



Anthem Blue Cross and Blue Shield – Ohio

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

**2009 OUTLINE OF MEDICARE SUPPLEMENT COVERAGE
 COVER PAGE
 STANDARD PLANS A, C, AND F**

Medicare supplement insurance can be sold in 12 standard plans plus two high deductible plans. This chart shows the benefits included in each of the standard Medicare Supplement plans. Every company must make available Plan “A.” Some plans may not be available in your state. You have the option to purchase an Anthem Medicare Supplement plan shown in gray.

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) or copayments for hospital outpatient services.
 - **Blood:** First three pints of blood each year.

Plan A	Plan B	Plan C	Plan D	Plan E	Plan F/F*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Facility Coinsurance	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
		Part B Deductible			Part B Deductible
					Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery		
				Preventive Care NOT covered by Medicare	

* Plans F and J also have an option called a High Deductible Plan F and a High Deductible Plan J. These high deductible plans pay the same benefits as Plans F and J after one has paid a calendar year \$2,000 deductible. Benefits from High Deductible Plans F and J 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 does not offer a high deductible option for Standard Medicare Supplement Plan F.

Plan G	Plan H	Plan I	Plan J/J*	Plan K**	Plan L**
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	100% of Part A hospitalization coinsurance, plus coverage for 365 days after Medicare benefits end 50% hospice cost sharing 50% of Medicare-eligible expenses for the first three pints of blood 50% Part B coinsurance, except 100% coinsurance for Part B preventive services	100% of Part A hospitalization coinsurance, plus coverage for 365 days after Medicare benefits end 75% hospice cost sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B coinsurance, except 100% coinsurance for Part B preventive services
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
Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible
			Part B Deductible		
Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)		
Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		
At-Home Recovery		At-Home Recovery	At-Home Recovery		
			Preventive Care NOT Covered by Medicare	\$4,620 Out-of-Pocket Limit***	\$2,310 Out-of-Pocket Limit***

* Plans F and J also have an option called a High Deductible Plan F and a High Deductible Plan J. These high deductible plans pay the same benefits as Plans F and J after one has paid a calendar year \$2,000 deductible. Benefits from High Deductible Plans F and J 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.

** Plans K and L provide for different cost sharing for items and services than Plans A-J. Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges." You will be responsible for paying excess charges.

*** The out-of-pocket annual limit will increase each year for inflation.



Anthem Blue Cross and Blue Shield – Ohio

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

**MONTHLY RATES – ANTHEM BLUE CROSS AND BLUE SHIELD
STANDARD PLANS A, C, AND F
Effective July 1, 2009**

Issue Age	Standardized Plan A	Standardized Plan C	Standardized Plan F
65	\$ 98.25	\$ 164.88*	\$ 171.19*
66-69	109.02	183.11**	190.29**
70-74	120.00	201.53	209.38
75-79	131.08	219.71	228.27
80+	141.95	238.16	247.33

* If you are age 65 and applying for coverage during open enrollment, you will receive a 10% discount off the current rate. Your discounted rate will be \$148.39 for Plan C and \$154.07 for Plan F. You will receive a 5% discount off the second year rate at age 66.

** If you are 66 and applying for coverage during open enrollment, you will receive a 5% discount off the current rate. Your discounted rate will be \$173.95 for Plan C and \$180.78 for Plan F.



Anthem Blue Cross and Blue Shield – Ohio

Administrative Office: P. O. Box 37730, Louisville, KY 40233-7730

Toll Free Telephone Number: 1-866-803-5169

MEDICARE SUPPLEMENT OUTLINE OF COVERAGE

Outline of Coverage for Policy Form Series

Standard Plan A,

Standard Plan C,

Standard Plan F

Retain This Outline For Your Records

Premium Information

With Issue-Age rating, your Medicare Supplement premium is determined by your age at the time of your enrollment. Anthem can increase your premium if we raise our table of premium rates for all policies like yours in this state. This policy does not contain provisions providing for a refund of premium upon surrender or cancellation of the policy. If termination of this coverage results from the death of the insured, the insured's estate is entitled to a refund of the unused premium.

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: 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, minus any amounts paid in claims.

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 associates 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 the "Medicare & You" handbook 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. 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.



Anthem Blue Cross and Blue Shield – Ohio

Administrative Office: P. O. Box 37730, Louisville, KY 40233-7730

Toll Free Telephone Number: 1-866-803-5169

**MEDICARE SUPPLEMENT OUTLINE OF COVERAGE
(CONTINUED)**

Guaranteed Acceptance and Renewal

Your acceptance into our Medicare Supplemental plans is guaranteed if you apply for coverage during your Open Enrollment Period. This period lasts for six months and begins on the first day of the month in which you are **both** age 65 **and** enrolled in Medicare Part B. During this period, we will waive any medical underwriting requirements. Certain circumstances may provide further opportunity for guaranteed acceptance. For details, consult the “Guide to Health Insurance for People with Medicare.”

Our Medicare Supplemental plans are guaranteed renewable.

STANDARD PLAN A

MEDICARE (PART A) HOSPITAL SERVICES – PER BENEFIT PERIOD

Medicare deductibles and co-insurance amounts are effective as of January 1, 2009. Medicare may change these amounts annually. 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.

**Part
A
Services**

Services	Medicare Pays	Standard Plan A Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies: First 60 days	All but \$1,068	\$0	\$1,068 (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 · 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	\$0	Up to \$133.50 a day
101st day and after	\$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.

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

Medicare deductibles and co-insurance amounts are effective as of January 1, 2009. Medicare may change these amounts annually. 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.

**Part
 A
 Services**

Services	Medicare Pays	Standard Plan A Pays	You Pay
Blood First three pints Additional amounts	\$0 100%	Three pints \$0	\$0 \$0
Hospice Care Available as long as your doctor certifies you are terminally ill and you elect to receive those services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

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

Medicare deductibles and co-insurance amounts are effective as of January 1, 2009. Medicare may change these amounts annually. 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.

**Part
B
Services**

Services	Medicare Pays	Standard Plan A 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	\$135 (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 three pints	\$0	All costs	\$0
Next \$135 of Medicare-approved amounts*	\$0	\$0	\$135 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services			
Tests for Diagnostic Services	100%	\$0	\$0

* Once you have been billed \$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.

STANDARD PLAN A
PARTS A & B

Medicare deductibles and co-insurance amounts are effective as of January 1, 2009. Medicare may change these amounts annually. 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.

Parts
A+B
 Services

Services	Medicare Pays	Standard Plan A Pays	You Pay
Home Health Care			
Medicare-Approved Services			
· Medically necessary skilled care services and medical supplies	100%	\$0	\$0
· Durable medical equipment			
First \$135 of Medicare-approved amounts*	\$0	\$0	\$135 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$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.

STANDARD PLAN C

MEDICARE (PART A) HOSPITAL SERVICES – PER BENEFIT PERIOD

Medicare deductibles and co-insurance amounts are effective as of January 1, 2009. Medicare may change these amounts annually. 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.

Part A Services	Services	Medicare Pays	Plan C Pays	You Pay
	Hospitalization* Semi-private room and board, general nursing and miscellaneous services and supplies: First 60 days 61st through 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 \$1,068 All but \$267 a day All but \$534 a day \$0 \$0	\$1,068 (Part A deductible) \$267 a day \$534 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 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 \$133.50 a day \$0	\$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.

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

Medicare deductibles and co-insurance amounts are effective as of January 1, 2009. Medicare may change these amounts annually. 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.

**Part
A
Services**

Services	Medicare Pays	Plan C Pays	You Pay
Blood			
First three pints	\$0	Three pints	\$0
Additional amounts	100%	\$0	\$0
Hospice Care			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

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

Medicare deductibles and co-insurance amounts are effective as of January 1, 2009. Medicare may change these amounts annually. 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.

**Part
B
Services**

Services	Medicare Pays	Plan C 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	\$135 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare-approved amounts)	\$0	\$0	All costs
Blood			
First three pints	\$0	All costs	\$0
Next \$135 of Medicare-approved amounts*	\$0	\$135 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services			
Tests for Diagnostic Services	100%	\$0	\$0

* Once you have been billed \$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.

STANDARD PLAN C
PARTS A & B – OTHER BENEFITS NOT COVERED BY MEDICARE

Medicare deductibles and co-insurance amounts are effective as of January 1, 2009. Medicare may change these amounts annually. 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.

	Services	Medicare Pays	Plan C Pays	You Pay
Parts A+B Services	Home Health Care			
	Medicare-Approved Services			
	· Medically necessary skilled care services and medical supplies	100%	\$0	\$0
	· Durable medical equipment First \$135 of Medicare-approved amounts*	\$0	\$135 (Part B deductible)	\$0
	Remainder of Medicare-approved amounts	80%	20%	\$0
Other Benefits Not Covered By Medicare	Foreign Travel – Not Covered by Medicare			
	Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States			
	First \$250 each calendar year	\$0	\$0	\$250
	Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

* Once you have been billed \$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.

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

Medicare deductibles and co-insurance amounts are effective as of January 1, 2009. Medicare may change these amounts annually. 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.

**Part
A
Services**

Services	Medicare Pays	Plan F Pays	You Pay
Hospitalization* Semi-private room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but \$1,068	\$1,068 (Part A deductible)	\$0
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
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

* 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.

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

Medicare deductibles and co-insurance amounts are effective as of January 1, 2009. Medicare may change these amounts annually. 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.

**Part
 A
 Services**

Services	Medicare Pays	Plan F Pays	You Pay
Blood First three pints Additional amounts	\$0 100%	Three pints \$0	\$0 \$0
Hospice Care Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

STANDARD PLAN F
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

Medicare deductibles and co-insurance amounts are effective as of January 1, 2009. Medicare may change these amounts annually. 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.

Part
B
Services

Services	Medicare Pays	Plan F 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	\$135 (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 three pints	\$0	All costs	\$0
Next \$135 of Medicare-approved amounts*	\$0	\$135 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services – Tests for Diagnostic Services	100%	\$0	\$0

* Once you have been billed \$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.

STANDARD PLAN F
PARTS A & B

Medicare deductibles and co-insurance amounts are effective as of January 1, 2009. Medicare may change these amounts annually. 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.

Parts
A+B
 Services

Services	Medicare Pays	Plan F Pays	You Pay
Home Health Care			
Medicare-Approved Services			
· Medically necessary skilled care services and medical supplies	100%	\$0	\$0
· Durable medical equipment First \$135 of Medicare-approved amounts*	\$0	\$135 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$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.

STANDARD PLAN F

OTHER BENEFITS – NOT COVERED BY MEDICARE

Medicare deductibles and co-insurance amounts are effective as of January 1, 2009. Medicare may change these amounts annually. 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.

Services	Medicare Pays	Plan F Pays	You Pay
Other Benefits Not Covered By Medicare	Foreign Travel – Not Covered by Medicare		
	Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States		
	First \$250 each calendar year	\$0	\$0
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum



*Anthem Blue Cross and Blue Shield is the trade name of
Community Insurance Company. Independent licensee of the
Blue Cross and Blue Shield Association. © ANTHEM is a registered
trademark. The Blue Cross and Blue Shield names and symbols are
registered marks of the Blue Cross and Blue Shield Association.*