Blue Cross of California

A New Approach to Medicare Supplemental Coverage

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for instant online quotes

Blue Cross Senior SmartChoice℠
(High Deductible Plan F)

SmartChoice Preferred℠
(High Deductible Plan F)

SmartChoice Plus℠
(High Deductible Plan F with Rider)

an advantage for making smart choices

Are you in good health and expect to remain that way?

Do you eat healthy foods whenever possible?

Are you an active person?

Do you seldom need to see a doctor?

Living a healthy lifestyle is clearly a smart choice.

Now, it can help lower the cost of your health insurance protection.

More Affordable Medicare Supplement Plans For Californians

Medicare and Blue Cross Both Sides Of The Story

Because they've made good choices and developed good habits for their well being, many Californians who are eligible for Medicare benefits are in good health. And, many expect to stay that way in the years ahead.

Blue Cross of California recognizes that active individuals who make smart decisions about their health, may also want to ***benefit from lower costs*** for their Medicare supplement (or 'Medigap') insurance protection.

Perhaps they seldom need medical care and, as a result, would ***benefit from a high deductible plan***. Many have the financial ability to cover small charges for an annual check-up or a portion of medical expenses for a minor emergency, but want protection should a more significant need ever arise.

The **Senior SmartChoice℠ Medicare Supplement (High Deductible Plan F), Senior SmartChoice Plus℠ (High Deductible Plan F with Rider)** with home and nursing care rider, and the **Senior SmartChoice Preferred℠ (High Deductible Plan F)** from Blue Cross are similar to other Medicare supplement plans. These plans are designed to provide benefits for expenses you incur as the result of an illness or injury. As you know, should you ever need significant care, the charges can quickly add up. These plans–with their $1,860 annual plan deductible*–are designed to protect you from these devastating costs–*but at a much lower monthly cost than other Medicare supplement plans*.

When it comes to Medicare, it is important that you know both sides of the story, and understand the advantages and disadvantages of relying solely on Medicare to provide for your health care needs.

Though Medicare covers many health care costs, *there are many medical services* that Medicare does not cover. This point is clearly made in the "Guide to Health Insurance for People with Medicare" which is published yearly by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services. As the guidebook suggests,

> ***"There are health care costs that Medicare either does not pay in full or does not pay at all. If you need or want services not covered by Medicare, you must pay all the bill."***

Why should I consider buying supplemental insurance? Before Medicare will pay for any of the medical services you want or need, you must first pay the Medicare *deductibles*. When combined with the *coinsurance* you are also required to pay, your costs can add up quickly. A supplemental health insurance policy can help pay the bills that Medicare does not cover, providing you with protection from the ever-increasing gaps in your Medicare coverage.

There are many different types of supplemental insurance policies available to you. Typically, plans with no or low deductibles will cost more in monthly premiums. *On the other hand, a high deductible plan may be the more affordable choice for those who seldom see a doctor, but want protection should the need arise.*

Making Smart Choices Can Help You Save

* Amount subject to change annually as determined by Medicare.

Medicare supplement insurance can be sold in only 12 standard plans (A-L) and Medicare SELECT plans. With respect to certain benefits, Medicare SELECT plans may offer restricted or limited provider networks. Blue Cross Senior Classic C Medicare Supplement Plan, Blue Cross Senior Classic F Medicare Supplement Plan, Blue Cross Senior Classic I Medicare Supplement Plan, Blue Cross Senior Classic J Medicare Supplement Plan, Senior SmartChoice Plan Medicare Supplement Plan (High Deductible Plan F), Senior SmartChoice PLUS (High Deductible Plan F with Rider) and Senior SmartChoice Preferred Plan Medicare Supplement Plan (High Deductible Plan F) are approved Medicare SELECT plans. The charts on pages 4 and 5 show the benefits available under each standard Medicare supplement plan. Every company must make available Plan "A", a non-SELECT Medicare Supplement plan. Some plans may not be available in your state. Basic Benefits for Plan K and L include similar services as plans A-J, but cost sharing for the basic benefits is at different levels.

Plan A	B	C	D	E	F†	G
ClaimFree Standard Plan A Medicare Supplement Plan		**Blue Cross Senior Classic Plan C Medicare Supplement Plan**			**Blue Cross Senior Classic Plan F Medicare Supplement Plan**	
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Ben
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Fa Coinsuran
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductibl
		Part B Deductible			Part B Deductible***	
					Part B Excess Charges at 100%	Part B Excess Ch at 80%
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Tr Emergenc
			At-Home Recovery			At-Home Recovery
				Preventive Care Not Covered by Medicare		

Note: These plans are intended only for people age 65 or older, who are enrolled in both Parts A and B of Medicare.

* Part B deductible covered only when using a Participating Prudent Buyer Provider. Part B deductible is covered when using a non-participating provider in limited circumstances, including emergency care.

† Plans F and J also have an option called a High Deductible F and a High Deductible Plan J. These high deductible plans pay the same or offer the same benefits as Plans F and J after one has paid a calendar year $1,860 deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses are $1,860. 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, in Plans F and J, the plan's separate foreign travel emergency

Basic Benefit: Included in All Plans.

- Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- Medical Expenses: Part B coinsurance amount.
- Blood: First 3 pints of blood each year.

Medicare SELECT disclosure about your right to purchase other plans: You may replace your Medicare SELECT plan with any Medicare supplement plan we offer of comparable or lesser benefits. This offer does not require proof of good health. The only non-SELECT Medicare Supplement plan offered by Blue Cross of California is ClaimFree Standard Plan A Medicare Supplement Plan.

	H	*I*	*J*†	*K*††	*L*††
		Blue Cross Senior Classic Plan I Medicare Supplement Plan	**Blue Cross Senior Classic Plan J Medicare Supplement Plan**		
efits	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
acility nce	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
e	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible
			Part B Deductible*		
harges		Part B Excess Charges at 100%	Part B Excess Charges at 100%		
ravel cy	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		
		At-Home Recovery	At-Home Recovery		
			Preventive Care Not Covered by Medicare	$4,140 Out-of-Pocket Limit†††	$2,070 Out-of-Pocket 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 for each year for inflation.

The Senior SmartChoice℠ Medicare Supplement Plan (High Deductible Plan F)

Providing Protection From the Gaps in Medicare.

The new **Senior SmartChoice Medicare Supplement Plan (High Deductible Plan F) from Blue Cross** will help pay for many of the health care bills that Medicare doesn't cover. Like thousands of Californians, you realize that Medicare Part A (Hospital coverage) and Part B (Doctor and other medical services) do *not* cover all expenses.

Medicare deductibles and coinsurance can add up to hundreds, even thousands of dollars each year. However, there are options for buying insurance plans that supplement Medicare's coverage, known as "Medi-gap" policies. Without coverage from plans like the **Senior SmartChoice Medicare Supplement Plan (High Deductible Plan F)**, these are bills *you* would have been expected to pay. With the **Senior SmartChoice Medicare Supplement Plan (High Deductible Plan F)**, after Medicare has paid its portion, we will cover your deductibles, coinsurance, and excess charges once your out-of-pocket expenses have reached the required annual $1,860 plan deductible for this plan.

Your **Senior SmartChoice Medicare Supplement Plan (High Deductible Plan F)** provides a wide range of benefits. These benefits are outlined within this booklet.

The Advantages Are Yours With The Senior SmartChoice Medicare Supplement Plan (High Deductible Plan F)

The **Senior SmartChoice Medicare Supplement Plan (High Deductible Plan F)** can help pay the bills that Medicare doesn't and provide you with protection from the ever-increasing gaps in Medicare *once you have met your annual plan deductible*.

Here are some highlights of the benefits:

Freedom to use the doctor of your choice, including over 50,000 Prudent Buyer® Physicians and specialists.

Freedom to use the hospital of your choice, including more than 300 Participating Hospitals.

Pays all Medicare Deductibles.*

No cost to you for Medicare Part B Excess Charges.*

Coverage for Skilled Nursing Facility Coinsurance.*

Benefits for Medicare Part A and Part B Coinsurance.*

Full conventional Medicare benefits at all providers, inside and outside California–anywhere in the United States.

Benefits for Foreign Travel Emergencies.

ClaimFree® Processing for virtually all Medicare Claims.

Guaranteed Renewable coverage.

Blue Cross Senior SmartChoice Plan is a Medicare Select Plan.

* After you pay the required annual plan deductible. Pays the Medicare Part B $131 annual deductible (if not already met under the required annual plan deductible) only when you use a participating Prudent Buyer Provider. Part B deductible is covered when using a non-participating provider in limited circumstances, including emergency care.

Freedom of Choice

You've earned the right to have a choice of the doctor or hospital you want to use, and we respect that right.

- ClaimFree Standard Plan A Medicare Supplement Plan, Blue Cross Senior Classic C Medicare Supplement Plan, Blue Cross Senior Classic F Medicare Supplement Plan, Blue Cross Senior Classic I Medicare Supplement Plan, Blue Cross Senior Classic J Medicare Supplement Plan and our high deductible F plans, Senior SmartChoice Medicare Supplement Plan High Deductible Plan F, Senior SmartChoice PLUS Medicare Supplement Plan High Deductible Plan F with Rider, and Senior SmartChoice Preferred Medicare Supplement Plan High Deductible Plan F.
- All offer you access to the Prudent buyer network, as well as any Medicare-participating physician and any Medicare approved hospital. You are covered whether or not you use a Prudent Buyer Physician.

Prudent Buyer Network of Participating Doctors and Hospitals.

The Prudent Buyer network offers you the choice of a wide variety of physicians and hospitals conveniently located throughout the state to help you with all of your healthy needs. This is the largest in California, with over one half of all physicians and hospitals in the state being Participating Prudent Buyer Providers. Over 50,000 physicians and more than 300 hospitals are Participating Prudent Buyer Providers, so there's a good chance that your current physician or hospital is already a member of our network.

Protection Against Excess Charges

Under Part B of Medicare, you could have out-or-pocket costs if your physician or medical supplier does not accept assignment of your Medicare claim and charges more than Medicare's approved amount. The difference to be paid is called the 'excess charge.'

Senior SmartChoice Medicare Supplement High Deductible Plan F and Senior SmartChoice Preferred Medicare Supplement High Deductible Plan F can save you the expense and worry about paying significant out-of-pocket costs because of gaps in Medicare. When you utilize Blue Cross of California's Prudent Buyer network, your doctor's charges for Medicare's covered services are paid in full. Even if you receive medical services from a provider that is not a member of the Prudent Buyer network, your doctor's charges for Medicare's covered services are still paid in full, except for the Medicare Part B $131 deductible.

ClaimFree Service

You may never have to fill out another claim form ever again. Blue Cross of California has created a way to put an end to the frustration caused by burdensome and tedious claim forms. Its called ClaimFree service, and we are the only health carrier in the state that provides you with this worry-free automatic claims payment service for both Parts A and B of Medicare.

The way it works is simple. When providers bill Medicare, a computerized display of the information is automatically sent to Blue Cross of California for processing. We then pay your doctor or hospital directly. This results in your medical bills being processed faster and more accurately.

In Network Versus Out of Network Services

When you receive services from a Participating Physician, Hospital, or other medical supplier that is a member of the Prudent Buyer network, this is referred to as "In Network."

When you receive services from any other physician, hospital, or medical supplier that is not a member of the Prudent Buyer network, this is referred to as "Out of Network."

Please note that there are financial and other advantages to making use of In Network services available to you through the Prudent Buyer network. But remember, the decision to use or not use In Network services is up to you, so you're not locked in.

Provider Directories

You will receive a directory listing the Participating Providers in your area when you sign up for your plan. If you do not, you may call your agent or your dedicated customer service unit, at 1-800-333-3883, and request a provider listing for your area.

how the annual plan deductible works

How The Senior SmartChoice℠ Medicare Supplement Plan (High Deductible Plan F) Works And Can Save You Money

Under the SmartChoice Medicare Supplement plan (High Deductible Plan F), Medicare pays all Medicare covered benefits first, while you are responsible for the corresponding Part A and/or Part B deductibles*** and coinsurance amounts. Once Medicare has paid its portion, and you have met your annual $1,860 deductible amount, your plan will pay all remaining covered charges.

Example: ***A 65 year old who visits a doctor 4 times a year.***

	Typical Medicare F Plan	Senior SmartChoice Plan (High Deductible Plan F)
Premium*	$1,668	$588
Doctors Visits (4)**	$0	$160.80
Total Costs	**$1,668**	**$748.80**
Total Savings		**$919.20**

* Premium for "Typical" Medicare F Plan based on Area 5 (Los Angeles) at $139 per month. Premium for Senior SmartChoice Plan (High Deductible Plan F) based on Area 5 (Los Angeles) at $49 per month.

** Doctor visits cost estimated at $70 per visit ($70 x 4 = $280). Member pays first $131 Part B deductible amount, leaving a balance of $149. Medicare covers 80% of remaining costs ($119.20) and member pays the coinsurance amount of 20% ($29.80). Member pays a total of $160.80 ($131+29.80).

*** If Medicare Part B deductible has not already been met as part of the annual plan deductible, it is covered in full only when using a Participating Prudent Buyer Provider.

EXCLUSIONS: Unless specifically stated otherwise, this policy does not cover or consider for payment any service or supply, or any portion of any service or supply that is not a Medicare Eligible Expense, nor will this policy duplicate any benefit paid by Medicare.

All benefits, except the foreign travel emergency deductible (a separate deductible), are subject to an annual $1,860 deductible. This means that you pay for covered services not paid for by Medicare until you have reached the policy $1,860 deductible.

Expenses that would satisfy the $1,860 annual plan deductible may include any combination of the following:

- Coinsurance amounts covered under Medicare's Basic Benefits
- Expenses applied toward the Medicare Part A Deductible, as determined by Medicare
- Expenses applied toward the Medicare Part B Annual Deductible, as determined by Medicare*
- Coinsurance amounts for Parts A & B services
- Skilled Nursing copayment expenses incurred while Medicare is paying Skilled Nursing Home Benefits
- 100% of Excess Charges incurred for health care services and supplies of the type covered under Part B of Medicare that exceed Medicare Eligible expenses
- Foreign Travel Emergency Coinsurance Amount

Not Eligible:

- Services not covered by Medicare
- Foreign Travel Emergency $250 deductible

* If Medicare Part B deductible has not already been met as part of the annual plan deductible, it is covered in full only when using a Participating Prudent Buyer Provider, or in other limited circumstances, including emergency care.

The Senior SmartChoice℠ Medicare Supplement Plan (High Deductible Plan F)

Once Medicare has paid its portion, and you pay the required annual plan deductible, the plan provides all the basic Medicare Benefits, plus the following:

- Pays the Part A $992 deductible
- Pays the Part B $131 deductible (only when using a Participating Provider, or in other limited circumstances, including emergency care)
- Benefits for Part B Excess Charges
- Coverage for Skilled Nursing Facility Coinsurance
- Benefits for Foreign Travel Emergency (separate $250 deductible applies)

Benefits (Effective January 1, 2007)	***Participating Providers***	***Any Other Providers***
Part A Deductible*	Yes	Yes
Basic Benefits*		
Part A Hospital (Days 61-90)	Yes	Yes
Lifetime Reserve Days (91-150)	Yes	Yes
365 Lifetime Hospital Days	Yes	Yes
Parts A and B Blood	Yes	Yes
Part B Coinsurance amount	Yes	Yes
Skilled Nursing Facility Coinsurance (Days 21-100)*	Yes	Yes
Part B Annual Deductible ($131)*	Yes	No
Part B Excess Charges at 100%*	Yes	Yes
Foreign Travel Emergency	Yes	Yes

* If Medicare Part B deductible has not already been met as part of the annual plan deductible, it is covered in full only when using a Participating Prudent Buyer Provider, or in other limited circumstances, including emergency care.

Outline of Medicare Supplement Coverage and Premium Information

Use this outline to compare benefits and premiums among policies.

Medicare supplement coverage/policies of this category are designed to supplement Medicare by covering some hospital, medical and surgical services that are partially covered by Medicare. Coverage is provided for hospital inpatient charges and some physicians' charges, subject to any deductibles and coinsurance provisions that may be in addition to those provided by Medicare, and subject to other limitations that may be set forth in the policy.

Policy Replacement

If you are replacing other health coverage, do NOT cancel it until you have actually received your new contract and are sure you want to keep it.

Notice

This contract may not fully cover all of your medical costs. Neither Blue Cross of California 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 "The Medicare Handbook" for further details and limitations applicable to Medicare.

Read Your Agreement

This brochure provides a brief description of important features of your program. This is not the Agreement and only the Agreement sets forth, in detail, the rights and obligations of both you and Blue Cross of California. You will receive your Blue Cross of California Agreement once you enroll. It is important that you read your Agreement carefully upon receiving it.

The Senior SmartChoice℠ Medicare Supplement Plan (High Deductible Plan F) from Blue Cross

Use the easy-to-read charts on the next 2 pages to learn how we can help you cover the gaps in Medicare

	Services	*Benefit*
Part A Services	**Hospitalization*** Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days 61st thru 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
	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 21st thru 100th day 101st day and after
	Blood*	First 3 pints Additional amounts
	Hospice Care*	Available as long as your doctor certifies you are terminally ill and you elect to receive these services
Part B Services	**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 $131 of Medicare approved amounts Remainder of Medicare approved amounts Part B Excess Charges (Above Medicare approved amounts)
	Blood*	First 3 pints Remainder of Medicare approved amounts Clinical Laboratory Services – Blood Tests for Diagnostic Services
Other Benefits	**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 Remainder of charges

* After you pay the required annual plan deductible.

Medicare Pays	*After Medicare has paid, and you have met the $1,860 deductible, Plan Pays*	*After meeting the $1,860 Deductible, You Pay*
All but the first $992 (Part A deductible)	$992 (Part A deductible)	$0
All but $248 per day coinsurance	$248 a day	$0 a day
All but $496 per day lifetime reserve	$496 a day	$0 a day
Nothing	100% of Medicare eligible expenses	$0 a day
	$0	All costs
All approved amounts	$0	$0
All but $124 a day	Up to $124 a day	$0
$0	$0	All costs
$0	3 pints	$0
100%	$0	$0
All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance
$0	$131**	$0
Generally 80%	Generally 20%	$0
$0	100%	$0
$0	3 pints	$0
Generally 80%	Generally 20%	$0
100%	$0	$0
$0	$0	$250
$0	Generally 80% to a lifetime maximum benefit of $50,000	Generally 20% and amounts over the $50,000 lifetime maximum

** If Medicare Part B deductible has not already been met as part of the annual plan deductible, it is covered in full only when using a Participating Prudent Buyer Provider, or in other limited circumstances, including emergency care.

Also Available... the SmartChoice Preferred℠ Medicare Supplement Plan (High Deductible Plan F)

The NEW SmartChoice Preferred (High Deductible Plan F) Medicare Supplement Plan provides all of the same benefits of the SmartChoice Plan (High Deductible Plan F) with the following additional benefits:

+ ***Coverage for Part B Deductible***
When using a Participating Prudent Buyer Physician/Provider, this plan will provide coverage for the Part B Deductible. Part B deductible is covered when using a non-participating provider in limited circumstances, including emergency care.

+ ***Physician Office Visit***
This plan provides coverage for unlimited physician office visits with a $5 copay when a Blue Cross Participating Prudent Buyer Physician/Provider is used. Copay applies to specific procedural codes and charges for physician office visit only.

+ ***Vision Care Benefits***
This plan provides basic vision care through an arrangement with Vision Service Plan (VSP). Basic vision care includes 100% coverage for one pair of standard eyeglass lenses (including single vision, bifocal and trifocal lenses) and up to $75 for one pair of frames OR up to $95 for one pair of contact lenses per 24-month period. An annual eye exam with a $20 copay is also covered.

+ ***Chiropractic Services***
This plan covers certain Medicare approved chiropractic services with a $10 office copay per visit.

SmartChoice Preferred℠ Plan

Use this easy reference chart to learn what we help cover with: *The Blue Cross Senior SmartChoice Preferred Plan (High Deductible Plan F)*

In this benefit chart, we provide a summary of what Medicare pays, as well as what we pay. In addition to the services covered under the SmartChoice Medicare Supplement Plan (High Deductible Plan F), your SmartChoice Preferred Medicare Supplement Plan (High Deductible Plan F) also provides coverage for the following services, which are not subject to calendar year deductible (unless otherwise noted):

Services	*Benefit*
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 $131 of Medicare approved amounts Remainder of Medicare approved amounts Part B Excess Charges (Above Medicare approved amounts)
Physician Office Visits Copay applies to specific procedural codes and charges for the physician office visit only. Services not considered part of an "office visit" include but are not limited to: x-rays, laboratory work, surgery.	Unlimited physician office visits, when using a Participating Provider
Medicare-covered Chiropractic Services	Manual manipulation of the spine to correct subluxation[4]
Vision Care Benefits-Not Covered by Medicare	Basic Vision Care through Vision Service Plan (VSP)

[1] Medicare Part B deductible covered in full when using a Participating Prudent Buyer Physician /Provider (not subject to the calendar year deductible). Part B deductible is covered when using a non-participating provider in limited circumstances, including emergency care.

[2] After you pay the required calendar year deductible.

[3] Copay applies to specific procedural codes and charges for the physician office visit only.

Medicare Pays	*Blue Cross Pays*	*You Pay*
Nothing	$131[1]	Nothing
Generally 80%	Generally 20%[2]	Nothing
Nothing	100%[2]	Nothing
Generally 80%	Generally 20%	$5 copay for physician office visit[3]
Generally 80%	Generally 20%	$10 copay
Nothing	100% coverage for one pair of standard eyeglass lenses and up to $75 for one pair of frames OR up to $95 for one pair of contact lenses per 24-month period. Remainder of eye exam.	$20 copay for eye exam and remainder of frames or contact lenses[5]

[4] Provided such treatment is legal in the State where performed. Chiropractic Maintenance Therapy is not covered by this policy.

[5] There may be an additional charge if you elect cosmetic lens option, such as progressive multifocal lenses, lens coating and lens tinting.

Also Available... SmartChoice PLUS℠ Medicare Supplement (High Deductible Plan F with Rider)

SmartChoice PLUS Medicare Supplement (High Deductible Plan F with Rider) combines the benefits of our SmartChoice Medicare supplement plan (High Deductible Plan F) with the additional coverage included with our home health care and nursing care rider.

This rider expands your SmartChoice Medicare Supplement Plan (High Deductible Plan F) coverage to help pay for a wide range of health services that Medicare and most other health plans don't cover. Services like home health, home support services and nursing facility care.

SmartChoice PLUS Medicare Supplement (High Deductible Plan F with Rider) is available to qualified applicants age 65 to 75, who are enrolled in both Parts A and B of Medicare. The rider portion of the plan is subject to additional underwriting requirements.

Why You May Need SmartChoice PLUS Medicare Supplement (High Deductible Plan F with Rider)

Increased life expectancy brings with it a greater risk of a sudden, serious illness or accidents that may require special care beyond which you would receive in the hospital. Often the care required falls outside the coverage provided by Medicare and traditional health plans. Examples of this type of care could include: recuperative care after a stroke, help with household chores, bathing, or dressing due to a short-term disability.

SmartChoice PLUS (High Deductible Plan F with Rider) from Blue Cross of California was designed to help pay for most of the costs of care following your hospital stay, and to help pay for recovery in your home or in a skilled nursing facility, with benefits that go beyond traditional Medicare supplement plans.

Additional rider benefits covered under the SmartChoice PLUS Medicare Supplement Plan (High Deductible Plan F with Rider) include*:

Residential Facility and Nursing Home Care:
Skilled, Intermediate or Custodial Care Rehabilitation Services, Physical, Occupational, or Speech Therapy, Medical Social Services

Home Health Care:
Registered Nurse and/or Licensed Vocational Nurse, Certified Home Health Aide, Licensed Therapist for Physical Therapy, Occupational Therapy, Speech Therapy

Home Support Services:
Personal Care Services (bathing, dressing), Chore Services (shopping, cleaning, etc.), Transportation and Escort Services, Respite Care (Relief for Caregivers), Adult Day Care, Bill Paying Services, Minor Home Repair Services

Doesn't Medicare Pay for Care in a Nursing Home or for Care in My Own Home?

Usually no. Medicare generally covers only a small portion of these costs and typically for only short periods of time. Medicare pays few, if any of the expenses associated with receiving care in a nursing home or in your own home... where most people would prefer to receive care. Medicare only covers the first 100 days of skilled care you might receive in a certified skilled nursing facility. After that you would be responsible for all costs.

Most people are forced to pay for the high cost of nursing home or home care from personal savings and assets. As a result, the financial burden rests on individuals and their families. Oftentimes, this can financially destroy everything they've worked their entire lives to save.

* Subject to benefit limitations and conditions including meeting the appropriate waiting period, elimination period and deductibles. Limited to services covered under the policy. See policy for additional services that may be covered.

SmartChoice Plus℠ Plan

THE SMARTCHOICE PLUS MEDICARE SUPPLEMENT PLAN (High Deductible Plan F with Rider) FROM BLUE CROSS OF CALIFORNIA...

Here is a summary of the rider benefits covered under the SmartChoice PLUS Medicare Supplement Plan (High Deductible Plan F with Rider) . The rider provides benefits for nursing and residential care facilities, home health and home support services not covered by Medicare.

Summary of Benefits

Rider Waiting Period	6 months
Nursing or Residential Care Facility Services*	
Facility Elimination Period	100 days**
Blue Cross Pays	100% of billed charges[1]
Home Healthcare and Home Support Services*	
Home Care Deductible	$1,000***
Blue Cross Pays	100% of billed charges[1]
Combined Daily Benefit Amount Up To	$100
Combined Maximum Lifetime Benefit	$36,500

* Benefits paid only when services are approved as part of the Plan of Care coordinated through a Care Manager.

** Rider Waiting Period must also be met. Coordinated with Medicare covered benefits. Facility Elimination Period needs to be met once over the lifetime of the policy.

*** Rider Waiting Period must also be met. Deductible needs to be met once over the lifetime of the policy.

[1] Limited to Maximum Daily Benefit Amount.

How Do the Rider Benefits Differ From Those of Long Term Care Insurance?

Both types of coverage are similar in that they both provide benefits for nursing home stays, and depending on the type of long term care plan, care in your home. Most Long Term Care (LTC) plans are purchased by individuals who want or need coverage for extended stays in a nursing home, assisted living facility, or for care at home (the average LTC policy purchased today is for 2 1/2 years of coverage or longer*). SmartChoice PLUS Medicare Supplement (High Deductible Plan F with Rider) is an affordable and ideal plan to help cover the costs of receiving care at home, in an assisted living facility or nursing home for shorter periods of time (a year or less). SmartChoice PLUS Medicare Supplement (High Deductible Plan F with Rider) provides up to a $100 daily benefit up to a lifetime maximum of $36,500 to cover part of the cost of care should you need it. The typical LTC plan can provide up to $350 daily benefits and coverage beyond $36,500 if you wish to have a greater level of coverage for a longer period of time.

*Source: HIAA

How the Rider Benefits Work

Step 1....

When you feel you need to access the rider benefits covered under your SmartChoice PLUS Medicare Supplement Plan (High Deductible Plan F with Rider), you must telephone Blue Cross Senior Services to initiate a Plan of Care. When you call, a Blue Cross customer service representative will ask you about your ability to perform certain daily activities such as: eating, bathing, dressing, toileting, etc. The Blue Cross representative will also ask you some questions regarding the type of services you are requesting. The answers to these questions will determine whether you qualify for rider benefits and if a Plan of Care is necessary.

Step 2...

If it is determined that a Plan of Care is necessary, your telephone assessment will be forwarded to a care manager who in coordination with you, your physician and other professionals and family members, will authorize, coordinate, and monitor the care that you need. You or your caregiver must agree in writing with the Plan of Care before any benefits will be provided.

Step 3...

Blue Cross will review the Plan of Care and if approved, will authorize the necessary chronic care services described in the Plan of Care. Blue Cross reserves the right to perform a reassessment of the Plan of Care following your receipt of three (3) months of benefits. If it is determined that a Plan of Care is not necessary, Blue Cross will provide you with information and can refer you to agencies or providers who can assist you with the services that you have requested. Any associated costs for these services will be your responsibility.

SmartChoice Plus℠ Plan

Use this easy reference chart to learn what we help cover with:

The Blue Cross Senior SmartChoice PLUS Medicare Supplement Plan (High Deductible Plan F with Rider)

Rider Benefits of the SmartChoice PLUS Medicare Supplement Plan (High Deductible Plan F with Rider)

In this benefit chart, we provide a summary of what Medicare pays, as well as what we pay.
In addition to the services covered under the SmartChoice Medicare Supplement Plan (High Deductible Plan F), your SmartChoice PLUS Medicare Supplement plan (High Deductible Plan F with Rider) also provides coverage for:

Services	*Benefit*
Skilled Nursing Facility Care	Beyond first 100 days of Medicare-covered services and/or supplies
Non-Skilled Nursing Facility Care	Non-skilled or custodial care in Skilled Nursing or Residential Facility
Home Health Care	Licensed home health services not covered by Medicare
Home Support Care	Home support and custodial care in the home

* Pays up to a lifetime maximum of $36,500 after Rider Waiting Period and applicable Facility Elimination Period and/or Home Care Service deductible has been met.

Medicare Pays	*Blue Cross Pays*	*You Pay*
Nothing	100% of covered charges (up to $100 per day) for Skilled Nursing Facility Care*	All costs incurred beyond the covered daily maximum.
Nothing	100% of covered charges (up to $100 per day) for Non-Skilled Nursing and Residential Facility Care*	All costs incurred beyond the covered daily maximum.
Nothing	100% of covered charges (up to $100 per day)*	All costs incurred beyond the covered daily maximum.
Nothing	100% of covered charges (up to $100 per day)*	All costs incurred beyond the covered daily maximum.

Member Billing

Premiums will be billed to you in one of the following ways:

- If your application is received in our office between the 1st and 14th of the month, your coverage will be effective on the 15th of the month. The first premium bill you receive will be for one-and-a-half (1-1/2) months. Thereafter, Blue Cross of California will bill you every two (2) months.
- If your application is received in our office between the 15th and 31st of the month, your coverage will begin on the 1st of the following month. Blue Cross of California will bill you bimonthly.

Your coverage is effective the 1st or 15th of the month after approval.

If you are replacing another health insurance policy, your coverage will be effective the date that your other plan ends. Your completed application must be received in our office prior to your effective date.

Blue Cross of California reserves the right to reject your application. If your application is rejected, you will be notified in writing and any payment you made will be refunded.

Monthly Checking Account Deduction

With the Blue Cross of California Monthly Checking Account Deduction Program, you can have your monthly Blue Cross premium withdrawn directly from your checking account on the sixth (6th) day of each month. When you receive your bank statement and cleared checks, your Blue Cross of California monthly checking account deduction will be included. To find out more about this convenient service, contact your Blue Cross of California Authorized Agent, or call us toll-free at **1-800-333-3883.**

Convenience of Summary Billing

Summary Billing offers you the convenience of consolidating your billing with any other Blue Cross of California Senior Plan Member, such as a spouse or relative. This means that we can combine separate billings onto a single statement, even if you and the other person(s) are enrolled in different Blue Cross of California *Senior Plans*.

The result is less paperwork for you because one statement, one check and one envelope does the job. Summary Billing is also available if you choose the monthly checking account deduction option.

Guaranteed Renewable

Blue Cross of California Medicare supplements are guaranteed renewable.

After the first one (1) month's payment, the term of this coverage is for two (2) months if you have chosen bimonthly coverage, or monthly if you have chosen monthly checking account deductions. It renews automatically, subject to the right of Blue Cross of California to change subscription charges. Any such changes would be made only upon 30 days written notice to all persons covered under the same plan as you.

We will not cancel your coverage, except for the reasons listed below:

- If we discover any concealment of material facts upon enrollment
- If you do not pay your subscription charges, your coverage will end automatically without notice from us
- You cease to be covered under both Parts A and B of Medicare
- You enroll in a Medicare Coordinated Care Plan

Coordinated Care Plans (also sometimes referred to as Medicare-at-Risk Plans) are special Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs) that seniors eligible for Medicare may be able to join. They essentially combine Medicare benefits with supplemental benefits. People who join must generally get all health care from providers affiliated with the plan, and they do not receive regular Medicare benefits for services obtained outside the plan.

Quality Assurance

In accordance with California law, Blue Cross continuously reviews the quality of care provided to you under this contract. Under Blue Cross' quality of care review system, Participating Providers are credentialed regularly, and the quality of the care they provide is reviewed on both a concurrent and prospective basis. Because members may obtain care from any Nonparticipating Provider they choose, Blue Cross is unable to review the credentials of such Nonparticipating Providers or to include them in prospective and concurrent review programs. Nevertheless, Blue Cross reviews the services provided by all providers, both participating and nonparticipating retrospectively.

30-Day Right to Examine

If you're not satisfied with your coverage, for whatever reason, just send back your Policy within 30 days of receiving it. The insurance will be canceled and your premium will be promptly refunded — no questions asked. What could be safer than that?

Medicare Changes

Blue Cross of California will send an annual notice to you 30 days prior to the effective date of Medicare changes, which will describe these changes and the changes in your Medicare supplement coverage.

Guaranteed Acceptance

Acceptance of your application is guaranteed if you are 65 or older and apply within six (6) months of your initial enrollment in Part B of Medicare. You must already be enrolled in both Parts A and B of Medicare to apply for these plans. However, persons with open enrollment rights and persons with guaranteed issue rights will not be denied acceptance into the Plan. Acceptance for this coverage is also guaranteed and pre-existing conditions will be waived if you meet any of the following conditions:

1. The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and the plan either terminates or ceases to provide all of those supplemental health benefits to the individual.

2. The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Medicare Part C, and any of the following circumstances apply:

   A) The certification of the organization or plan has been terminated.

   B) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides.

   C) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the secretary. Those changes in circumstances shall not include termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the federal Social Security Act where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856, or the plan is terminated for all individuals within a residence area.

   D) The Medicare Advantage plan in which the individual is enrolled reduces any of its benefits or increases the amount of cost sharing or discontinues for other than good cause relating to quality of care, its relationship or contract under the plan with a provider who is currently furnishing services to the individual. An individual shall be eligible under this subparagraph for a Medicare supplement contract issued by the same issuer through which the individual was enrolled at the time the reduction, increase, or discontinuance described above occurs or, commencing January 1, 2007, for one issued by a subsidiary of the parent company of that issuer or by a network that contracts with the parent company of that issuer.

E) The individual demonstrates, in accordance with guidelines established by the secretary, either of the following:

i) The organization offering the plan substantially violated a material provision of the organization's contract under this article in relation to the individual, including the failure to provide on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide the covered care in accordance with applicable quality standards.

ii) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual.

F) The individual meets other exceptional conditions as the secretary may provide.

3. The individual is 65 years of age or older, is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act, and circumstances similar to those described in paragraph (2) exist that would permit discontinuance of the individual's enrollment with the provider, if the individual were enrolled in a Medicare Advantage plan.

4. The individual meets both of the following conditions:

A) The individual is enrolled with any of the following:

i) An eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost).

ii) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999.

iii) An organization under an agreement under Section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan).

iv) An organization under a Medicare Select policy.

B) The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph (2) or (3).

5. he individual is enrolled under a Medicare supplement contract, and the enrollment ceases because of any of the following circumstances:

A) The insolvency of the issuer or bankruptcy of the nonissuer organization, or other involuntary termination of coverage or enrollment under the contract.

B) The issuer of the contract substantially violated a material provision of the contract.

C) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the contract's provisions in marketing the contract to the individual.

6. The individual meets both of the following conditions:

A) The individual was enrolled under a Medicare supplement contract and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under Medicare Part C, any eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the Social Security Act, or a Medicare Select policy.

B) The subsequent enrollment under subparagraph (A) is terminated by the individual during any period within the first 12 months of the subsequent enrollment (during which the enrollee is permitted to terminate the subsequent enrollment under Section 1851(e) of the federal Social Security Act).

7. The individual upon first becoming eligible for benefits under Medicare Part A at age 65 years of age, enrolls in a Medicare Advantage plan under Medicare Part C or with a PACE provider under Section 1894 of the Social Security Act, and disenrolls from the plan or program not later than 12 months after the effective date of enrollment.

8. The individual while enrolled under a Medicare supplement contract that covers outpatient prescription drugs enrolls in a Medicare Part D plan during the initial enrollment period, terminates enrollment in the Medicare supplement contract, and submits evidence of enrollment in Medicare Part D along with the application for a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including F with high deductible), K or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage.

Complete Answers Are Very Important

When you fill out the application for the new contract, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your contract and refuse to pay any claims if you leave out or falsify important medical information; this would not apply if you are in your guaranteed acceptance period described in the section titled 'Guaranteed Acceptance'. Review the application carefully before you sign it. Be certain that all information has been properly recorded.

What Is Not Covered

Some expenses the **Senior SmartChoice Medicare Supplement Plan (High Deductible Plan F)** does not cover are: the Part B deductible (out of network), custodial care; prescription drugs; dental care or treatment; dentures; foot care; eye examinations or eyeglasses (unless covered by Medicare); hearing aids; chiropractic care (unless covered by Medicare*).

Other expenses the **Senior SmartChoice Medicare Supplement Plan (High Deductible Plan F)** does not cover are: private duty nursing; personal comfort items; services for which no charge is made; services rendered by relatives; any services or supplies not specifically listed as covered in your Agreement; services rendered during a hospital stay which began before coverage is in force or after coverage has been terminated; any conditions covered under Workers' Compensation; any conditions covered by any Federal Government agency; conditions resulting from war, invasion or atomic explosion; custodial care and rest cures; routine physical examinations; inpatient admissions primarily for diagnostic studies when inpatient bed care is not medically necessary; acupuncture; dental work; cosmetic surgery or other services for beautification; services primarily for weight reduction as the main method of treatment and services not approved by Medicare unless specified elsewhere.

Some expenses the **SmartChoice PLUS Medicare Supplement (High Deductible Plan F with Rider)** Plan does not cover are: any costs in excess of the maximum amounts stated in the benefits section of this brochure and any services which are not authorized by Blue Cross of California as part of the plan of care for nursing and residential care facility or home support services.

Some expenses the **SmartChoice Preferred Medicare Supplement Plan (High Deductible Plan F)** does not cover are Chiropractic services that are not covered by Medicare, including Maintenance Therapy and cosmetic lens options, such as progressive multifacial lenses, lens coating and lens tinting.

* If Medicare Part B deductible has not already been met as part of the annual plan deductible, it is covered in full only when using a Participating Prudent Buyer Provider.

Grievance Procedure

All complaints and disputes relating to coverage under this plan must be resolved in accordance with Blue Cross' grievance procedure. Grievances may be made by telephone or in writing.

All grievances received by Blue Cross will be acknowledged in writing, together with a description of how Blue Cross of California proposes to resolve the grievance. Grievances that cannot be resolved by this procedure shall be submitted to arbitration.

Member Grievance Procedure

We are certain that you will be completely satisfied with your Blue Cross of California plan, but if you should ever have a complaint or problem, please follow the Member Grievance Procedure:

Step 1.

Contact Blue Cross of California.
You can call us at 1-800-333-3883.
You can write to us at the following address:
P.O. Box 9053
Oxnard, CA 93031-9053.

Your grievance will be reviewed and you will receive a response within 30 days.

Step 2.

If you are not satisfied with the response, you can submit the grievance to binding arbitration.

Arbitration

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to, this Agreement, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court. The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this Binding Arbitration provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, state law governing agreements to arbitrate shall apply. The Member and Blue Cross agree to be bound by these arbitration provisions and acknowledge that they are giving up their right to trial by court or jury.

California Health & Safety Code section 1363.1 requires that any arbitration agreement include the following notice: "It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration."

The Member and Blue Cross agree to give up the right to participate in class arbitrations against each other. Even if applicable law permits class actions or class arbitrations, the Member waives any right to pursue, on a class basis, any such controversy or claim against Blue Cross and Blue Cross waives any right to pursue, on a class basis, any such controversy or claim against the Member. The arbitration findings will be final and binding except to the extent that state or federal law provides for the judicial review of arbitration proceedings. The arbitration is initiated by the Member making written demand on Blue Cross. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS"), according to its applicable Rules and Procedures. If for any reason JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by agreement of the Member and Blue Cross, or by order of the court, if the Member and Blue Cross cannot agree.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to whom the parties have agreed, in which cases, Blue Cross will assume all or a portion of the costs of the arbitration.

Please send all Binding Arbitration demands in writing to:

Blue Cross of California
P.O. Box 9053,
Oxnard, CA 93031-9053

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 1-800-333-8333) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Web site www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.

Questions?

After you receive your Agreement, please feel free to contact your Blue Cross of California Authorized Agent, or call us toll-free at **1-800-333-3883.**

You can write to us at the following address:
P.O. Box 9063
Oxnard, CA 93031-9063.

Consumers may call the State of California Department of Insurance Consumer Hotline for information about insurance coverage at **1-800-927-4357**.

Health Maintenance Organizations (HMO) require that a specific primary care physician (gatekeeper) authorize all medical services outside the scope of his or her office. A Preferred Provider Organization (PPO) allows members to choose their own physician and specialist anytime, anywhere within the provider network. The **Senior SmartChoice Medicare Supplement Plan (High Deductible Plan F)** is a PPO that provides members with a network of over 50,000 physicians statewide.

Visit our Web site
www.bluecrossca.com

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