



BlueCross BlueShield  
of Nebraska

## 2009 Nebraska Farm Bureau - Outline of **BlueSenior Classic** Medicare Supplemental Coverage - Benefit Plans A, B, C, F and G

Rates Valid Through March 31, 2010

These charts show the benefits included in each of the standard Medicare supplemental plans. Every company must make available Plan "A." Some plans may not be available in Nebraska.

**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 (20% of Medicare-approved expenses) or co-payments for hospital outpatient services.

**Blood:** First three pints of blood each year.

BlueSenior Classic Plan A	BlueSenior Classic Plan B	BlueSenior Classic Plan C	Plan D	Plan E	BlueSenior Classic Plan F, F*	BlueSenior Classic Plan G	Plan H	Plan I	Plan J, 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

\* 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 are \$2,000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

**Plans F and J high deductible options are not offered by Blue Cross and Blue Shield of Nebraska.**

## 2009 Nebraska Farm Bureau - Outline of **BlueSenior Classic** Medicare Supplemental Coverage - Benefit Plans K and L

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 K**	Plan L**
	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
<b>Skilled Nursing Coinsurance</b>	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
<b>Part A Deductible</b>	50% Part A Deductible	75% Part A Deductible
<b>Part B Deductible</b>		
<b>Part B Excess (100%)</b>		
<b>Foreign Travel Emergency</b>		
<b>At-Home Recovery</b>		
<b>Preventive Care NOT covered by Medicare</b>		
<b>2009 out-of-pocket annual limit</b>	\$4,620***	\$2,310***

\*\* Plans K and L provide for different cost-sharing for items and services than Plans A-J.  
Plans K and L are not offered by Blue Cross and Blue Shield of Nebraska.

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.

# BlueSenior Classic Monthly Premiums Preferred\*

Age	Plan A		Plan B		Plan C		Plan F		Plan G	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
65	\$76.07	\$68.46	\$139.64	\$125.68	\$134.32	\$120.89	\$142.80	\$128.52	\$89.71	\$78.68
66	\$79.12	\$71.20	\$145.22	\$130.71	\$139.70	\$125.73	\$148.51	\$133.66	\$89.71	\$78.68
67	\$82.53	\$74.33	\$151.51	\$136.43	\$145.73	\$131.23	\$154.94	\$139.51	\$89.71	\$78.68
68	\$85.20	\$76.68	\$156.39	\$140.75	\$150.44	\$135.39	\$159.93	\$143.94	\$91.50	\$80.21
69	\$88.62	\$79.80	\$162.68	\$146.49	\$156.49	\$140.90	\$166.36	\$149.79	\$94.56	\$82.89
70	\$92.42	\$83.22	\$169.66	\$152.77	\$163.20	\$146.95	\$173.50	\$156.23	\$99.13	\$86.93
71	\$95.47	\$85.96	\$175.25	\$157.79	\$168.57	\$151.78	\$179.22	\$161.37	\$103.97	\$91.24
72	\$99.65	\$89.69	\$182.92	\$164.63	\$175.96	\$158.37	\$187.07	\$168.36	\$106.93	\$93.75
73	\$103.07	\$92.80	\$189.21	\$170.36	\$182.00	\$163.87	\$193.50	\$174.22	\$111.51	\$97.79
74	\$106.12	\$95.54	\$194.80	\$175.39	\$187.38	\$168.71	\$199.20	\$179.36	\$115.64	\$101.38
75	\$109.17	\$98.28	\$200.38	\$180.41	\$192.75	\$173.54	\$204.92	\$184.50	\$119.68	\$104.97
76	\$112.20	\$101.02	\$205.97	\$185.44	\$198.12	\$178.37	\$210.63	\$189.64	\$123.80	\$108.55
77	\$115.25	\$103.76	\$211.55	\$190.47	\$203.49	\$183.21	\$216.35	\$194.78	\$127.84	\$112.14
78	\$118.29	\$106.50	\$217.14	\$195.49	\$208.87	\$188.05	\$222.05	\$199.92	\$131.96	\$115.73
79	\$120.57	\$108.56	\$221.33	\$199.27	\$212.89	\$191.67	\$226.34	\$203.78	\$135.02	\$118.42
80	\$125.52	\$112.96	\$230.40	\$207.37	\$221.63	\$199.47	\$235.62	\$212.05	\$141.57	\$124.16
81	\$126.28	\$113.65	\$231.80	\$208.62	\$222.97	\$200.67	\$237.05	\$213.34	\$142.64	\$125.06
82	\$127.03	\$114.34	\$233.20	\$209.88	\$224.31	\$201.88	\$238.48	\$214.63	\$143.63	\$125.95
83	\$127.80	\$115.02	\$234.59	\$211.13	\$225.66	\$203.09	\$239.90	\$215.91	\$144.61	\$126.85
84	\$128.56	\$115.70	\$236.00	\$212.40	\$227.00	\$204.30	\$241.33	\$217.20	\$145.69	\$127.75
85+	\$129.32	\$116.39	\$237.39	\$213.65	\$228.35	\$205.51	\$242.76	\$218.48	\$146.23	\$128.29

**Rates Valid Through March 31, 2010.** Premium is based on your gender and age as of April 1, 2009

\* Applicants qualifying for guarantee issue automatically receive the Preferred rates if they are non-tobacco users. All other applicants who pass medical underwriting and have not used tobacco products for at least 12 months qualify for these rates.

# BlueSenior Classic Monthly Premiums Standard

Age	Plan A		Plan B		Plan C		Plan F		Plan G	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
65	\$87.47	\$78.73	\$153.60	\$138.24	\$147.70	\$132.93	\$157.11	\$141.40	\$98.66	\$86.52
66	\$90.97	\$81.87	\$159.74	\$143.77	\$153.61	\$138.24	\$163.39	\$147.05	\$98.66	\$86.52
67	\$94.90	\$85.46	\$166.65	\$150.07	\$160.26	\$144.31	\$170.47	\$153.50	\$98.66	\$86.52
68	\$97.97	\$88.17	\$172.03	\$154.82	\$165.43	\$148.88	\$175.96	\$158.36	\$100.63	\$88.20
69	\$101.90	\$91.76	\$178.95	\$161.12	\$172.07	\$154.94	\$183.04	\$164.81	\$103.98	\$91.16
70	\$106.27	\$95.69	\$186.63	\$168.04	\$179.46	\$161.58	\$190.89	\$171.87	\$109.02	\$95.60
71	\$109.77	\$98.84	\$192.77	\$173.57	\$185.36	\$166.90	\$197.17	\$177.53	\$114.35	\$100.33
72	\$114.59	\$103.13	\$201.21	\$181.10	\$193.48	\$174.14	\$205.82	\$185.23	\$117.61	\$103.10
73	\$118.52	\$106.72	\$208.12	\$187.39	\$200.13	\$180.19	\$212.88	\$191.68	\$122.64	\$107.54
74	\$122.02	\$109.86	\$214.28	\$192.92	\$206.04	\$185.51	\$219.16	\$197.33	\$127.17	\$111.48
75	\$125.52	\$113.01	\$220.42	\$198.45	\$211.95	\$190.82	\$225.45	\$202.98	\$131.61	\$115.43
76	\$129.02	\$116.16	\$226.56	\$203.98	\$217.86	\$196.14	\$231.73	\$208.64	\$136.15	\$119.38
77	\$132.52	\$119.31	\$232.70	\$209.51	\$223.77	\$201.46	\$238.02	\$214.30	\$140.59	\$123.33
78	\$136.02	\$122.46	\$238.85	\$215.04	\$229.67	\$206.78	\$244.30	\$219.95	\$145.13	\$127.27
79	\$138.64	\$124.81	\$243.45	\$219.18	\$234.11	\$210.77	\$249.02	\$224.19	\$148.48	\$130.23
80	\$144.32	\$129.89	\$253.44	\$228.10	\$243.70	\$219.33	\$259.23	\$233.31	\$155.69	\$136.54
81	\$145.21	\$130.68	\$254.98	\$229.48	\$245.18	\$220.67	\$260.81	\$234.72	\$156.87	\$137.53
82	\$146.08	\$131.47	\$256.52	\$230.86	\$246.66	\$221.99	\$262.38	\$236.14	\$157.95	\$138.52
83	\$146.95	\$132.26	\$258.05	\$232.25	\$248.14	\$223.33	\$263.94	\$237.55	\$159.04	\$139.51
84	\$147.82	\$133.04	\$259.59	\$233.63	\$249.62	\$224.65	\$265.51	\$238.97	\$160.22	\$140.49
85+	\$148.70	\$133.83	\$261.12	\$235.01	\$251.09	\$225.98	\$267.09	\$240.38	\$160.81	\$141.08

**Rates Valid Through March 31, 2010.** Premium is based on your gender and age as of April 1, 2009

**Premium Information** - Your premium will change according to your age and any changes in Medicare deductible and coinsurance amounts. Otherwise, your premium cannot be changed unless we make the same change for all policies like yours in the state. Premium rates will be reviewed and adjusted each year effective with an annual renewal date of April 1. Your rate for the entire year will be based on your age as of the April 1 renewal date and **will not change again until April 1st of the following year.** When we change your premium, we will notify you in writing at least 31 days before payment is required.

**Your contract is guaranteed renewable.** It cannot be canceled because of the number of claims you file or the amount of benefits you collect. It should be expected that your premiums will increase whenever Medicare deductibles or coinsurance provisions change, or when higher medical costs require a greater charge.

**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 Blue Cross and Blue Shield of Nebraska.

**Right To Return Policy** - If you find that you are not satisfied with your policy, you may return it to Blue Cross and Blue Shield of Nebraska; P.O. Box 3248; Omaha, NE 68180-0001. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

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

**Notice** - These policies may not fully cover all of your medical costs. Neither Blue Cross and Blue Shield of Nebraska 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 & You" handbook for more details.

**Complete Answers Are Very Important** - When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. 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.

### **These Contracts Do Not Provide Benefits For:**

- ➔ Services which are not considered a Medicare-eligible expense, or are not covered by Medicare.
- ➔ Benefits which would duplicate those provided by Medicare.
- ➔ A service provided prior to the effective date of coverage, or after your coverage has been canceled or terminated.
- ➔ A service for which you have no obligation to pay. Your contract does not pay for charges which are in excess of the amount a doctor can lawfully collect under Medicare.
- ➔ Services for any illness or injury for which benefits are provided or are available under any workers' compensation, employers' liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.
- ➔ Services which are not covered under your plan's standardized benefit package.
- ➔ Prescription drugs.

**Comparing Medicare Supplemental Plans** - Federal regulations require that companies sell Medicare Supplemental coverage from among 12 standard plans, labeled A through L. Blue Cross and Blue Shield of Nebraska offers five of these 12 plans to members: A, B, C, F and G.

# BlueSenior Classic -- 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 A Pays	You Pay
<b>HOSPITALIZATION*</b>			
<b>Semiprivate room and board, general nursing, miscellaneous services and supplies.</b>			
First 60 days	All but \$1,068	\$0	\$1,068 (Part A deductible)
61st through 90th day	All but \$267 a day	\$267 a day	\$0
91st day and after: While using 60 lifetime reserve days	All but \$534 a day	\$534 a day	\$0
Once lifetime reserve days are used: 365 additional days	\$0	100% of Medicare-eligible expenses	\$0
Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b>			
<b>You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare- approved facility within 30 days after leaving the hospital.</b>			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$133.50 a day	\$0	Up to \$133.50 a day
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
<b>Available as long as your doctor certifies you are terminally ill and you elect to receive these services.</b>			
	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

**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.

# BlueSenior Classic -- Plan A

## 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 A Pays	You Pay
<b>MEDICAL EXPENSES IN OR OUT OF THE 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 and durable medical equipment.			
First \$135 of Medicare-approved amounts*	\$0	\$0	\$135 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B excess charges (above Medicare-approved amounts)	\$0	\$0	All costs
<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 -- TESTS FOR DIAGNOSTIC SERVICES</b>			
	100%	\$0	\$0
<b>PARTS A AND B</b> <b>HOME HEALTH CARE -- MEDICARE-APPROVED SERVICES</b>			
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

# BlueSenior Classic -- 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.

Services	Medicare Pays	Plan B Pays	You Pay
<b>HOSPITALIZATION*</b>			
<b>Semiprivate room and board, general nursing, miscellaneous services and supplies.</b>			
First 60 days	All but \$1,068	\$1,068 (Part A deductible)	\$0
61st through 90th day	All but \$267 a day	\$267 a day	\$0
91st day and after: While using 60 lifetime reserve days	All but \$534 a day	\$534 a day	\$0
Once lifetime reserve days are used: 365 additional days	\$0	100% of Medicare-eligible expenses	\$0
Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b>			
<b>You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.</b>			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$133.50 a day	\$0	Up to \$133.50 a day
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
<b>Available as long as your doctor certifies you are terminally ill and you elect to receive these services.</b>			
	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

**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.

# BlueSenior Classic -- 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 THE 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 and durable medical equipment.			
First \$135 of Medicare-approved amounts*	\$0	\$0	\$135 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B excess charges (above Medicare-approved amounts)	\$0	\$0	All costs
<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 -- TESTS FOR DIAGNOSTIC SERVICES</b>			
	100%	\$0	\$0
<b>PARTS A AND B</b> <b>HOME HEALTH CARE -- MEDICARE-APPROVED SERVICES</b>			
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

# BlueSenior Classic -- 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 C Pays	You Pay
<b>HOSPITALIZATION*</b>			
<b>Semiprivate room and board, general nursing, miscellaneous services and supplies.</b>			
First 60 days	All but \$1,068	\$1,068 (Part A deductible)	\$0
61st through 90th day	All but \$267 a day	\$267 a day	\$0
91st day and after: While using 60 lifetime reserve days	All but \$534 a day	\$534 a day	\$0
Once lifetime reserve days are used: 365 additional days	\$0	100% of Medicare-eligible expenses	\$0
Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b>			
<b>You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.</b>			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$133.50 a day	Up to \$133.50 a day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
<b>Available as long as your doctor certifies you are terminally ill and you elect to receive these services.</b>			
	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

**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.

# BlueSenior Classic -- 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 THE 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 and durable medical equipment.			
First \$135 of Medicare-approved amounts*	\$0	\$135 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B excess charges (above Medicare-approved amounts)	\$0	\$0	All costs
<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 -- TESTS FOR DIAGNOSTIC SERVICES</b>			
	100%	\$0	\$0
<b>PARTS A AND B</b> <b>HOME HEALTH CARE -- MEDICARE-APPROVED SERVICES</b>			
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

# BlueSenior Classic -- Plan C

## Other Benefits -- Not Covered By Medicare

Services	Medicare Pays	Plan C Pays	You Pay
<b>FOREIGN TRAVEL -- NOT COVERED BY MEDICARE</b>			
<b>Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.A.</b>			
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

# BlueSenior Classic -- 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 F Pays	You Pay
<b>HOSPITALIZATION*</b>			
<b>Semiprivate room and board, general nursing, miscellaneous services and supplies.</b>			
First 60 days	All but \$1,068	\$1,068 (Part A deductible)	\$0
61st through 90th day	All but \$267 a day	\$267 a day	\$0
91st day and after: While using 60 lifetime reserve days	All but \$534 a day	\$534 a day	\$0
Once lifetime reserve days are used: 365 additional days	\$0	100% of Medicare-eligible expenses	\$0
Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b>			
<b>You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.</b>			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$133.50 a day	Up to \$133.50 a day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
<b>Available as long as your doctor certifies you are terminally ill and you elect to receive these services.</b>			
	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

**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.

# BlueSenior Classic -- 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 THE 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 and durable medical equipment.			
First \$135 of Medicare-approved amounts*	\$0	\$135 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B excess charges (above Medicare-approved amounts)	\$0	100%	\$0
<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 -- TESTS FOR DIAGNOSTIC SERVICES</b>			
	100%	\$0	\$0
<b>PARTS A AND B HOME HEALTH CARE -- MEDICARE-APPROVED SERVICES</b>			
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

# BlueSenior Classic -- Plan F

## Other Benefits -- Not Covered By Medicare

Services	Medicare Pays	Plan F Pays	You Pay
<b>FOREIGN TRAVEL -- NOT COVERED BY MEDICARE</b>			
<b>Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.A.</b>			
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

# BlueSenior Classic -- Plan G

## Medicare (Part A) -- Hospital Services -- Per Benefit Period

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

Services	Medicare Pays	Plan G Pays	You Pay
<b>HOSPITALIZATION*</b>			
<b>Semiprivate room and board, general nursing, miscellaneous services and supplies.</b>			
First 60 days	All but \$1,068	\$1,068 (Part A deductible)	\$0
61st through 90th day	All but \$267 a day	\$267 a day	\$0
91st day and after: While using 60 lifetime reserve days	All but \$534 a day	\$534 a day	\$0
Once lifetime reserve days are used: 365 additional days	\$0	100% of Medicare-eligible expenses	\$0
Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b>			
<b>You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.</b>			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$133.50 a day	Up to \$133.50 a day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
<b>Available as long as your doctor certifies you are terminally ill and you elect to receive these services.</b>			
	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

**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.

# BlueSenior Classic -- Plan G

## 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 G Pays	You Pay
<b>MEDICAL EXPENSES IN OR OUT OF THE 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 and durable medical equipment.			
First \$135 of Medicare-approved amounts*	\$0	\$0	\$135 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B excess charges (above Medicare-approved amounts)	\$0	80%	20%
<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 -- TESTS FOR DIAGNOSTIC SERVICES</b>			
	100%	\$0	\$0
<b>PARTS A AND B</b> <b>HOME HEALTH CARE -- MEDICARE-APPROVED SERVICES</b>			
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

# BlueSenior Classic -- Plan G

## Other Benefits -- Not Covered By Medicare

Services	Medicare Pays	Plan G Pays	You Pay
<b>FOREIGN TRAVEL -- NOT COVERED BY MEDICARE</b>			
<b>Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.A.</b>			
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
<b>AT-HOME RECOVERY -- NOT COVERED BY MEDICARE</b>			
<b>Home care certified by your doctor for personal care during recovery from an injury or illness for which Medicare approved a Home Care Treatment Plan</b>			
Benefit for each visit	\$0	Up to \$40* per visit	Balance
Number of visits covered (must be received within 8 weeks of last Medicare-approved visit)	\$0	Up to the number of Medicare-approved visits, not to exceed 7 each week	Balance
Calendar year maximum	\$0	\$1,600*	Balance

\*These amounts can change each year. Please consult the most recent version of:  
*"Choosing a Medica Policy: Your Guide to Health Insurance for People with Medicare."*

# Medicare

## Supplemental Coverage

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