



Anthem Blue Cross Blue Shield – Colorado

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

Toll Free Telephone Number: 1-877-831-3000



**OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE
BENEFIT STANDARD PLANS A, B, F, I, J, L AND
SMARTCHOICE (HIGH DEDUCTIBLE PLAN F)**



Medicare supplement insurance can be sold in 12 standard plans plus two high deductible plans. This chart shows the benefits included in each plan. 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.

- 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).
 - Blood: First three pints of blood each year.

Plan A	Plan B	Plan C	Plan D	Plan E	Plan F/F*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible
					Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			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 offer the same benefits as Plans F and J after one has paid a calendar year \$1,900 deductible. Benefits from High Deductible Plans F and J will not begin until out-of-pocket expenses exceed \$1,900. 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.

Plan G	Plan H	Plan I	Plan J/J*	Plan K**	Plan L**
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	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 Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	50% Skilled Nursing Coinsurance	75% Skilled Nursing Coinsurance
Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible
			Part B Deductible		
Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)		
Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		
At-home Recovery		At-home Recovery	At-home Recovery		
			Preventive Care NOT Covered by Medicare	\$4,440 Out-of-Pocket Limit***	\$2,220 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 offer the same benefits as Plans F and J after one has paid a calendar year \$1,900 deductible. Benefits from High Deductible Plans F and J will not begin until out-of-pocket expenses exceed \$1,900. 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 other 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 PLANS A, B, F, I, J, L AND SMARTCHOICE (HIGH DEDUCTIBLE PLAN F)

Effective January 1, 2008

Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Jefferson, Larimer and Pueblo*

Attained Age	Plan A		Plan B		Plan I		Plan J	
	Male	Female	Male	Female	Male	Female	Male	Female
<65	\$ 171.30	\$ 160.90	\$ 187.00	\$ 178.00	\$ 239.50	\$ 227.50	\$ 283.20	\$ 269.00
65-69	116.60	108.20	132.30	122.40	169.30	156.60	200.30	185.20
70-74	139.60	127.20	158.20	144.20	204.30	185.50	241.70	219.40
75-79	159.90	146.20	181.10	165.10	234.70	213.10	277.50	252.10
80+	177.20	157.40	199.70	178.40	258.30	230.50	305.40	272.60

All Other Counties in Colorado*

Attained Age	Plan A		Plan B		Plan I		Plan J	
	Male	Female	Male	Female	Male	Female	Male	Female
<65	\$ 157.00	\$ 147.40	\$ 171.50	\$ 163.10	\$ 219.50	\$ 208.70	\$ 258.60	\$ 245.70
65-69	107.00	99.10	121.50	112.20	155.30	143.70	182.70	169.00
70-74	128.10	116.60	145.10	132.20	187.40	170.20	220.60	200.30
75-79	146.70	134.10	166.00	151.40	215.30	195.50	253.40	230.20
80+	162.50	144.20	183.20	163.70	236.80	211.40	278.90	248.90

* Rating Areas for Anthem CO Plans A, B, I and J with 5-year age bands, are different from rating areas for other Anthem CO Medicare Supplement Plans with single year age bands Plan F, SmartChoice High Deductible Plans F & L).



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**MONTHLY RATES – STANDARD PLANS A, B, F, I, J, L AND
SMARTCHOICE (HIGH DEDUCTIBLE PLAN F)**

Effective January 1, 2008

<i>Plan F</i>	<i>Area 1</i>		<i>Area 2</i>		<i>Area 3</i>	
	<i>Male</i>	<i>Female</i>	<i>Male</i>	<i>Female</i>	<i>Male</i>	<i>Female</i>
<i>Attained Age</i>						
<65	\$ 201.00	\$ 173.20	\$ 182.80	\$ 157.10	\$ 164.60	\$ 141.10
65	148.60	128.30	134.70	116.50	120.80	104.80
66	153.90	132.60	140.00	120.80	126.10	109.00
67	161.40	139.00	146.50	126.10	131.50	113.30
68	166.80	144.30	151.80	131.50	136.80	118.70
69	174.20	150.70	158.20	136.80	142.20	122.90
70	180.70	156.10	164.60	142.20	148.60	128.30
71	188.10	162.50	171.00	147.50	153.90	132.60
72	196.70	168.90	178.50	153.90	160.40	139.00
73	208.50	178.50	189.20	162.50	170.00	146.50
74	220.20	189.20	199.90	172.10	179.60	155.00
75	233.00	201.00	211.70	182.80	190.30	164.60
76	245.90	212.70	223.40	193.50	201.00	174.20
77	260.80	224.50	237.30	204.20	213.80	183.90
78	268.30	232.00	243.70	210.60	219.10	189.20
79	276.90	238.40	251.20	217.00	226.60	195.60
80+	285.40	245.90	259.80	223.40	234.10	201.00

Area 1 includes Adams, Arapahoe, Archuleta, Denver, Douglass & Jefferson counties.

Area 2 includes Boulder, Larimer, Pueblo & Broomfield counties.

Area 3 includes all other counties in Colorado.



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MONTHLY RATES – STANDARD PLANS A, B, F, I, J, L AND SMARTCHOICE (HIGH DEDUCTIBLE PLAN F)

Effective January 1, 2008

<i>Plan L</i>	<i>Area 1</i>		<i>Area 2</i>		<i>Area 3</i>	
	<i>Male</i>	<i>Female</i>	<i>Male</i>	<i>Female</i>	<i>Male</i>	<i>Female</i>
<i>Attained Age</i>						
<65	\$ 128.30	\$ 110.10	\$ 116.50	\$ 100.50	\$ 104.80	\$ 90.90
65	95.10	82.30	86.60	74.80	78.00	67.30
66	98.30	84.50	89.80	77.00	81.20	69.50
67	102.60	88.70	93.00	80.20	83.40	72.70
68	106.90	91.90	97.30	83.40	87.70	74.80
69	112.20	96.20	101.60	87.70	91.90	79.10
70	116.50	100.50	105.80	90.90	95.10	82.30
71	120.80	104.80	110.10	95.10	99.40	85.50
72	126.10	108.00	114.40	98.30	102.60	88.70
73	132.60	115.50	120.80	104.80	109.00	94.10
74	141.10	120.80	128.30	110.10	115.50	99.40
75	149.70	128.30	135.80	116.50	121.90	104.80
76	157.10	136.80	143.20	124.00	129.30	111.20
77	166.80	143.20	151.80	130.40	136.80	117.60
78	172.10	148.60	156.10	134.70	140.00	120.80
79	177.50	152.90	161.40	139.00	145.40	125.10
80+	182.80	157.10	165.70	143.20	149.70	129.30

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MONTHLY RATES – STANDARD PLANS A, B, F, I, J, L AND SMARTCHOICE (HIGH DEDUCTIBLE PLAN F)

Effective January 1, 2008

SmartChoice High Deductible Plan F

<i>Attained Age</i>	<i>Area 1</i>		<i>Area 2</i>		<i>Area 3</i>	
	<i>Male</i>	<i>Female</i>	<i>Male</i>	<i>Female</i>	<i>Male</i>	<i>Female</i>
<65	\$ 67.30	\$ 57.70	\$ 60.90	\$ 52.40	\$ 54.50	\$ 47.00
65	49.20	43.80	44.90	39.60	40.60	35.30
66	51.30	44.90	47.00	40.60	42.80	36.30
67	54.50	47.00	49.20	42.80	43.80	38.50
68	56.70	48.10	51.30	43.80	46.00	39.60
69	58.80	50.20	53.50	46.00	48.10	41.70
70	60.90	53.50	55.60	48.10	50.20	43.80
71	63.10	55.60	57.70	50.20	52.40	44.90
72	66.30	56.70	59.90	51.30	53.50	46.00
73	69.50	59.90	63.10	54.50	56.70	49.20
74	73.80	63.10	67.30	57.70	60.90	52.40
75	79.10	67.30	71.60	60.90	64.10	54.50
76	82.30	71.60	74.80	65.20	67.30	58.80
77	88.70	74.80	80.20	68.40	72.70	62.00
78	90.90	78.00	82.30	70.60	73.80	63.10
79	93.00	80.20	84.50	72.70	75.90	65.20
80+	96.20	82.30	87.70	74.80	79.10	67.30

Area 1 includes Adams, Arapahoe, Archuleta, Denver, Douglass & Jefferson counties.

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MEDICARE SUPPLEMENT COVERAGE

Outline of Coverage for Policy Form Series

**Standard Plan A, Standard Plan B,
Standard Plan F, Standard Plan I
Standard Plan J, Standard Plan L
SmartChoice (High Deductible F Plans^A)
Retain This Outline For Your Records**

Premium Information

Your premium rate increases based upon your Attained Age. 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 cost. 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 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.

STANDARD PLAN A

MEDICARE (PART A) HOSPITAL SERVICES — PER BENEFIT PERIOD

Medicare deductibles and co-insurance amounts are effective as of January 1, 2008. 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 and You Handbook" for more details.

Services	Medicare Pays	Standard Plan A Pays	You Pay
Hospitalization Semiprivate room and board, general nursing and miscellaneous services and supplies: First 60 days	All but \$1,024/benefit period*	\$0	\$1,024 (Part A Deductible)
61st through 90th day	All but \$256 a day	\$256 a day	\$0
91st day and after:			
· While using 60 lifetime reserve days	All but \$512 a day	\$512 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
Skilled Nursing Facility Care You must meet Medicare's requirement, 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 \$128 a day	\$0	Up to \$128 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 Plan 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.

***Once you have been billed \$135 of Medicare-Approved amounts for covered services, your Part B Deductible will have been met for the calendar year.

Part
A
Services

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

Medicare deductibles and co-insurance amounts are effective as of January 1, 2008. 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 and You Handbook" for more details.

**Part
 A
 Services**

Services	Medicare Pays	Standard Plan A Pays	You Pay
Blood			
First three pints	\$0	Three pints	\$0
Additional amounts	100%	\$0	\$0
Hospice Care			
Available as long as your doctor certifies you are terminally ill and you elect to receive 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, 2008. 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 and You Handbook" for more details.

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

***Once you have been billed \$135 of Medicare-Approved amounts for covered services, your Part B Deductible will have been met for the calendar year.

Part
B
Services

**STANDARD PLAN A
PARTS A & B**

Medicare deductibles and co-insurance amounts are effective as of January 1, 2008. 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 and You Handbook" for more details.

Part
A+B
Services

Services	Medicare Pays	Standard Plan A Pays	You Pay
Home Health Care Medicare-approved Services			
· Medically-necessary skilled care services and medical supplies	100%	\$0	\$0
· Durable medical equipment			
First \$135 of Medicare-approved amounts	\$0	\$0	\$135***
Remainder of Medicare-approved amounts	80%	20%	\$0

***Once you have been billed \$135 of Medicare-Approved amounts for covered services, your Part B Deductible will have been met for the calendar year.

STANDARD PLAN B

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

Medicare deductibles and co-insurance amounts are effective as of January 1, 2008. 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 and You Handbook" for more details.

**Part
A
Services**

Services	Medicare Pays	Standard Plan B Pays	You Pay
Hospitalization			
Semi-private room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but \$1,024/benefit period*	\$1,024 (Part A Deductible)	\$0
61st through 90th day	All but \$256 a day	\$256 a day	\$0
91st day and after:			
· While using 60 lifetime reserve days	All but \$512 a day	\$512 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
Skilled Nursing Facility Care			
You must meet Medicare's requirement, 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 \$128 a day	\$0	Up to \$128 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 Plan 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.

*** Once you have been billed \$135 of Medicare-Approved amounts for covered services, your Part B Deductible will have been met for the calendar year.

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

Medicare deductibles and co-insurance amounts are effective as of January 1, 2008. 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 and You Handbook" for more details.

**Part
 A
 Services**

Services	Medicare Pays	Standard Plan B Pays	You Pay
Blood First three pints Additional amounts	\$0 100%	Three pints \$0	\$0 \$0
Hospice Care 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 B
 MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

Medicare deductibles and co-insurance amounts are effective as of January 1, 2008. 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 and You Handbook" for more details.

**Part
 B
 Services**

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

***Once you have been billed \$135 of Medicare-Approved amounts for covered services, your Part B Deductible will have been met for the calendar year.

STANDARD PLAN B

PARTS A & B

Medicare deductibles and co-insurance amounts are effective as of January 1, 2008. 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 and You Handbook" for more details.

Part
A+B
Services

Services	Medicare Pays	Standard Plan B Pays	You Pay
Home Health Care Medicare-approved Services			
· Medically-necessary skilled care services and medical supplies	100%	\$0	\$0
· Durable medical equipment			
First \$135 of Medicare-approved amounts	\$0	\$0	\$135***
Remainder of Medicare-approved amounts	80%	20%	\$0

***Once you have been billed \$135 of Medicare-Approved amounts for covered services, your Part B Deductible will have been met for the calendar year.

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

Medicare deductibles and co-insurance amounts are effective as of January 1, 2008. 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 and You Handbook" for more details.

Services	Medicare Pays	Standard Plan F Pays	You Pay
Hospitalization			
Semi-private room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but \$1,024/benefit period*	\$1,024 (Part A Deductible)	\$0
61st through 90th day	All but \$256 a day	\$256 a day	\$0
91st day and after:			
· While using 60 lifetime reserve days	All but \$512 a day	\$512 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
Skilled Nursing Facility Care			
You must meet Medicare's requirement, 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 \$128 a day	Up to \$128 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 Plan 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.
- *** Once you have been billed \$135 of Medicare-Approved amounts for covered services, your Part B Deductible will have been met for the calendar year.

Part
A
Services

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

Medicare deductibles and co-insurance amounts are effective as of January 1, 2008. 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 and You Handbook" for more details.

**Part
 A
 Services**

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

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

Medicare deductibles and co-insurance amounts are effective as of January 1, 2008. 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 and You Handbook" for more details.

**Part
B
Services**

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

***Once you have been billed \$135 of Medicare-Approved amounts for covered services, your Part B Deductible will have been met for the calendar year.

STANDARD PLAN F

PARTS A & B

Medicare deductibles and co-insurance amounts are effective as of January 1, 2008. 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 and You Handbook" for more details.

Services	Medicare Pays	Standard Plan F Pays	You Pay
Home Health Care			
Medicare-approved Services			
· Medically-necessary skilled care services and medical supplies	100%	\$0	\$0
· Durable medical equipment			
First \$135 of Medicare-approved amounts***	\$0	\$135	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0

***Once you have been billed \$135 of Medicare-Approved amounts for covered services, your Part B Deductible will have been met for the calendar year.

Part
A+B
Services

STANDARD PLAN F

OTHER BENEFITS – NOT COVERED BY MEDICARE

Medicare deductibles and co-insurance amounts are effective as of January 1, 2008. 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 and You Handbook" for more details.

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

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

Medicare deductibles and co-insurance amounts are effective as of January 1, 2008. 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 and You Handbook" for more details.

Services	Medicare Pays	Standard Plan I Pays	You Pay
Hospitalization			
Semi-private room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but \$1,024/benefit period*	\$1,024 (Part A Deductible)	\$0
61st through 90th day	All but \$256 a day	\$256 a day	\$0
91st day and after:			
· While using 60 lifetime reserve days	All but \$512 a day	\$512 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
Skilled Nursing Facility Care			
You must meet Medicare's requirement, 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 \$128 a day	Up to \$128 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 Plan 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.
- *** Once you have been billed \$135 of Medicare-Approved amounts for covered services, your Part B Deductible will have been met for the calendar year.

Part
A
Services

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

Medicare deductibles and co-insurance amounts are effective as of January 1, 2008. 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 and You Handbook" for more details.

**Part
 A
 Services**

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

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

Medicare deductibles and co-insurance amounts are effective as of January 1, 2008. 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 and You Handbook" for more details.

**Part
 B
 Services**

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

***Once you have been billed \$135 of Medicare-Approved amounts for covered services, your Part B Deductible will have been met for the calendar year.

**STANDARD PLAN I
PARTS A & B**

Medicare deductibles and co-insurance amounts are effective as of January 1, 2008. 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 and You Handbook" for more details.

Part
A+B
Services

Services	Medicare Pays	Standard Plan I Pays	You Pay
Home Health Care Medicare-approved Services			
· Medically-necessary skilled care services and medical supplies	100%	\$0	\$0
· Durable medical equipment			
First \$135 of Medicare-approved amounts	\$0	\$0	\$135***
Remainder of Medicare-approved amounts	80%	20%	\$0

***Once you have been billed \$135 of Medicare-Approved amounts for covered services, your Part B Deductible will have been met for the calendar year.

STANDARD PLAN I

OTHER BENEFITS — NOT COVERED BY MEDICARE

Medicare deductibles and co-insurance amounts are effective as of January 1, 2008. 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 and You Handbook" for more details.

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

STANDARD PLAN J

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

Medicare deductibles and co-insurance amounts are effective as of January 1, 2008. 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 and You Handbook" for more details.

Services	Medicare Pays	Standard Plan J Pays	You Pay
Hospitalization			
Semi-private room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but \$1,024/benefit period*	\$1,024 (Part A Deductible)	\$0
61st through 90th day	All but \$256 a day	\$256 a day	\$0
91st day and after:			
· While using 60 lifetime reserve days	All but \$512 a day	\$512 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
Skilled Nursing Facility Care			
You must meet Medicare's requirement, 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 \$128 a day	Up to \$128 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 Plan 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.

*** Once you have been billed \$135 of Medicare-Approved amounts for covered services, your Part B Deductible will have been met for the calendar year.

Part
A
Services

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

Medicare deductibles and co-insurance amounts are effective as of January 1, 2008. 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 and You Handbook" for more details.

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

Part
A
 Services

STANDARD PLAN J

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

Medicare deductibles and co-insurance amounts are effective as of January 1, 2008. 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 and You Handbook" for more details.

**Part
B
Services**

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

***Once you have been billed \$135 of Medicare-Approved amounts for covered services, your Part B Deductible will have been met for the calendar year.

STANDARD PLAN J

PARTS A & B

Medicare deductibles and co-insurance amounts are effective as of January 1, 2008. 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 and You Handbook" for more details.

Part
A+B
Services

Services	Medicare Pays	Standard Plan J Pays	You Pay
Home Health Care			
Medicare-approved Services			
· Medically-necessary skilled care services and medical supplies	100%	\$0	\$0
· Durable medical equipment First \$135 of Medicare-approved amounts***	\$0	\$135	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0

***Once you have been billed \$135 of Medicare-Approved amounts for covered services, your Part B Deductible will have been met for the calendar year.

STANDARD PLAN J

OTHER BENEFITS — NOT COVERED BY MEDICARE

Medicare deductibles and co-insurance amounts are effective as of January 1, 2008. 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 and You Handbook" for more details.

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

STANDARD PLAN J

OTHER BENEFITS – NOT COVERED BY MEDICARE

Medicare deductibles and co-insurance amounts are effective as of January 1, 2008. 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 and You Handbook" for more details.

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

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

STANDARD PLAN L

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

Medicare deductibles and co-insurance amounts are effective as of January 1, 2008. 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 and You Handbook" for more details. You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$2,220 each calendar year. The amounts that count toward your annual limit are noted with the symbol Δ in the chart. Once you reach the annual limit, the plan pays 100% of your Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.** Δ Applies to amounts that count toward your annual out-of-pocket limit.

Services	Medicare Pays	Standard Plan L Pays	You Pay
Hospitalization Semi-private room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but \$1,024/ benefit period*	\$768 (75% of Part A Deductible)	Δ \$256 (25%) of Medicare Part A Deductible
61st through 90th day	All but \$256 a day	\$256 a day	\$0**
91st day and after:			
· While using 60 lifetime reserve days	All but \$512 a day	\$512 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.

** \$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

*** 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. NOTICE: When your Medicare Plan 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.

**** Once you have been billed \$135 of Medicare-Approved amounts for covered services, your Part B Deductible will have been met for the calendar year.

Part
A
Services

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

Medicare deductibles and co-insurance amounts are effective as of January 1, 2008. 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 and You Handbook" for more details. You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$2,220 each calendar year. The amounts that count toward your annual limit are noted with the symbol Δ in the chart. Once you reach the annual limit, the plan pays 100% of your Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.** Δ Applies to amounts that count toward your annual out-of-pocket limit.

**Part
A
Services**

Services	Medicare Pays	Standard Plan L Pays	You Pay
Skilled Nursing Facility Care You must meet Medicare's requirement, 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 \$128 a day	Up to \$96 (75%) a day	Δ Up to \$32 (25%) 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.

** \$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

*** 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. NOTICE: When your Medicare Plan 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.

**** Once you have been billed \$135 of Medicare-Approved amounts for covered services, your Part B Deductible will have been met for the calendar year.

STANDARD PLAN L

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

Medicare deductibles and co-insurance amounts are effective as of January 1, 2008. 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 and You Handbook" for more details. You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$2,220 each calendar year. The amounts that count toward your annual limit are noted with the symbol Δ in the chart. Once you reach the annual limit, the plan pays 100% of your Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.** Δ Applies to amounts that count toward your annual out-of-pocket limit.

Part
A
Services

Services	Medicare Pays	Standard Plan L Pays	You Pay
Blood First three pints	\$0	75%	Δ 25%
Additional amounts	100%	\$0	\$0
Hospice Care Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	75% of coinsurance copayments	Δ 25% of coinsurance or copayments

STANDARD PLAN L

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

Medicare deductibles and co-insurance amounts are effective as of January 1, 2008. 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 and You Handbook" for more details. You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$2,220 each calendar year. The amounts that count toward your annual limit are noted with the symbol Δ in the chart. Once you reach the annual limit, the plan pays 100% of your Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.** Δ Applies to amounts that count toward your annual out-of-pocket limit.

Services	Medicare Pays	Standard Plan L Pays	You Pay
Medical Expenses – In or Out of the Hospital and Outpatient Hospital Treatment such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment			
First \$135 of Medicare-approved amounts (Part B Deductible)	\$0	\$0	Δ \$135****
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare-approved amount	Generally 80%	Generally 15%	Δ Generally 5%
Part B Excess Charges (Above Medicare-approved amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of \$2,220)

**** Once you have been billed \$135 of Medicare-Approved amounts for covered services, your Part B Deductible will have been met for the calendar year.

Part
B
Services

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

Medicare deductibles and co-insurance amounts are effective as of January 1, 2008. 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 and You Handbook" for more details. You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$2,220 each calendar year. The amounts that count toward your annual limit are noted with the symbol Δ in the chart. Once you reach the annual limit, the plan pays 100% of your Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.** Δ Applies to amounts that count toward your annual out-of-pocket limit.

Part
B
Services

Services	Medicare Pays	Standard Plan L Pays	You Pay
Blood			
First three pints	\$0	75%	Δ 25%
Next \$135 of Medicare-approved amounts	\$0	\$0	Δ \$135****
Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Δ Generally 5%
Clinical Laboratory Services – Tests for Diagnostic Services	100%	\$0	\$0

**** Once you have been billed \$135 of Medicare-Approved amounts for covered services, your Part B Deductible will have been met for the calendar year.

STANDARD PLAN L

PARTS A & B

Medicare deductibles and co-insurance amounts are effective as of January 1, 2008. 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 and You Handbook" for more details. You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$2,220 each calendar year. The amounts that count toward your annual limit are noted with the symbol Δ in the chart. Once you reach the annual limit, the plan pays 100% of your Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.** Δ Applies to amounts that count toward your annual out-of-pocket limit.

Services	Medicare Pays	Standard Plan L Pays	You Pay
Home Health Care Medicare-approved Services			
· Medically-necessary skilled care services and medical supplies	100%	\$0	\$0
· Durable medical equipment			
First \$135 of Medicare-approved amounts	\$0	\$0	Δ \$135****
Remainder of Medicare-approved amounts	80%	15%	Δ 5%

**** Once you have been billed \$135 of Medicare-Approved amounts for covered services, your Part B Deductible will have been met for the calendar year.

Part
A+B
Services

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

The High Deductible Plan pays the same as Plan F after one has paid a calendar year \$1,900 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are \$1,900. Out-of-pocket expenses for the deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductible for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

**Part
A
Services**

Services	Medicare Pays	After You Pay \$1,900 Deductible, Plan Pays	In Addition To \$1,900 Deductible, You Pay
Hospitalization			
Semi-private room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but \$1,024/benefit period*	\$1,024 (Part A Deductible)	\$0
61st through 90th day	All but \$256 a day	\$256 a day	\$0
91st day and after:			
· While using 60 lifetime reserve days	All but \$512 a day	\$512 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
Skilled Nursing Facility Care			
You must meet Medicare's requirement, 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 \$128 a day	Up to \$128 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 Plan 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.

***Once you have been billed \$135 of Medicare-Approved amounts for covered services, your Part B Deductible will have been met for the calendar year.

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

The High Deductible Plan pays the same as Plan F after one has paid a calendar year \$1,900 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are \$1,900. Out-of-pocket expenses for the deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductible for Part A and Part B, but does not include the plan’s separate foreign travel emergency deductible.

Part
A
Services

Services	Medicare Pays	After You Pay \$1,900 Deductible, Plan Pays	In Addition To \$1,900 Deductible, You Pay
Blood First three pints Additional amounts	\$0 100%	Three pints \$0	\$0 \$0
Hospice Care Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

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

The High Deductible Plan pays the same as Plan F after one has paid a calendar year \$1,900 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are \$1,900. Out-of-pocket expenses for the deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductible for Part A and Part B, but does not include the plan’s separate foreign travel emergency deductible.

**Part
 B
 Services**

Services	Medicare Pays	After You Pay \$1,900 Deductible, Plan Pays	In Addition To \$1,900 Deductible, You Pay
Medical Expenses – In or Out of the Hospital and Outpatient Hospital Treatment such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment			
First \$135 of Medicare-approved amounts (Part B Deductible)***	\$0	\$135	\$0
Remainder of Medicare-approved amount	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare-approved amounts)	\$0	100%	\$0
Blood			
First three pints	\$0	All costs	\$0
Next \$135 of Medicare-approved amounts***	\$0	\$135	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services – Tests for Diagnostic Services	100%	\$0	\$0

***Once you have been billed \$135 of Medicare-Approved amounts for covered services, your Part B Deductible will have been met for the calendar year.

SmartChoice (High Deductible Plan F)

PARTS A & B

The High Deductible Plan pays the same as Plan F after one has paid a calendar year \$1,900 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are \$1,900. Out-of-pocket expenses for the deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductible for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

Part
A+B
Services

Services	Medicare Pays	After You Pay \$1,900 Deductible, Plan Pays	In Addition To \$1,900 Deductible, You Pay
Home Health Care Medicare-approved Services			
· Medically-necessary skilled care services and medical supplies	100%	\$0	\$0
· Durable medical equipment			
First \$135 of Medicare-approved amounts***	\$0	\$135	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0

***Once you have been billed \$135 of Medicare-Approved amounts for covered services, your Part B Deductible will have been met for the calendar year.

SmartChoice (High Deductible Plan F)
OTHER BENEFITS – NOT COVERED BY MEDICARE

The High Deductible Plan pays the same as Plan F after one has paid a calendar year \$1,900 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are \$1,900. Out-of-pocket expenses for the deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductible for Part A and Part B, but does not include the plan’s separate foreign travel emergency deductible.

Services	Medicare Pays	After You Pay \$1,900 Deductible,* Plan Pays	In Addition To \$1,900 Deductible,* You Pay
Other Benefits Not Covered By Medicare			
Foreign Travel – Not Covered by Medicare			
Medically-necessary emergency care services beginning during the first 60 days of each trip outside the United States			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	Generally 80% to a lifetime maximum benefit of \$50,000	Generally 20% and amounts over the \$50,000 lifetime maximum



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