

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE (BENEFIT PLANS A, C, F AND J)

This chart shows the benefits included in each plan. Every insurance company must offer Plan A. Some plans may not be available in Idaho.

BASIC BENEFITS INCLUDED IN ALL PLANS

<p>HOSPITALIZATION: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end</p>	<p>MEDICAL EXPENSES: Part B coinsurance (20% of Medicare approved expenses)</p>	<p>BLOOD: First 3 pints of blood each year</p>
---	--	---

CLASSIC BLUE PLAN A	B	CLASSIC BLUE PLAN C	D	E	CLASSIC BLUE PLAN F	G	H	I	CLASSIC BLUE PLAN J
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	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 A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-home Recovery			At-home Recovery		At-home Recovery	At-home Recovery
				Preventive Care					Preventive Care

MEDICARE (PART A) HOSPITAL SERVICES – PER BENEFIT PERIOD

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

SERVICES	MEDICARE	CLASSIC BLUE PLAN A	CLASSIC BLUE PLAN C	CLASSIC BLUE PLAN F	CLASSIC BLUE PLAN J
Hospitalization <i>Semiprivate room and board, general nursing and miscellaneous services and supplies</i>					
First 60 days	Covers all but \$1,068	Covers \$0	Covers \$1,068 (your Part A deductible)	Covers \$1,068 (your Part A deductible)	Covers \$1,068 (your Part A deductible)
Days 61 through 90	Covers all but \$267 a day	Covers up to \$267 a day	Covers up to \$267 a day	Covers up to \$267 a day	Covers up to \$267 a day
Days 91 and after, while using 60 lifetime reserve days	Covers all but \$534 a day	Covers up to \$534 a day	Covers up to \$534 a day	Covers up to \$534 a day	Covers up to \$534 a day
After lifetime reserve days are used, additional 365 days	Covers \$0	Pays 100% of Medicare eligible charges	Pays 100% of Medicare eligible charges	Pays 100% of Medicare eligible charges	Pays 100% of Medicare eligible charges
Beyond the additional 365 days	Covers \$0	Covers \$0	Covers \$0	Covers \$0	Covers \$0

Skilled Nursing Facility Care

You must meet Medicare's requirements, including having been in the hospital for at least three days and entered a Medicare approved facility within 30 days after leaving the hospital

First 20 days	Covers all approved amounts	Covers \$0	Covers \$0	Covers \$0	Covers \$0
Days 21 through 100	Covers all but \$133 a day	Covers \$0	Covers up to \$133 a day	Covers up to \$133 a day	Covers up to \$133 a day
Day 101 and after	Covers \$0	Covers \$0	Covers \$0	Covers \$0	Covers \$0

Blood

First 3 pints	Covers \$0	Covers 3 pints	Covers 3 pints	Covers 3 pints	Covers 3 pints
Additional amounts	Covers 80%	Covers 20% of approved charges	Covers 20% of approved charges	Covers 20% of approved charges	Covers 20% of approved charges

Hospice Care

Available as long as your doctor certifies that you are terminally ill and you elect to receive these services

	Covers all but limited coinsurance for outpatient drugs and inpatient respite care	Covers \$0	Covers \$0	Covers \$0	Covers \$0
--	--	------------	------------	------------	------------

MEDICARE (PART B) HOSPITAL SERVICES – PER CALENDAR YEAR

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

SERVICES	MEDICARE	CLASSIC BLUE PLAN A	CLASSIC BLUE PLAN C	CLASSIC BLUE PLAN F	CLASSIC BLUE PLAN J
----------	----------	---------------------	---------------------	---------------------	---------------------

Medical Expenses

Inpatient and outpatient hospital treatment such as, physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, outpatient facility charges

First \$135 of Medicare approved amounts*	Covers \$0	Covers \$0	Covers \$135 (your Part B deductible)	Covers \$135 (your Part B deductible)	Covers \$135 (your Part B deductible)
Remainder of Medicare approved amounts*	Covers 80%	Covers 20%	Covers 20%	Covers 20%	Covers 20%
Part B excess charges (above Medicare approved amounts)	Covers \$0	Covers \$0	Covers \$0	Covers 100% of Medicare Part B excess charges up to a limiting charge as determined by Medicare	Covers 100% of Medicare Part B excess charges up to a limiting charge as determined by Medicare

Blood

First 3 pints	Covers \$0	Covers all costs	Covers all costs	Covers all costs	Covers all costs
Next \$135 of Medicare approved amounts*	Covers \$0	Covers \$0	Covers \$135 (your Part B deductible)	Covers \$135 (your Part B deductible)	Covers \$135 (your Part B deductible)
Remainder of Medicare approved amounts*	Covers 80%	Covers 20%	Covers 20%	Covers 20%	Covers 20%

Home Health Care

Medicare approved services

Medically necessary skilled care and services and medical supplies	Covers 100%	Covers \$0	Covers \$0	Covers \$0	Covers \$0
--	-------------	------------	------------	------------	------------

Durable Medical Equipment

First \$135 of Medicare approved amounts*	Covers \$0	Covers \$0	Covers \$135 (your Part B deductible)	Covers \$135 (your Part B deductible)	Covers \$135 (your Part B deductible)
Remainder of Medicare approved amounts	Covers 80%	Covers 20%	Covers 20%	Covers 20%	Covers 20%