**Changes effective January 1, 2011*

Highmark Blue Cross Blue Shield West Virginia
614 Market Street
P.O. Box 1948
Parkersburg, West Virginia 26102

Outline of Medicare Supplemental Benefit Plans A, C, F, FHD and N

This chart shows the benefits offered by **Highmark Blue Cross Blue Shield West Virginia (Highmark WV) effective January 1st, 2011: A, C, F, FHD and N**

BASIC BENEFITS INCLUDED IN ALL PLANS.

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (20% of Medicare-approved expenses) or co-payments.
Blood: First three pints of blood each calendar year.
Hospice: Part A coinsurance.

2011 Standardized Medicare Supplemental plans offered by Highmark WV effective 1/1/2011

PLAN A	PLAN C	PLAN F	PLAN FHD*	PLAN N
Basic including 100% Part B coinsurance	Basic including 100% Part B coinsurance	Basic including 100% Part B coinsurance	Basic including Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 co-payment for office visit and up to $50 co-payment for ER.
	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance
	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 (100%)	
	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			High Deductible ($2,000 in 2011)	

* Plan F has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,000 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed $2,000. Out-of-pocket expenses for this deductible that would ordinarily be paid by this Policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plans separate foreign travel emergency deductible. Effective 1/1/2011, only “2011” Medigap plans may be offered for sale

PREMIUM INFORMATION

Effective January 1, 2011

Highmark Blue Cross Blue Shield West Virginia can only raise your premium if we raise the premium for all policies like yours in this State. The premiums for the Highmark WV Medifil Medicare supplement are based on criteria established by Highmark Blue Cross Blue Shield West Virginia. Please carefully review the information below to determine the amount of premium which you will pay:

PLAN A	PLAN C	PLAN F
If you apply for Highmark WV Medifil Plan A, your monthly premium for Highmark WV Medifil Plan A coverage will be:	**If you apply for Highmark WV Medifil Plan C, your monthly premium for Highmark WV Medifil Plan C coverage will be:**	**If you apply for Highmark WV Medifil Plan F, your monthly premium for Highmark WV Medifil Plan F coverage will be:**
*Thru Age 64 $123.51	*Thru Age 64 $181.37	*Thru Age 64 $184.08
Age 65-69 $111.16	Age 65-69 $163.20	Age 65-69 $165.66
Age 70-74 $141.99	Age 70-74 $208.53	Age 70-74 $211.66
Age 75-79 $160.52	Age 75-79 $235.71	Age 75-79 $239.26
Age 80+ $190.94	Age 80+ $280.34	Age 80+ $284.58

PLAN FHD	PLAN N
If you apply for Highmark WV Medifil Plan FHD, your monthly premium for Highmark WV Medifil Plan FHD coverage will be:	**If you apply for Highmark WV Medifil Plan N, your monthly premium for Highmark WV Medifil Plan N coverage will be:**
*Thru Age 64 $78.05	*Thru Age 64 $164.38
Age 65-69 $70.24	Age 65-69 $147.93
Age 70-74 $89.74	Age 70-74 $189.02
Age 75-79 $101.45	Age 75-79 $213.66
Age 80+ $120.67	Age 80+ $254.13

When your age moves you to a different rating bracket, your rate will change on the first day of the month of your birthday.
***Specific restrictions apply**.

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 Highmark Blue Cross Blue Shield West Virginia.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to **Highmark Blue Cross Blue Shield West Virginia, 614 Market Street, P.O. Box 1948, Parkersburg, West Virginia 26102**. 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.

Highmark Blue Cross Blue Shield West Virginia is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or review The Medicare 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. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

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

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 $1,132.00	$0	$1,132.00(Part A Deductible)
61st thru 90th day	All but $283.00 a day	$283.00 a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $566.00 a day	$566.00 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 $141.50 a day	$0	Up to $141.50 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 co-payment or coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	$0

** When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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 the

balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

Medicare (Part B) - Medical Services - Per Calendar Year

* Once you have been billed $162.00 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 $162.00 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts Part B Excess Charges (Above Medicare-Approved Amounts)	 $0 80% $0	 $0 20% $0	 $162.00 (Part B Deductible) $0 All Costs
BLOOD First 3 pints Next $162.00 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	 $0 $0 80%	 All Costs $0 20%	 $0 $162.00 (Part B Deductible) $0
CLINICAL LABORATORY SERVICES – BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

Plan A

Parts A and B

* Once you have been billed $162.00 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 $162.00 of Medicare-Approved Amounts*	$0	$0	$162.00 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,132.00	$1,132.00 (Part A Deductible)	$0
61st thru 90th day	All but $283.00 a day	$283.00 a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $566.00 a day	$566.00 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 $141.50 a day	Up to $141.50 a day	$0
101st day 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 co-payment or coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	$0

** When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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 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 $162.00 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 $162.00 of Medicare-Approved Amounts*	$0	$162.00 (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $162.00 of Medicare-Approved Amounts*	$0	$162.00 (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - BLOOD TEST FOR DIAGNOSTIC SERVICES	100%	$0	$0

Parts A and B

* Once you have been billed $162.00 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 $162.00 of Medicare-Approved Amounts*	$0	$0	$0
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 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 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 $1,132.00	$1,132.00 (Part A Deductible)	$0
61st thru 90th day	All but $283.00 a day	$283.00 a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $566.00 a day	$566.00 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 $141.50 a day	Up to $141.50 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 co-payment or coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	$0

** When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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 the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F

Medicare (Part B) - Medical Services - Per Calendar Year

* Once you have been billed $162.00 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 $162.00 of Medicare-Approved Amounts*	$0	$162.00 (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $162.00 of Medicare-Approved Amounts*	$0	$162.00 (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - BLOOD TEST FOR DIAGNOSTIC SERVICES	100%	$0	$0

* Once you have been billed $162.00 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 $162.00 of Medicare-Approved Amounts*	$0	$0	$0
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 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 F HIGH DEDUCTIBLE

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	AFTER YOU PAY $2,000 DEDUCTIBLE, PLAN PAYS	IN ADDITION TO $2,000 DEDUCTIBLE, YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days 61st thru 90th day	All but $1,132.00	$1,132.00 (Part A Deductible)	$0
91st day and after:	All but $283.00 a day	$283.00 a day	$0
- While using 60 lifetime reserve days			
- Once lifetime reserve days are used:	All but $566.00 a day	$566.00 a day	$0
- 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 $141.50 a day	Up to $141.50 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$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 co-payment or coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	$0

** When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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 the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F HIGH DEDUCTIBLE

Medicare (Part B) - Medical Services - Per Calendar Year

* Once you have been billed $162.00 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	AFTER YOU PAY $2,000 DEDUCTIBLE, PLAN PAYS	IN ADDITION TO THE $2,000 DEDUCTIBLE,YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as: Physicians services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $162.00 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts Part B Excess Charges (Above Medicare-Approved Amounts)	 $0 80% $0	 $162.00 (Part B Deductible) 20% 100%	 $0 $0 $0
BLOOD First 3 pints Next $162.00 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	 $0 $0 80%	 All Costs $162.00 (Part B Deductible) 20%	 $0 $0 $0
CLINICAL LABORATORY SERVICES - BLOOD TEST FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN FHD

Parts A and B

* Once you have been billed $162.00 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	AFTER YOU PAY $2,000 DEDUCTIBLE, PLAN PAYS	IN ADDITION TO THE $2,000 DEDUCTIBLE,YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES - Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment First $162.00 of Medicare-Approved Amounts*	$0	$0	$0
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 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

BENEFITS FOR 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 MEDICARE DEDUCTIBLES FOR PART A AND PART B, BUT DOES NOT INCLUDE THE PLAN'S SEPARATE FOREIGN TRAVEL EMERGENCY DEDUCTIBLE.

MEDIGAPBLUE 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 $1,132	$1,132 (Part A deductible)	$0
61st thru 90th day	All but $283 a day	$283 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $566 a day	$566 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 $141.50 a day	Up to $141.50 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 co-payment/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.

MEDIGAPBLUE PLAN N

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $162 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 $162 of Medicare Approved Amounts*	$0	$0	$162 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The emergency room visit 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 emergency room visit 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 $162 of Medicare Approved Amounts*	$0	$0	$162 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDIGAPBLUE PLAN N

PARTS A & B

* Once you have been billed $162 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 $162 of Medicare Approved Amounts*	$0	$0	$162 (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