



Anthem Blue Cross – California

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

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

**OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE
BENEFIT STANDARD PLANS A, C, F, I, J, SMARTCHOICE
(HIGH DEDUCTIBLE PLAN F), SMARTCHOICE PREFERRED,
SMARTCHOICE PLUS AND ADVANTAGECARE**

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, C, F, I, J,
SMARTCHOICE (HIGH DEDUCTIBLE PLAN F), SMARTCHOICE
PREFERRED, SMARTCHOICE PLUS AND ADVANTAGECARE**

Effective March 1, 2008

ClaimFree® 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	\$ 96	\$ 184	\$ 101	\$ 194	\$ 94	\$ 182
67-69	99	190	104	201	99	190
70-74	126	220	133	235	126	220
75+	158	283	167	301	158	283

Blue Cross Senior Classic 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	\$ 113	\$ 217	\$ 133	\$ 258	\$ 124	\$ 243
67-69	117	224	137	268	130	252
70-74	160	285	190	327	179	308
75-79	207	377	235	438	222	413
80+	210	382	241	446	227	421

Blue Cross Senior Classic 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	\$ 121	\$ 236	\$ 147	\$ 287	\$ 139	\$ 271
67-69	126	245	153	298	143	281
70-74	170	302	209	368	197	346
75-79	218	390	261	468	246	442
80+	220	394	264	475	249	448



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SMARTCHOICE (HIGH DEDUCTIBLE PLAN F), SMARTCHOICE
PREFERRED, SMARTCHOICE PLUS AND ADVANTAGECARE
Effective March 1, 2008**

Blue Cross Classic I <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 & Spouse</i>	<i>Member Only</i>	<i>Member & Spouse</i>
65-69	\$ 119	\$ 235	\$ 138	\$ 273
70-74	159	295	187	345
75-79	204	376	233	433
80+	211	391	243	446

Blue Cross Classic J <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 & Spouse</i>	<i>Member Only</i>	<i>Member & Spouse</i>
65-69	\$ 156	\$ 304	\$ 175	\$ 342
70-74	211	389	237	439
75-79	266	493	296	550
80+	269	500	298	554

<i>Attained Age</i>	Blue Cross SmartChoice Plan*		Blue Cross SmartChoice Preferred Plan*	
	<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

Blue Cross SmartChoice Plus Plan Rider & AdvantageCare Rider (All Areas)

<i>Issue Age</i>	65	66	67	68	69	70	71	72	73	74	75
Monthly Premium**	\$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 Monthly premium to be added to the Blue Cross Senior SmartChoice premium.
AdvantageCare Rider Monthly premium to be added to the Blue Cross Senior Classic F premium.



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How to Determine Your Rate:

The rate is based on your age, as of the effective date of the policy. Rates for the SmartChoice Plan and SmartChoice Preferred Plan 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 for **ClaimFree Standard Plan A, Blue Cross Senior Classic C, Blue Cross Senior Classic F, Blue Cross Senior Classic I, Blue Cross Senior Classic J, Blue Cross Senior SmartChoice, Senior SmartChoice Preferred and Senior SmartChoice PLUS Plan Rider and AdvantageCare Rider** effective March 1, 2008.

MONTHLY RATES – STANDARD PLANS A, C, F, I, J, SMARTCHOICE (HIGH DEDUCTIBLE PLAN F), SMARTCHOICE PREFERRED, SMARTCHOICE PLUS AND ADVANTAGECARE *Effective March 1, 2008*

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 COVERAGE

Outline of Coverage for Policy Form Series

**Standard Plan A, Standard Plan C,
Standard Plan F, Standard Plan I
Standard Plan J,
SmartChoice (High Deductible F Plans),
SmartChoice Preferred, SmartChoice Plus,
AdvantageCare Rider
Retain This Outline For Your Records**

Premium Information

Your premium rate increases based upon your Attained Age, except SmartChoice Plus Rider and the AdvantageCare 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 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 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 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.

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.

Part
A+B
Services

STANDARD PLAN C

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 C 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	\$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.

Part
A
Services

**STANDARD PLAN C
 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 C 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 C
 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 C 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	\$135 Generally 20% \$0	\$0 \$0 All Costs
Blood First three pints Next \$135 of Medicare-approved amounts Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$135 20%	\$0 \$0 \$0
Clinical Laboratory Services Tests for Diagnostic Services	100%	\$0	\$0

Part
B
 Services

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

Part
A+B
Services

Other
Benefits –
Not Covered
by Medicare

**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 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 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.

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.

Part
B
Services

**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.

Part
A+B
Services

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.

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.

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.

Part
B
Services

**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.

**Part
 A
 Services**

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

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.

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
Remainder of charges	\$0	Generally 80% to a lifetime maximum benefit of \$50,000	Generally 20% and amounts over the \$50,000 lifetime maximum

SmartChoice PreferredSM (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.

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.
- † There may be additional charge if you elect cosmetic lens option, such as progressive multifocal lenses, lens coating and lens tinting.
- †† Copay applies to specific procedural codes and charges for physician office visit only.
- ††† Provided such treatment is legal in the state where performed. Chiropractic Maintenance Therapy is not covered by this policy.
- †††† Benefits are not subject to \$1,900 annual deductible

**Part
A
Services**

SmartChoice PreferredSM (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 PreferredSM (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 PreferredSM (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 PreferredSM (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
<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 First \$250 each calendar year Remainder of charges</p>	<p>\$0 \$0</p>	<p>\$0 Generally 80% to a lifetime maximum benefit of \$50,000</p>	<p>\$250 Generally 20% and amounts over the \$50,000 lifetime maximum</p>
<p>Vision Care not covered by medicare These benefits are not subject to the 1,900 annual deductible.</p> <p>Glass lenses</p> <p>Frames</p> <p>Contacts</p>	<p>\$0 \$0 \$0</p>	<p>100% for 1 pair of standard eyeglass lenses</p> <p>up to \$75 per 24 month period Or "see contacts benefit"</p> <p>Up to \$95 for one pair per 24 month period</p>	<p>\$20 copay^{††††} for eye exam and remainder of frames or contact lenses^{††}</p> <p>\$20 copay^{††††} for eye exam and remainder of frames or contact lenses^{††}</p> <p>\$20 copay^{††††} for eye exam and remainder of frames or contact lenses^{††}</p>

^{††} Copay applies to specific procedural codes and charges for physician office visit only.

^{††††} Benefits are not subject to \$1,900 annual deductible

SmartChoice PreferredSM (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
Physician Office Visits These benefits are not subject to the 1,900 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 ^{†††} when using a Participating Provider ^{††}
Chiropractic Services These benefits are not subject to the 1,900 annual deductible. Manual Manipulation of spine to correct Subluxation	Generally 80%	Generally 20%	\$10 copay ^{†††} when using a Participating Provider ^{†††}

† There may be additional charge if you elect cosmetic lens option, such as progressive multifocal lenses, lens coating and lens tinting.
 †† Copay applies to specific procedural codes and charges for physician office visit only.
 ††† Provided such treatment is legal in the state where performed. Chiropractic Maintenance Therapy is not covered by this policy.
 †††† Benefits are not subject to \$1,900 annual deductible

**SmartChoice PlusSM (High Deductible Plan F) with Rider
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.

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

†† 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.

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

**SmartChoice PlusSM (High Deductible Plan F) with Rider
 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 PlusSM (High Deductible Plan F) with Rider
 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.

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.

**Part
B
Services**

**SmartChoice PlusSM (High Deductible Plan F) with Rider
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 PlusSM (High Deductible Plan F) with Rider
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 Remainder of charges	\$0 \$0	\$0 Generally 80% to a lifetime maximum benefit of \$50,000	\$250 Generally 20% and amounts over the \$50,000 lifetime maximum

SmartChoice PlusSM (High Deductible Plan F) with Rider
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
Voluntary Individual Outcomes Management Program (if applicable) Nursing or Residential Care Facility Services Rider provides benefits for nursing facility care beyond the first 100 days of Medicare covered services and supplies and residential care facilities. Combined Daily Benefit \$100 and Combined Lifetime Benefit \$36,500 with Home Health and Home Support Services	\$0	100% of billed charges [†] , After 6 months Rider waiting period and 100 days Facility Elimination period ^{††} Up to \$100 per day.	All cost beyond the covered daily maximum amount and amounts above the \$36,500 Lifetime maximum benefit.
Home Health and Home Support Services Rider provides benefits for home health and home support services not covered by Medicare. Combined Daily Benefit \$100 and Combined Lifetime Benefit \$36,500 with Nursing or Residential Care Facility Services	80%	100% of billed charges [†] , After \$1,000 Home Health and Support Deductible, 6 months Rider waiting period and 100 days Facility Elimination period ^{††} Up to \$100 per day.	All cost beyond the covered daily maximum amount and amounts above the \$36,500 Lifetime maximum benefit.

[†] Benefits paid only when services are approved as part of the Plan of Care coordinated through a Care Manager.

^{††} 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.

^{†††} Provided such treatment is legal in the state where performed. Chiropractic Maintenance Therapy is not covered by this policy.

AdvantageCareSM (Classic F w/HHC& Nsg. Care)
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

Services	Medicare Pays	Plan 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.

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

†† 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.

††† Rider Waiting Period must also be met. Deductible needs to be met once over the lifetime of the policy.

Part
A
 Services

AdvantageCareSM (Classic F w/HHC& Nsg. Care)
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

Services	Medicare Pays	Plan 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

AdvantageCareSM (Classic F w/HHC& Nsg. Care)
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

Services	Medicare Pays	Plan Pays	You Pay
Medical Expenses – In or Out of the Hospital and Outpatient Hospital Treatment such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests 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	\$135 Generally 20% 100%	\$0 \$0 \$0
Blood First three pints Next \$135 of Medicare-approved amounts*** Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$135 20%	\$0 \$0 \$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

AdvantageCareSM (Classic F w/HHC& Nsg. Care)
PARTS A & B - OTHER BENEFITS – NOT COVERED BY MEDICARE

Services	Medicare Pays	Plan Pays	You Pay
Part A+B Services Home Health Care Medicare-approved Services <ul style="list-style-type: none"> · Medically-necessary skilled care services and medical supplies · Durable medical equipment First \$135 of Medicare-approved amounts*** Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$135 20%	\$0 \$0 \$0
Other Benefits Not Covered By Medicare Foreign Travel – Not Covered by Medicare Medically-necessary emergency care services beginning during the first 60 days of each trip outside the United States First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 Generally 80% to a lifetime maximum benefit of \$50,000	\$250 Generally 20% and amounts over the \$50,000 lifetime maximum

***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.

AdvantageCareSM (Classic F w/HHC& Nsg. Care)
OTHER BENEFITS – NOT COVERED BY MEDICARE

Services	Medicare Pays	Plan Pays	You Pay
Nursing or Residential Care Facility Services Rider provides benefits for nursing facility care beyond the first 100 days of Medicare covered services and supplies and residential care facilities. Combined Daily Benefit \$100 and Combined Lifetime Benefit \$36,500 with Home Health and Home Support Services	\$0	100% of billed charges [†] , After 6 months Rider waiting period and 100 days Facility Elimination period ^{††} Up to \$100 per day.	All cost beyond the covered daily maximum amount and amounts above the \$36,500 Lifetime maximum benefit.
Home Health and Home Support Services Rider provides benefits for home health and home support services not covered by Medicare. Combined Daily Benefit \$100 and Combined Lifetime Benefit \$36,500 with Nursing or Residential Care Facility Services	80%	100% of billed charges [†] , After \$1,000 Home Health and Support Deductible, 6 months Rider waiting period and 100 days Facility Elimination period ^{††} Up to \$100 per day.	All cost beyond the covered daily maximum amount and amounts above the \$36,500 Lifetime maximum benefit.

[†] Benefits paid only when services are approved as part of the Plan of Care coordinated through a Care Manager.

^{††} 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.

^{†††} Provided such treatment is legal in the state where performed. Chiropractic Maintenance Therapy is not covered by this policy.



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