



**Anthem Blue Cross – California**

Administrative Office: PO Box 9063, Oxnard, CA 93031-9063

Toll Free Telephone Number: 1-888-211-9813

**2009 OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE  
BENEFIT PLANS STANDARD A AND CLASSIC C, F, I, AND J, HIGH  
DEDUCTIBLE PLAN F (SMARTCHOICE, SMARTCHOICE PREFERRED<sup>SM</sup>,  
AND SMARTCHOICE PLUS<sup>SM</sup>) AND CLASSIC PLAN F WITH A RIDER  
(ADVANTAGECARE<sup>SM</sup>)**

Medicare supplement insurance can be sold in 12 standard plans plus two high deductible plans. This chart shows the benefits included in each of the standard Medicare Supplement plans. Every company must make available Plan “A.” Some plans may not be available in your state. You have the option to purchase an Anthem Medicare Supplement Plan shown in gray.

See Outline of Coverage sections for details about ALL plans.

- Basic Benefits: Included in Plans A - J.**
- **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.
  - **Blood:** First three pints of blood each year.

<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>	<b>Plan E</b>	<b>Plan F/F*</b>
<b>Basic Benefits</b>	Basic Benefits	<b>Basic Benefits</b>	Basic Benefits	Basic Benefits	<b>Basic Benefits</b>
		<b>Skilled Nursing Facility Coinsurance</b>	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	<b>Skilled Nursing Facility Coinsurance</b>
	Part A Deductible	<b>Part A Deductible</b>	Part A Deductible	Part A Deductible	<b>Part A Deductible</b>
		<b>Part B Deductible</b>			<b>Part B Deductible</b>
					Part B Excess (100%)
		<b>Foreign Travel Emergency</b>	Foreign Travel Emergency	Foreign Travel Emergency	<b>Foreign Travel Emergency</b>
			At-Home Recovery		
				Preventive Care NOT covered by Medicare	

\* Plans F and J also have an option called a High Deductible Plan F and a High Deductible Plan J. These high deductible plans pay the same benefits as Plans F and J after one has paid a calendar year \$2,000 deductible. Benefits from High Deductible Plans F and J will not begin until out-of-pocket expenses exceed \$2,000. 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. Anthem does not offer a high deductible option for Standard Medicare Supplement Plan J.

<b>Plan G</b>	<b>Plan H</b>	<b>Plan I</b>	<b>Plan J/J*</b>	<b>Plan K**</b>	<b>Plan L**</b>
Basic Benefits	Basic Benefits	<b>Basic Benefits</b>	<b>Basic Benefits</b>	100% of Part A hospitalization coinsurance, plus coverage for 365 days after Medicare benefits end 50% hospice cost sharing 50% of Medicare-eligible expenses for the first three pints of blood 50% Part B coinsurance, except 100% coinsurance for Part B preventive services	100% of Part A hospitalization coinsurance, plus coverage for 365 days after Medicare benefits end 75% hospice cost sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B coinsurance, except 100% coinsurance for Part B preventive services
Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	<b>Skilled Nursing Facility Coinsurance</b>	<b>Skilled Nursing Facility Coinsurance</b>	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	Part A Deductible	<b>Part A Deductible</b>	<b>Part A Deductible</b>	50% Part A Deductible	75% Part A Deductible
			<b>Part B Deductible</b>		
Part B Excess (80%)		<b>Part B Excess (100%)</b>	<b>Part B Excess (100%)</b>		
Foreign Travel Emergency	Foreign Travel Emergency	<b>Foreign Travel Emergency</b>	<b>Foreign Travel Emergency</b>		
At-Home Recovery		<b>At-Home Recovery</b>	<b>At-Home Recovery</b>		
			<b>Preventive Care NOT Covered by Medicare</b>	\$4,620 Out-of-Pocket Limit***	\$2,310 Out-of-Pocket Limit***

\* Plans F and J also have an option called a High Deductible Plan F and a High Deductible Plan J. These high deductible plans pay the same benefits as Plans F and J after one has paid a calendar year \$2,000 deductible. Benefits from High Deductible Plans F and J will not begin until out-of-pocket expenses exceed \$2,000. 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. Anthem does not offer a high deductible option for Standard Medicare Supplement Plan J.

\*\* Plans K and L provide for different cost sharing for items and services than Plans A-J. Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges." You will be responsible for paying excess charges.

\*\*\* The out-of-pocket annual limit will increase each year for inflation.



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**MONTHLY RATES – STANDARD PLAN A AND CLASSIC PLANS C, F, I, AND J, HIGH DEDUCTIBLE PLAN F (SMARTCHOICE, SMARTCHOICE PREFERRED<sup>SM</sup>, AND SMARTCHOICE PLUS<sup>SM</sup>) AND CLASSIC PLAN F WITH A RIDER (ADVANTAGECARE<sup>SM</sup>)**

**Effective March 1, 2009**

**Standard Plan A**

Attained Age	Area 1, 2, and 3 Counties		Area 4 and 5 Counties		Area 6 Counties	
	Member Only	Member & Spouse	Member Only	Member & Spouse	Member Only	Member & Spouse
65-66	\$ 98	\$ 188	\$ 103	\$ 198	\$ 96	\$ 186
67-69	101	194	106	205	101	194
70-74	129	224	136	240	129	224
75+	161	289	170	307	161	289

**Classic Plan C**

Attained Age	Area 1, 2, and 3 Counties		Area 4 and 5 Counties		Area 6 Counties	
	Member Only	Member & Spouse	Member Only	Member & Spouse	Member Only	Member & Spouse
65-66	\$ 119	\$ 229	\$ 140	\$ 272	\$ 131	\$ 257
67-69	124	237	145	283	137	266
70-74	169	301	201	345	189	325
75-79	219	398	248	463	234	436
80+	222	403	254	471	240	445

**Classic Plan F**

Attained Age	Area 1, 2, and 3 Counties		Area 4 and 5 Counties		Area 6 Counties	
	Member Only	Member & Spouse	Member Only	Member & Spouse	Member Only	Member & Spouse
65-66	\$ 128	\$ 249	\$ 155	\$ 303	\$ 147	\$ 286
67-69	133	259	162	315	151	297
70-74	180	319	221	389	208	365
75-79	230	412	276	494	260	467
80+	232	416	279	502	263	473

Rates are subject to change March 1, 2010.



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*Effective March 1, 2009*

<b>Classic Plan I</b> <i>Attained Age</i>	<i>Area 1, 2, and 3 Counties</i>		<i>Area 4, 5, and 6 Counties</i>	
	<i>Member Only</i>	<i>Member &amp; Spouse</i>	<i>Member Only</i>	<i>Member &amp; Spouse</i>
65-69	\$126	\$248	\$146	\$288
70-74	\$168	\$311	\$197	\$364
75-79	\$215	\$397	\$246	\$457
80+	\$223	\$413	\$256	\$471

<b>Classic Plan J</b> <i>Attained Age</i>	<i>Area 1, 2, and 3 Counties</i>		<i>Area 4, 5, and 6 Counties</i>	
	<i>Member Only</i>	<i>Member &amp; Spouse</i>	<i>Member Only</i>	<i>Member &amp; Spouse</i>
65-69	\$164	\$319	\$184	\$359
70-74	\$222	\$408	\$249	\$461
75-79	\$279	\$518	\$311	\$578
80+	\$282	\$525	\$313	\$582

<i>Attained Age</i>	<b>SmartChoice Plan*</b>		<b>SmartChoice Preferred Plan*</b>	
	<i>Area 1, 2, and 3 Counties</i>	<i>Area 4, 5, and 6 Counties</i>	<i>Area 1, 2, and 3 Counties</i>	<i>Area 4, 5, and 6 Counties</i>
65-69	\$ 27	\$ 32	\$ 45	\$ 54
70-74	38	45	61	72
75-79	46	55	72	87
80+	48	59	76	93

**SmartChoice Plus Plan Rider & AdvantageCare Rider (All Areas)**

<i>Issue Age</i>	65	66	67	68	69	70	71	72	73	74	75
<b>Monthly Premium**</b>	\$39	\$44	\$48	\$53	\$57	\$62	\$70	\$78	\$86	\$94	\$102

\* For individuals who are paying by the Blue Cross Checking Account Deduction Program (the monthly amount is deducted directly from the member's checking account).

\*\* SmartChoice Plus Plan Rider Monthly premium to be added to the SmartChoice premium. AdvantageCare Rider Monthly premium to be added to the Classic F premium.



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**How to Determine Your Rate:** Identify the category (Member Only or Member and Spouse) to which you belong, as well as the area you reside in. The Member Only rate is based on your age, as of the effective date of the policy. The Member and Spouse rate is based on the age of the older spouse, as of the effective date of the policy. To be eligible for two-party (Member & Spouse) rates, applicants must 1) enroll during their initial six-month Medicare Guarantee Issue period or, 2) enroll within six months of terminating their Group policy or, 3) pass underwriting (both the Member and the Spouse).

All rates are based on your attained age. Your premiums will change as you change age groups. Rates for the SmartChoice Plus Plan Rider are based on Issue Age. Premiums will always be based on the age of the individual when the policy is issued. For the SmartChoice Plus Plan, combine the rates of the SmartChoice Plan and the SmartChoice Plus Plan Rider. This is your monthly premium amount.

Rates for AdvantageCare combine the rates of Classic F Plan based on your Attained Age. Your premiums will change as you change age groups. The rates for the AdvantageCare Rider are based on Issue Age. Your premiums will always be based on the age you are when your policy is issued. For the AdvantageCare Plan, combine the rates of the Classic F Plan and the AdvantageCare Rider. This is your monthly premium amount.

**Billing Information:** Your initial premium is for one (1) month's payment and will be due upon enrollment. We will bill you bimonthly (every 2 months) thereafter, unless you returned your Monthly Checking Account Deduction Authorization with your application.

## **MONTHLY RATES – STANDARD PLAN A AND CLASSIC PLANS C, F, I, AND J, HIGH DEDUCTIBLE PLAN F (SMARTCHOICE, SMARTCHOICE PREFERRED<sup>SM</sup>, AND SMARTCHOICE PLUS<sup>SM</sup>) AND CLASSIC PLAN F WITH A RIDER (ADVANTAGECARE<sup>SM</sup>)**

*Effective March 1, 2009*

Monthly rates for **Standard Plan A, Classic Plan C, Classic Plan F, Classic Plan I, Classic Plan J, High Deductible Plan F (SmartChoice, SmartChoice Preferred<sup>SM</sup> and SmartChoice Plus<sup>SM</sup>) and Classic Plan F with a Rider (AdvantageCare<sup>SM</sup>)** are effective March 1, 2009.

**Area 1 Counties:** Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, Yuba

**Area 2 Counties:** Fresno, Imperial, Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin, San Luis Obispo, Santa Barbara ZIP codes beginning with 932 and 934, Santa Cruz, Solano, Sonoma, Stanislaus

**Area 3 Counties:** Alameda, Contra Costa, Marin, San Francisco, San Mateo, Santa Barbara (except for ZIP codes beginning with 932 and 934; see Area 2), Santa Clara

**Area 4 Counties:** Orange

**Area 5 Counties:** Los Angeles (except those Los Angeles ZIP codes listed in Area 6)

**Area 6 Counties:** The following Los Angeles ZIP codes: 91702, 91703, 91706, 91714, 91715, 91716, 91721, 91722, 91723, 91724, 91731, 91732, 91733, 91734, 91735, 91740, 91744, 91745, 91746, 91747, 91748, 91749, 91754, 91756, 91765, 91770, 91771, 91772, 91774, 91775, 91776, 91778, 91780, 91788, 91789, 91790, 91791, 91792, 91793, 91795, 91798, 91799, 93510, 93532, 93534, 93535, 93536, 93539, 93543, 93544, 93550, 93551, 93552, 93553, 93563, 93584, 93586, 93590, 93591, Riverside, San Bernardino, San Diego, Ventura



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## **MEDICARE SUPPLEMENT OUTLINE OF COVERAGE**

### **Outline of Coverage for Policy Form Series**

**Standard Plan A, Classic Plan C, Classic Plan F, Classic Plan I, Classic Plan J, High Deductible Plan F (SmartChoice, SmartChoice Preferred<sup>SM</sup> and SmartChoice Plus<sup>SM</sup>) and Classic Plan F with a Rider (AdvantageCare<sup>SM</sup>)**

**Retain This Outline For Your Records**

### **Premium Information**

Your premium rate increases based upon your Attained Age, except the rate for the SmartChoice Plus Rider or the AdvantageCare Rider are based on your age at the time you purchased the rider. We will recalculate your age for each billing and your premium rate will be automatically increased based upon your Attained Age. Anthem can increase your premium if we raise our table of premium rates for all policies like yours in this state.

This policy does not contain provisions providing for a refund of premium upon surrender or cancellation of the policy. If termination of this coverage results from the death of the insured, the insured's estate is entitled to a refund of the unused premium.

### **Disclosures**

Use this outline to compare benefits and premiums among policies.

### **Read Your Policy Very Carefully**

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

### **Right To Return Policy**

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

### **Policy Replacement**

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

### **Notice**

This policy may not fully cover all of your medical costs. Neither Anthem nor its associates 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 the "Medicare & You" handbook 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. Anthem 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.



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## **MEDICARE SUPPLEMENT OUTLINE OF COVERAGE (CONTINUED)**

### **Guaranteed Acceptance and Renewal**

Your acceptance into our Medicare Supplemental plans is guaranteed if you apply for coverage during your Open Enrollment Period. This period lasts for six months and begins on the first day of the month in which you are both age 65 and enrolled in Medicare Part B. During this period, we will waive any medical underwriting requirements. Certain circumstances may provide further opportunity for guaranteed acceptance. For details, consult the "Guide to Health Insurance for People with Medicare."

Our Medicare Supplemental plans are guaranteed renewable.

### **In-Network (Participating) or Out-of-Network (Non-Participating) Services**

"In-network services" are those you receive from participating physicians or other providers that are members of the Prudent Buyer network. You will receive a participating provider directory when you enroll in your plan.

"Out-of-network services" are those you receive from physicians or other providers who do not participate in the Prudent Buyer network.

Please note that there are financial and other advantages to obtaining services from Prudent Buyer network providers. But remember that the decision about which providers to use is up to you.

## STANDARD PLAN A

### MEDICARE (PART A) HOSPITAL SERVICES – PER BENEFIT PERIOD

Medicare deductibles and co-insurance amounts are effective as of January 1, 2009. Medicare may change these amounts annually. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the “Medicare & You” handbook for more details.

**Part  
A  
Services**

Services	Medicare Pays	Standard Plan A Pays	You Pay
<b>Hospitalization*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies: First 60 days	All but \$1,068	\$0	\$1,068 (Part A deductible)
61st through 90th day	All but \$267 a day	\$267 a day	\$0
91st day and after: · While using 60 lifetime reserve days · Once lifetime reserve days are used – Additional 365 days	All but \$534 a day \$0	\$534 a day 100% of Medicare-eligible expenses	\$0 \$0**
– Beyond the additional 365 days	\$0	\$0	All costs
<b>Skilled Nursing Facility Care*</b> You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$133.50 a day	\$0	Up to \$133.50 a day
101st day and after	\$0	\$0	All costs

\* 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.

**STANDARD PLAN A  
 MEDICARE (PART A) HOSPITAL SERVICES – PER BENEFIT PERIOD**

Medicare deductibles and co-insurance amounts are effective as of January 1, 2009. Medicare may change these amounts annually. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the “Medicare & You” handbook for more details.

**Part  
 A  
 Services**

<b>Services</b>	<b>Medicare Pays</b>	<b>Standard Plan A Pays</b>	<b>You Pay</b>
<b>Blood</b> First three pints Additional amounts	\$0 100%	Three pints \$0	\$0 \$0
<b>Hospice Care</b> Available as long as your doctor certifies you are terminally ill and you elect to receive those services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

**STANDARD PLAN A  
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

Medicare deductibles and co-insurance amounts are effective as of January 1, 2009. Medicare may change these amounts annually. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the “Medicare & You” handbook for more details.

**Part  
B  
Services**

<b>Services</b>	<b>Medicare Pays</b>	<b>Standard Plan A Pays</b>	<b>You Pay</b>
<b>Medical Expenses – In or Out of the Hospital and Outpatient Hospital Treatment</b> such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment			
First \$135 of Medicare-approved amounts*	\$0	\$0	\$135 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare-approved amounts)	\$0	\$0	All costs
<b>Blood</b>			
First three pints	\$0	All costs	\$0
Next \$135 of Medicare-approved amounts*	\$0	\$0	\$135 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>Clinical Laboratory Services</b>			
Tests for Diagnostic Services	100%	\$0	\$0

\* Once you have been billed \$135 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.

**STANDARD PLAN A**  
**PARTS A & B**

Medicare deductibles and co-insurance amounts are effective as of January 1, 2009. Medicare may change these amounts annually. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the “Medicare & You” handbook for more details.

Parts  
**A+B**  
 Services

Services	Medicare Pays	Standard Plan A Pays	You Pay
<b>Home Health Care</b>			
<b>Medicare-Approved Services</b>			
· Medically necessary skilled care services and medical supplies	100%	\$0	\$0
· Durable medical equipment			
First \$135 of Medicare-approved amounts*	\$0	\$0	\$135 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0

\* Once you have been billed \$135 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.

**CLASSIC PLAN C**

**MEDICARE (PART A) HOSPITAL SERVICES – PER BENEFIT PERIOD**

Medicare deductibles and co-insurance amounts are effective as of January 1, 2009. Medicare may change these amounts annually. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the “Medicare & You” handbook for more details.

**Parts  
A  
Services**

<b>Services</b>	<b>Medicare Pays</b>	<b>Standard Plan C Pays</b>	<b>You Pay</b>
<b>Hospitalization*</b>			
Semi-private room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but \$1,068	\$1,068 (Part A deductible)	\$0
61st through 90th day	All but \$267 a day	\$267 a day	\$0
91st day and after:			
· While using 60 lifetime reserve days	All but \$534 a day	\$534 a day	\$0
· Once lifetime reserve days are used			
– Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
– Beyond the additional 365 days	\$0	\$0	All costs
<b>Skilled Nursing Facility Care*</b>			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$133.50 a day	Up to \$133.50 a day	\$0
101st day and after	\$0	\$0	All costs

\* 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.

**CLASSIC PLAN C**  
**MEDICARE (PART A) HOSPITAL SERVICES – PER BENEFIT PERIOD**

Medicare deductibles and co-insurance amounts are effective as of January 1, 2009. Medicare may change these amounts annually. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the “Medicare & You” handbook for more details.

**Part**  
**A**  
**Services**

<b>Services</b>	<b>Medicare Pays</b>	<b>Standard Plan C Pays</b>	<b>You Pay</b>
<b>Blood</b>			
First three pints	\$0	Three pints	\$0
Additional amounts	100%	\$0	\$0
<b>Hospice Care</b>			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

**CLASSIC PLAN C  
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

Medicare deductibles and co-insurance amounts are effective as of January 1, 2009. Medicare may change these amounts annually. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the “Medicare & You” handbook for more details.

**Part  
B  
Services**

<b>Services</b>	<b>Medicare Pays</b>	<b>Standard Plan C Pays</b>	<b>You Pay</b>
<b>Medical Expenses – In or Out of the Hospital and Outpatient Hospital Treatment</b> such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment			
First \$135 of Medicare-approved amounts*	\$0	\$135 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare-approved amounts)	\$0	\$0	All costs
<b>Blood</b>			
First three pints	\$0	All costs	\$0
Next \$135 of Medicare-approved amounts*	\$0	\$135 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>Clinical Laboratory Services</b>			
Tests for Diagnostic Services	100%	\$0	\$0

\* Once you have been billed \$135 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.

**CLASSIC PLAN C**  
**PARTS A & B AND OTHER BENEFITS NOT COVERED BY MEDICARE**

Medicare deductibles and co-insurance amounts are effective as of January 1, 2009. Medicare may change these amounts annually. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the “Medicare & You” handbook for more details.

	<b>Services</b>	<b>Medicare Pays</b>	<b>Standard Plan C Pays</b>	<b>You Pay</b>
<b>Parts A+B Services</b>	<b>Home Health Care Medicare-Approved Services</b>			
	· Medically necessary skilled care services and medical supplies	100%	\$0	\$0
	· Durable medical equipment First \$135 of Medicare-approved amounts*	\$0	\$135 (Part B deductible)	\$0
	Remainder of Medicare-approved amounts	80%	20%	\$0
<b>Other Benefits – Not Covered by Medicare</b>	<b>Foreign Travel – Not Covered by Medicare</b>			
	Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States			
	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 \$135 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.

**CLASSIC PLAN F  
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

Medicare deductibles and co-insurance amounts are effective as of January 1, 2009. Medicare may change these amounts annually. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the “Medicare & You” handbook for more details.

**Part  
A  
Services**

<b>Services</b>	<b>Medicare Pays</b>	<b>Standard Plan F Pays</b>	<b>You Pay</b>
<b>Hospitalization*</b>			
Semi-private room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but \$1,068	\$1,068 (Part A deductible)	\$0
61st through 90th day	All but \$267 a day	\$267 a day	\$0
91st day and after:			
· While using 60 lifetime reserve days	All but \$534 a day	\$534 a day	\$0
· Once lifetime reserve days are used:			
– Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
– Beyond the additional 365 days	\$0	\$0	All costs
<b>Skilled Nursing Facility Care*</b>			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$133.50 a day	Up to \$133.50 a day	\$0
101st day and after	\$0	\$0	All costs

\* 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.

**CLASSIC PLAN F  
 MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

Medicare deductibles and co-insurance amounts are effective as of January 1, 2009. Medicare may change these amounts annually. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the “Medicare & You” handbook for more details.

**Part  
 A  
 Services**

<b>Services</b>	<b>Medicare Pays</b>	<b>Standard Plan F Pays</b>	<b>You Pay</b>
<b>Blood</b> First three pints Additional amounts	\$0 100%	Three pints \$0	\$0 \$0
<b>Hospice Care</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

**CLASSIC PLAN F**  
**MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

Medicare deductibles and co-insurance amounts are effective as of January 1, 2009. Medicare may change these amounts annually. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the “Medicare & You” handbook for more details.

**Part**  
**B**  
**Services**

<b>Services</b>	<b>Medicare Pays</b>	<b>Standard Plan F Pays</b>	<b>You Pay</b>
<b>Medical Expenses – In or Out of the Hospital and Outpatient Hospital Treatment</b> such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment			
First \$135 of Medicare-approved amounts*	\$0	\$135 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare-approved amounts)	\$0	100%	\$0
<b>Blood</b>			
First three pints	\$0	All costs	\$0
Next \$135 of Medicare-approved amounts*	\$0	\$135 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>Clinical Laboratory Services –</b> Tests for Diagnostic Services	100%	\$0	\$0

\* Once you have been billed \$135 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.

**CLASSIC PLAN F  
PARTS A & B**

Medicare deductibles and co-insurance amounts are effective as of January 1, 2009. Medicare may change these amounts annually. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the “Medicare & You” handbook for more details.

Parts  
**A+B**  
Services

Services	Medicare Pays	Standard Plan F Pays	You Pay
<b>Home Health Care Medicare-Approved Services</b>			
· Medically necessary skilled care services and medical supplies	100%	\$0	\$0
· Durable medical equipment First \$135 of Medicare-approved amounts*	\$0	\$135 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0

\* Once you have been billed \$135 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.

**CLASSIC PLAN F**

**OTHER BENEFITS — NOT COVERED BY MEDICARE**

Medicare deductibles and co-insurance amounts are effective as of January 1, 2009. Medicare may change these amounts annually. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the “Medicare & You” handbook for more details.

Services	Medicare Pays	Standard Plan F Pays	You Pay
<b>Other Benefits Not Covered By Medicare</b>	<b>Foreign Travel — Not Covered by Medicare</b>		
	Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States		
	First \$250 each calendar year	\$0	\$0
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

## High Deductible Plan F (SmartChoice)

### MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

The High Deductible Plan pays the same benefits as Plan F after one has paid a calendar year \$2,000 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are \$2,000. 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.

## Part A Services

Services	Medicare Pays	After You Pay \$2,000 Deductible, Plan Pays	In Addition To \$2,000 Deductible, You Pay
<b>Hospitalization*</b>			
Semi-private room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but \$1,068	\$1,068 (Part A deductible)	\$0
61st through 90th day	All but \$267 a day	\$267 a day	\$0
91st day and after:			
· While using 60 lifetime reserve days	All but \$534 a day	\$534 a day	\$0
· Once lifetime reserve days are used:			
– Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
– Beyond the additional 365 days	\$0	\$0	All costs
<b>Skilled Nursing Facility Care*</b>			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$133.50 a day	Up to \$133.50 a day	\$0
101st day and after	\$0	\$0	All costs

\* 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.

## High Deductible Plan F (SmartChoice)

### MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

The High Deductible Plan pays the same benefits as Plan F after one has paid a calendar year \$2,000 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are \$2,000. 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.

**Part  
A  
Services**

Services	Medicare Pays	After You Pay \$2,000 Deductible, Plan Pays	In Addition To \$2,000 Deductible, You Pay
<b>Blood</b> First three pints Additional amounts	\$0 100%	Three pints \$0	\$0 \$0
<b>Hospice Care</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

**High Deductible Plan F (SmartChoice)**  
**MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

The High Deductible Plan pays the same benefits as Plan F after one has paid a calendar year \$2,000 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are \$2,000. 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.

**Part  
B  
Services**

Services	Medicare Pays	After You Pay \$2,000 Deductible, Plan Pays	In Addition To \$2,000 Deductible, You Pay
<b>Medical Expenses – In or Out of the Hospital and Outpatient Hospital Treatment</b> such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment			
First \$135 of Medicare-approved amounts*	\$0	\$135 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare-approved amounts)	\$0	100%	\$0
<b>Blood</b>			
First three pints	\$0	All costs	\$0
Next \$135 of Medicare-approved amounts*	\$0	\$135 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>Clinical Laboratory Services –</b> Tests for Diagnostic Services	100%	\$0	\$0

\* Once you have been billed \$135 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 (SmartChoice)

### PARTS A & B

The High Deductible Plan pays the same benefits as Plan F after one has paid a calendar year \$2,000 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are \$2,000. 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.

Parts  
**A+B**  
Services

Services	Medicare Pays	After You Pay \$2,000 Deductible, Plan Pays	In Addition To \$2,000 Deductible, You Pay
<b>Home Health Care Medicare-Approved Services</b>			
· Medically necessary skilled care services and medical supplies	100%	\$0	\$0
· Durable medical equipment			
First \$135 of Medicare-approved amounts*	\$0	\$135 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0

\* Once you have been billed \$135 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 (SmartChoice)**  
**OTHER BENEFITS – NOT COVERED BY MEDICARE**

The High Deductible Plan pays the same benefits as Plan F after one has paid a calendar year \$2,000 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are \$2,000. 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.

Services	Medicare Pays	After You Pay \$2,000 Deductible, Plan Pays	In Addition To \$2,000 Deductible, You Pay
<b>Other Benefits Not Covered By Medicare</b>	<b>Foreign Travel – Not Covered by Medicare</b>		
	Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States		
	\$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

## High Deductible Plan F (SmartChoice Preferred)

### MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

The High Deductible Plan pays the same benefits as Plan F after one has paid a calendar year \$2,000 deductible (plus additional benefits for vision care, physician office visits and chiropractic services). Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are \$2,000. 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.

**Part  
A  
Services**

Services	Medicare Pays	After You Pay \$2,000 Deductible, Plan Pays	In Addition To \$2,000 Deductible, You Pay
<b>Hospitalization*</b>			
Semi-private room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but \$1,068	\$1,068 (Part A deductible)	\$0
61st through 90th day	All but \$267 a day	\$267 a day	\$0
91st day and after:			
· While using 60 lifetime reserve days	All but \$534 a day	\$534 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

\* 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.

## High Deductible Plan F (SmartChoice Preferred)

### MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

The High Deductible Plan pays the same benefits as Plan F after one has paid a calendar year \$2,000 deductible (plus additional benefits for vision care, physician office visits and chiropractic services). Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are \$2,000. 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.

**Part  
A  
Services**

Services	Medicare Pays	After You Pay \$2,000 Deductible, Plan Pays	In Addition To \$2,000 Deductible, You Pay
<b>Skilled Nursing Facility Care*</b> You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st through 100th day 101st day and after	All approved amounts All but \$133.50 a day \$0	\$0 Up to \$133.50 a day \$0	\$0 \$0 All costs
<b>Blood</b> First three pints Additional amounts	\$0 100%	Three pints \$0	\$0 \$0
<b>Hospice Care</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

\* 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.

## High Deductible Plan F (SmartChoice Preferred)

### MEDICARE (PART B) – HOSPITAL SERVICES – PER CALENDAR YEAR

The High Deductible Plan pays the same benefits as Plan F after one has paid a calendar year \$2,000 deductible (plus additional benefits for vision care, physician office visits and chiropractic services). Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are \$2,000. 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.

## Part B Services

Services	Medicare Pays	After You Pay \$2,000 Deductible, Plan Pays	In Addition To \$2,000 Deductible, You Pay
<b>Medical Expenses – In or Out of the Hospital and Outpatient Hospital Treatment</b> such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment			
First \$135 of Medicare-approved amounts*	\$0	\$135 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare-approved amounts)	\$0	100%	\$0
<b>Blood</b>			
First three pints	\$0	All costs	\$0
Next \$135 of Medicare-approved amounts*	\$0	\$135 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>Clinical Laboratory Services –</b> Tests for Diagnostic Services	100%	\$0	\$0

\* Once you have been billed \$135 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 (SmartChoice Preferred)

### PARTS A & B

The High Deductible Plan pays the same benefits as Plan F after one has paid a calendar year \$2,000 deductible (plus additional benefits for vision care, physician office visits and chiropractic services). Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are \$2,000. 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.

Parts  
**A+B**  
Services

Services	Medicare Pays	After You Pay \$2,000 Deductible, Plan Pays	In Addition To \$2,000 Deductible, You Pay
<b>Home Health Care</b>			
<b>Medicare-Approved Services</b>			
· Medically necessary skilled care services and medical supplies	100%	\$0	\$0
· Durable medical equipment			
First \$135 of Medicare-approved amounts*	\$0	\$135 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0

\* Once you have been billed \$135 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 (SmartChoice Preferred)

### OTHER BENEFITS – NOT COVERED BY MEDICARE

The High Deductible Plan pays the same benefits as Plan F after one has paid a calendar year \$2,000 deductible (plus additional benefits for vision care, physician office visits and chiropractic services). Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are \$2,000. 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.

Services	Medicare Pays	After You Pay \$2,000 Deductible, Plan Pays	In Addition To \$2,000 Deductible, You Pay	
<b>Other Benefits Not Covered By Medicare</b>	<b>Foreign Travel – Not Covered by Medicare</b>			
	Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States			
	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
<b>Vision Care Not Covered by Medicare</b>				
These benefits are <b>not</b> subject to the \$2,000 annual deductible.				
	Glass lenses	\$0	100% for 1 pair of standard eyeglass lenses or see "Contacts" below	\$20 copay <sup>††††</sup> for eye exam and extra charges for cosmetic lenses <sup>†</sup>
	Frames	\$0	Up to \$75 per 24-month period or see "Contacts" below	\$20 copay <sup>††††</sup> for eye exam and remainder of frames costs <sup>††</sup>
	Contacts	\$0	Up to \$95 for one pair per 24-month period	\$20 copay <sup>††††</sup> for eye exam and remainder of contact lenses <sup>††</sup> costs

<sup>†</sup> There may be additional charge if you elect cosmetic lens option, such as progressive multifocal lenses, lens coating and lens tinting.

<sup>††</sup> Copay applies to specific procedural codes and charges for physician office visit only.

<sup>††††</sup> Benefits are not subject to \$2,000 annual deductible

## High Deductible Plan F (SmartChoice Preferred)

### OTHER BENEFITS – NOT COVERED BY MEDICARE

The High Deductible Plan pays the same benefits as Plan F after one has paid a calendar year \$2,000 deductible (plus additional benefits for vision care, physician office visits and chiropractic services). Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are \$2,000. 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.

	Services	Medicare Pays	After You Pay \$2,000 Deductible, Plan Pays	In Addition To \$2,000 Deductible, You Pay
<b>Voluntary Individual Outcomes Management Program (if applicable)</b>	<b>Physician Office Visits</b> These benefits are not subject to the \$2,000 annual deductible. Copay applies to specific procedural codes and charges for the physician office visit only. Services not considered part of the "office visit" include, but are not limited to, x-rays, laboratory work, surgery. Benefit: Unlimited physician office visits, when using a Participating Provider.	Generally 80%	Generally 20%	\$5 copay <sup>†††</sup> when using a Participating Provider <sup>††</sup>
	<b>Chiropractic Services</b> These benefits are not subject to the \$2,000 annual deductible. Manual Manipulation of spine to correct Subluxation	Generally 80%	Generally 20%	\$10 copay <sup>†††</sup> when using a Participating Provider <sup>††</sup>

<sup>††</sup> Copay applies to specific procedural codes and charges for physician office visit only.

<sup>†††</sup> Provided such treatment is legal in the state where performed. Chiropractic Maintenance Therapy is not covered by this policy.

<sup>††††</sup> Benefits are not subject to \$2,000 annual deductible

**High Deductible Plan F with Rider (SmartChoice Plus)**  
**MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

The High Deductible Plan pays the same benefits as Plan F after one has paid a calendar year \$2,000 deductible (plus additional benefits for nursing or residential care facility services and home health and home support services). Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are \$2,000. 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.

**Part  
A  
Services**

<b>Services</b>	<b>Medicare Pays</b>	<b>After You Pay \$2,000 Deductible, Plan Pays</b>	<b>In Addition To \$2,000 Deductible, You Pay</b>
<b>Hospitalization*</b>			
Semi-private room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but \$1,068	\$1,068 (Part A deductible)	\$0
61st through 90th day	All but \$267 a day	\$267 a day	\$0
91st day and after:			
· While using 60 lifetime reserve days	All but \$534 a day	\$534 a day	\$0
· Once lifetime reserve days are used:			
– Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
– Beyond the additional 365 days	\$0	\$0	All costs
<b>Skilled Nursing Facility Care*</b>			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$133.50 a day	Up to \$133.50 a day	\$0
101st day and after	\$0	\$0	All costs

\* 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.

**High Deductible Plan F with Rider (SmartChoice Plus)**  
**MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

The High Deductible Plan pays the same benefits as Plan F after one has paid a calendar year \$2,000 deductible (plus additional benefits for nursing or residential care facility services and home health and home support services). Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are \$2,000. 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.

**Part**  
**A**  
**Services**

<b>Services</b>	<b>Medicare Pays</b>	<b>After You Pay \$2,000 Deductible, Plan Pays</b>	<b>In Addition To \$2,000 Deductible, You Pay</b>
<b>Blood</b> First three pints Additional amounts	\$0 100%	Three pints \$0	\$0 \$0
<b>Hospice Care</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

**High Deductible Plan F with Rider (SmartChoice Plus)**  
**MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

The High Deductible Plan pays the same benefits as Plan F after one has paid a calendar year \$2,000 deductible (plus additional benefits for nursing or residential care facility services and home health and home support services). Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are \$2,000. 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.

**Part  
B  
Services**

<b>Services</b>	<b>Medicare Pays</b>	<b>After You Pay \$2,000 Deductible, Plan Pays</b>	<b>In Addition To \$2,000 Deductible, You Pay</b>
<b>Medical Expenses – In or Out of the Hospital and Outpatient Hospital Treatment</b> such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment			
First \$135 of Medicare-approved amounts*	\$0	\$135 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare-approved amounts)	\$0	100%	\$0
<b>Blood</b>			
First three pints	\$0	All costs	\$0
Next \$135 of Medicare-approved amounts*	\$0	\$135 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>Clinical Laboratory Services –</b> Tests for Diagnostic Services	100%	\$0	\$0

\* Once you have been billed \$135 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 with Rider (SmartChoice Plus)

### PARTS A & B

The High Deductible Plan pays the same benefits as Plan F after one has paid a calendar year \$2,000 deductible (plus additional benefits for nursing or residential care facility services and home health and home support services). Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are \$2,000. 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.

Parts  
**A+B**  
Services

Services	Medicare Pays	After You Pay \$2,000 Deductible, Plan Pays	In Addition To \$2,000 Deductible, You Pay
<b>Home Health Care Medicare-Approved Services</b>			
· Medically necessary skilled care services and medical supplies	100%	\$0	\$0
· Durable medical equipment			
First \$135 of Medicare-approved amounts*	\$0	\$135 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0

\* Once you have been billed \$135 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 with Rider (SmartChoice Plus)

### OTHER BENEFITS – NOT COVERED BY MEDICARE

The High Deductible Plan pays the same benefits as Plan F after one has paid a calendar year \$2,000 deductible (plus additional benefits for nursing or residential care facility services and home health and home support services). Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are \$2,000. 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.

Services	Medicare Pays	After You Pay \$2,000 Deductible, Plan Pays	In Addition To \$2,000 Deductible, You Pay
<b>Other Benefits Not Covered By Medicare</b>	<b>Foreign Travel – Not Covered by Medicare</b>		
	Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States		
	\$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

## High Deductible Plan F with Rider (SmartChoice Plus)

### OTHER BENEFITS – NOT COVERED BY MEDICARE

The High Deductible Plan pays the same benefits as Plan F after one has paid a calendar year \$2,000 deductible (plus additional benefits for nursing or residential care facility services and home health and home support services). Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are \$2,000. 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.

	Services	Medicare Pays	After You Pay \$2,000 Deductible, Plan Pays	In Addition To \$2,000 Deductible, You Pay
<b>Voluntary Individual Outcomes Management Program (if applicable)</b>	<b>Nursing or Residential Care Facility Services</b> Rider provides benefits for nursing or residential care facility services beyond the first 100 days of Medicare-covered services and supplies. Combined Daily Benefit is \$100 and Combined Lifetime Benefit is \$36,500 with Home Health and Home Support Services	\$0	100% of billed charges <sup>†</sup> , up to \$100 per day. Benefits are provided only after satisfaction of the 6-month Rider waiting period and 100-day Facility Elimination period. <sup>††</sup>	All costs beyond the covered daily maximum amount and amounts above the \$36,500 Lifetime maximum benefit.
	<b>Home Health and Home Support Services</b> Rider provides benefits for home health and home support services not covered by Medicare. Combined Daily Benefit is \$100 and Combined Lifetime Benefit is \$36,500 with Nursing or Residential Care Facility Services	80%	100% of billed charges <sup>†</sup> , up to \$100 per day. Benefits are provided only after satisfaction of the \$1,000 Home Health and Home Support Services deductible, the 6-month Rider waiting period and 100-day Facility Elimination period. <sup>††</sup>	All costs beyond the covered daily maximum amount and amounts above the \$36,500 Lifetime maximum benefit.

<sup>†</sup> Benefits paid only when services are approved as part of the Plan of Care coordinated through a Care Manager.

<sup>††</sup> Rider Waiting Period must also be met. Coordinated with Medicare covered benefits. Facility Elimination Period needs to be met once over the lifetime of the policy.

## Classic Plan F with Rider (AdvantageCare)

### MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

AdvantageCare pays the same benefits as Classic Plan F, plus additional benefits for nursing or residential care facility services and home health and home support services. Medicare deductibles and coinsurance amounts are effective as of January 1, 2009. Medicare may change these amounts annually. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult the “Medicare & You” handbook for more details.

**Part  
A  
Services**

Services	Medicare Pays	Plan Pays	You Pay
<b>Hospitalization*</b> Semi-private room and board, general nursing and miscellaneous services and supplies: First 60 days	All but \$1,068	\$1,068 (Part A deductible)	\$0
61st through 90th day	All but \$267 a day	\$267 a day	\$0
91st day and after: · While using 60 lifetime reserve days · Once lifetime reserve days are used: – Additional 365 days	All but \$534 a day \$0	\$534 a day 100% of Medicare-eligible expenses	\$0 \$0**
– Beyond the additional 365 days	\$0	\$0	All costs
<b>Skilled Nursing Facility Care*</b> You must meet Medicare’s requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$133.50 a day	Up to \$133.50 a day	\$0
101st day and after	\$0	\$0	All costs

\* 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.

**Classic Plan F with Rider (AdvantageCare)**

**MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

AdvantageCare pays the same benefits as Classic Plan F, plus additional benefits for nursing or residential care facility services and home health and home support services. Medicare deductibles and coinsurance amounts are effective as of January 1, 2009. Medicare may change these amounts annually. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult the “Medicare & You” handbook for more details.

**Part  
A  
Services**

<b>Services</b>	<b>Medicare Pays</b>	<b>Plan Pays</b>	<b>You Pay</b>
<b>Blood</b> First three pints Additional amounts	\$0 100%	Three pints \$0	\$0 \$0
<b>Hospice Care</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

**Classic Plan F with Rider (AdvantageCare)**

**MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

AdvantageCare pays the same benefits as Classic Plan F, plus additional benefits for nursing or residential care facility services and home health and home support services. Medicare deductibles and coinsurance amounts are effective as of January 1, 2009. Medicare may change these amounts annually. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult the “Medicare & You” handbook for more details.

**Part  
B  
Services**

<b>Services</b>	<b>Medicare Pays</b>	<b>Plan Pays</b>	<b>You Pay</b>
<b>Medical Expenses – In or Out of the Hospital and Outpatient Hospital Treatment</b> such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment			
First \$135 of Medicare-approved amounts*	\$0	\$135 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare-approved amounts)	\$0	100%	\$0
<b>Blood</b>			
First three pints	\$0	All costs	\$0
Next \$135 of Medicare-approved amounts*	\$0	\$135 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>Clinical Laboratory Services –</b> Tests for Diagnostic Services	100%	\$0	\$0

\* Once you have been billed \$135 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.

**Classic Plan F with Rider (AdvantageCare)**

**PARTS A & B AND OTHER BENEFITS – NOT COVERED BY MEDICARE**

AdvantageCare pays the same benefits as Classic Plan F, plus additional benefits for nursing or residential care facility services and home health and home support services. Medicare deductibles and coinsurance amounts are effective as of January 1, 2009. Medicare may change these amounts annually. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult the “Medicare & You” handbook for more details.

Parts  
**A+B**  
Services

Other  
Benefits  
Not  
Covered By  
Medicare

Services	Medicare Pays	Plan Pays	You Pay
<b>Home Health Care Medicare-Approved Services</b>			
· Medically necessary skilled care services and medical supplies	100%	\$0	\$0
· Durable medical equipment			
First \$135 of Medicare-approved amounts*	\$0	\$135 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>Foreign Travel – Not Covered by Medicare</b>			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0 maximum benefit of \$50,000	80% to a lifetime over the \$50,000 lifetime maximum	20% and amounts

\* Once you have been billed \$135 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.

**Classic Plan F with Rider (AdvantageCare)**  
**OTHER BENEFITS – NOT COVERED BY MEDICARE**

AdvantageCare pays the same benefits as Classic Plan F, plus additional benefits for nursing or residential care facility services and home health and home support services. Medicare deductibles and coinsurance amounts are effective as of January 1, 2009. Medicare may change these amounts annually. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult the “Medicare & You” handbook for more details.

	<b>Services</b>	<b>Medicare Pays</b>	<b>Plan Pays</b>	<b>You Pay</b>
<b>Voluntary Individual Outcomes Management Program (if applicable)</b>	<p><b>Nursing or Residential Care Facility Services</b>            Rider provides benefits for nursing or residential care facility services beyond the first 100 days of Medicare-covered services and supplies. Combined Daily Benefit is \$100 and Combined Lifetime Benefit is \$36,500 with Home Health and Home Support Services</p>	\$0	100% of billed charges <sup>†</sup> , up to \$100 per day. Benefits are provided only after satisfaction of the 6-month Rider waiting period and 100-day Facility Elimination period. <sup>††</sup>	All costs beyond the covered daily maximum amount and amounts above the \$36,500 Lifetime maximum benefit.
	<p><b>Home Health and Home Support Services</b>            Rider provides benefits for home health and home support services not covered by Medicare. Combined Daily Benefit is \$100 and Combined Lifetime Benefit is \$36,500 with Nursing or Residential Care Facility Services</p>	80%	100% of billed charges <sup>†</sup> , up to \$100 per day. Benefits are provided only after satisfaction of the \$1,000 Home Health and Home Support Services deductible, the 6-month Rider waiting period and 100-day Facility Elimination period. <sup>††</sup>	All costs beyond the covered daily maximum amount and amounts above the \$36,500 Lifetime maximum benefit.

<sup>†</sup> Benefits paid only when services are approved as part of the Plan of Care coordinated through a Care Manager.

<sup>††</sup> Rider Waiting Period must also be met. Coordinated with Medicare covered benefits. Facility Elimination Period needs to be met once over the lifetime of the policy.

**CLASSIC PLAN I**  
**MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

Medicare deductibles and co-insurance amounts are effective as of January 1, 2009. Medicare may change these amounts annually. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the “Medicare & You” handbook for more details.

**Part**  
**A**  
**Services**

Services	Medicare Pays	Standard Plan I Pays	You Pay
<b>Hospitalization*</b>			
Semi-private room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but \$1,068*	\$1,068 (Part A deductible)	\$0
61st through 90th day	All but \$267 a day	\$267 a day	\$0
91st day and after:			
· While using 60 lifetime reserve days	All but \$534 a day	\$534 a day	\$0
· Once lifetime reserve days are used:			
– Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
– Beyond the additional 365 days	\$0	\$0	All costs
<b>Skilled Nursing Facility Care*</b>			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$133.50 a day	Up to \$133.50 a day	\$0
101st day and after	\$0	\$0	All costs

\* 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

**CLASSIC PLAN I  
 MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

Medicare deductibles and co-insurance amounts are effective as of January 1, 2009. Medicare may change these amounts annually. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the “Medicare & You” handbook for more details.

**Part  
 A  
 Services**

<b>Services</b>	<b>Medicare Pays</b>	<b>Standard Plan I Pays</b>	<b>You Pay</b>
<b>Blood</b> First three pints Additional amounts	\$0 100%	Three pints \$0	\$0 \$0
<b>Hospice Care</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

**CLASSIC PLAN I**  
**MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

Medicare deductibles and co-insurance amounts are effective as of January 1, 2009. Medicare may change these amounts annually. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the “Medicare & You” handbook for more details.

**Part  
B  
Services**

<b>Services</b>	<b>Medicare Pays</b>	<b>Standard Plan I Pays</b>	<b>You Pay</b>
<b>Medical Expenses – In or Out of the Hospital and Outpatient Hospital Treatment</b> such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment First \$135 of Medicare-approved amounts*	\$0	\$0	\$135 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare-approved amounts)	\$0	100%	\$0
<b>Blood</b> First three pints Next \$135 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 All costs \$0
<b>Clinical Laboratory Services –</b> Tests for Diagnostic Services	100%	\$0	\$0

\* Once you have been billed \$135 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.

**CLASSIC PLAN I  
PARTS A & B**

Medicare deductibles and co-insurance amounts are effective as of January 1, 2009. Medicare may change these amounts annually. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the “Medicare & You” handbook for more details.

Parts  
**A+B**  
Services

Services	Medicare Pays	Standard Plan I Pays	You Pay
<b>Home Health Care Medicare-Approved Services</b>			
· Medically necessary skilled care services and medical supplies	100%	\$0	\$0
· Durable medical equipment First \$135 of Medicare-approved amounts*	\$0	\$0	\$135 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0

\* Once you have been billed \$135 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.

**CLASSIC PLAN I**

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

Medicare deductibles and co-insurance amounts are effective as of January 1, 2009. Medicare may change these amounts annually. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the “Medicare & You” handbook for more details.

	Services	Medicare Pays	Standard Plan I Pays	You Pay
<b>Other Benefits Not Covered By Medicare</b>	<b>Foreign Travel – Not Covered by Medicare</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
	<b>At-Home Recovery Services – Not Covered by Medicare</b> Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan. • Benefit for each visit • Number of visits covered (must be received within eight weeks of last Medicare-approved visit) • Calendar year maximum	\$0 \$0 \$0	Actual charges up to \$40 a visit Up to the number of Medicare-approved visits, not to exceed seven each week \$1,600	Balance Any visits exceeding seven per week Any amount over \$1,600 per year

**CLASSIC PLAN J**

**MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

Medicare deductibles and co-insurance amounts are effective as of January 1, 2009. Medicare may change these amounts annually. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the “Medicare & You” handbook for more details.

**Part  
A  
Services**

<b>Services</b>	<b>Medicare Pays</b>	<b>Standard Plan J Pays</b>	<b>You Pay</b>
<b>Hospitalization*</b>			
Semi-private room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but \$1,068	\$1,068 (Part A deductible)	\$0
61st through 90th day	All but \$267 a day	\$267 a day	\$0
91st day and after:			
· While using 60 lifetime reserve days	All but \$534 a day	\$534 a day	\$0
· Once lifetime reserve days are used:			
– Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
– Beyond the additional 365 days	\$0	\$0	All costs
<b>Skilled Nursing Facility Care*</b>			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$133.50 a day	Up to \$133.50 a day	\$0
101st day and after	\$0	\$0	All costs

\* 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.

**CLASSIC PLAN J  
 MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

Medicare deductibles and co-insurance amounts are effective as of January 1, 2009. Medicare may change these amounts annually. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the “Medicare & You” handbook for more details.

**Part  
 A  
 Services**

<b>Services</b>	<b>Medicare Pays</b>	<b>Standard Plan J Pays</b>	<b>You Pay</b>
<b>Blood</b> First three pints Additional amounts	\$0 100%	Three pints \$0	\$0 \$0
<b>Hospice Care</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

**CLASSIC PLAN J**  
**MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR**

Medicare deductibles and co-insurance amounts are effective as of January 1, 2009. Medicare may change these amounts annually. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the “Medicare & You” handbook for more details.

**Part**  
**B**  
**Services**

<b>Services</b>	<b>Medicare Pays</b>	<b>Standard Plan J Pays</b>	<b>You Pay</b>
<b>Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment</b> such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment First \$135 of Medicare-approved amounts*	\$0	\$135 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare-approved amounts)	\$0	100%	\$0
<b>Blood</b> First three pints Next \$135 of Medicare-approved amounts*	\$0 \$0	All costs \$135 (Part B deductible)	\$0 \$0
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>Clinical Laboratory Services —</b> Tests for Diagnostic Services	100%	\$0	\$0

\* Once you have been billed \$135 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.

**CLASSIC PLAN J  
PARTS A & B**

Medicare deductibles and co-insurance amounts are effective as of January 1, 2009. Medicare may change these amounts annually. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the “Medicare & You” handbook for more details.

Parts  
**A+B**  
Services

Services	Medicare Pays	Standard Plan J Pays	You Pay
<b>Home Health Care Medicare-Approved Services</b>			
· Medically necessary skilled care services and medical supplies	100%	\$0	\$0
· Durable medical equipment First \$135 of Medicare-approved amounts*	\$0	\$135 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0

\* Once you have been billed \$135 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.

**CLASSIC PLAN J**

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

Medicare deductibles and co-insurance amounts are effective as of January 1, 2009. Medicare may change these amounts annually. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the “Medicare & You” handbook for more details.

	<b>Services</b>	<b>Medicare Pays</b>	<b>Standard Plan J Pays</b>	<b>You Pay</b>
<b>Other Benefits Not Covered By Medicare</b>	<b>Foreign Travel – Not Covered by Medicare</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
	<b>At-Home Recovery Services – Not Covered by Medicare</b> Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan.  • Benefit for each visit  • Number of visits covered (must be received within eight weeks of last Medicare-approved visit)  • Calendar year maximum	\$0 \$0 \$0	Actual charges up to \$40 a visit Up to the number of Medicare-approved visits, not to exceed seven each week \$1,600	Balance  Any visits exceeding seven per week  Any amount over \$1,600 per year

**CLASSIC PLAN J**

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

Medicare deductibles and co-insurance amounts are effective as of January 1, 2009. Medicare may change these amounts annually. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the “Medicare & You” handbook for more details.

	Services	Medicare Pays	Standard Plan J Pays	You Pay
<b>Other Benefits Not Covered By Medicare</b>	<b>PREVENTIVE MEDICAL CARE BENEFIT*** NOT COVERED BY MEDICARE</b>			
	Some annual physical and preventive tests & services (such as, digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diptheria booster and education), administered or ordered by your doctor when not covered by Medicare.			
	First \$120 each calendar year	\$0	\$120	\$0
	Additional charges	\$0	\$0	All costs

\*\*\* Medicare benefits are subject to change. Please consult the latest “Guide to Health Insurance for People with Medicare.”



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