Anthem BlueCross

Anthem Blue Cross – California

2013 Outline of Medicare Supplement Coverage

Cover Page (1 of 2)

Plans A, F, High Ded F, G & N

Benefit Chart of Medicare Supplement Plans Sold for Effective Dates On or After June 1, 2010

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state. Plans shown in gray are available for purchase.

Plans A, F, High Deductible F & N are available to those who are under age 65 and qualify for Medicare due to disability (noted with a diamond '✦').

Basic Benefits:

- **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. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.
- **Blood –** First three pints of blood each year.
- **Hospice –** Part A coinsurance.

PLAN	A✦	B	C	D	F✦ | F*✦	G	K	L	M	N✦
Basic coverage	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance*	Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
Skilled Nursing Facility coinsurance			✓	✓	✓	✓	50%	75%	✓	✓

(continued on next page)

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Anthem Blue Cross – California

2013 Outline of Medicare Supplement Coverage

Cover Page (2 of 2)

Plans A, F, High Ded F, G & N

PLAN	A✦	B	C	D	F✦ | F*✦	G	K	L	M	N✦
Part A Deductible		✓	✓	✓	✓	✓	50%	75%	50%	✓
Part B Deductible			✓		✓					
Part B Excess					✓	✓				
Foreign Travel Emergency			✓	✓	✓	✓			✓	✓
Out-of-pocket limit							$4,800; paid at 100% after limit reached	$2,400; paid at 100% after limit reached		

* Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,110 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed $2,110. 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.

Premium Information

The following pages are designed to help you determine the premium for the plan you select. First, locate your zip code to determine your Rating Area, and then refer to the Monthly Premium pages to find the assigned monthly premium based on your age at the requested policy effective date.

Premiums and future changes in premiums are determined by several factors, including your age, where you reside, and the costs of medical services and supplies.

Premiums are subject to change on or after the Renewal Date in accordance with the terms of the Policy. Renewal Date is defined as generally March 1, subject to state approval. Your Premium Billing Preference does not guarantee your premium for any specific time period. Any state-approved premium changes will be applied starting on your next Renewal Date following your Coverage Effective Date, regardless of your Premium Billing Preference. The selected Premium Billing Preference will take effect on the first day of payment period which immediately follows your Coverage Effective Date. For example, if your Coverage Effective Date is September 1 and you pick the Quarterly Premium Billing Preference, Quarterly premium billing will start on October 1; if you select the Annual Premium Billing Preference, Annual premium billing will start on January 1. Any premiums billed for the period of time from your Coverage Effective Date to the start of your selected Premium Billing Preference will be prorated to reflect the Premium Billing Preference selected.

We, Anthem Blue Cross, can only raise your premium if we raise the premium for all plans like yours in this State. We will recalculate your age each year to determine your new attained age. Your premium may increase annually at your plan renewal based upon your new attained age.

Anthem BlueCross

Anthem Blue Cross – California

Monthly Premium

Plans A, F, High Ded F, G & N

Effective March 1, 2013

Premiums are subject to change.

5-Digit Zip Code Area Guide

To determine your premium, refer to the zip code listing to determine which area you live in, then select your age as of your requested policy effective date from the following Monthly Premium pages.

1. Go to **Column 1** and locate the Prefix (first 3 digits of your Zip Code) (P.O. Box addresses are not acceptable.)
2. Then move to **Column 2** and locate the last two digits of your Zip Code.
3. **Column 3** is your Rating Area. (note: Some zip codes are assigned Multiple Rating Areas.*)
4. See Premium Chart for your area.

1 Prefix	2 (Last two digits of Zip Code)	3 Area
900	01-91, 93-96, 99	5
901	01-03, 89	5
902	01, 02, 09-13, 20-24, 30-33, 39-42, 45, 47-51, 54, 55, 60-64, 66, 67, 70, 72, 74, 75, 77, 78, 80, 90, 91-96	5
902	65	5, 6*
903	01-13, 97, 98	5
904	01-11	5
905	01-10	5
906	20-22, 24, 32, 33, 80	4
906	01-10, 12, 37, 39, 40, 50-52, 59-62, 70, 71	5
906	23, 30, 31, 38	4, 5*
907	20, 21, 40, 42, 43	4
907	01-04, 06, 07, 10-17, 23, 31-34, 44-49, 55	5
908	01-10, 13-15, 22, 31-35, 40, 42, 44-48, 53, 88, 95, 99	5
910	01, 03, 06-12, 16, 17, 20, 21, 23-25, 30, 31, 40-43, 46, 66, 77	5
911	01-10, 14-18, 21, 23-26, 29, 31, 82, 84, 85, 88, 89, 91, 99	5
912	01-10, 14, 21, 22, 24-26	5
913	01-03, 05, 06, 08-10, 13, 16, 21, 22, 24-35, 37, 40-46, 50-57, 63-65, 67, 71, 72, 76, 80-88, 90, 92-96, 99	5
913	19, 20, 58-60, 77	6
913	04, 07, 11, 61, 62	5, 6*
914	01-13, 16, 23, 26, 36, 70, 82, 95-97, 99	5
915	01-08, 10, 21-23, 26	5
916	01-12, 14-18	5
917	11, 41, 50, 59, 67-69, 73, 97	5
917	01, 02, 06, 08, 10, 14-16, 22-24, 29-40, 43-49, 52, 54-56, 58, 61-65, 70-72, 75, 76, 78, 80, 84-86, 88-93, 95, 98, 99	6
917	09, 66	5, 6*
918	01-04, 41, 96, 99	5
919	01-03, 05, 06, 08-17, 21, 31-35, 41-48, 50, 51, 62, 63, 76-80, 87, 90	6
920	03, 07-11, 13, 14, 18-30, 33, 36-40, 46, 49, 51, 52, 54-61, 64-72, 74, 75, 78, 79, 81-86, 88, 90-93, 96	6
920	04	2, 6*
921	01-24, 26-40, 42, 43, 45, 47, 49, 50, 52-55, 58-79, 82, 84, 86, 87, 90-99	6

*** Counties With Zip Codes That Cross Rating Area Boundaries:** ▌ **Area 1** Includes Calaveras, Inyo, Kings, Mendocino, Monterey, Placer, San Benito, Sutter, Tulare, Tuolumne, and Yolo. ▌ **Area 2** Includes Fresno, Imperial, Kern, Mariposa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, and Stanislaus. ▌ **Area 3** Includes Alameda, Contra Costa, Santa Barbara, and Santa Clara. ▌ **Area 4** Includes Orange. ▌ **Area 5** Includes Los Angeles. ▌ **Area 6** Includes Riverside, San Bernardino, San Diego, and Ventura.

5-Digit Zip Code Area Guide (Continued)

To determine your premium, refer to the zip code listing to determine which area you live in, then select your age as of your requested policy effective date from the following Monthly Premium pages.

1. Go to **Column 1** and locate the Prefix (first 3 digits of your Zip Code) (P.O. Box addresses are not acceptable.)
2. Then move to **Column 2** and locate the last two digits of your Zip Code.
3. **Column 3** is your Rating Area. (note: Some zip codes are assigned Multiple Rating Areas.*)
4. See Premium Chart for your area.

1 Prefix	2 (Last two digits of Zip Code)	3 Area
922	22, 27, 31-33, 43, 44, 49-51, 57, 59, 66, 73, 75, 81, 83	2
922	01-03, 10, 11, 20, 23, 26, 30, 34-36, 39-42, 47, 48, 52-56, 58, 60-64, 67, 68, 70, 76-78, 80, 82, 84-86, 92	6
922	25, 74	2, 6*
923	28, 84, 89	1
923	01, 04, 05, 07-18, 20-27, 29, 31-42, 44-47, 50, 52, 54, 56-59, 63-66, 68, 69, 71-78, 82, 85, 86, 91-95, 97-99	6
924	01-08, 10-15, 18, 23, 24, 27	6
925	01-09, 13-19, 21, 22, 30-32, 36, 39, 43-46, 48, 49, 51-57, 61-64, 67, 70-72, 81-87, 89-93, 95, 96, 99	6
926	02-07, 09, 10, 12, 14-20, 23-30, 37, 46-63, 72-79, 83-85, 88, 90-94, 97, 98	4
927	01-12, 25, 28, 35, 80-82, 99	4
928	01-09, 11, 12, 14-17, 21-23, 25, 31-38, 40-46, 50, 56, 57, 59, 61-71, 85-87, 99	4
928	60, 77-83	6
930	14, 67	2
930	01-07, 09-12, 15, 16, 20-24, 30-36, 40-44, 60-66, 93, 94, 99	6
930	13	3, 6*
931	01-03, 05-11, 16-18, 20, 21, 30, 40, 50, 60, 90, 99	2
932	01, 02, 04, 07, 08, 12, 18, 19, 21, 23, 27, 30, 32, 35, 37, 39, 44, 46, 47, 56-58, 60-62, 65-67, 70-72, 74, 75, 77-79, 82, 86, 90-92	1
932	03, 05, 06, 16, 20, 22, 24-26, 34, 40, 41, 49-51, 54, 55, 63, 68, 76, 80, 83, 85, 87	2
932	10, 15, 38, 42, 43, 45, 52	1-3, 5, 6*
933	01-09, 11-14, 80-90	2
934	50	1
934	01-03, 05-10, 12, 20-24, 27-30, 32-38, 40-49, 52-58, 60, 61, 63-65, 75, 83	2
934	26, 51	1, 2*
935	12-15, 17, 22, 26, 29, 30, 41, 42, 45, 46, 49	1
935	01, 02, 04, 05, 18, 19, 23, 24, 28, 31, 54, 56, 61, 81, 96	2
935	99	5
935	10, 32, 34-36, 39, 43, 44, 50-53, 58, 62, 63, 84, 86, 90-92	6
935	16, 27, 55, 60	1, 2, 5, 6*

* **Counties With Zip Codes That Cross Rating Area Boundaries:** ▌ **Area 1** Includes Calaveras, Inyo, Kings, Mendocino, Monterey, Placer, San Benito, Sutter, Tulare, Tuolumne, and Yolo. ▌ **Area 2** Includes Fresno, Imperial, Kern, Mariposa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, and Stanislaus. ▌ **Area 3** Includes Alameda, Contra Costa, Santa Barbara, and Santa Clara. ▌ **Area 4** Includes Orange. ▌ **Area 5** Includes Los Angeles. ▌ **Area 6** Includes Riverside, San Bernardino, San Diego, and Ventura.

5-Digit Zip Code Area Guide (Continued)

To determine your premium, refer to the zip code listing to determine which area you live in, then select your age as of your requested policy effective date from the following Monthly Premium pages.

1. Go to **Column 1** and locate the Prefix (first 3 digits of your Zip Code) (P.O. Box addresses are not acceptable.)
2. Then move to **Column 2** and locate the last two digits of your Zip Code.
3. **Column 3** is your Rating Area. (note: Some zip codes are assigned Multiple Rating Areas.*)
4. See Premium Chart for your area.

1 Prefix	2 (Last two digits of Zip Code)	3 Area
936	03, 15, 33, 47, 66, 70, 73	1
936	01, 02, 04-14, 16, 19-28, 30, 34-40, 42-45, 48-53, 57, 60-62, 64, 65, 67-69, 75	2
936	18, 31, 41, 46, 54, 56	1, 2*
937	01-12, 14-18, 20-30, 37, 40, 41, 44, 45, 47, 50, 55, 60, 61, 64, 65, 71-80, 84, 86, 90-94	2
938	44, 88	2
939	01, 02, 05-08, 12, 15, 20-28, 30, 32, 33, 40, 42-44, 50, 53-55, 60, 62	1
940	02, 05, 10, 11, 13-28, 30, 35, 37-44, 60-66, 70, 74, 80, 83, 85-89	3
941	01-12, 14-47, 50-56, 58-64, 71, 72, 75, 77, 88, 99	3
942	03-09, 11, 29, 30, 32, 34-37, 39, 40, 44-50, 52, 54, 56-59, 61-63, 67-69, 71, 73, 74, 77- 80, 82-91, 93-99	2
943	01-06, 09	3
944	01-04, 97	3
945	03, 08, 10, 12, 15, 33-35, 58, 59, 62, 67, 71, 73, 74, 76, 81, 85, 89-92, 99	2
945	01, 02, 06, 07, 09, 11, 13, 16-31, 36-53, 55-57, 60, 61, 63-66, 68-70, 72, 75, 77-80, 82, 83, 86-88, 95-98	3
945	05, 14	2, 3*
946	01-15, 17-25, 49, 59-62, 66	3
947	01-10, 12, 20	3
948	01-08, 20, 50	3
949	22, 23, 26-28, 31, 51-55, 72, 75, 99	2
949	01, 03, 04, 12-15, 20, 24, 25, 29, 30, 33, 37-42, 45-50, 56, 57, 60, 63-66, 70, 71, 73, 74, 76-79, 98	3
950	04, 12, 24, 39, 43, 45, 75	1
950	01, 03, 05-07, 10, 17-19, 41, 60-67, 73, 77	2
950	02, 08, 09, 11, 13-15, 20, 21, 26, 30-32, 35-38, 42, 44, 46, 50-56, 70, 71	3
950	23, 33, 76	1, 2, 3*
951	01, 03, 06, 08-13, 15-36, 38-41, 48, 50-61, 64, 70, 72, 73, 90-94, 96	3
952	21-26, 28, 29, 32, 33, 45-52, 54, 55, 57	1
952	01-13, 15, 19, 20, 27, 31, 34, 37, 40-42, 53, 58, 67, 69, 96, 97	2
952	30, 36	1, 2*
953	05, 09, 10, 14, 27, 35, 46, 47, 64, 70, 72, 73, 75, 79, 83	1

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4. See Premium Chart for your area.

1 Prefix	2 (Last two digits of Zip Code)	3 Area
953	01, 03, 04, 06, 07, 12, 13, 15-20, 22-26, 28, 30, 33, 34, 36-38, 40, 41, 43-45, 48, 50-58, 60, 61, 63, 65-69, 74, 76, 78, 80-82, 85-89, 97	2
953	11, 21, 29, 77, 91	1, 2, 3*
954	10, 15, 17, 18, 20, 22-24, 26-29, 32, 35, 37, 43, 45, 49, 51, 53, 54, 56-61, 63, 64, 66-70, 81, 82, 85, 88, 90, 93, 94	1
954	01-07, 09, 12, 16, 19, 21, 30, 31, 33, 36, 39, 41, 42, 44, 46, 48, 50, 52, 62, 65, 71-73, 76, 80, 86, 87, 92, 97	2
954	25	1, 2*
955	01-03, 11, 14, 18, 19, 21, 24-28, 31, 32, 34, 36-38, 40, 42, 43, 45-56, 58, 59, 60, 62-71, 73, 85, 87, 89, 95	1
956	01-07, 12-14, 17, 19, 23, 27, 29, 31, 33-37, 40, 42, 44-46, 48, 50, 51, 53, 54, 56, 58, 59, 61, 63-69, 72, 74-79, 81, 82, 84, 85, 89, 91, 92, 95, 97-99	1
956	08-11, 15, 20, 21, 24, 25, 28, 30, 32, 38, 39, 41, 52, 55, 60, 62, 70, 71, 73, 80, 83, 86-88, 90, 93, 96	2
956	16, 18, 26, 94	1, 2*
957	01, 03, 09, 12-15, 17, 20-22, 24, 26, 28, 35, 36, 46, 47, 62, 65, 76, 98, 99	1
957	41, 42, 57-59, 63	2
958	11-35, 38, 40-43, 51-53, 60, 64-67, 87, 94, 99	2
958	36, 37	1, 2*
959	01, 03, 10, 12-20, 22-30, 32, 34-51, 53-63, 65-84, 86-88, 91-93	1
960	01-03, 06-11, 13-17, 19-25, 27-29, 31-35, 37-41, 44, 46-52, 54-59, 61-65, 67-71, 73-76, 78-80, 84-97, 99	1
961	01, 03-30, 32-37, 40-43, 45, 46, 48, 50-52, 54-58, 60-62	1
976	35	1

*** Counties With Zip Codes That Cross Rating Area Boundaries:** ▌ **Area 1** Includes Calaveras, Inyo, Kings, Mendocino, Monterey, Placer, San Benito, Sutter, Tulare, Tuolumne, and Yolo. ▌ **Area 2** Includes Fresno, Imperial, Kern, Mariposa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, and Stanislaus. ▌ **Area 3** Includes Alameda, Contra Costa, Santa Barbara, and Santa Clara. ▌ **Area 4** Includes Orange. ▌ **Area 5** Includes Los Angeles. ▌ **Area 6** Includes Riverside, San Bernardino, San Diego, and Ventura.

Premium — Age 65 and Over

To determine your premium, select your age as of your requested policy effective date, and the area as determined by the zip code listing on pages 4 - 7.

Attained Age	Plan A						Plan F					
	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6
65	$ 90.78	$ 90.78	$ 90.78	$126.17	$126.17	$119.24	$136.16	$136.16	$136.16	$177.70	$177.70	$150.01
66	94.46	94.46	94.46	131.29	131.29	124.08	141.69	141.69	141.69	184.92	184.92	156.10
67	98.27	98.27	98.27	136.58	136.58	129.08	147.41	147.41	147.41	192.38	192.38	162.40
68	102.23	102.23	102.23	142.08	142.08	134.28	153.34	153.34	153.34	200.12	200.12	168.93
69	106.32	106.32	106.32	147.77	147.77	139.66	159.48	159.48	159.48	208.14	208.14	175.70
70	110.57	110.57	110.57	153.68	153.68	145.24	165.87	165.87	165.87	216.48	216.48	182.74
71	114.98	114.98	114.98	159.81	159.81	151.04	172.47	172.47	172.47	225.09	225.09	190.01
72	119.55	119.55	119.55	166.16	166.16	157.04	179.34	179.34	179.34	234.06	234.06	197.58
73	124.29	124.29	124.29	172.75	172.75	163.27	186.45	186.45	186.45	243.34	243.34	205.41
74	129.21	129.21	129.21	179.58	179.58	169.72	193.82	193.82	193.82	252.95	252.95	213.53
75	134.29	134.29	134.29	186.65	186.65	176.40	201.45	201.45	201.45	262.91	262.91	221.94
76	139.59	139.59	139.59	194.01	194.01	183.36	209.38	209.38	209.38	273.26	273.26	230.67
77	145.06	145.06	145.06	201.61	201.61	190.54	217.59	217.59	217.59	283.98	283.98	239.72
78	150.74	150.74	150.74	209.50	209.50	198.00	226.11	226.11	226.11	295.10	295.10	249.11
79	156.63	156.63	156.63	217.69	217.69	205.74	234.95	234.95	234.95	306.63	306.63	258.84
80+	162.73	162.73	162.73	226.17	226.17	213.75	244.10	244.10	244.10	318.57	318.57	268.92

Premium — Age 65 and Over (Continued)

To determine your premium, select your age as of your requested policy effective date, and the area as determined by the zip code listing on pages 4 - 7.

Attained Age	Plan High Ded F						Plan G					
	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6
65	$41.30	$41.30	$41.30	$57.40	$57.40	$54.25	$127.32	$127.32	$127.32	$176.95	$176.95	$149.93
66	42.98	42.98	42.98	59.73	59.73	56.45	132.48	132.48	132.48	184.13	184.13	156.01
67	44.71	44.71	44.71	62.14	62.14	58.73	137.82	137.82	137.82	191.55	191.55	162.30
68	46.51	46.51	46.51	64.64	64.64	61.09	143.37	143.37	143.37	199.27	199.27	168.84
69	48.37	48.37	48.37	67.23	67.23	63.54	149.12	149.12	149.12	207.25	207.25	175.60
70	50.31	50.31	50.31	69.92	69.92	66.08	155.07	155.07	155.07	215.53	215.53	182.62
71	52.31	52.31	52.31	72.71	72.71	68.72	161.26	161.26	161.26	224.13	224.13	189.91
72	54.39	54.39	54.39	75.60	75.60	71.45	167.67	167.67	167.67	233.04	233.04	197.45
73	56.55	56.55	56.55	78.59	78.59	74.28	174.32	174.32	174.32	242.28	242.28	205.28
74	58.78	58.78	58.78	81.70	81.70	77.21	181.21	181.21	181.21	251.86	251.86	213.40
75	61.10	61.10	61.10	84.92	84.92	80.26	188.36	188.36	188.36	261.79	261.79	221.81
76	63.50	63.50	63.50	88.26	88.26	83.41	195.77	195.77	195.77	272.09	272.09	230.54
77	65.99	65.99	65.99	91.72	91.72	86.68	203.45	203.45	203.45	282.77	282.77	239.59
78	68.58	68.58	68.58	95.32	95.32	90.09	211.41	211.41	211.41	293.83	293.83	248.96
79	71.26	71.26	71.26	99.04	99.04	93.60	219.67	219.67	219.67	305.31	305.31	258.69
80+	74.04	74.04	74.04	102.90	102.90	97.25	228.23	228.23	228.23	317.21	317.21	268.77

Premium Information — Age 65 and Over (Continued)

To determine your premium, select your age as of your requested policy effective date, and the area as determined by the zip code listing on pages 4 - 7.

Attained Age	Plan N					
	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6
65	$ 85.49	$ 85.49	$ 85.49	$118.82	$118.82	$ 91.30
66	88.96	88.96	88.96	123.64	123.64	95.00
67	92.55	92.55	92.55	128.63	128.63	98.84
68	96.27	96.27	96.27	133.80	133.80	102.81
69	100.13	100.13	100.13	139.17	139.17	106.94
70	104.13	104.13	104.13	144.73	144.73	111.21
71	108.28	108.28	108.28	150.50	150.50	115.64
72	112.59	112.59	112.59	156.48	156.48	120.24
73	117.06	117.06	117.06	162.69	162.69	125.01
74	121.68	121.68	121.68	169.12	169.12	129.95
75	126.47	126.47	126.47	175.78	175.78	135.07
76	131.45	131.45	131.45	182.70	182.70	140.39
77	136.61	136.61	136.61	189.87	189.87	145.90
78	141.96	141.96	141.96	197.31	197.31	151.61
79	147.50	147.50	147.50	205.01	205.01	157.53
80+	153.25	153.25	153.25	213.00	213.00	163.67

Save $2 on your monthly premium! Enroll in our Automatic Bank Draft or Electronic Fund Transfer (EFT) program and you will save $2 on your monthly premium. (To enroll, simply complete the Premium Payment Form.)

—OR—

Save $48 by paying your premium for the entire year! (Note: Based on the policy effective date, the discount may be pro-rated the first year.)

Save 5% when more than one member in the household enrolls in a Medicare Supplement plan with us. The discount is for policies with effective dates of June 1, 2010 or after and available to those members who occupy the same housing unit.

Monthly Premium

Plans A, F, High Ded F & N
Effective March 1, 2013

Premiums are subject to change.

Premium — Under Age 65

To determine your premium, select your age as of your requested policy effective date, and the area as determined by the zip code listing on pages 4 - 7.

Age	A						F					
	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6
< 65	$185.43	$185.43	$185.43	$257.72	$257.72	$243.57	$278.15	$278.15	$278.15	$363.01	$363.01	$306.44

Age	Plan High Ded F						Plan N					
	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6
< 65	$84.36	$84.36	$84.36	$117.25	$117.25	$110.81	$174.63	$174.63	$174.63	$242.71	$242.71	$186.50

Anthem Blue Cross – California

Disclosure Page

Plans A, F, High Ded F, G & N

Disclosures

Use this outline to compare benefits and premiums among policies.

Medicare deductibles and coinsurance amounts are effective as of January 1, 2013. Medicare may change their amounts annually.

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 Blue Cross.

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: PO 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.

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 Blue Cross 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 and 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. 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.

Retain this outline for your records.

PLAN A

MEDICARE (PART A) HOSPITAL SERVICES — PER BENEFIT PERIOD

PART **A** Services

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,184	$0	$1,184 (Part A deductible)
61st thru 90th day	All but $296 a day	$296 a day	$0
91st day and after: · While using 60 lifetime reserve days	All but $592 a day	$592 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

(continued on next page)

* 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 A

MEDICARE (PART A) HOSPITAL SERVICES — PER BENEFIT PERIOD

PART **A** Services

Services	Medicare Pays	Plan Pays	You Pay
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
21st thru 100th day	All but $148 a day	$0	Up to $148 a day
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

* 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.

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

PART B Services

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 $147 of Medicare Approved Amounts*	$0	$0	$147 (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 3 pints	$0	All costs	$0
Next $147 of Medicare Approved Amounts*	$0	$0	$147 (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 $147 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.

PLAN A
MEDICARE (PART A) HOSPITAL & (PART B) MEDICAL SERVICES

PARTS **A+B** Services

Services	Medicare Pays	Plan Pays	You Pay
Home Health Care — Medicare Approved Services			
· Medically necessary skilled care services and medical supplies	100%	$0	$0
· Durable medical equipment:			
— First $147 of Medicare approved amounts*	$0	$0	$147 (Part B deductible)
— Remainder of Medicare approved amounts	80%	20%	$0

* Once you have been billed $147 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.

PLAN F

MEDICARE (PART A) HOSPITAL SERVICES — PER BENEFIT PERIOD

PART **A** Services

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,184	$1,184 (Part A deductible)	$0
61st thru 90th day	All but $296 a day	$296 a day	$0
91st day and after: · While using 60 lifetime reserve days	All but $592 a day	$592 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

(continued on next page)

* 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 F

MEDICARE (PART A) HOSPITAL SERVICES — PER BENEFIT PERIOD

PART **A** Services

Services	Medicare Pays	Plan Pays	You Pay
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
21st thru 100th day	All but $148 a day	Up to $148 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

* 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.

PLAN F

MEDICARE (PART B) MEDICAL SERVICES — PER CALENDAR YEAR

PART B Services

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 $147 of Medicare Approved Amounts*	$0	$147 (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 3 pints	$0	All costs	$0
Next $147 of Medicare Approved Amounts*	$0	$147 (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 $147 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.

PLAN F
MEDICARE (PART A) HOSPITAL & (PART B) MEDICAL SERVICES
OTHER BENEFITS — NOT COVERED BY MEDICARE

PARTS A+B Services

Services	Medicare Pays	Plan Pays	You Pay
Home Health Care — Medicare Approved Services			
· Medically necessary skilled care services and medical supplies	100%	$0	$0
· Durable medical equipment:			
— First $147 of Medicare approved amounts*	$0	$147 (Part B deductible)	$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 lifetime maximum

* Once you have been billed $147 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

MEDICARE (PART A) HOSPITAL SERVICES — PER BENEFIT PERIOD

PART **A** Services

Services	Medicare Pays	After You Pay $2,110 Deductible,** Plan Pays	In Addition to $2,110 Deductible,** You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,184	$1,184 (Part A deductible)	$0
61st thru 90th day	All but $296 a day	$296 a day	$0
91st day and after: · While using 60 lifetime reserve days	All but $592 a day	$592 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

(continued on next page)

* 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.

** This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,110 deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $2,110. 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.

*** 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

MEDICARE (PART A) HOSPITAL SERVICES — PER BENEFIT PERIOD

PART **A** Services

Services	Medicare Pays	After You Pay $2,110 Deductible,** Plan Pays	In Addition to $2,110 Deductible,** You Pay
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
21st thru 100th day	All but $148 a day	Up to $148 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

* 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.

** This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,110 deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $2,110. 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.

HIGH DEDUCTIBLE PLAN F

MEDICARE (PART B) MEDICAL SERVICES — PER CALENDAR YEAR

PART **B** Services

Services	Medicare Pays	After You Pay $2,110 Deductible,** Plan Pays	In Addition to $2,110 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, durable medical equipment			
First $147 of Medicare Approved Amounts*	$0	$147 (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 3 pints	$0	All costs	$0
Next $147 of Medicare Approved Amounts*	$0	$147 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

(continued on next page)

* Once you have been billed $147 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.

** This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,110 deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $2,110. 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.

HIGH DEDUCTIBLE PLAN F

MEDICARE (PART B) MEDICAL SERVICES — PER CALENDAR YEAR

PART **B** Services

Services	Medicare Pays	After You Pay $2,110 Deductible,** Plan Pays	In Addition to $2,110 Deductible,** You Pay
Clinical Laboratory Services			
Tests for Diagnostic Services	100%	$0	$0

** This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,110 deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $2,110. 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.

HIGH DEDUCTIBLE PLAN F
MEDICARE (PART A) HOSPITAL & (PART B) MEDICAL SERVICES
OTHER BENEFITS — NOT COVERED BY MEDICARE

PARTS A+B Services

Services	Medicare Pays	After You Pay $2,110 Deductible,** Plan Pays	In Addition to $2,110 Deductible,** You Pay
Home Health Care — Medicare Approved Services			
· Medically necessary skilled care services and medical supplies	100%	$0	$0
· Durable medical equipment:			
— First $147 of Medicare approved amounts*	$0	$147 (Part B deductible)	$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 lifetime maximum

* Once you have been billed $147 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.

** This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,110 deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $2,110. 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.

PLAN G

MEDICARE (PART A) HOSPITAL SERVICES — PER BENEFIT PERIOD

PART A Services

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,184	$1,184 (Part A deductible)	$0
61st thru 90th day	All but $296 a day	$296 a day	$0
91st day and after: · While using 60 lifetime reserve days	All but $592 a day	$592 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

(continued on next page)

* 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 G

MEDICARE (PART A) HOSPITAL SERVICES — PER BENEFIT PERIOD

PART **A** Services

Services	Medicare Pays	Plan Pays	You Pay
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
21st thru 100th day	All but $148 a day	Up to $148 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

* 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.

PLAN G

MEDICARE (PART B) MEDICAL SERVICES — PER CALENDAR YEAR

PART B Services

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 $147 of Medicare Approved Amounts*	$0	$0	$147 (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 3 pints	$0	All costs	$0
Next $147 of Medicare Approved Amounts*	$0	$0	$147 (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 $147 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.

PLAN G
MEDICARE (PART A) HOSPITAL & (PART B) MEDICAL SERVICES
OTHER BENEFITS — NOT COVERED BY MEDICARE

PARTS A+B Services

Services	Medicare Pays	Plan Pays	You Pay
Home Health Care — Medicare Approved Services			
· Medically necessary skilled care services and medical supplies	100%	$0	$0
· Durable medical equipment:			
— First $147 of Medicare approved amounts*	$0	$0	$147 (Part B deductible)
— 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 lifetime maximum

* Once you have been billed $147 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.

PLAN N

MEDICARE (PART A) HOSPITAL SERVICES — PER BENEFIT PERIOD

PART **A** Services

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,184	$1,184 (Part A deductible)	$0
61st thru 90th day	All but $296 a day	$296 a day	$0
91st day and after: · While using 60 lifetime reserve days	All but $592 a day	$592 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

(continued on next page)

* 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 N

MEDICARE (PART A) HOSPITAL SERVICES — PER BENEFIT PERIOD

PART **A** Services

Services	Medicare Pays	Plan Pays	You Pay
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
21st thru 100th day	All but $148 a day	Up to $148 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

* 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.

PLAN N

MEDICARE (PART B) MEDICAL SERVICES — PER CALENDAR YEAR

PART **B** Services

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 $147 of Medicare Approved Amounts*	$0	$0	$147 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges			
Above Medicare Approved Amounts	$0	$0	All costs
Blood			
First 3 pints	$0	All costs	$0
Next $147 of Medicare Approved Amounts*	$0	$0	$147 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

(continued on next page)

* Once you have been billed $147 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.

PLAN N

MEDICARE (PART B) MEDICAL SERVICES — PER CALENDAR YEAR
MEDICARE (PART A) HOSPITAL & (PART B) MEDICAL SERVICES
OTHER BENEFITS — NOT COVERED BY MEDICARE

PART B Services

Services	Medicare Pays	Plan Pays	You Pay
Clinical Laboratory Services			
Tests for Diagnostic Services	100%	$0	$0

PARTS A+B Services

Home Health Care — Medicare Approved Services			
· Medically necessary skilled care services and medical supplies	100%	$0	$0
· Durable medical equipment:			
— First $147 of Medicare approved amounts*	$0	$0	$147 (Part B deductible)
— 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 lifetime maximum

* Once you have been billed $147 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.

Anthem BlueCross

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Health. Join In.

Medicare Supplement Guaranteed Issue Guideline

Important: Please note this Guide is only a summary, and is intended to help you identify the different situations that may qualify you for a Guaranteed Acceptance into an Anthem Blue Cross Medicare Supplement Plan.

Listed below are situations in which a Medicare applicant/member has the right to purchase a Medigap policy. These rights are commonly called Guaranteed Issue (GI) rights. In these circumstances, acceptance into a Medicare Supplemental policy is guaranteed regardless of the applicant's medical condition(s).

Anthem Blue Cross offers certain Medicare Supplement plans on a Guaranteed Issue basis. The plans available may vary depending on the individual's Guaranteed Issue situation.

Situations

1. **Part B effective date:** You are eligible for Guaranteed Issue if you are (a) at least 65 years of age, or (b) if you are under age 65 and do not have End Stage Renal Disease; and you apply for an Anthem Blue Cross Medicare Supplement Plan prior to or during the six-month period beginning with the first day of the month of your Part B effective date. ***With your application, you must submit*** evidence that you have Medicare Parts A and B.
2. **Disabled and receiving Medicare benefits prior to your 65th birthday:** Upon your 65th birthday you will receive a 6-month Guaranteed Issue period beginning with the first of the month in which you reach age 65. ***With your application, you must submit*** evidence that you have Medicare Parts A and B.
3. **Termination of coverage or reduction of coverage under a group-sponsored health plan:** If you are receiving health care coverage through your group employer and you decide to terminate the group plan, or the benefits of the group plan are reduced, you are entitled to a 6-month Guaranteed Issue period beginning on the date of termination or benefit reduction. ***With your application, you must provide*** proof of disenrollment or benefit reduction.
4. **Medicare Advantage (MA) coverage ends due to the Plan leaving the program or area:** You are entitled to a Guaranteed Issue period beginning on the date you receive the notice of termination of your MA plan and ending 123 days after the date of such termination to select a Medigap plan from any company in the area. ***With your application, you must provide*** proof of disenrollment.
5. **Termination of health care for military retiree or spouse or dependents due to military base closure, or if the base no longer offers services, or if you relocated:** If you are a Medicare-eligible military retiree or dependent and at least 65, you are entitled to a 6-month Guaranteed Issue period beginning the date you lost health care services at the military base. ***With your application, you must provide*** proof of termination of prior insurance.

(continued)

6. **Upon becoming eligible for Medicare benefits at age 65, you enrolled in a MA plan and then disenrolled within 12 months:** You are entitled to a Guaranteed Issue period of 63 days beginning with the date of disenrollment from the MA plan. ***With your application, you must provide*** proof of prior insurance.
7. **Disenroll from a Select, PACE or MA plan within 1 year of leaving a Medigap policy for the first time.** You are entitled to re-enroll in your original Medigap policy within 63 days of your disenrollment in one of these plans, beginning with the date of termination. This must be your first time enrolled in a Select, PACE, or MA plan. ***With your application, you must provide*** proof of prior insurance.
8. **Birthday Rule:** You are entitled to acceptance into equal or lesser value plans for 30 days beginning on your birthday. You must have a Medicare Supplement Plan and, ***with your application, you must provide*** proof of prior coverage.
9. **Leave your plan as a result of fraud committed by the plan:** You are entitled to a 63-day Guaranteed Issue period beginning with the latter of the date of termination or the fraud determination date. ***With your application, you must provide*** proof of prior coverage and provide a determination letter stating the plan was at fault.
10. **Your Anthem Blue Cross MA plan reduces benefits, increases the cost sharing amount or premium or discontinues a provider who currently furnishes services to you for other than good cause related to quality of care, its relationship or contract:** If any one of these events occurs, you are entitled to a Guaranteed Issue period beginning on the date such reduction, increase or discontinuance occurs and ending 63 days following that date. ***With your application, you must provide*** proof of prior coverage.
11. **Another carrier's MA plan in which you are enrolled reduces benefits, increases** premium by 15 percent or more; or increases the physician, hospital or drug copayments by 15 percent or more, or discontinues a provider who currently furnishes services to you for other than good cause related to quality of care, its relationship or contract, and that carrier and its affiliates do not offer Medicare Supplement products in your area**. You have a** guaranteed issue right that can only be **exercised during the MA annual open enrollment period**, except when the MA plan discontinues its relationship with the treating provider. ***You must provide proof of prior coverage***.
12. **If you lost coverage because you moved out of the service area of your plan,** you are entitled to a Guaranteed Issue period for up to 6 months following the termination of your contract. ***With your application, you must provide*** proof, such as a letter from your prior carrier stating, "You will no longer have coverage due to moving out of the covered service area."
13. **If you had Medi-Cal or Medicaid benefits and have lost eligibility for those benefits,** you are guaranteed acceptance into a Medicare Supplement plan, provided that you apply within 6 months of losing eligibility that you received from Medi-Cal or Medicaid. ***With your application, you must provide*** a copy of the notice of loss of eligibility that you received from Medi-Cal or Medicaid.

Anthem Blue Cross

Optional Language Coding Sheet

To answer the two questions in [Section F] of your enrollment form, please select the appropriate code in each section below. Then write the code on the line next to the appropriate question on your enrollment form. For example, if you prefer to speak CANTONES***e***, please complete Question 1 with code "W02." ("What is your preferred spoken language? section 1 — Code: W02")

IMPORTANT: Completing these questions is strictly voluntary. The information you provide will not be used in determining eligibility or insurability.

1. Preferred Spoken Language

American Indian ..... NAI	Iliko ..... ILO	Scottish ..... GLA
Arabic ..... ARA	Indonesian ..... IND	Sign Language, American ..... SGN
Aramaic ..... ARC	Irish ..... GLE	Sign Language, Other W07
Armenian ..... HYE	Italian ..... ITA	Spanish ..... SPA
Cambodian/Khmer W01	Japanese ..... JPN	Speech Loss ..... ZZS
Cantonese W02	Korean ..... KOR	Tagalog ..... TGL
Chinese ..... ZHO	Lao ..... LAO	Tahitian ..... TAH
English ..... ENG	Mandarin W05	Thai ..... THA
Farsi W04	MEIN W08	Turkish ..... TUR
French ..... FRA	Nigerian W06	Vietnamese ..... VIE
German ..... DEU	Persian ..... FAS	OTHER NON-ENGLISH W09
Hawaiian ..... HAW	Polish ..... POL	UNDETERMINED ..... UND
Hebrew ..... HEB	Portuguese ..... POR	DECLINE TO STATE W03
Hearing loss ..... ZZH	Pushto ..... PUS	
Hindi ..... HIN	Russian ..... RUS	
Hmong ..... HMN	Samoan ..... SMO	

2. Preferred Written Language

American Indian ..... NAI	Hmong ..... HMN	Pushto ..... PUS
Arabic ..... ARA	Iliko ..... ILO	Russian ..... RUS
Aramaic ..... ARC	Indonesian ..... IND	Samoan ..... SMO
Armenian ..... HYE	Irish ..... GLE	Scottish ..... GLA
Cambodian W01	Italian ..... ITA	Spanish ..... SPA
Cantonese W02	Japanese ..... JPN	Tagalog ..... TGL
Chinese ..... ZHO	Korean ..... KOR	Tahitian ..... TAH
English ..... ENG	Lao ..... LAO	Thai ..... THA
Farsi W04	Mandarin W05	Turkish ..... TUR
French ..... FRA	MEIN W08	Vietnamese ..... VIE
German ..... DEU	Nigerian W06	OTHER NON-ENGLISH W09
Hawaiian ..... HAW	Persian ..... FAS	UNDETERMINED ..... UND
Hebrew ..... HEB	Polish ..... POL	DECLINE TO STATE W03
Hindi ..... HIN	Portuguese ..... POR	