

*Medicare*

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Supplemental  
Coverage  
Outline

■ *MediGap-65 – Maryland*

Offered by  
CareFirst of Maryland, Inc.\*  
d/b/a  
CareFirst BlueCross BlueShield  
10455 Mill Run Circle  
Owings Mills, Maryland 21117-5559

A not-for-profit health service plan

\*An independent licensee of the Blue Cross and Blue Shield Association

## CareFirst BlueCross BlueShield\*

### Outline of Medicare Supplement Coverage Benefit Plans A,B,C,F\*\*

- These charts show 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.
- See Outlines of Coverage sections for details about ALL plans.

**BASIC BENEFITS** for 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.

Medigap-65 PLAN A	Medigap-65 PLAN B	Medigap-65 PLAN C	PLAN D	PLAN E	Medigap-65 PLAN F**	PLAN G	PLAN H	PLAN I	PLAN J**
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	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	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 A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
				Preventive Care NOT covered by Medicare					Preventive Care NOT covered by Medicare

\* CareFirst BlueCross BlueShield is an independent licensee of the Blue Cross and Blue Shield Association.

\*\* 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.

## CareFirst BlueCross BlueShield Outline of Medicare Supplement Coverage

Basic Benefits for Plans K and L include similar services as plans A – J, but cost-sharing for the basic benefits is at different levels.

PLAN J**	PLAN K***	PLAN L***
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	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive care Not covered by Medicare		
	\$4,620 Out-of-Pocket Annual Limit****	\$2,310 Out-of-Pocket Annual Limit****

\*\*\* 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.

See Outlines of Coverage for details and exceptions.

# CAREFIRST BLUECROSS BLUESHIELD

2009 MONTHLY PREMIUM RATES EFFECTIVE JANUARY 1, 2009 (BILLED QUARTERLY)					
Age	Plan A	Plan B	Plan C	Plan F	High-Deductible Plan F
<b>Under 65</b>	<b>\$152.82</b>	<b>—</b>	<b>\$407.26</b>	<b>—</b>	<b>—</b>
<b>65-69</b>	<b>\$113.82</b>	<b>\$140.48</b>	<b>\$163.37</b>	<b>\$167.41</b>	<b>\$52.84</b>
<b>70-74</b>	<b>\$140.48</b>	<b>\$173.40</b>	<b>\$201.64</b>	<b>\$206.65</b>	<b>\$65.22</b>
<b>75-79</b>	<b>\$166.53</b>	<b>\$205.58</b>	<b>\$239.09</b>	<b>\$245.01</b>	<b>\$77.33</b>
<b>80-84</b>	<b>\$191.69</b>	<b>\$236.64</b>	<b>\$275.19</b>	<b>\$282.02</b>	<b>\$89.01</b>
<b>85 AND OVER</b>	<b>\$204.96</b>	<b>\$252.97</b>	<b>\$294.16</b>	<b>\$301.46</b>	<b>\$95.14</b>

**PREMIUM INFORMATION**

CareFirst BlueCross BlueShield (CareFirst) can only raise your premium if we raise the premium of all certificates, like yours, in this State. You may expect a change in your premium anytime, except during the initial year of coverage. You may also expect a rate increase which will be effective on the first of the month in which you change from one age group to another (except if the change is during the initial year of coverage in which case the increase will be deferred until after the initial year of coverage) as shown below:

- 1) Under age 65
- 2) Age 65 through 69
- 3) Age 70 through 74
- 4) Age 75 through 79
- 5) Age 80 through 84
- 6) Age 85 and over

**DISCLOSURES**

Use this outline to compare benefits and premiums among policies.

**READ YOUR CERTIFICATE 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 CERTIFICATE**

If you find that you are not satisfied with your certificate, you may return it to:

**CareFirst of Maryland, Inc.  
d/b/a CareFirst BlueCross BlueShield  
Individual Market Division  
10455 Mill Run Circle, 4th Floor  
Owings Mills, Maryland 21117**

If you send the certificate back to us within 30 days after you receive it, we will treat the certificate as if it had never been issued and return all of your payments.

**CERTIFICATE REPLACEMENT**

If you are replacing another health insurance certificate, do NOT cancel it until you have actually received your new certificate and are sure you want to keep it.

**NOTICE**

This certificate may not fully cover all of your medical costs. Neither CareFirst BlueCross BlueShield or 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 your new certificate, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your certificate and refuse to pay any claims if you leave out or falsify important medical information. Review the application carefully before you sign it. Be certain that all information has been properly recorded.

## MediGap-65 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.

**\*\*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.

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
<b>■ Hospitalization*</b>			
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 thru 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
<b>■ Skilled Nursing Facility Care*</b>			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- Approved facility within 30 days after leaving the hospital			
• First 20 days	All approved amounts	\$0	\$0
• 21st thru 100th day	All but \$133.50 a day	\$0	Up to \$133.50 a day
• 101st day and after	\$0	\$0	All costs
<b>■ Blood</b>			
• First 3 pints	\$0	3 pints	\$0
• Additional amounts	100%	\$0	\$0
<b>■ Hospice Care</b>			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services			
	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

# MediGap-65 PLAN A

## Medicare Part B Hospital Services Per Calendar Year

\*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.

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
<b>■ Medical Expenses-In Or Out Of Hospital And Outpatient Hospital Treatment</b> Such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, 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
<b>■ Part B Excess Charges</b> (Above Medicare-Approved Amounts)	\$0	\$0	All costs
<b>■ Blood</b>			
• First 3 pints	\$0	All costs	\$0
• Next \$135 of Medicare-Approved Amounts*	\$0	\$0	\$135 (Part B Deductible)
• Remainder of Medicare-Approved Amounts	80%	20%	\$0
<b>■ Clinical Laboratory Services</b>			
• Tests for diagnostic services	100%	\$0	\$0
<b>Medicare Parts A and B</b>			
<b>■ Home Health Care</b> 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

## MediGap-65 PLAN B

### Medicare Part A Hospital Services Per Benefit Period

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

\*\***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.

SERVICES	MEDICARE PAYS	PLAN B PAYS	YOU PAY
<b>■ Hospitalization*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies			
• First 60 days	All but \$1,068	\$1,068 (Part A Deductible)	\$0
• 61st thru 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
<b>■ Skilled Nursing Facility Care*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- Approved facility within 30 days after leaving the hospital			
• First 20 days	All approved amounts	\$0	\$0
• 21st thru 100th day	All but \$133.50 a day	\$0	Up to \$133.50 a day
• 101st day and after	\$0	\$0	All costs
<b>■ Blood</b>			
• First 3 pints	\$0	3 pints	\$0
• Additional amounts	100%	\$0	\$0
<b>■ Hospice Care</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

## MediGap-65 PLAN B

### Medicare Part B Medical Services Per Calendar Year

\*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.

SERVICES	MEDICARE PAYS	PLAN B PAYS	YOU PAY
<b>■ Medical Expenses-In Or Out Of Hospital And Outpatient Hospital Treatment</b> Such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, 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
<b>■ Part B Excess Charges</b> (Above Medicare-Approved Amounts)	\$0	\$0	All costs
<b>■ Blood</b>			
• First 3 pints	\$0	All costs	\$0
• Next \$135 of Medicare-Approved Amounts*	\$0	\$0	\$135 (Part B Deductible)
• Remainder of Medicare-Approved Amounts	80%	20%	\$0
<b>■ Clinical Laboratory Services</b>			
• Tests for diagnostic services	100%	\$0	\$0
<b>Medicare Parts A and B</b>			
<b>■ Home Health Care</b> 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

## MediGap-65 PLAN C

### Medicare Part A Hospital Services Per Benefit Period

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

\*\* **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.

SERVICES	MEDICARE PAYS	PLAN C PAYS	YOU PAY
<b>■ Hospitalization*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
• First 60 days	All but \$1,068	\$1,068 (Part A Deductible)	\$0
• 61st thru 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
<b>■ Skilled Nursing Facility Care*</b>			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
• First 20 days	All approved amounts	\$0	\$0
• 21st thru 100th day	All but \$133.50 a day	Up to \$133.50 a day	\$0
• 101st day and after	\$0	\$0	All costs
<b>■ Blood</b>			
• First 3 pints	\$0	3 pints	\$0
• Additional amounts	100%	\$0	\$0
<b>■ Hospice Care</b>			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

## MediGap-65 PLAN C

### Medicare Part B Medical Services Per Calendar Year

\*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.

SERVICES	MEDICARE PAYS	PLAN C PAYS	YOU PAY
<b>■ Medical Expenses-In Or Out Of Hospital And Outpatient Hospital Treatment</b> - Such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, 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
<b>■ Part B Excess Charges</b> - (Above Medicare-Approved Amounts)			
	\$0	\$0	All costs
<b>■ Blood</b>			
• First 3 pints	\$0	All costs	\$0
• Next \$135 of Medicare-Approved Amounts*	\$0	\$135 (Part B Deductible)	\$0
• Remainder of Medicare-Approved Amounts	80%	20%	\$0
<b>■ Clinical Laboratory Services</b>			
• Tests for diagnostic services	100%	\$0	\$0
<b>Medicare Parts A and B</b>			
<b>■ Home Health Care</b> 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
<b>Other Benefits Not Covered by Medicare</b>			
<b>■ Foreign Travel-Not Covered by Medicare</b> - Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
• First \$250 each calendar year	\$0	\$0	\$250
• Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

## MediGap-65 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.

\*\* **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.

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
<b>■ Hospitalization*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
• First 60 days	All but \$1,068	\$1,068 (Part A Deductible)	\$0
• 61st thru 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
<b>■ Skilled Nursing Facility Care*</b>			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
• First 20 days	All approved amounts	\$0	\$0
• 21st thru 100th day	All but \$133.50 a day	Up to \$133.50 a day	\$0
• 101st day and after	\$0	\$0	All costs
<b>■ Blood</b>			
• First 3 pints	\$0	3 pints	\$0
• Additional amounts	100%	\$0	\$0
<b>■ Hospice Care</b>			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services			
	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

## MediGap-65 PLAN F

### Medicare Part B Medical Services Per Calendar Year

\*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.

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
<b>■ Medical Expenses-In Or Out Of Hospital And Outpatient Hospital Treatment</b> - Such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, 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
<b>■ Part B Excess Charges</b> - (Above Medicare-Approved Amounts)			
	\$0	100%	\$0
<b>■ Blood</b>			
• First 3 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
<b>■ Clinical Laboratory Services</b>			
• Tests for diagnostic services	100%	\$0	\$0
<b>Medicare Parts A and B</b>			
<b>■ Home Health Care</b> 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
<b>Other Benefits Not Covered by Medicare</b>			
<b>■ Foreign Travel-Not Covered by Medicare</b> - Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
• First \$250 each calendar year	\$0	\$0	\$250
• Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

# MediGap-65 HIGH-DEDUCTIBLE PLAN F\*

## Medicare Part A Hospital Services Per Benefit Period

**\*This High Deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2,000 deductible. Benefits from the High Deductible Plan F will not begin until out-of-pocket expenses are \$2,000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan’s separate foreign travel emergency deductible.**

**\*\*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.

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
<b>■ Hospitalization**</b> Semiprivate room and board, general nursing and miscellaneous services and supplies		<b>After you pay \$2,000 deductible*, High Deductible Plan F pays</b>	<b>In addition to \$2,000 deductible*, you pay</b>
• First 60 days	All but \$1,068	\$1,068 (Part A Deductible)	\$0
• 61st thru 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
<b>■ Skilled Nursing Facility Care**</b> You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
• First 20 days	All approved amounts	\$0	\$0
• 21st thru 100th day	All but \$133.50 a day	Up to \$133.50 a day	\$0
• 101st day and after	\$0	\$0	All costs
<b>■ Blood</b>			
• First 3 pints	\$0	3 pints	\$0
• Additional amounts	100%	\$0	\$0
<b>■ Hospice Care</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

## MediGap-65 HIGH-DEDUCTIBLE PLAN F\*

### Medicare Part B Medical Services Per Calendar Year

\*This High Deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2,000 deductible. Benefits from the High Deductible Plan F will not begin until out-of-pocket expenses are \$2,000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

\*\*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.

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
<b>■ Medical Expenses-In Or Out Of Hospital And Outpatient Hospital Treatment</b> - Such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:		<b>After you pay \$2,000 deductible*, High Deductible Plan F pays</b>	<b>In addition to \$2,000 deductible*, you pay</b>
<ul style="list-style-type: none"> <li>• First \$135 of Medicare-Approved Amounts*</li> </ul>	\$0	\$135 (Part B Deductible)	\$0
<ul style="list-style-type: none"> <li>• Remainder of Medicare-Approved Amounts</li> </ul>	Generally 80%	Generally 20%	\$0
<b>■ Part B Excess Charges</b> - (Above Medicare-Approved Amounts)	\$0	100%	\$0
<b>■ Blood</b>			
<ul style="list-style-type: none"> <li>• First 3 pints</li> </ul>	\$0	All costs	\$0
<ul style="list-style-type: none"> <li>• Next \$135 of Medicare-Approved Amounts*</li> </ul>	\$0	\$135 (Part B Deductible)	\$0
<ul style="list-style-type: none"> <li>• Remainder of Medicare-Approved Amounts</li> </ul>	80%	20%	\$0
<b>■ Clinical Laboratory Services</b>			
<ul style="list-style-type: none"> <li>• Tests for diagnostic services</li> </ul>	100%	\$0	\$0
<b>Medicare Parts A and B</b>			
<b>■ Home Health Care</b> Medicare-Approved Services			
<ul style="list-style-type: none"> <li>• Medically necessary skilled care services and medical supplies</li> </ul>	100%	\$0	\$0
<ul style="list-style-type: none"> <li>• Durable medical equipment</li> </ul>			
<ul style="list-style-type: none"> <li>— First \$135 of Medicare-Approved Amounts*</li> </ul>	\$0	\$135 (Part B Deductible)	\$0
<ul style="list-style-type: none"> <li>— Remainder of Medicare-Approved Amounts</li> </ul>	80%	20%	\$0
<b>Other Benefits Not Covered by Medicare</b>			
<b>■ Foreign Travel-Not Covered by Medicare</b> - Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
<ul style="list-style-type: none"> <li>• First \$250 each calendar year</li> </ul>	\$0	\$0	\$250
<ul style="list-style-type: none"> <li>• Remainder of charges</li> </ul>	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum



These benefits described are issued under Policy  
Form Numbers: 3097, 3149, 3098, 3099 as amended  
CFMI HI DED PLAN F (10/04)



CareFirst BlueCross BlueShield  
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