F

MEDICARE (PART A) HOSPITAL SERVICES — PER BENEFIT PERIOD

PART **A** Services

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,156	$1,156 (Part A deductible)	$0
61st thru 90th day	All but $289 a day	$289 a day	$0
91st day and after: · While using 60 lifetime reserve days	All but $578 a day	$578 a day	$0
· Once lifetime reserve days are used: — Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs

(continued on next page)

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

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F

MEDICARE (PART A) HOSPITAL SERVICES — PER BENEFIT PERIOD

PART **A** Services

Services	Medicare Pays	Plan Pays	You Pay
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $144.50 a day	Up to $144.50 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN F

MEDICARE (PART B) MEDICAL SERVICES — PER CALENDAR YEAR

PART **B** Services

Services	Medicare Pays	Plan Pays	You Pay
Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment Such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $140 of Medicare Approved Amounts*	$0	$140 (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 $140 of Medicare Approved Amounts*	$0	$140 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
Clinical Laboratory Services			
Tests for Diagnostic Services	100%	$0	$0

* Once you have been billed $140 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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

PARTS A+B Services

Services	Medicare Pays	Plan Pays	You Pay
Home Health Care — Medicare Approved Services			
· Medically necessary skilled care services and medical supplies	100%	$0	$0
· Durable medical equipment:			
— First $140 of Medicare approved amounts*	$0	$140 (Part B deductible)	$0
— Remainder of Medicare approved amounts	80%	20%	$0

OTHER BENEFITS

Not Covered by Medicare

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

* Once you have been billed $140 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

HIGH DEDUCTIBLE PLAN F

MEDICARE (PART A) HOSPITAL SERVICES — PER BENEFIT PERIOD

PART **A** Services

Services	Medicare Pays	After You Pay $2,070 Deductible,** Plan Pays	In Addition to $2,070 Deductible,** You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,156	$1,156 (Part A deductible)	$0
61st thru 90th day	All but $289 a day	$289 a day	$0
91st day and after: · While using 60 lifetime reserve days	All but $578 a day	$578 a day	$0
· Once lifetime reserve days are used: — Additional 365 days	$0	100% of Medicare eligible expenses	$0***
— Beyond the additional 365 days	$0	$0	All costs

(continued on next page)

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

** This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,070 deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $2,070. 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.

*** 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.

HIGH DEDUCTIBLE PLAN F

MEDICARE (PART A) HOSPITAL SERVICES — PER BENEFIT PERIOD

PART **A** Services

Services	Medicare Pays	After You Pay $2,070 Deductible,** Plan Pays	In Addition to $2,070 Deductible,** You Pay
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $144.50 a day	Up to $144.50 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

** This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,070 deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $2,070. 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.

HIGH DEDUCTIBLE PLAN F

MEDICARE (PART B) MEDICAL SERVICES — PER CALENDAR YEAR

PART **B** Services

Services	Medicare Pays	After You Pay $2,070 Deductible,** Plan Pays	In Addition to $2,070 Deductible,** You Pay
Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment Such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $140 of Medicare Approved Amounts*	$0	$140 (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 $140 of Medicare Approved Amounts*	$0	$140 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

(continued on next page)

* Once you have been billed $140 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

** This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,070 deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $2,070. 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.

HIGH DEDUCTIBLE PLAN F

MEDICARE (PART B) MEDICAL SERVICES — PER CALENDAR YEAR

PART **B** Services

Services	Medicare Pays	After You Pay $2,070 Deductible,** Plan Pays	In Addition to $2,070 Deductible,** You Pay
Clinical Laboratory Services			
Tests for Diagnostic Services	100%	$0	$0

** This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,070 deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $2,070. 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.

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

PARTS A+B Services

Services	Medicare Pays	After You Pay $2,070 Deductible,** Plan Pays	In Addition to $2,070 Deductible,** You Pay
Home Health Care — Medicare Approved Services			
· Medically necessary skilled care services and medical supplies	100%	$0	$0
· Durable medical equipment:			
— First $140 of Medicare approved amounts*	$0	$140 (Part B deductible)	$0
— Remainder of Medicare approved amounts	80%	20%	$0

OTHER BENEFITS

Not Covered by Medicare

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

* Once you have been billed $140 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

** This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,070 deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $2,070. 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.

PLAN G

MEDICARE (PART A) HOSPITAL SERVICES — PER BENEFIT PERIOD

PART A Services

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,156	$1,156 (Part A deductible)	$0
61st thru 90th day	All but $289 a day	$289 a day	$0
91st day and after: · While using 60 lifetime reserve days	All but $578 a day	$578 a day	$0
· Once lifetime reserve days are used: — Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs

(continued on next page)

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

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G

MEDICARE (PART A) HOSPITAL SERVICES — PER BENEFIT PERIOD

PART **A** Services

Services	Medicare Pays	Plan Pays	You Pay
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $144.50 a day	Up to $144.50 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN G

MEDICARE (PART B) MEDICAL SERVICES — PER CALENDAR YEAR

PART **B** Services

Services	Medicare Pays	Plan Pays	You Pay
Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment Such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $140 of Medicare Approved Amounts*	$0	$0	$140 (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
Next $140 of Medicare Approved Amounts*	$0	$0	$140 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Clinical Laboratory Services			
Tests for Diagnostic Services	100%	$0	$0

* Once you have been billed $140 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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

PARTS A+B Services

Services	Medicare Pays	Plan Pays	You Pay
Home Health Care — Medicare Approved Services			
· Medically necessary skilled care services and medical supplies	100%	$0	$0
· Durable medical equipment:			
— First $140 of Medicare approved amounts*	$0	$0	$140 (Part B deductible)
— Remainder of Medicare approved amounts	80%	20%	$0

OTHER BENEFITS

Not Covered by Medicare

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

* Once you have been billed $140 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

PLAN N

MEDICARE (PART A) HOSPITAL SERVICES — PER BENEFIT PERIOD

PART **A** Services

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,156	$1,156 (Part A deductible)	$0
61st thru 90th day	All but $289 a day	$289 a day	$0
91st day and after: · While using 60 lifetime reserve days	All but $578 a day	$578 a day	$0
· Once lifetime reserve days are used: — Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs

(continued on next page)

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

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

MEDICARE (PART A) HOSPITAL SERVICES — PER BENEFIT PERIOD

PART **A** Services

Services	Medicare Pays	Plan Pays	You Pay
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $144.50 a day	Up to $144.50 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN N

MEDICARE (PART B) MEDICAL SERVICES — PER CALENDAR YEAR

PART **B** Services

Services	Medicare Pays	Plan Pays	You Pay
Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment Such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $140 of Medicare Approved Amounts*	$0	$0	$140 (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 $140 of Medicare Approved Amounts*	$0	$0	$140 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

(continued on next page)

* Once you have been billed $140 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

PLAN N

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

PART B Services

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

PARTS A+B Services

Home Health Care — Medicare Approved Services			
· Medically necessary skilled care services and medical supplies	100%	$0	$0
· Durable medical equipment:			
— First $140 of Medicare approved amounts*	$0	$0	$140 (Part B deductible)
— Remainder of Medicare approved amounts	80%	20%	$0

OTHER BENEFITS — Not Covered by Medicare

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

* Once you have been billed $140 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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