



Administrative Office: P. O. Box 37730, Louisville, KY 40233-7730  
 Toll Free Telephone Number: 1-866-803-5169

**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. Plan A is only available to current Anthem members who are under age 65 and qualify for Medicare due to disability. Plans E, H, I, and J are no longer available for sale.

**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, 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	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 \$4,620; paid at 100% after limit reached	Out-of-pocket limit \$2,310; 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 \$2,000 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed \$2,000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.



**Anthem Blue Cross and Blue Shield - Ohio**

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## Monthly Rates

**Plan A**

**Effective June 1, 2010**

Rates are subject to change.

### Premium Information

We, Anthem, can only raise your premium if we raise the premium for all plans like yours in this State.

### Disability Benefit Plan A Premium

	Monthly
Plan A	\$ 365.86

**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.

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## Disclosures

Use this outline to compare benefits and premiums among policies.

Medicare deductibles and coinsurance amounts are effective as of January 1, 2010. Medicare may change their amounts annually.

**This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I, and J are no longer available for sale.**

## 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.

## Right to Return Policy

If you find that you are not satisfied with your policy, you may return it to us at our Administrative Office: P. O. Box 37730, Louisville, KY 40233-7730. 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 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.

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**Retain this outline for your records.**

**PLAN A**  
**MEDICARE (PART A) HOSPITAL SERVICES – PER BENEFIT PERIOD**

**PART**  
**A**  
**Services**

\* 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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,100	\$0	\$1,100 (Part A deductible)
61 <sup>st</sup> thru 90 <sup>th</sup> day	All but \$275 a day	\$275 a day	\$0
91 <sup>st</sup> day and after: · While using 60 lifetime reserve days	All but \$550 a day	\$550 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)

\*\* 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**

\* 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
<b>SKILLED NURSING FACILITY CARE*</b> 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 <sup>st</sup> thru 100 <sup>th</sup> day	All but \$137.50 a day	\$0	Up to \$137.50 a day
101 <sup>st</sup> day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b> 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

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

**PART B**  
**Services**

\* Once you have been billed \$155 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
<b>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</b>			
First \$155 of Medicare Approved Amounts*	\$0	\$0	\$155 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> Above Medicare Approved Amounts	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next \$155 of Medicare Approved Amounts*	\$0	\$0	\$155 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES</b> Tests for Diagnostic Services	100%	\$0	\$0

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

**PARTS**  
**A+B**  
**Services**

\* Once you have been billed \$155 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
<b>HOME HEALTH CARE — MEDICARE APPROVED SERVICES</b>			
· Medically necessary skilled care services and medical supplies	100%	\$0	\$0
· Durable medical equipment:			
— First \$155 of Medicare approved amounts*	\$0	\$0	\$155 (Part B deductible)
— Remainder of Medicare approved amounts	80%	20%	\$0



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