



Anthem Blue Cross and Blue Shield – Wisconsin

Administrative Office: PO Box 9063, Oxnard, CA 93031-9063
Toll Free Telephone Number: 1-888-211-9815

**2009 OUTLINE OF MEDICARE SUPPLEMENT COVERAGE
COVER PAGE – VALUE PLUS, 25% COST SHARE AND
50% COST SHARE PLAN**

The Wisconsin Insurance Commissioner has set standards for Medicare Supplement insurance. This policy meets these standards. It, along with Medicare, may not cover all of your medical costs. You should review carefully all policy limitations. For an explanation of these standards and other important information, see the "Wisconsin Guide to Health Insurance for People with Medicare" included in this package. Do not buy this policy if you did not get the guide.

See Outlines of Coverage sections for details about All plans.

Basic Benefits: Included in Plans A-J.

- 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).
- Blood: First three pints of blood each year.

Value Plus	25% Cost Share	50% Cost Share
Basic Benefits	Basic Benefits	Basic Benefits
Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
Home Health Care	Home Health Care	Home Health Care
Preventive Care NOT Covered by Medicare		

* You may purchase optional benefit riders for additional premium. With the Value Plus Plan, you may choose riders for Part A Deductible, Part B Deductible, Part B Excess, Foreign Travel, and Home Health Care. With the Cost Share plans, you may choose a rider for Home Health Care.



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MONTHLY RATES – VALUE PLUS PLAN

Effective January 1, 2009

VALUE PLUS PLAN

Attained Age	Area 1 Female						Area 1 Male					
	Base	Part A Deductible	Part B Deductible	Home Health	Excess Charges	Foreign Travel	Base	Part A Deductible	Part B Deductible	Home Health	Excess Charges	Foreign Travel
<65	\$ 296.98	\$ 58.05	\$ 11.55	\$ 4.62	\$ 13.77	\$ 6.88	\$ 319.95	\$ 62.53	\$ 11.55	\$ 4.98	\$ 14.83	\$ 7.42
65	92.11	18.94	11.55	1.62	4.48	2.26	99.24	20.41	11.55	1.75	4.82	2.44
66	99.66	19.84	11.55	1.69	4.71	2.36	107.37	21.38	11.55	1.81	5.07	2.54
67	104.37	20.75	11.55	1.75	4.93	2.47	112.44	22.36	11.55	1.88	5.31	2.66
68	109.07	21.66	11.55	1.81	5.16	2.57	117.51	23.33	11.55	1.95	5.55	2.77
69	113.78	22.56	11.55	1.87	5.38	2.67	122.58	24.31	11.55	2.01	5.80	2.87
70	118.49	23.46	11.55	1.93	5.61	2.78	127.65	25.28	11.55	2.08	6.04	2.99
71	123.19	24.37	11.55	1.99	5.83	2.87	132.71	26.26	11.55	2.15	6.29	3.10
72	127.90	25.27	11.55	2.06	6.06	2.98	137.79	27.22	11.55	2.22	6.53	3.21
73	133.62	26.36	11.55	2.14	6.33	3.11	143.96	28.40	11.55	2.30	6.82	3.34
74	139.36	27.45	11.55	2.22	6.59	3.22	150.14	29.57	11.55	2.40	7.10	3.48
75	145.09	28.54	11.55	2.30	6.86	3.35	156.31	30.74	11.55	2.48	7.39	3.60
76	150.83	29.63	11.55	2.39	7.13	3.48	162.49	31.92	11.55	2.57	7.69	3.74
77	156.55	30.72	11.55	2.47	7.40	3.59	168.66	33.09	11.55	2.66	7.97	3.87
78	163.60	32.10	11.55	2.59	7.71	3.76	176.26	34.58	11.55	2.79	8.30	4.05
79	170.65	33.46	11.55	2.71	8.01	3.92	183.85	36.06	11.55	2.93	8.63	4.23
80+	191.80	37.60	11.55	3.08	8.94	4.42	206.63	40.50	11.55	3.32	9.62	4.76

Area 1 Includes Milwaukee, Waukesha, Racine, Kenosha, Washington and Ozaukee Counties.

Area 2 Includes Dane, Brown and Outagamie Counties.

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VALUE PLUS PLAN

Attained Age	Area 2 Female						Area 2 Male					
	Base	Part A Deductible	Part B Deductible	Home Health	Excess Charges	Foreign Travel	Base	Part A Deductible	Part B Deductible	Home Health	Excess Charges	Foreign Travel
<65	\$ 252.44	\$ 49.33	\$ 11.55	\$ 3.93	\$ 11.70	\$ 5.85	\$ 271.95	\$ 53.15	\$ 11.55	\$ 4.23	\$ 12.60	\$ 6.31
65	78.29	16.10	11.55	1.38	3.81	1.92	84.34	17.34	11.55	1.48	4.10	2.07
66	84.72	16.88	11.55	1.43	4.00	2.00	91.27	18.18	11.55	1.55	4.30	2.16
67	88.71	17.64	11.55	1.48	4.19	2.10	95.57	19.01	11.55	1.60	4.52	2.26
68	92.72	18.40	11.55	1.54	4.39	2.18	99.88	19.83	11.55	1.65	4.73	2.35
69	96.71	19.18	11.55	1.59	4.58	2.27	104.19	20.66	11.55	1.72	4.93	2.45
70	100.71	19.94	11.55	1.64	4.77	2.35	108.50	21.49	11.55	1.77	5.14	2.54
71	104.72	20.71	11.55	1.70	4.96	2.45	112.81	22.31	11.55	1.82	5.34	2.63
72	108.71	21.48	11.55	1.75	5.15	2.53	117.12	23.14	11.55	1.88	5.55	2.72
73	113.58	22.41	11.55	1.81	5.37	2.64	122.37	24.14	11.55	1.96	5.80	2.84
74	118.46	23.33	11.55	1.89	5.61	2.75	127.61	25.13	11.55	2.04	6.04	2.96
75	123.33	24.25	11.55	1.96	5.83	2.85	132.86	26.13	11.55	2.11	6.29	3.06
76	128.20	25.19	11.55	2.02	6.06	2.95	138.12	27.13	11.55	2.18	6.53	3.18
77	133.07	26.11	11.55	2.10	6.29	3.05	143.37	28.12	11.55	2.26	6.77	3.30
78	139.06	27.27	11.55	2.20	6.55	3.19	149.82	29.38	11.55	2.37	7.06	3.45
79	145.05	28.45	11.55	2.30	6.82	3.34	156.27	30.64	11.55	2.48	7.34	3.59
80+	163.03	31.96	11.55	2.62	7.60	3.75	175.63	34.43	11.55	2.82	8.18	4.05

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VALUE PLUS PLAN

Attained Age	Area 3 Female						Area 3 Male					
	Base	Part A Deductible	Part B Deductible	Home Health	Excess Charges	Foreign Travel	Base	Part A Deductible	Part B Deductible	Home Health	Excess Charges	Foreign Travel
<65	\$ 267.29	\$ 52.24	\$ 11.55	\$ 4.16	\$ 12.39	\$ 6.19	\$ 287.95	\$ 56.28	\$ 11.55	\$ 4.48	\$ 13.35	\$ 6.68
65	82.90	17.04	11.55	1.46	4.03	2.04	89.32	18.37	11.55	1.57	4.35	2.19
66	89.70	17.86	11.55	1.52	4.23	2.13	96.64	19.24	11.55	1.63	4.56	2.29
67	93.94	18.68	11.55	1.57	4.44	2.22	101.20	20.12	11.55	1.70	4.78	2.40
68	98.17	19.49	11.55	1.63	4.64	2.31	105.76	21.00	11.55	1.75	5.00	2.49
69	102.41	20.30	11.55	1.69	4.84	2.41	110.32	21.87	11.55	1.81	5.22	2.59
70	106.64	21.12	11.55	1.74	5.05	2.49	114.88	22.75	11.55	1.88	5.44	2.69
71	110.88	21.93	11.55	1.79	5.25	2.59	119.44	23.63	11.55	1.93	5.66	2.79
72	115.11	22.75	11.55	1.84	5.46	2.68	124.01	24.51	11.55	1.99	5.87	2.88
73	120.27	23.72	11.55	1.92	5.69	2.79	129.56	25.56	11.55	2.07	6.14	3.01
74	125.42	24.71	11.55	1.99	5.94	2.90	135.12	26.62	11.55	2.15	6.39	3.13
75	130.58	25.68	11.55	2.07	6.18	3.01	140.68	27.67	11.55	2.23	6.66	3.24
76	135.74	26.66	11.55	2.14	6.41	3.13	146.24	28.73	11.55	2.31	6.91	3.37
77	140.91	27.64	11.55	2.22	6.66	3.23	151.79	29.79	11.55	2.40	7.18	3.49
78	147.24	28.89	11.55	2.33	6.93	3.38	158.63	31.11	11.55	2.51	7.47	3.65
79	153.58	30.13	11.55	2.44	7.21	3.53	165.47	32.45	11.55	2.63	7.77	3.81
80+	172.61	33.84	11.55	2.78	8.05	3.98	185.96	36.45	11.55	2.99	8.66	4.28

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MONTHLY RATES – 25% COST SHARE PLAN

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25% COST SHARE PLAN

	Area 1				Area 2				Area 3			
	Female		Male		Female		Male		Female		Male	
Attained Age	25% Cost Sharing	Home Health	25% Cost Sharing	Home Health	25% Cost Sharing	Home Health	25% Cost Sharing	Home Health	25% Cost Sharing	Home Health	25% Cost Sharing	Home Health
<65	\$ 229.44	\$ 4.62	\$ 245.77	\$ 4.98	\$ 195.02	\$ 3.93	\$ 208.90	\$ 4.23	\$ 206.49	\$ 4.16	\$ 221.19	\$ 4.48
65	84.44	1.62	89.56	1.75	71.77	1.38	76.12	1.48	75.99	1.46	80.60	1.57
66	89.37	1.69	94.87	1.81	75.97	1.43	80.64	1.55	80.43	1.52	85.38	1.63
67	92.72	1.75	98.47	1.88	78.81	1.48	83.71	1.60	83.44	1.57	88.63	1.70
68	96.06	1.81	102.07	1.95	81.64	1.54	86.76	1.65	86.44	1.63	91.87	1.75
69	99.39	1.87	105.67	2.01	84.48	1.59	89.81	1.72	89.45	1.69	95.10	1.81
70	102.72	1.93	109.26	2.08	87.32	1.64	92.88	1.77	92.45	1.74	98.34	1.88
71	106.06	1.99	112.86	2.15	90.15	1.70	95.93	1.82	95.46	1.79	101.57	1.93
72	109.41	2.06	116.46	2.22	92.99	1.75	98.99	1.88	98.46	1.84	104.81	1.99
73	113.46	2.14	120.82	2.30	96.44	1.81	102.70	1.96	102.12	1.92	108.75	2.07
74	117.51	2.22	125.20	2.40	99.88	1.89	106.41	2.04	105.77	1.99	112.68	2.15
75	121.57	2.30	129.55	2.48	103.33	1.96	110.12	2.11	109.41	2.07	116.60	2.23
76	125.63	2.39	133.93	2.57	106.78	2.02	113.84	2.18	113.07	2.14	120.54	2.31
77	129.68	2.47	138.30	2.66	110.23	2.10	117.55	2.26	116.71	2.22	124.47	2.40
78	134.68	2.59	143.69	2.79	114.48	2.20	122.13	2.37	121.22	2.33	129.32	2.51
79	139.68	2.71	149.08	2.93	118.73	2.30	126.71	2.48	125.72	2.44	134.17	2.63
80+	154.70	3.08	165.24	3.32	131.49	2.62	140.46	2.82	139.22	2.78	148.72	2.99

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MONTHLY RATES – 50% COST SHARE PLAN

Effective January 1, 2009

50% COST SHARE PLAN

	Area 1				Area 2				Area 3			
	Female		Male		Female		Male		Female		Male	
Attained Age	50% Cost Sharing	Home Health	50% Cost Sharing	Home Health	50% Cost Sharing	Home Health	50% Cost Sharing	Home Health	50% Cost Sharing	Home Health	50% Cost Sharing	Home Health
<65	\$ 172.31	\$ 4.62	\$ 184.05	\$ 4.98	\$ 146.47	\$ 3.93	\$ 156.45	\$ 4.23	\$ 155.09	\$ 4.16	\$ 165.65	\$ 4.48
65	68.18	1.62	71.86	1.75	57.95	1.38	61.08	1.48	61.36	1.46	64.67	1.57
66	71.72	1.69	75.67	1.81	60.96	1.43	64.32	1.55	64.55	1.52	68.11	1.63
67	74.13	1.75	78.26	1.88	63.01	1.48	66.53	1.60	66.72	1.57	70.44	1.70
68	76.52	1.81	80.85	1.95	65.04	1.54	68.72	1.65	68.87	1.63	72.76	1.75
69	78.92	1.87	83.42	2.01	67.08	1.59	70.91	1.72	71.03	1.69	75.08	1.81
70	81.31	1.93	86.01	2.08	69.12	1.64	73.11	1.77	73.18	1.74	77.41	1.88
71	83.71	1.99	88.59	2.15	71.16	1.70	75.30	1.82	75.34	1.79	79.73	1.93
72	86.11	2.06	91.18	2.22	73.19	1.75	77.50	1.88	77.51	1.84	82.07	1.99
73	89.03	2.14	94.31	2.30	75.67	1.81	80.17	1.96	80.13	1.92	84.88	2.07
74	91.93	2.22	97.46	2.40	78.14	1.89	82.84	2.04	82.74	1.99	87.70	2.15
75	94.85	2.30	100.58	2.48	80.62	1.96	85.50	2.11	85.36	2.07	90.52	2.23
76	97.76	2.39	103.73	2.57	83.10	2.02	88.17	2.18	87.99	2.14	93.35	2.31
77	100.67	2.47	106.86	2.66	85.57	2.10	90.83	2.26	90.61	2.22	96.17	2.40
78	104.27	2.59	110.74	2.79	88.63	2.20	94.13	2.37	93.84	2.33	99.66	2.51
79	107.86	2.71	114.61	2.93	91.68	2.30	97.41	2.48	97.07	2.44	103.15	2.63
80+	118.64	3.08	126.21	3.32	100.84	2.62	107.28	2.82	106.77	2.78	113.59	2.99

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MEDICARE SUPPLEMENT OUTLINE OF COVERAGE

Outline of Coverage for Policy Form Series

**Value Plus, 25% Cost Share,
50% Cost Share**

Retain This Outline For Your Records

Premium Information

We, Anthem Blue Cross and Blue Shield, can only raise your premium if we raise the premium for all policies like yours in this state. If you change age categories, your premium will increase to that rate at the beginning of the policy term following your birthday. Also, if your residence changes such that you move into a new rating area, your rates may be adjusted. Finally, if your coverage begins prior to age 65, you will remain in the same age category for the duration of your policy.

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.

Disclosure

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 Your Policy

If you find that you are not satisfied with your policy, you may return it to Anthem Blue Cross and Blue Shield, P.O. Box 3047, Milwaukee, WI 53201-3047. 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 directly to you, minus any amounts paid in claims.

Notice

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult the “Medicare & You” handbook for more details.

Neither Anthem Blue Cross and Blue Shield nor its agents are connected with Medicare.

NOTICE: This policy may not fully cover all of your medical costs.

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. Anthem 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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MEDICARE SUPPLEMENT OUTLINE OF COVERAGE (CONTINUED)

Guaranteed Acceptance and Renewal

Your acceptance into our Medicare Supplemental plans is guaranteed and you will not have to answer any questions about your health if you are eligible and you apply for coverage:

- Within the first six months following your enrollment in Medicare Part B; or
- You apply within the first six months following your 65th birthday if your Medicare Part B coverage was effective before your 65th birthday; or
- You apply within 63 days of losing or terminating coverage under any one of the following:
 - a group plan supplementing Medicare that terminated or ceased to provide some or all supplemental benefits;
 - a group plan primary to Medicare that terminated or ceased to provide all health benefits because you left the plan;
 - a Medicare Supplement plan that involuntarily terminated you, went bankrupt, became insolvent, misrepresented the policy or substantially violated a material provision of the policy;
 - a Medicare Risk, Medicare Cost, Medicare Advantage or Medicare prepayment health plan under which your coverage terminated for reasons other than for failure to pay a premium or for disruptive behavior;
 - a Medicare Advantage plan that you enrolled in when you were first eligible for Medicare at age 65 and that you had for no more than 12 months;
 - a Medicare Advantage, Medicare Risk, Medicare Cost or Medicare Select plan that you had for no more than 12 months and that replaced an Anthem Blue Cross and Blue Shield Medicare Supplement plan.

If you do not qualify for guaranteed acceptance into one of our Medicare Supplement plans, you must answer the health question on the application.

Our Medicare Supplemental plans are guaranteed renewable.



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MEDICARE SUPPLEMENT OUTLINE OF COVERAGE (CONTINUED)

25% COST-SHARING PLAN

You will pay one-quarter the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$2,310 each calendar year. The amounts that count toward your annual limit are noted with the symbol (Δ) in the charts on the following pages. Once you reach the annual limit, the policy pays 100% of your Medicare copayments and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

50% COST-SHARING PLAN

You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$4,620 each calendar year. The amounts that count toward your annual limit are noted with the symbol (Δ) in the charts on the following pages. Once you reach the annual limit, the policy pays 100% of your Medicare copayments and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

VALUE PLUS

MEDICARE (PART A) HOSPITAL SERVICES — PER BENEFIT PERIOD

For full details about Value Plus coverage, refer to the Value Plus Policy or call Anthem Blue Cross and Blue Shield.

**Part
A
Services**

Services	Medicare Pays	Value Plus Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies: First 60 days	All but \$1,068	\$0 or Optional Part A Deductible Rider [†]	\$1,068 or \$0 [†]
61st through 90th day	All but \$267 a day	\$267 a day	\$0
91st day and after: · While using 60 lifetime reserve days · Once lifetime reserve days are used — Additional 365 days	All but \$534 a day \$0	\$534 a day 100% of Medicare-eligible expenses	\$0 \$0**
— Beyond the additional 365 days	\$0	\$0	All costs
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$133.50 a day	Up to \$133.50 a day	\$0
101st day and after	\$0	\$0	All costs for 101st day and after 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.

** 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.

† These are optional riders. You may purchase these benefits if you pay an additional premium.

VALUE PLUS

MEDICARE (PART A) HOSPITAL SERVICES — PER BENEFIT PERIOD

For full details about Value Plus coverage, refer to the Value Plus Policy or call Anthem Blue Cross and Blue Shield.

**Part
A
Services**

Services	Medicare Pays	Value Plus Pays	You Pay
Inpatient Psychiatric Care Inpatient psychiatric care in a participating psychiatric hospital	190 day per lifetime	175 additional days per lifetime	Beyond 365 days
Blood First three pints	\$0	Three pints	\$0
Additional amounts	100%	\$0	\$0

**VALUE PLUS
MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR**

For full details about Value Plus coverage, refer to the Value Plus Policy or call Anthem Blue Cross and Blue Shield.

**Part
B
Services**

Services	Medicare Pays	Value Plus 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 and durable medical equipment First \$135 of Medicare-approved amounts*	\$0	\$0 or Optional Part B Deductible Rider [†]	\$135 (Part B deductible) or \$0 [†]
Remainder of Medicare-approved amounts	Generally 80%	Generally 20% or Optional Part B Excess Charges Rider ^{† ††}	Charges in excess of Medicare-approved charges or Charges not paid by Medicare or \$0 ^{† ††}
Blood First three pints Next \$135 of Medicare-approved amounts*	\$0 \$0	All costs \$0 or Optional Part B Deductible Rider [†]	\$0 \$135 (Part B deductible) or \$0 [†]
Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services Tests for Diagnostic Services	100%	\$0	\$0

* Once you have been billed \$135 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.
 † These are optional riders. You may purchase these benefits if you pay an additional premium.
 †† For doctors who do not accept assignment, Anthem Blue Cross and Blue Shield pays the difference between what Medicare pays and the amount charged by the provider, up to the limiting charge allowed by Medicare.

**VALUE PLUS
PARTS A & B**

For full details about Value Plus coverage, refer to the Value Plus Policy or call Anthem Blue Cross and Blue Shield.

Parts
A+B
Services

Services	Medicare Pays	Value Plus Pays	You Pay
Home Health Care Medicare-Approved Services · Medically necessary skilled care services and medical supplies	100% of charges for visits considered medically necessary by Medicare	40 visits in addition to those paid by Medicare or Optional Additional Home Health Rider [†]	Beyond 40 visits per calendar year or Beyond 365 visits [†]

† These are optional riders. You may purchase these benefits if you pay an additional premium.

**VALUE PLUS
ADDITIONAL BENEFITS**

For full details about Value Plus coverage, refer to the Value Plus Policy or call Anthem Blue Cross and Blue Shield.

	Services	Medicare Pays	Value Plus Pays	You Pay
Additional Benefits	Foreign Travel – Not Covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States First \$250 each calendar year	\$0	\$0 or Optional Foreign Travel Rider†	Charges while traveling outside the country or \$250 deductible†
	Remainder of charges	\$0	\$0 or Optional Foreign Travel Rider†	All Charges or 20% of charges for the first 60 days up to the \$50,000 lifetime maximum; 100% after 60 days or \$50,000 maximum†
	Diabetic Equipment & Supplies Self-education programs and one insulin infusion pump (provided you use it for 30 days before buying it)	Medicare generally does not cover diabetic supplies	The full, usual, customary and reasonable charge, less what Medicare paid	Charges in excess of the full, usual, customary and reasonable charge
	Licensed Skilled Nursing Facility Care The facility does not have to be certified by Medicare, no prior hospitalization is required and the stay does not have to meet Medicare's definition of skilled care.	\$0 for services beyond those covered under Part A	Up to 30 days per admission for medically necessary care	Charges for care beyond 30 days per admission

† These are optional riders. You may purchase these benefits if you pay an additional premium.

**VALUE PLUS
ADDITIONAL BENEFITS**

For full details about Value Plus coverage, refer to the Value Plus Policy or call Anthem Blue Cross and Blue Shield.

	Services	Medicare Pays	Value Plus Pays	You Pay
Additional Benefits	Chiropractic Services Manual manipulation of spine to correct subluxation	80% for manual manipulations of the spine to correct a subluxation that can be demonstrated by X-ray	The full usual, customary and reasonable charge, less what Medicare pays for Medicare-eligible expenses	Charges in excess of the full, usual, customary and reasonable charge
	Kidney Disease Care Inpatient and outpatient expenses for dialysis, transplantation or donor-related services	80%	Up to \$30,000 per year	Charges in excess of \$30,000 per year
	Preventive Medical Care Benefit – Not Covered By Medicare Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare. First \$300 each calendar year for Annual Wellcare Medical Exam, including Diagnostic X-rays & Laboratory Exams First \$25 each calendar year for Immunizations and Injections, such as flu and vitamin shots	\$0	\$300 (If Medicare pays, then we supplement Medicare’s payment and do not charge against the \$300 maximum) \$25 (If Medicare pays, then we supplement Medicare’s payment and do not charge against the \$25 maximum)	Charges in excess of \$300 per year Charges in excess of \$25 per year

VALUE PLUS

OPTIONAL BENEFITS FOR MEDICARE SUPPLEMENT PLAN

For full details about Value Plus coverage, refer to the Value Plus Policy or call Anthem Blue Cross and Blue Shield.

	Services	Medicare Pays	Value Plus Pays	You Pay
Optional Benefits for Medicare Supplement Plan	Part A Deductible [†]	\$0	100% of Part A Deductible	\$0
	365 Home Health Care Visits [†]	100% of charges for visits considered medically necessary by Medicare	An aggregate of 365 visits per year, including those covered by Medicare	Charges for visits beyond 365 per year
	Part B Deductible [†]	\$0	100% of Part B Deductible	\$0
	Part B Excess Charges ^{††}	\$0	Difference between what Medicare pays and the amount charged by the provider, up to the limiting charge allowed by Medicare	\$0
	Foreign Travel Rider [†]	\$0	After a separate foreign travel deductible of \$250, covers 80% of expenses associated with emergency medical care received outside the U.S.A. during the first 60 days of a trip with a lifetime maximum of \$50,000 in covered expenses	\$250, Then 20% of charges for the first 60 Days up to the \$50,000 Lifetime maximum; 100% beyond 60 Days or over \$50,000 maximum

† These are optional riders. You may purchase these benefits if you pay an additional premium.

†† For doctors who do not accept assignment, Anthem Blue Cross and Blue Shield pays the difference between what Medicare pays and the amount charged by the provider, up to the limiting charge allowed by Medicare.

25% COST SHARE

MEDICARE (PART A) HOSPITAL SERVICES — PER BENEFIT PERIOD

You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$2,310 each calendar year. The amounts that count toward your annual limit are noted with the symbol Δ in the chart. Once you reach the annual limit, the plan pays 100% of your Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

**Part
A
Services**

Services	Medicare Pays	25% Cost Share Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but \$1,068	\$801 (75% of Part A deductible)	Δ \$267 (25% of Part A deductible)
61st through 90th day	All but \$267 a day	\$267 a day	\$0
91st day and after:			
· While using 60 lifetime reserve days	All but \$534 a day	\$534 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

* 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.

Δ Applies to amounts that count toward your annual out-of-pocket limit.

25% COST SHARE

MEDICARE (PART A) HOSPITAL SERVICES – PER BENEFIT PERIOD

You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$2,310 each calendar year. The amounts that count toward your annual limit are noted with the symbol Δ in the chart. Once you reach the annual limit, the plan pays 100% of your Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

Part
A
Services

Services	Medicare Pays	25% Cost Share Pays	You Pay
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st through 100th day 101st day and after	All approved amounts All but \$133.50 a day \$0	\$0 Up to \$101.50 a day \$0	\$0 Δ Up to \$32 a day All costs
Inpatient Psychiatric Care Inpatient psychiatric care in a participating psychiatric hospital	190 days per lifetime	175 additional days per lifetime	Beyond 365 days
Hospice Care Available as long as your doctor certifies you are terminally ill and you elect to receive those services	Generally, most Medicare-eligible expenses for outpatient drugs and inpatient respite care	75% of coinsurance or copayments	Δ 25% of coinsurance or copayments
Blood First three pints Additional amounts	\$0 100%	75% \$0	Δ 25% \$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.

Δ Applies to amounts that count toward your annual out-of-pocket limit.

**25% COST SHARE
 MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$2,310 each calendar year. The amounts that count toward your annual limit are noted with the symbol Δ in the chart. Once you reach the annual limit, the plan pays 100% of your Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

**Part
 B
 Services**

Services	Medicare Pays	25% Cost Share 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 and durable medical equipment First \$135 of Medicare-approved amounts*	\$0	\$0	Δ \$135 (Part B deductible)
Preventive Benefits for Medicare-covered services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Δ Generally 5%
Part B Excess Charges (Above Medicare-approved amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of \$2,310)

* Once you have been billed \$135 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.

Δ Applies to amounts that count toward your annual out-of-pocket limit.

**25% COST SHARE
 MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$2,310 each calendar year. The amounts that count toward your annual limit are noted with the symbol Δ in the chart. Once you reach the annual limit, the plan pays 100% of your Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

**Part
 B
 Services**

Services	Medicare Pays	25% Cost Share Pays	You Pay
Blood			
First three pints	\$0	75%	Δ 25%
Next \$135 of Medicare-approved amounts*	\$0	\$0	Δ \$135 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Δ Generally 5%
Clinical Laboratory Services			
Tests for Diagnostic Services	100%	\$0	\$0

* Once you have been billed \$135 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.

Δ Applies to amounts that count toward your annual out-of-pocket limit.

25% COST SHARE

PARTS A & B

You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$2,310 each calendar year. The amounts that count toward your annual limit are noted with the symbol Δ in the chart. Once you reach the annual limit, the plan pays 100% of your Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

Parts
A+B
Services

Services	Medicare Pays	25% Cost Share Pays	You Pay
<p>Home Health Care Medicare-Approved Services</p> <ul style="list-style-type: none"> · Medically necessary skilled care services and medical supplies 	<p>100% of charges for visits considered medically necessary by Medicare</p>	<p>40 visits in addition to those paid by Medicare or Optional Additional Home Health Rider[†]</p>	<p>Beyond 40 visits per calendar year or Beyond 365 visits[†]</p>

† This is an optional rider. You may purchase these benefits if you pay an additional premium.

25% COST SHARE

OTHER BENEFITS — NOT COVERED BY MEDICARE — AND OPTIONAL BENEFITS FOR MEDICARE SUPPLEMENT PLAN

You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$2,310 each calendar year. The amounts that count toward your annual limit are noted with the symbol Δ in the chart. Once you reach the annual limit, the plan pays 100% of your Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

	Services	Medicare Pays	25% Cost Share Pays	You Pay
Other Benefits Not Covered By Medicare	Chiropractic Services Manual manipulation of spine to correct subluxation	80% for manual manipulations of the spine to correct a subluxation that can be demonstrated by X-ray	The full usual, customary and reasonable charge, less what Medicare pays for Medicare-eligible expenses	Charges in excess of the full, usual, customary and reasonable charge
	Kidney Disease Care Inpatient and outpatient expenses for dialysis, transplantation or donor-related services	80%	Up to \$30,000 per year	Charges in excess of \$30,000 per year
Optional Benefits for Medicare Supplement Plan	365 Home Health Care Visits†	100% of charges for visits considered medically necessary by Medicare	An aggregate of 365 visits per year, including those covered by Medicare	Charges for visits beyond 365 per year

† This is an optional rider. You may purchase these benefits if you pay an additional premium.

50% COST SHARE

MEDICARE (PART A) HOSPITAL SERVICES — PER BENEFIT PERIOD

You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$4,620 each calendar year. The amounts that count toward your annual limit are noted with a Δ in the chart. Once you reach the annual limit, the plan pays 100% of your Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

**Part
A
Services**

Services	Medicare Pays	50% Cost Share Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but \$1,068	\$534 (50% of Part A Deductible)	Δ \$534 (50% of Part A Deductible)
61st through 90th day	All but \$267 a day	\$267 a day	\$0
91st day and after:			
· While using 60 lifetime reserve days	All but \$534 a day	\$534 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

* 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.

Δ Applies to amounts that count toward your annual out-of-pocket limit.

50% COST SHARE

MEDICARE (PART A) HOSPITAL SERVICES – PER BENEFIT PERIOD

You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$4,620 each calendar year. The amounts that count toward your annual limit are noted with a Δ in the chart. Once you reach the annual limit, the plan pays 100% of your Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

**Part
A
Services**

Services	Medicare Pays	50% Cost Share Pays	You Pay
<p>Skilled Nursing Facility Care* You must meet Medicare’s requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital</p> <p>First 20 days 21st through 100th day 101st day and after</p>	<p>All approved amounts All but \$133.50 a day \$0</p>	<p>\$0 Up to \$66.75 a day \$0</p>	<p>\$0 Δ Up to \$66.75 a day All costs for 101st day and after per benefit period*</p>
<p>Inpatient Psychiatric Care Inpatient psychiatric care in a participating psychiatric hospital</p>	<p>190 days per lifetime</p>	<p>175 additional days per lifetime</p>	<p>Beyond 365 days</p>
<p>Blood First three pints Additional amounts</p>	<p>\$0 100%</p>	<p>50% \$0</p>	<p>Δ 50% \$0</p>
<p>Hospice Care Available as long as your doctor certifies you are terminally ill and you elect to receive those services</p>	<p>Generally, most Medicare-eligible expenses for outpatient drugs and inpatient respite care</p>	<p>50% of coinsurance or copayments</p>	<p>Δ 50% of coinsurance or copayments</p>

* 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.

Δ Applies to amounts that count toward your annual out-of-pocket limit.

**50% COST SHARE
 MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$4,620 each calendar year. The amounts that count toward your annual limit are noted with a Δ in the chart. Once you reach the annual limit, the plan pays 100% of your Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

**Part
 B
 Services**

Services	Medicare Pays	50% Cost Share 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 and durable medical equipment			
First \$135 of Medicare-approved amounts*	\$0	\$0	Δ \$135 (Part B deductible)
Preventive Benefits for Medicare-covered services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
Remainder of Medicare-approved amounts	Generally 80%	Generally 10%	Δ Generally 10%
Blood			
First three pints	\$0	50%	Δ 50%
Next \$135 of Medicare-approved amounts*	\$0	\$0	Δ \$135 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 10%	Δ Generally 10%
Clinical Laboratory Services			
Tests for Diagnostic Services	100%	\$0	\$0

* Once you have been billed \$135 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.

Δ Applies to amounts that count toward your annual out-of-pocket limit.

50% COST SHARE

PARTS A & B

You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$4,620 each calendar year. The amounts that count toward your annual limit are noted with a Δ in the chart. Once you reach the annual limit, the plan pays 100% of your Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

Parts
A+B
Services

Services	Medicare Pays	50% Cost Share Pays	You Pay
<p>Home Health Care Medicare-Approved Services</p> <ul style="list-style-type: none"> · Medically necessary skilled care services and medical supplies 	<p>100% of charges for visits considered medically necessary by Medicare</p>	<p>40 visits in addition to those paid by Medicare or Optional Additional Home Health Rider[†]</p>	<p>Beyond 40 visits per calendar year or Beyond 365 visits[†]</p>

† This is an optional rider. You may purchase these benefits if you pay an additional premium.

50% COST SHARE

OTHER BENEFITS — NOT COVERED BY MEDICARE — AND OPTIONAL BENEFITS FOR MEDICARE SUPPLEMENT PLAN

You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$4,620 each calendar year. The amounts that count toward your annual limit are noted with a Δ in the chart. Once you reach the annual limit, the plan pays 100% of your Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

	Services	Medicare Pays	50% Cost Share Pays	You Pay
Other Benefits Not Covered By Medicare	Chiropractic Services Manual manipulation of spine to correct subluxation	80% for manual manipulations of the spine to correct a subluxation that can be demonstrated by X-ray	The full usual, customary and reasonable charge, less what Medicare pays for Medicare-eligible expenses	Charges in excess of the full, usual, customary and reasonable charge
	Kidney Disease Care Inpatient and outpatient expenses for dialysis, transplantation or donor-related services	80%	Up to \$30,000 per year	Charges in excess of \$30,000 per year
Optional Benefits for Medicare Supplement Plan	365 Home Health Care Visits[†]	100% of charges for visits considered medically necessary by Medicare	An aggregate of 365 visits per year, including those covered by Medicare	Charges for visits beyond 365 per year

† This is an optional rider. You may purchase these benefits if you pay an additional premium.



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