

Outline of Medicare Supplement Coverage – Cover Page:

Standard Medicare Supplement Benefit Plans A, B, F, I and J

Medicare Supplement insurance can be sold in only ten 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 **Colorado**.

BASIC BENEFITS: Included in all Plans.

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (20% of Medicare-approved expenses) or, in the case of hospital outpatient department services under a prospective payment system, applicable Copayments.

Blood: First three pints of blood each year.

You have the option to purchase an Anthem Medicare Supplement Plan shown in gray.

A	B	C	D	E	F	F†	G	H	I	J	J†
Basic Benefits	Basic Benefits	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	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 A Deductible	Part A Deductible
		Part B 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%	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	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery				At-Home Recovery		At-Home Recovery	At-Home Recovery	At-Home Recovery
							Basic Drugs (\$1,250 Limit)		Basic Drugs (\$1,250 Limit)		Extended Drugs (\$3,000 Limit)
				Preventive Care							Preventive Care

† Standard Medicare Supplement Plans F and J have an option called a high deductible Plan F and high deductible Plan J. These high deductible plans pay the same or offer the same benefits a Plans F and J after one has paid a calendar year \$1,730 deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses are \$1,730. 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 does not include, in Plan J, the plan’s separate prescription drug deductible or, in Plans F and J, the plan’s separate foreign travel emergency deductible. **Anthem does not offer a high deductible option for Standard Medicare Supplement Plans F and J.**

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PREMIUM INFORMATION

These monthly premiums are effective January 1, 2005.

We, Anthem Blue Cross and Blue Shield, can only raise your premium if we raise the premium for all policies like yours in this state. Premiums automatically increase as you get older. You can expect your premiums to increase due to changes in age.

Age at Enrollment	PLAN A		PLAN B		PLAN F	
	Male	Female	Male	Female	Male	Female
<65 Disabled	M1	\$138.00	M1	\$129.60	M1	\$143.50
	M2	\$126.60	M2	\$118.80	M2	\$131.50
65 - 69	M1	\$94.00	M1	\$87.20	M1	\$98.70
	M2	\$86.20	M2	\$79.90	M2	\$90.50
70 - 74	M1	\$112.50	M1	\$102.50	M1	\$116.20
	M2	\$103.20	M2	\$94.00	M2	\$106.60
75 -79	M1	\$128.90	M1	\$117.80	M1	\$133.00
	M2	\$118.20	M2	\$108.00	M2	\$122.00
80+	M1	\$142.80	M1	\$126.80	M1	\$143.80
	M2	\$130.90	M2	\$116.20	M2	\$131.90
<65 Disabled	M1	\$205.10	M1	\$188.10	M1	\$199.00
	M2	\$182.50	M2	\$173.70	M2	\$189.50
65 - 69	M1	\$137.80	M1	\$126.30	M1	\$140.40
	M2	\$119.00	M2	\$106.60	M2	\$117.20
70 - 74	M1	\$168.30	M1	\$154.30	M1	\$160.70
	M2	\$140.40	M2	\$122.00	M2	\$131.90
75 -79	M1	\$192.60	M1	\$176.60	M1	\$189.50
	M2	\$160.70	M2	\$143.80	M2	\$153.10
80+	M1	\$211.90	M1	\$194.40	M1	\$205.10
	M2	\$173.70	M2	\$154.30	M2	\$168.30

Age at Enrollment	PLAN I		PLAN J	
	Male	Female	Male	Female
<65 Disabled	M1	\$307.40	M1	\$362.50
	M2	\$281.90	M2	\$331.00
65 - 69	M1	\$217.40	M1	\$256.40
	M2	\$199.40	M2	\$233.90
70 - 74	M1	\$262.30	M1	\$309.40
	M2	\$240.50	M2	\$282.40
75 -79	M1	\$301.30	M1	\$355.30
	M2	\$276.40	M2	\$324.30
80+	M1	\$331.70	M1	\$391.00
	M2	\$304.10	M2	\$357.00
<65 Disabled	M1	\$292.10	M1	\$344.40
	M2	\$267.90	M2	\$314.50
65 - 69	M1	\$201.10	M1	\$237.00
	M2	\$184.40	M2	\$216.40
70 - 74	M1	\$238.10	M1	\$280.80
	M2	\$218.40	M2	\$256.40
75 -79	M1	\$273.60	M1	\$322.60
	M2	\$251.00	M2	\$294.60
80+	M1	\$296.00	M1	\$348.90
	M2	\$271.50	M2	\$318.50

M1 – Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Jefferson, Larimer, and Pueblo counties
M2 – El Paso, Mesa, Weld and rural counties

Rural counties include Alamosa, Archuleta, Baca, Bent, Chaffee, Cheyenne, Clear Creek, Conejos, Costilla, Crowley, Custer, Delta, Dolores, Eagle, Elbert, Fremont, Garfield, Gilpin, Grand, Gunnison, Hinsdale, Huerfano, Jackson, Kiowa, Kit Carson, La Plata, Lake, Las Animas, Lincoln, Logan, Mineral, Moffat, Montezuma, Montrose, Morgan, Otero, Ouray, Park, Phillips, Pitkin, Prowers, Rio Blanco, Rio Grande, Routt, Saguache, San Juan, San Miguel, Sedgwick, Summit, Teller, Washington, Yuma

DISCLOSURES

(all plans)

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 your insurance company.

RIGHT TO RETURN POLICY

If you find you are not satisfied with your policy, you may return it to Anthem Blue Cross and Blue Shield, P.O. Box 17349, Denver, CO 80217-0349. 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 **approval of** 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 Blue Cross and Blue Shield nor its agents 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 "*Medicare & You*" 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, if required. The company 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.

PLANS A & B

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		Plan A \$0	Plan A \$912 (Part A Deductible)
First 60 days	All but \$912/benefit period*	Plan B \$912* (Part A Deductible)	Plan B \$0
61 st through 90 th day	All but \$228 a day	\$228/day	\$0
91 st day and after: While using 60 lifetime reserve days	All but \$456 a day	\$456/day	\$0
Once lifetime reserve days are used – Additional 365 days	\$0	100% of Medicare eligible expensed	\$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 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21 st through 100 th day	All but \$114 a day	\$0	Up to \$114 a day
101 st day and after	\$0	\$0	All Costs
BLOOD			
First three pints	\$0	3 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 drug and inpatient respite care.	\$0	Balance

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

** **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.

(Plans A & B continued)

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, durable medical equipment.			
First \$110 of Medicare-Approved Amounts*** (Part B Deductible)	\$0	\$0	\$110
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 \$110 of Medicare-Approved Amounts ***	\$0	\$0	All Costs
Remainder of Medicare –Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES – Blood Tests For Diagnostic Services	100%	\$0	\$0
MEDICARE PARTS A AND B			
HOME HEALTH CARE			
MEDICARE- APPROVED SERVICES – Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment – first \$110 of Medicare – Approved Amounts **	\$0	\$0	\$110
Remainder of Medicare – Approved Amounts	80%	20%	\$0

*** Once you have been billed \$110 of Medicare – Approved amounts for covered services your Part B Deductible will have been met for the calendar year.

**** In the case of the hospital outpatient department services under a prospective payment system, generally Medicare pays a pre-determined fee for a specific service, and this plan pays the remaining applicable Copayment.

PLAN F

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 \$912/benefit period*	\$912* (Part A Deductible)	\$0
61 st through 90 th day	All but \$228 a day	\$228/ day	\$0
91 st day and after: While using 60 lifetime reserve days	All but \$456 a day	\$456/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 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21 st through 100 th day	All but \$114 a day	Up to \$114 a day	\$0
101 st day and after	\$0	\$0	All Costs
BLOOD			
First three pints	\$0	3 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 co- insurance for outpatient drugs and inpatient respite care.	\$0	Balance

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

** **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.

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, durable medical equipment. First \$110 of Medicare-Approved Amounts *** (Part B Deductible)	\$0	\$110	\$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 \$110 of Medicare-Approved Amounts ***	\$0	\$110	\$0
Remainder of Medicare-Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES – Blood Tests For Diagnostic Services	100%	\$0	\$0
MEDICARE PARTS A AND B			
HOME HEALTH CARE MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment – first \$110 of Medicare-Approved Amounts ***	\$0	\$110	\$0
Remainder of Medicare-Approved Amounts	80%	20%	\$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 USA 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 maximum

*** Once you have been billed \$110 of Medicare-Approved amounts for covered services your Part B deductible will have been met for the calendar year.

**** In the case of the hospital outpatient department services under a prospective payment system, generally Medicare pays a pre-determined fee for a specific service, and this plan pays the remaining applicable Copayment.

PLAN I

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 \$912/benefit period	\$912* (Part A Deductible)	\$0
61 st through 90 th day	All but \$228 a day	\$228/day	\$0
91 st day and after: While using 60 lifetime reserve days	All but \$456 a day	\$456/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 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 st through 100 th day	All but \$114 a day	Up to \$114 a day	\$0
101 st day and after	\$0	\$0	All Costs
BLOOD			
First three pints	\$0	3 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 co-insurance for outpatient drugs and inpatient respite care.	\$0	Balance

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

** **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.

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, durable medical equipment.			
First \$110 of Medicare-Approved Amounts *** (Part B Deductible)	\$0	\$0	\$110
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 \$110 of Medicare-Approved Amounts ***	\$0	\$0	\$110
Remainder of Medicare-Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES - Blood Tests For Diagnostic Services	100%	\$0	\$0
MEDICARE PARTS A AND B			
HOME HEALTH CARE MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment – first \$110 of Medicare-Approved Amounts ***	\$0	\$0	\$110
Remainder of Medicare-Approved Amounts	80%	20%	\$0
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	\$0	Actual charges 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 7 each week	
Calendar year maximum	\$0	\$1,600	

*** Once you have been billed \$110 of Medicare-Approved amounts for covered services your Part B Deductible will have been met for the calendar year.

**** In the case of the hospital outpatient department services under a prospective payment system, generally Medicare pays a pre-determined fee for a specific service, and this plan pays the remaining applicable Copayment.

(Plan I continued)

SERVICES	MEDICARE PAYS	PLAN PAYS	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 USA 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 maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS – NOT COVERED BY MEDICARE First \$250 each calendar year	\$0	\$0	\$250
Next \$2,500 each calendar year	\$0	50% - \$1,250 calendar yr. maximum benefit	50% and all costs after \$1,250 calendar yr. maximum
Over \$2,500 each calendar year	\$0	\$0	All Costs

PLAN J

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 \$912/benefit period*	\$912* (Part A Deductible)	\$0
61 st through 90 th day	All but \$228 a day	\$228/day	\$0
91 st day and after: While using 60 lifetime reserve days	All but \$456 a day	\$456/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 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21 st through 100 th day	All but \$114 a day	Up to \$114 a day	\$0
BLOOD			
First three pints	\$0	3 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 co-insurance for outpatient drugs and inpatient respite care.	\$0	Balance

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

** **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.

(Plan J continued)

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 test, durable medical equipment.			
First \$110 of Medicare-Approved Amounts*** (Part B Deductible)	\$0	\$110	\$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 \$110 of Medicare-Approved Amounts ***	\$0	\$110	\$0
Remainder of Medicare-Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES – Blood Tests For Diagnostic Services	100%	\$0	\$0
MEDICARE PARTS A AND B			
HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment – first \$110 of Medicare-Approved Amounts***	\$0	\$110	\$0
Remainder of Medicare-Approved Amounts	80%	20%	\$0
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	\$0	Actual charges to \$40 a visit	Balance
Number of visit's covered (must be received within eight weeks of last Medicare-Approved visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
Calendar year maximum	\$0	\$1,600	

*** Once you have been billed \$110 of Medicare-Approved amounts for covered services your Part B Deductible will have been met for the calendar year.

**** In the case of the hospital outpatient department services under a prospective payment system, generally Medicare pays a pre-determined fee for a specific service, and this plan pays the remaining applicable Copayment.

(Plan J continued)

SERVICES	MEDICARE PAYS	PLAN PAYS	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 USA			
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 maximum
EXTENDED OUTPATIENT PRESCRIPTION DRUGS – NOT COVERED BY MEDICARE			
First \$250 each calendar year	\$0	\$0	\$250
Next \$6,000 each calendar year	\$0	50% - \$3,000 calendar year maximum benefit	50% and all costs after \$3,000 calendar yr. maximum
Over \$6,000 each calendar year	\$0	\$0	All Costs
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.

