Anthem BlueCross BlueShield

The purpose of this communication is the solicitation of insurance. Contact will be made by an insurance agent or insurance company.

# IMPORTANT NOTICE – PLEASE READ
# 2019 Medicare Cost-Sharing Amounts

Dear Prospective Member:

The Centers for Medicare & Medicaid Services (CMS) have not released the 2019 Medicare cost-sharing amounts as of the printing of this booklet. Please note that the Outline of Coverage that follows this notice includes the current 2018 Medicare cost-share amounts and premium rates effective as of January 1, 2019.

The Medicare amounts are your responsibility with only Original Medicare. Coverage of these Medicare amounts varies by Medicare Supplement plan. If you enroll in a plan that covers the Medicare amount(s); such as, the deductible for Medicare Part A (2018 = $1,340), Part B (2018 = $183), the amount covered by the plan you enroll in will be adjusted to cover the 2019 Medicare amounts once they are released.

Anthem

# Medicare Supplement Outline of Coverage

## Plans A, F, G & N

## Anthem Blue Cross and Blue Shield New Hampshire 2019

This booklet includes premium rates, Medicare deductibles, copays and maximum out-of-pocket costs.

Call toll-free 1-888-596-0272 with questions.
Administrative Office: 3000 Goffs Falls Road, Manchester, NH 03111-0001

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# Benefit Chart of Medicare Supplement Plans Sold on or After June 1, 2010

This chart shows the benefits included in each of the standard Medicare Supplement plans. Plans shown in gray are available for purchase.

These same plans are available to those who are under 65 and qualify for Medicare due to disability.

**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.

| Benefits | A | B | C | D | F | F*[1] | G | K | L | M | N |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Basic Coverage, Including 100% Part B Coinsurance | ✓ | ✓ | ✓ | ✓ | ✓* | ✓* | ✓ | | | ✓ | ✓▲ |
| Hospitalization & Preventative Care /Other Basic Benefits | | | | | | | | **100**% /**50**% | **100**% /**75**% | | |
| Skilled Nursing Facility Coinsurance | | | ✓ | ✓ | ✓ | ✓ | ✓ | **50**% | **75**% | ✓ | ✓ |
| Part A Deductible | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | **50**% | **75**% | **50**% | ✓ |
| Part B Deductible | | | ✓ | | ✓ | ✓ | | | | | |
| Part B Excess (100%) | | | | | ✓ | ✓ | ✓ | | | | |
| Foreign Travel Emergency | | | ✓ | ✓ | ✓ | ✓ | ✓ | | | ✓ | ✓ |
| Out-of-pocket Limit; Paid at 100% after Limit is Reached | | | | | | | | **$5,240** | **$2,620** | | |

* 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 $2,240 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses exceed $2,240. 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.

1 High Deductible Plan F is not available.

▲ Basic benefits, EXCEPT up to $20 copayment for office visit, and up to $50 copayment for emergency room visit.

# Finding Your Monthly Premium

**Plans A, F, G & N | Effective January 1, 2019**
Premiums are subject to change.

## Here's some important information, before we get started:

Premiums are subject to change on or after the Renewal Date in accordance with the terms of the Policy. We, Anthem, can only raise your premium if we raise the premium for all plans like yours in this State.

## Find Your Premium

Premiums (and future changes to premiums) are determined by several factors, including age, gender, plan, and the costs of medical services and supplies.

## Compare Plans

After locating the monthly premium, you are ready to review the individual plan pages. These pages provide details of the covered services and what each plan pays. Based on your individual needs, these pages will help you determine the plan that is best for you. You are now ready to **ENROLL**!

## Don't miss out on a chance to SAVE!

These optional discounts are offered for all of the following Premium Tables, for ages 65 and over.

**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.

## Ways to Enroll

**Sales Department***
**Call 1-888-211-9813**
(TTY/TDD: **711**)
8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30

**Customer Service**
**Call 1-800-333-3883**
(TTY/TDD: **711**)
8 a.m. to 8 p.m.
seven days a week

**Visit us Online**
**www.anthem.com**
- Enroll online
- Find a doctor
- Find a pharmacy
- List of covered drugs

***Let's Begin***

* By calling this number, you will reach an authorized licensed insurance agent who can answer questions about our plans and enrollment.

# Finding Your Monthly Premium

**Plans A, F, G & N | Effective January 1, 2019**

Premiums are subject to change. Premium is based upon your age, gender and plan.

## PREMIUM INFORMATION

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

| Age* | Male | | | | Female | | | |
|---|---|---|---|---|---|---|---|---|
| | Plan A | Plan F | Plan G | Plan N | Plan A | Plan F | Plan G | Plan N |
| <65 | $369.37 | $549.88 | $426.17 | $392.47 | $335.79 | $499.89 | $387.44 | $ 356.80 |
| 65 | 129.70 | 193.09 | 149.64 | 137.81 | 117.91 | 175.54 | 136.05 | 125.29 |
| 66 | 139.86 | 208.21 | 161.36 | 148.60 | 127.13 | 189.27 | 146.69 | 135.08 |
| 67 | 143.31 | 213.35 | 165.35 | 152.27 | 130.28 | 193.96 | 150.32 | 138.43 |
| 68 | 146.98 | 218.81 | 169.59 | 156.17 | 133.60 | 198.90 | 154.17 | 141.97 |
| 69 | 150.78 | 224.49 | 173.98 | 160.22 | 137.07 | 204.06 | 158.15 | 145.64 |
| 70 | 155.07 | 230.86 | 178.92 | 164.76 | 140.98 | 209.89 | 162.66 | 149.79 |
| 71 | 158.90 | 236.55 | 183.34 | 168.84 | 144.45 | 215.06 | 166.66 | 153.48 |
| 72 | 162.89 | 242.50 | 187.95 | 173.08 | 148.08 | 220.45 | 170.85 | 157.34 |
| 73 | 166.22 | 247.46 | 191.80 | 176.63 | 151.11 | 224.97 | 174.36 | 160.57 |
| 74 | 169.58 | 252.45 | 195.66 | 180.18 | 154.16 | 229.51 | 177.87 | 163.80 |
| 75 | 172.92 | 257.41 | 199.52 | 183.74 | 157.20 | 234.01 | 181.36 | 167.01 |
| 76 | 176.31 | 262.47 | 203.42 | 187.33 | 160.28 | 238.62 | 184.93 | 170.31 |
| 77 | 179.62 | 267.39 | 207.23 | 190.84 | 163.28 | 243.08 | 188.40 | 173.50 |
| 78 | 182.31 | 271.41 | 210.34 | 193.71 | 165.74 | 246.73 | 191.22 | 176.10 |
| 79 | 185.00 | 275.42 | 213.46 | 196.57 | 168.19 | 250.38 | 194.06 | 178.71 |
| 80 | 201.77 | 300.37 | 232.78 | 214.37 | 183.42 | 273.07 | 211.64 | 194.90 |
| 81 | 218.52 | 325.32 | 252.12 | 232.18 | 198.66 | 295.76 | 229.21 | 211.08 |
| 82 | 235.29 | 350.28 | 271.48 | 250.01 | 213.90 | 318.42 | 246.80 | 227.28 |
| 83 | 252.05 | 375.23 | 290.82 | 267.82 | 229.13 | 341.11 | 264.37 | 243.46 |
| 84 | 268.82 | 400.18 | 310.15 | 285.62 | 244.37 | 363.80 | 281.96 | 259.66 |
| 85 | 285.57 | 425.15 | 329.49 | 303.43 | 259.61 | 386.49 | 299.53 | 275.84 |
| 86 | 302.33 | 450.07 | 348.82 | 321.23 | 274.83 | 409.16 | 317.12 | 292.04 |
| 87 | 319.09 | 475.04 | 368.16 | 339.04 | 290.07 | 431.85 | 334.70 | 308.23 |
| 88 | 335.85 | 499.99 | 387.51 | 356.86 | 305.31 | 454.53 | 352.28 | 324.41 |
| 89 | 352.62 | 524.93 | 406.84 | 374.66 | 320.55 | 477.20 | 369.84 | 340.59 |
| 90+ | 369.37 | 549.88 | 426.17 | 392.47 | 335.79 | 499.89 | 387.44 | 356.80 |

* Age as of the date the plan is issued.

# Important Plan Disclosures

**Plans A, F, G & N**
Retain this outline for your records.

## 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 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: 3000 Goffs Falls Road, Manchester, NH 03111-0001. 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. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

## 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 | All but $1,340 | $0 | $1,340 (Part A deductible) |
| 61st thru 90th day | All but $335 a day | $335 a day | $0 |
| 91st day and after: • While using 60 lifetime reserve days | All but $670 a day | $670 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 |
| **▼ 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 $167.50 a day | $0 | Up to $167.50 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 |

** 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.

*(continued)*

## Medicare (Part B) – Medical Services – Per Calendar Year

* Once you have been billed $183 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 $183 of Medicare Approved Amounts* | $0 | $0 | $183 (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 $183 of Medicare Approved Amounts* | $0 | $0 | $183 (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

| 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 $183 of Medicare approved amounts* | $0 | $0 | $183 (Part B deductible) |
| — Remainder of Medicare approved amounts | 80% | 20% | $0 |

## 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 | All but $1,340 | $1,340 (Part A deductible) | $0 |
| 61st thru 90th day | All but $335 a day | $335 a day | $0 |
| 91st day and after: • While using 60 lifetime reserve days | All but $670 a day | $670 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 |
| **▼ 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 $167.50 a day | Up to $167.50 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 |

*** 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.

*(continued)*

## Medicare (Part B) – Medical Services – Per Calendar Year

* Once you have been billed $183 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 $183 of Medicare Approved Amounts* | $0 | $183 (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 $183 of Medicare Approved Amounts* | $0 | $183 (Part B deductible) | $0 |
| Remainder of Medicare Approved Amounts | 80% | 20% | $0 |
| **▼ Clinical Laboratory Services** | | | |
| Tests for Diagnostic Services | 100% | $0 | $0 |

## 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 $183 of Medicare Approved Amounts* | $0 | $183 (Part B deductible) | $0 |
| — Remainder of Medicare approved amounts | 80% | 20% | $0 |

*(continued)*

## Other Benefits – Not Covered by Medicare

| Services | Medicare Pays | Plan Pays | You Pay |
|---|---|---|---|
| ▼ **Foreign Travel — Not Covered by Medicare**<br>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 |

## Plan G

### 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 | All but $1,340 | $1,340 (Part A deductible) | $0 |
| 61st thru 90th day | All but $335 a day | $335 a day | $0 |
| 91st day and after: • While using 60 lifetime reserve days | All but $670 a day | $670 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 |
| **▼ 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 $167.50 a day | Up to $167.50 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 |

** 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.

*(continued)*

## Medicare (Part B) – Medical Services – Per Calendar Year

* Once you have been billed $183 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 $183 of Medicare Approved Amounts* | $0 | $0 | $183 (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 $183 of Medicare Approved Amounts* | $0 | $0 | $183 (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

| 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 $183 of Medicare Approved Amounts* | $0 | $0 | $183 (Part B deductible) |
| — Remainder of Medicare approved amounts | 80% | 20% | $0 |

*(continued)*

## Other Benefits – Not Covered by Medicare

| Services | Medicare Pays | Plan Pays | You Pay |
|---|---|---|---|
| ▼ **Foreign Travel — Not Covered by Medicare**<br>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 |

## 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 | All but $1,340 | $1,340 (Part A deductible) | $0 |
| 61st thru 90th day | All but $335 a day | $335 a day | $0 |
| 91st day and after: • While using 60 lifetime reserve days | All but $670 a day | $670 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 |
| **▼ 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 $167.50 a day | Up to $167.50 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 |

** 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.

## Medicare (Part B) – Medical Services – Per Calendar Year

* Once you have been billed $183 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 $183 of Medicare Approved Amounts* | $0 | $0 | $183 (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 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. | Up to $20 per office visit and up to $50 per emergency room visit. The 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 | $0 | All costs | $0 |
| Next $183 of Medicare Approved Amounts* | $0 | $0 | $183 (Part B deductible) |
| Remainder of Medicare Approved Amounts | 80% | 20% | $0 |
| ▼ **Clinical Laboratory Services** | | | |
| Tests for Diagnostic Services | 100% | $0 | $0 |

*(continued)*

## Parts A & B Services

* Once you have been billed $183 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 |
|---|---|---|---|
| **▼ Home Health Care — Medicare Approved Services** | | | |
| • Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| • Durable medical equipment: | | | |
| — First $183 of Medicare approved amounts* | $0 | $0 | $183 (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 |

3000 Goffs Falls Road
Manchester, NH 03111-0001



2019_OOC-NH (Rev. 10_2018)