

HIGHMARK BLUE SHIELD
Benefit Chart of Medicare Supplement Plans Sold on or After June 1, 2010
MEDIGAP BLUE - Benefit Plans A, B, C, F, High Deductible F and N

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make available Plans A, B, and C or F. Some plans may not be available in your state.

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 | Plan B | Plan C | Plan D | Plan F ¹ / F ^{1,2} | Plan G | Plan K | Plan L | Plan M | Plan N ¹ |
|--|--|--|--|---|--|--|--|--|---|
| 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 ² | 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 | Skilled Nursing Facility Coinsurance | Skilled Nursing Facility Coinsurance | Skilled Nursing Facility Coinsurance | 50% Skilled Nursing Facility Coinsurance | 75% 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 | 50% Part A Deductible | 75% Part A Deductible | 50% Part A Deductible | Part A Deductible |
| | | Part B Deductible | | Part B Deductible | | | | | |
| | | | | 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 |
| | | | | | | Out-of-pocket limit \$4,800 paid at 100% after limit reached | Out-of-pocket limit \$2,400 paid at 100% after limit reached | | |

¹ Available only to applicants who enroll within 6 months following enrollment in Medicare Part B, or who convert from another Highmark Blue Shield Plan or who are guaranteed the right to purchase these plans under applicable federal or state laws.

² 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.

**Medicare Supplement
Medigap Blue Plans A, B, C, F, High Deductible F, and N**

**EFFECTIVE JANUARY 1, 2013
MONTHLY SUBSCRIPTION RATES**

| Age | Plan A | | Plan B | | Plan C | | Plan F* | Plan F(HD)* | Plan N* |
|---------------|-----------|----------|-----------|----------|-----------|----------|-----------|-------------|-----------|
| | Preferred | Standard | Preferred | Standard | Preferred | Standard | Preferred | Preferred | Preferred |
| <65 | \$91.65 | - | \$108.45 | - | \$126.50 | - | \$126.75 | \$64.60 | \$92.10 |
| 65 | \$91.65 | \$137.50 | \$108.45 | \$162.70 | \$126.50 | \$189.75 | \$126.75 | \$64.60 | \$92.10 |
| 66 | \$95.40 | \$143.10 | \$113.00 | \$169.50 | \$131.95 | \$197.95 | \$132.15 | \$67.00 | \$95.80 |
| 67 | \$99.00 | \$148.50 | \$117.40 | \$176.10 | \$137.20 | \$205.80 | \$137.40 | \$69.35 | \$99.45 |
| 68 | \$102.70 | \$154.05 | \$121.95 | \$182.95 | \$142.60 | \$213.90 | \$142.85 | \$71.75 | \$103.20 |
| 69 | \$106.30 | \$159.45 | \$126.30 | \$189.45 | \$147.85 | \$221.75 | \$148.10 | \$74.05 | \$106.80 |
| 70 | \$110.05 | \$165.10 | \$130.85 | \$196.25 | \$153.25 | \$229.90 | \$153.50 | \$76.45 | \$110.55 |
| 71 | \$113.75 | \$170.65 | \$135.40 | \$203.10 | \$158.65 | \$238.00 | \$158.90 | \$78.85 | \$114.30 |
| 72 | \$117.35 | \$176.05 | \$139.80 | \$209.70 | \$163.90 | \$245.85 | \$164.15 | \$81.20 | \$117.90 |
| 73 | \$121.05 | \$181.60 | \$144.30 | \$216.45 | \$169.30 | \$253.95 | \$169.60 | \$83.60 | \$121.65 |
| 74 | \$124.70 | \$187.05 | \$148.70 | \$223.05 | \$174.55 | \$261.85 | \$174.85 | \$85.95 | \$125.25 |
| 75 | \$129.05 | \$193.60 | \$154.05 | \$231.10 | \$180.95 | \$271.45 | \$181.25 | \$88.75 | \$129.70 |
| 76 | \$133.00 | \$199.50 | \$158.85 | \$238.30 | \$186.65 | \$280.00 | \$187.00 | \$91.30 | \$133.65 |
| 77 | \$136.95 | \$205.45 | \$163.70 | \$245.55 | \$192.40 | \$288.60 | \$192.75 | \$93.85 | \$137.60 |
| 78 | \$140.90 | \$211.35 | \$168.50 | \$252.75 | \$198.15 | \$297.25 | \$198.50 | \$96.40 | \$141.60 |
| 79 | \$144.85 | \$217.25 | \$173.30 | \$259.95 | \$203.90 | \$305.85 | \$204.25 | \$98.95 | \$145.55 |
| 80 | \$146.75 | \$220.15 | \$175.65 | \$263.50 | \$206.65 | \$310.00 | \$207.05 | \$100.20 | \$147.45 |
| 81 | \$149.90 | \$224.85 | \$179.45 | \$269.20 | \$211.25 | \$316.90 | \$211.65 | \$102.25 | \$150.65 |
| 82 | \$153.05 | \$229.60 | \$183.30 | \$274.95 | \$215.85 | \$323.80 | \$216.20 | \$104.30 | \$153.80 |
| 83 | \$156.20 | \$234.30 | \$187.15 | \$280.75 | \$220.45 | \$330.70 | \$220.80 | \$106.30 | \$157.00 |
| 84 | \$159.35 | \$239.05 | \$191.00 | \$286.50 | \$225.00 | \$337.50 | \$225.40 | \$108.35 | \$160.15 |
| 85+ | \$163.10 | \$244.65 | \$195.55 | \$293.35 | \$230.45 | \$345.70 | \$230.85 | \$110.75 | \$163.90 |

*Available only to those applicants enrolling inside the 6 month period following enrollment in Medicare Part B or who are guaranteed the right to purchase these programs under applicable federal or state law. To qualify you must have been previously enrolled in a Medicare Advantage plan, Medicare SELECT, or other similar plan, or 65 years of age or older and enrolled in a Program of All-Inclusive Care for the Elderly. To determine if you are eligible, please contact Highmark Blue Shield at 1-877-987-4876. (TTY: 1-800-345-3816)

TRANSFER OF COVERAGE

Subscribers moving into the Highmark Blue Shield 21-county service area who are currently enrolled in a Blue Cross and Blue Shield Medicare Supplement or Medicare Advantage program may transfer their coverage to a Highmark Blue Shield Medigap Blue Plan at a coverage level equal to or lesser than their current program.

PREMIUM INFORMATION

We, Highmark Blue Shield, can only raise your premium if we raise the premium for all policies like yours in the Commonwealth of Pennsylvania. Premiums for these attained age plans are billed at the age which a member has attained on the first day of enrollment in any given calendar year in accordance with the premium schedule on the previous pages.

The Company may change subscription rates with the approval of the Pennsylvania Insurance Department.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to Highmark Blue Shield at 1800 Center Street, Camp Hill, Pennsylvania 17011.. 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.

Highmark Blue Shield and its agents are not 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.

MEDIGAP BLUE PLAN A
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 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.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|--|---|
| HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the additional 365 days | All but \$1,184 All but \$296 a day All but \$592 a day \$0 \$0 | \$0 \$296 a day \$592 a day 100% of Medicare eligible expenses \$0 | \$1,184 (Part A deductible) \$0 \$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 21 st thru 100th day 101st day and after | All approved amounts All but \$148 a day \$0 | \$0 \$0 \$0 | \$0 Up to \$148 a day All costs |
| BLOOD First 3 pints Additional amounts | \$0 100% | 3 pints \$0 | \$0 \$0 |
| HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance | \$0 |

** **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.

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

* 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.

| 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 |

PARTS A & B

| 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 |

MEDIGAP BLUE PLAN B
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 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.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|--|---|
| HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the additional 365 days | All but \$1,184 All but \$296 a day All but \$592 a day \$0 \$0 | \$1,184 (Part A deductible) \$296 a day \$592 a day 100% of Medicare eligible expenses \$0 | \$0 \$0 \$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 21 st thru 100th day 101st day and after | All approved amounts All but \$148 a day \$0 | \$0 \$0 \$0 | \$0 Up to \$148 a day All costs |
| BLOOD First 3 pints Additional amounts | \$0 100% | 3 pints \$0 | \$0 \$0 |
| HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance | \$0 |

** **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.

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

* 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.

| 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 |

PARTS A & B

| 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 |

MEDIGAP BLUE PLAN C
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 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.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|--|---|
| HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the additional 365 days | All but \$1,184 All but \$296 a day All but \$592 a day \$0 \$0 | \$1,184 (Part A deductible) \$296 a day \$592 a day 100% of Medicare eligible expenses \$0 | \$0 \$0 \$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 21 st thru 100th day 101st day and after | All approved amounts All but \$148 a day \$0 | \$0 Up to \$148 a day \$0 | \$0 \$0 All costs |
| BLOOD First 3 pints Additional amounts | \$0 100% | 3 pints \$0 | \$0 \$0 |
| HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance | \$0 |

** **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.

MEDIGAP BLUE PLAN C
MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* 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.

| 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* Remainder of Medicare Approved Amounts | \$0 Generally 80% | \$147 (Part B deductible) Generally 20% | \$0 \$0 |
| Part B Excess Charges (Above Medicare Approved Amounts) | \$0 | \$0 | All costs |
| BLOOD First 3 pints Next \$147 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts | \$0 \$0 80% | All costs \$147 (Part B deductible) 20% | \$0 \$0 \$0 |
| CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES | 100% | \$0 | \$0 |

MEDIGAP BLUE PLAN C

PARTS A & B

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|----------------------|---------------------------|----------------|
| HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies —Durable medical equipment | 100% | \$0 | \$0 |
| 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

| SERVICES | MEDICARE PAYS | PLAN 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 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 |

MEDIGAP BLUE PLAN F
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 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.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|--|---|
| HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the additional 365 days | All but \$1,184 All but \$296 a day All but \$592 a day \$0 \$0 | \$1,184 (Part A deductible) \$296 a day \$592 a day 100% of Medicare eligible expenses \$0 | \$0 \$0 \$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 21 st thru 100th day 101st day and after | All approved amounts All but \$148 a day \$0 | \$0 Up to \$148 a day \$0 | \$0 \$0 All costs |
| BLOOD First 3 pints Additional amounts | \$0 100% | 3 pints \$0 | \$0 \$0 |
| HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance | \$0 |

** **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.

MEDIGAP BLUE PLAN F
MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* 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.

| 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 |

MEDIGAP BLUE PLAN F

PARTS A & B

| 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

| SERVICES | MEDICARE PAYS | PLAN 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 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 |

**MEDIGAP BLUE HIGH DEDUCTIBLE PLAN F
 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 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.**

| 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 61st thru 90th day 91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the additional 365 days | All but \$1,184 All but \$296 a day All but \$592 a day \$0 \$0 | \$1,184 (Part A deductible) \$296 a day \$592 a day 100% of Medicare eligible expenses \$0 | \$0 \$0 \$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 21 st thru 100th day 101st day and after | All approved amounts All but \$148 a day \$0 | \$0 Up to \$148 a day \$0 | \$0 \$0 All costs |
| BLOOD First 3 pints Additional amounts | \$0 100% | 3 pints \$0 | \$0 \$0 |
| HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance | \$0 |

***** 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.

**MEDIGAP BLUE HIGH DEDUCTIBLE PLAN F
MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

* 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.**

| 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 |
| CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES | 100% | \$0 | \$0 |

MEDIGAP BLUE HIGH DEDUCTIBLE PLAN F

PARTS A & B

| 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 —Durable medical equipment | 100% | \$0 | \$0 |
| 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

| SERVICES | MEDICARE PAYS | AFTER YOU PAY \$2,110 DEDUCTIBLE** PLAN PAYS | IN ADDITION TO \$2,110 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 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 |

MEDIGAP BLUE PLAN N
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 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.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|--|---|
| HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the additional 365 days | All but \$1,184 All but \$296 a day All but \$592 a day \$0 \$0 | \$1,184 (Part A deductible) \$296 a day \$592 a day 100% of Medicare eligible expenses \$0 | \$0 \$0 \$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 21 st thru 100th day 101st day and after | All approved amounts All but \$148 a day \$0 | \$0 Up to \$148 a day \$0 | \$0 \$0 All costs |
| BLOOD First 3 pints Additional amounts | \$0 100% | 3 pints \$0 | \$0 \$0 |
| HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance | \$0 |

** **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.

MEDIGAP BLUE PLAN N
MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* 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.

| 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* Remainder of Medicare Approved Amounts | \$0 Generally 80% | \$0 Balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. The emergency room visit co-payment 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 | \$147 (Part B deductible) Up to \$20 per office visit and up to \$50 per emergency room visit. The emergency room visit co-payment 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 Next \$147 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts | \$0 \$0 80% | All costs \$0 20% | \$0 \$147 (Part B deductible) \$0 |
| CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES | 100% | \$0 | \$0 |

MEDIGAP BLUE PLAN N

PARTS A & B

| 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

| SERVICES | MEDICARE PAYS | PLAN 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 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 |



1800 Center Street, Camp Hill, Pennsylvania 17011

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