Anthem

**Anthem Blue Cross Blue Shield – Colorado**
Administrative Office: PO Box 9063, Oxnard, CA 93031-9063
Toll Free Telephone Number: 1-877-831-3000

# 2009 OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE BENEFIT STANDARD PLANS A, B, F, I, J, L AND HIGH DEDUCTIBLE PLAN F (SMARTCHOICE)

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

**See Outlines of Coverage sections for details about ALL plans.**

**Basic Benefits: Included in Plans A - J.**

- **Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.**
- **Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services.**
- **Blood: First three pints of blood each year.**

| 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 Facility Coinsurance | Skilled Nursing Facility Coinsurance | Skilled Nursing Facility Coinsurance | **Skilled Nursing Facility Coinsurance** |
| | **Part A Deductible** | Part A Deductible | Part A Deductible | Part A Deductible | **Part 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 pay the same benefits as Plans F and J after one has paid a calendar year $2,000 deductible. Benefits from High Deductible Plans F and J will not begin until out-of-pocket expenses exceed $2,000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible. Anthem does not offer a high deductible option for Standard Medicare Supplement Plan J.

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| 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<br>50% hospice cost sharing<br>50% of Medicare-eligible expenses for the first three pints of blood<br>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**<br>**75% hospice cost sharing**<br>**75% of Medicare-eligible expenses for the first three pints of blood**<br>**75% Part B coinsurance, except 100% coinsurance for Part B preventive services** |
| Skilled Nursing Facility Coinsurance | Skilled Nursing Facility Coinsurance | **Skilled Nursing Facility Coinsurance** | **Skilled Nursing Facility Coinsurance** | 50% Skilled Nursing Facility Coinsurance | **75% Skilled Nursing Facility 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** | $4,620 Out-of-Pocket Limit*** | **$2,310 Out-of-Pocket Limit*** ** |

* Plans F and J also have an option called a High Deductible Plan F and a High Deductible Plan J. These high deductible plans pay the same benefits as Plans F and J after one has paid a calendar year $2,000 deductible. Benefits from High Deductible Plans F and J will not begin until out-of-pocket expenses exceed $2,000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible. Anthem does not offer a high deductible option for Standard Medicare Supplement Plan J.

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

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

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

*Effective April 1, 2009*

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

| | ***Plan A*** | | ***Plan B*** | | ***Plan I*** | | ***Plan J*** | |
|---|---|---|---|---|---|---|---|---|
| *Attained Age* | *Male* | *Female* | *Male* | *Female* | *Male* | *Female* | *Male* | *Female* |
| <65 | $ 176.40 | $ 165.70 | $ 192.60 | $ 183.30 | $ 246.70 | $ 234.30 | $ 291.70 | $ 277.10 |
| 65-69 | 120.10 | 111.40 | 136.30 | 126.10 | 174.40 | 161.30 | 206.30 | 190.80 |
| 70-74 | 143.80 | 131.00 | 162.90 | 148.50 | 210.40 | 191.30 | 249.00 | 226.00 |
| 75-79 | 164.70 | 150.60 | 186.50 | 170.10 | 241.70 | 219.50 | 285.80 | 259.70 |
| 80+ | 182.50 | 162.10 | 205.70 | 183.80 | 266.00 | 237.40 | 314.60 | 280.80 |

All Other Counties in Colorado*

| | ***Plan A*** | | ***Plan B*** | | ***Plan I*** | | ***Plan J*** | |
|---|---|---|---|---|---|---|---|---|
| *Attained Age* | *Male* | *Female* | *Male* | *Female* | *Male* | *Female* | *Male* | *Female* |
| <65 | $ 161.70 | $ 151.80 | $ 176.60 | $ 168.00 | $ 266.10 | $ 215.00 | $ 266.40 | $ 253.10 |
| 65-69 | 110.20 | 102.10 | 125.10 | 115.60 | 160.00 | 148.00 | 188.20 | 174.10 |
| 70-74 | 131.90 | 120.10 | 149.50 | 136.20 | 193.00 | 175.30 | 227.20 | 206.30 |
| 75-79 | 151.10 | 138.10 | 171.00 | 155.90 | 221.80 | 201.40 | 261.00 | 237.10 |
| 80+ | 167.40 | 148.50 | 188.70 | 168.60 | 243.90 | 217.70 | 287.30 | 256.40 |

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

**Rates are subject to change January 1, 2010.**

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

*Effective April 1, 2009*

| ***Plan F*** | ***Area 1*** | | ***Area 2*** | | ***Area 3*** | |
|---|---|---|---|---|---|---|
| *Attained Age* | *Male* | *Female* | *Male* | *Female* | *Male* | *Female* |
| <65 | $ 207.00 | $ 178.40 | $ 188.30 | $ 161.80 | $ 169.50 | $ 145.30 |
| 65 | 153.10 | 132.10 | 138.70 | 120.00 | 124.40 | 107.90 |
| 66 | 158.50 | 136.60 | 144.20 | 124.40 | 129.90 | 112.30 |
| 67 | 166.20 | 143.20 | 150.90 | 129.90 | 135.40 | 116.70 |
| 68 | 171.80 | 148.60 | 156.40 | 135.40 | 140.90 | 122.30 |
| 69 | 179.40 | 155.20 | 162.90 | 140.90 | 146.50 | 126.60 |
| 70 | 186.10 | 160.80 | 169.50 | 146.50 | 153.10 | 132.10 |
| 71 | 193.70 | 167.40 | 176.10 | 151.90 | 158.50 | 136.60 |
| 72 | 202.60 | 174.00 | 183.90 | 158.50 | 165.20 | 143.20 |
| 73 | 214.80 | 183.90 | 194.90 | 167.40 | 175.10 | 150.90 |
| 74 | 226.80 | 194.90 | 205.90 | 177.30 | 185.00 | 159.70 |
| 75 | 240.00 | 207.00 | 218.10 | 188.30 | 196.00 | 169.50 |
| 76 | 253.30 | 219.10 | 230.10 | 199.30 | 207.00 | 179.40 |
| 77 | 268.60 | 231.20 | 244.40 | 210.30 | 220.20 | 189.40 |
| 78 | 276.30 | 239.00 | 251.00 | 216.90 | 225.70 | 194.90 |
| 79 | 285.20 | 245.60 | 258.70 | 223.50 | 233.40 | 201.50 |
| 80+ | 294.00 | 253.30 | 267.60 | 230.10 | 241.10 | 207.00 |

Area 1 includes Adams, Arapahoe, Broomfield, Denver, Douglas & Jefferson counties.

Area 2 includes Boulder, Larimer & Pueblo counties.

Area 3 includes all other counties in Colorado.

Electronic Funds Transfer (EFT) Discount: a $2.00 discount per month off the total premium is available when monthly payments are paid through the Checking Account Deduction Program.

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

*Effective April 1, 2009*

| ***Plan L*** | ***Area 1*** | | ***Area 2*** | | ***Area 3*** | |
|---|---|---|---|---|---|---|
| *Attained Age* | *Male* | *Female* | *Male* | *Female* | *Male* | *Female* |
| <65 | $ 132.10 | $ 113.40 | $ 120.00 | $ 103.50 | $ 107.90 | $ 93.60 |
| 65 | 98.00 | 84.80 | 89.20 | 77.00 | 80.30 | 69.30 |
| 66 | 101.20 | 87.00 | 92.50 | 79.30 | 83.60 | 71.60 |
| 67 | 105.70 | 91.40 | 95.80 | 82.60 | 85.90 | 74.90 |
| 68 | 110.10 | 94.70 | 100.20 | 85.90 | 90.30 | 77.00 |
| 69 | 115.60 | 99.10 | 104.60 | 90.30 | 94.70 | 81.50 |
| 70 | 120.00 | 103.50 | 109.00 | 93.60 | 98.00 | 84.80 |
| 71 | 124.40 | 107.90 | 113.40 | 98.00 | 102.40 | 88.10 |
| 72 | 129.90 | 111.20 | 117.80 | 101.20 | 105.70 | 91.40 |
| 73 | 136.60 | 119.00 | 124.40 | 107.90 | 112.30 | 96.90 |
| 74 | 145.30 | 124.40 | 132.10 | 113.40 | 119.00 | 102.40 |
| 75 | 154.20 | 132.10 | 139.90 | 120.00 | 125.60 | 107.90 |
| 76 | 161.80 | 140.90 | 147.50 | 127.70 | 133.20 | 114.50 |
| 77 | 171.80 | 147.50 | 156.40 | 134.30 | 140.90 | 121.10 |
| 78 | 177.30 | 153.10 | 160.80 | 138.70 | 144.20 | 124.40 |
| 79 | 182.80 | 157.50 | 166.20 | 143.20 | 149.80 | 128.90 |
| 80+ | 188.30 | 161.80 | 170.70 | 147.50 | 154.20 | 133.20 |

Area 1 includes Adams, Arapahoe, Broomfield, Denver, Douglas & Jefferson counties.

Area 2 includes Boulder, Larimer & Pueblo counties.

Area 3 includes all other counties in Colorado.

**Rates are subject to change January 1, 2010.**

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

*Effective April 1, 2009*

| ***SmartChoice High Deductible Plan F*** | ***Area 1*** | | ***Area 2*** | | ***Area 3*** | |
|---|---|---|---|---|---|---|
| *Attained Age* | *Male* | *Female* | *Male* | *Female* | *Male* | *Female* |
| <65 | $ 69.30 | $ 59.40 | $ 62.70 | $ 54.00 | $ 56.10 | $ 48.40 |
| 65 | 50.70 | 45.10 | 46.20 | 40.80 | 41.80 | 36.40 |
| 66 | 52.80 | 46.20 | 48.40 | 41.80 | 44.10 | 37.40 |
| 67 | 56.10 | 48.40 | 50.70 | 44.10 | 45.10 | 39.70 |
| 68 | 58.40 | 49.50 | 52.80 | 45.10 | 47.40 | 40.80 |
| 69 | 60.60 | 51.70 | 55.10 | 47.40 | 49.50 | 43.00 |
| 70 | 62.70 | 55.10 | 57.30 | 49.50 | 51.70 | 45.10 |
| 71 | 65.00 | 57.30 | 59.40 | 51.70 | 54.00 | 46.20 |
| 72 | 68.30 | 58.40 | 61.70 | 52.80 | 55.10 | 47.40 |
| 73 | 71.60 | 61.70 | 65.00 | 56.10 | 58.40 | 50.70 |
| 74 | 76.00 | 65.00 | 69.30 | 59.40 | 62.70 | 54.00 |
| 75 | 81.50 | 69.30 | 73.70 | 62.70 | 66.00 | 56.10 |
| 76 | 84.80 | 73.70 | 77.00 | 67.20 | 69.30 | 60.60 |
| 77 | 91.40 | 77.00 | 82.60 | 70.50 | 74.90 | 63.90 |
| 78 | 93.60 | 80.30 | 84.80 | 72.70 | 76.00 | 65.00 |
| 79 | 95.80 | 82.60 | 87.00 | 74.90 | 78.20 | 67.20 |
| 80+ | 99.10 | 84.80 | 90.30 | 77.00 | 81.50 | 69.30 |

Area 1 includes Adams, Arapahoe, Broomfield, Denver, Douglas & Jefferson counties.

Area 2 includes Boulder, Larimer & Pueblo counties.

Area 3 includes all other counties in Colorado.

Electronic Funds Transfer (EFT) Discount: a $2.00 discount per month off the total premium is available when monthly payments are paid through the Checking Account Deduction Program.

**Rates are subject to change January 1, 2010.**

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# MEDICARE SUPPLEMENT OUTLINE OF COVERAGE

**Outline of Coverage for Policy Form Series**

**Standard Plan A, Standard Plan B, Standard Plan F, High Deductible Plan F (SmartChoice), Standard Plan I Standard Plan J, Standard Plan L**

**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.

## 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.

## Disclosures

Use this outline to compare benefits and premiums among policies.

## Right To Return Policy

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

## Policy Replacement

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

## Notice

This policy may not fully cover all of your medical costs. Neither Anthem nor its associates are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult the "Medicare & You" handbook for more details.

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## 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.

## Guaranteed Acceptance and Renewal

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

Our Medicare Supplemental plans are guaranteed renewable.

## STANDARD PLAN A

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

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

**Part A Services**

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

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

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

## STANDARD PLAN A

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

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

**Part A Services**

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

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

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

**Part B Services**

| 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* | $0 | $0 | $135 (Part B deductible) |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 20% | $0 |
| **Part B Excess Charges** (Above Medicare-approved amounts) | $0 | $0 | All costs |
| **Blood** | | | |
| First three pints | $0 | All costs | $0 |
| Next $135 of Medicare-approved amounts* | $0 | $0 | $135 (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| **Clinical Laboratory Services** Tests for Diagnostic Services | 100% | $0 | $0 |

* Once you have been billed $135 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

## STANDARD PLAN A
### PARTS A & B

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

**Parts A+B Services**

| Services | Medicare Pays | Standard Plan A Pays | You Pay |
|---|---|---|---|
| **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 (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |

* Once you have been billed $135 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

## STANDARD PLAN B

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

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

**Part A Services**

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

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

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

## STANDARD PLAN B

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

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

**Part A Services**

| Services | Medicare Pays | Standard Plan B Pays | You Pay |
|---|---|---|---|
| **Blood** | | | |
| First three pints | $0 | Three pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **Hospice Care**<br>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, 2009. Medicare may change these amounts annually. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the "Medicare & You" handbook for more details.

**Part B Services**

| 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* | $0 | $0 | $135 (Part B deductible) |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 20% | $0 |
| **Part B Excess Charges** (Above Medicare-approved amounts) | $0 | $0 | All costs |
| **Blood** | | | |
| First three pints | $0 | All costs | $0 |
| Next $135 of Medicare-approved amounts* | $0 | $0 | $135 (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| **Clinical Laboratory Services** Tests for Diagnostic Services | 100% | $0 | $0 |

* Once you have been billed $135 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

## STANDARD PLAN B
### PARTS A & B

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

**Parts A+B Services**

| Services | Medicare Pays | Standard Plan 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 (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |

* Once you have been billed $135 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

## STANDARD PLAN F

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

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

**Part A Services**

| 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 $1,068 | $1,068 (Part A deductible) | $0 |
| 61st through 90th day | All but $267 a day | $267 a day | $0 |
| 91st day and after: | | | |
| · While using 60 lifetime reserve days | All but $534 a day | $534 a day | $0 |
| · Once lifetime reserve days are used: | | | |
| — Additional 365 days | $0 | 100% of Medicare-eligible expenses | $0** |
| — Beyond the additional 365 days | $0 | $0 | All costs |
| **Skilled Nursing Facility Care*** You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st through 100th day | All but $133.50 a day | Up to $133.50 a day | $0 |
| 101st day and after | $0 | $0 | All costs |

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

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

## STANDARD PLAN F

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

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

**Part A Services**

| Services | Medicare Pays | Standard Plan F Pays | You Pay |
|---|---|---|---|
| **Blood** | | | |
| First three pints | $0 | Three pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **Hospice Care**<br>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, 2009. Medicare may change these amounts annually. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the "Medicare & You" handbook for more details.

**Part B Services**

| 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* | $0 | $135 (Part B deductible) | $0 |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 20% | $0 |
| **Part B Excess Charges** (Above Medicare-approved amounts) | $0 | 100% | $0 |
| **Blood** | | | |
| First three pints | $0 | All costs | $0 |
| Next $135 of Medicare-approved amounts* | $0 | $135 (Part B deductible) | $0 |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| **Clinical Laboratory Services —** Tests for Diagnostic Services | 100% | $0 | $0 |

* Once you have been billed $135 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

## STANDARD PLAN F
### PARTS A & B

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

**Parts A+B Services**

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

* Once you have been billed $135 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

## STANDARD PLAN F
### OTHER BENEFITS — NOT COVERED BY MEDICARE

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

**Other Benefits Not Covered By Medicare**

| Services | Medicare Pays | Standard Plan F Pays | You Pay |
|---|---|---|---|
| **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 | 80% to a lifetime maximum benefit of $50,000 | 20% and amounts over the $50,000 lifetime maximum |

## High Deductible Plan F (SmartChoice)

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

The High Deductible Plan pays the same benefits as Plan F after one has paid a calendar year $2,000 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are $2,000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

**Part A Services**

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

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

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

## High Deductible Plan F (SmartChoice)

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

The High Deductible Plan pays the same benefits as Plan F after one has paid a calendar year $2,000 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are $2,000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

**Part A Services**

| Services | Medicare Pays | After You Pay $2,000 Deductible, Plan Pays | In Addition To $2,000 Deductible, You Pay |
|---|---|---|---|
| **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 |

## High Deductible Plan F (SmartChoice)

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

The High Deductible Plan pays the same benefits as Plan F after one has paid a calendar year $2,000 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are $2,000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

**Part B Services**

| Services | Medicare Pays | After You Pay $2,000 Deductible, Plan Pays | In Addition To $2,000 Deductible, You Pay |
|---|---|---|---|
| **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* | $0 | $135 (Part B deductible) | $0 |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 20% | $0 |
| **Part B Excess Charges** (Above Medicare-approved amounts) | $0 | 100% | $0 |
| **Blood** | | | |
| First three pints | $0 | All costs | $0 |
| Next $135 of Medicare-approved amounts* | $0 | $135 (Part B deductible) | $0 |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| **Clinical Laboratory Services —** Tests for Diagnostic Services | 100% | $0 | $0 |

* Once you have been billed $135 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

## High Deductible Plan F (SmartChoice)
**PARTS A & B**

The High Deductible Plan pays the same benefits as Plan F after one has paid a calendar year $2,000 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are $2,000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

**Parts A+B Services**

| Services | Medicare Pays | After You Pay $2,000 Deductible, Plan Pays | In Addition To $2,000 Deductible, You Pay |
|---|---|---|---|
| **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 (Part B deductible) | $0 |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |

* Once you have been billed $135 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

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

The High Deductible Plan pays the same benefits as Plan F after one has paid a calendar year $2,000 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are $2,000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

**Other Benefits Not Covered By Medicare**

| Services | Medicare Pays | After You Pay $2,000 Deductible, Plan Pays | In Addition To $2,000 Deductible, You Pay |
|---|---|---|---|
| **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 | 80% to a lifetime maximum benefit of $50,000 | 20% and amounts over the $50,000 lifetime maximum |

## STANDARD PLAN I

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

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

**Part A Services**

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

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

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

## STANDARD PLAN I

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

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

**Part A Services**

| Services | Medicare Pays | Standard Plan I Pays | You Pay |
|---|---|---|---|
| **Blood** | | | |
| First three pints | $0 | Three pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **Hospice Care**<br>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, 2009. Medicare may change these amounts annually. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the "Medicare & You" handbook for more details.

**Part B Services**

| 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* | $0 | $0 | $135 (Part B deductible) |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 20% | $0 |
| **Part B Excess Charges** (Above Medicare-approved amounts) | $0 | 100% | $0 |
| **Blood** | | | |
| First 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 (which are noted with an asterisk), 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, 2009. Medicare may change these amounts annually. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the "Medicare & You" handbook for more details.

**Parts A+B Services**

| Services | Medicare Pays | Standard Plan I Pays | You Pay |
|---|---|---|---|
| **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 (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |

* Once you have been billed $135 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

## STANDARD PLAN I

### OTHER BENEFITS — NOT COVERED BY MEDICARE

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

**Other Benefits Not Covered By Medicare**

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

## STANDARD PLAN J

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

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

**Part A Services**

| 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 $1,068 | $1,068 (Part A deductible) | $0 |
| 61st through 90th day | All but $267 a day | $267 a day | $0 |
| 91st day and after: | | | |
| · While using 60 lifetime reserve days | All but $534 a day | $534 a day | $0 |
| · Once lifetime reserve days are used: | | | |
| — Additional 365 days | $0 | 100% of Medicare-eligible expenses | $0** |
| — Beyond the additional 365 days | $0 | $0 | All costs |
| **Skilled Nursing Facility Care*** You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st through 100th day | All but $133.50 a day | Up to $133.50 a day | $0 |
| 101st day and after | $0 | $0 | All costs |

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

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

## STANDARD PLAN J

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

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

**Part A Services**

| Services | Medicare Pays | Standard Plan J Pays | You Pay |
|---|---|---|---|
| **Blood** | | | |
| First three pints | $0 | Three pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **Hospice Care**<br>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, 2009. Medicare may change these amounts annually. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the "Medicare & You" handbook for more details.

**Part B Services**

| 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* | $0 | $135 (Part B deductible) | $0 |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 20% | $0 |
| **Part B Excess Charges** (Above Medicare-approved amounts) | $0 | 100% | $0 |
| **Blood** | | | |
| First three pints | $0 | All costs | $0 |
| Next $135 of Medicare-approved amounts* | $0 | $135 (Part B deductible) | $0 |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| **Clinical Laboratory Services —** Tests for Diagnostic Services | 100% | $0 | $0 |

* Once you have been billed $135 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

## STANDARD PLAN J
### PARTS A & B

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

**Parts A+B Services**

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

* Once you have been billed $135 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

## STANDARD PLAN J

### OTHER BENEFITS — NOT COVERED BY MEDICARE

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

**Other Benefits Not Covered By Medicare**

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

## STANDARD PLAN J

### OTHER BENEFITS — NOT COVERED BY MEDICARE

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

**Other Benefits Not Covered By Medicare**

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

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

## STANDARD PLAN L

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

Medicare deductibles and co-insurance amounts are effective as of January 1, 2009. Medicare may change these amounts annually. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the "Medicare & You" handbook for more details. You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $2,310 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 and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

**Part A Services**

| 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 $1,068 | $801 (75% of Part A deductible) | $267 (25% of Medicare Part A deductible) |
| 61st through 90th day | All but $267 a day | $267 a day | $0 |
| 91st day and after: | | | |
| · While using 60 lifetime reserve days | All but $534 a day | $534 a day | $0 |
| · Once lifetime reserve days are used: | | | |
| — Additional 365 days | $0 | 100% of Medicare-eligible expenses | $0** |
| — Beyond the additional 365 days | $0 | $0 | All costs |

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

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

## STANDARD PLAN L

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

Medicare deductibles and co-insurance amounts are effective as of January 1, 2009. Medicare may change these amounts annually. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the "Medicare & You" handbook for more details. You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $2,310 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 and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

**Part A Services**

| Services | Medicare Pays | Standard Plan L Pays | You Pay |
|---|---|---|---|
| **Skilled Nursing Facility Care*** You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st through 100th day | All but $133.50 a day | Up to $96 (75%) a day | 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.

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**Part A Services**

| Services | Medicare Pays | Standard Plan L Pays | You Pay |
|---|---|---|---|
| **Blood** | | | |
| First three pints | $0 | 75% | 25% |
| Additional amounts | 100% | $0 | $0 |
| **Hospice Care**<br>Available as long as your doctor certifies you are terminally ill and you elect to receive these services | Generally, most Medicare-eligible expenses for outpatient drugs and inpatient respite care | 75% of coinsurance or copayments | 25% of coinsurance or copayments |

## STANDARD PLAN L

### MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR

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**Part B Services**

| 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* | $0 | $0 | $135 (Part B deductible) |
| 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 amounts | Generally 80% | Generally 15% | Generally 5% |
| **Part B Excess Charges** (Above Medicare-approved amounts) | $0 | $0 | All costs (and they do not count toward annual out-of-pocket limit of $2,310) |

* Once you have been billed $135 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

## STANDARD PLAN L

### MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR

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**Part B Services**

| Services | Medicare Pays | Standard Plan L Pays | You Pay |
|---|---|---|---|
| **Blood** | | | |
| First three pints | $0 | 75% | 25% |
| Next $135 of Medicare-approved amounts* | $0 | $0 | $135 (Part B deductible) |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 15% | 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 (which are noted with an asterisk), 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, 2009. Medicare may change these amounts annually. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the "Medicare & You" handbook for more details. You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $2,310 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 and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

**Parts A+B Services**

| 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 | $135 (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 15% | 5% |

* Once you have been billed $135 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

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