Anthem Blue Cross and Blue Shield
TRB Group Medicare Supplemental Plan 2020

A benefit period begins on the day you are admitted 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.

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,408	**Amount after Medicare pays**	**$250** copay
61st through the 90th day	All but $352 per day	**Amount after Medicare pays**	**$0** copay
91st day and after: While using 60 lifetime reserve days	All but $704 per day	**Amount after Medicare pays**	**$0** copay
Once lifetime reserve days are used- **Unlimited Hospital days**	$0	**100% of Medicare eligible expenses**	**$0** copay
SKILLED NURSING FACILITY CARE- You must meet Medicare's requirements, including admission as an inpatient 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** copay
21st through 100th day	All but $176 per day	**Amount after Medicare pays**	**$250** copay
101st days and after	$0	$0	All Costs
BLOOD			
First three pints	$0	**3 pints**	**$0** copay
Additional amounts	100%	$0	**$0** copay
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	**$250** copay per visit (only if the services are not covered in full by Medicare)

Medicare (Part B) - Medical Services - Per 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.	80% of the Medicare approved amount except for the $198 Part B deductible	**Amount after Medicare pays**	Medicare Part B deductible **$198** **$10** copay office visit **$0** copay Physical, occupational, speech therapy. DME supplies. Including but not limited to radiation therapy, x-rays, PET, CT, MRI scans **$100** copay Ambulance **$100** copay ER (waived if admitted)
Remainder of Medicare-Approved Amounts	80% of the Medicare approved amount except for the $198 Part B deductible	**Amount after Medicare pays**	**$0**
Part B Excess Charge (Above Medicare-approved amounts)	$0	**$0**	**15%** Above the Medicare approved amounts
Durable medical equipment	80% of the Medicare approved amount except for the $198 Part B deductible	**Amount after Medicare pays**	**$0**
Outpatient Hospital	80% of the Medicare approved amount except for the $198 Part B deductible	**Amount after Medicare pays**	**$100** copay per visit for each Medicare-covered outpatient **hospital facility** or ambulatory surgical center, or outpatient visit for surgery.

BLOOD			
First three pints	$0	**All Costs**	**$0** copay
CLINICAL LABORATORY SERVICES - Blood Tests For Diagnostic Services	100%	$0	**$0** copay
MEDICARE PARTS A AND B			
HOME HEALTH CARE MEDICARE-APPROVED SERVICES - Medically necessary skilled care services and medical supplies	100%	$0	**$0** copay
Durable medical equipment	80% of the Medicare approved amount except for the $198 Part B deductible	**Amount after Medicare pays**	**$0** copay
OTHER BENEFITS - NOT COVERED BY MEDICARE			
Prescription Wigs	Not Covered	**Prescription wigs after chemotherapy with no dollar limit.** **One wig every year.**	**$0** copay
Routine Hearing	Not Covered	Routine hearing exams are limited to 1 every 12 months and are 100% covered with no annual dollar limit. Hearing aids are covered at 100%, one aid per ear every 24 months.	**$0** copay
Routine Vision Services	Not Covered	Routine vision exams are limited to 1 per year. Eyewear is limited to a $240 maximum benefit every 24 months.	**$0** copay for routine vision exams. After the plan pays benefits for routine vision exams, including refraction and eyewear, you are responsible for the remaining cost.

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	Not covered	In-patient Hospital Facility Charge- **30 days of approved Medicare expenses** paid at 80%. Physician charges related to in-patient stay paid at 80%. Out-patient charges paid at 80%. Prescriptions and lab charges are not covered.	**$250** copay per visit and 20% balance **$10** copay for provider or other services

Annual out-of-pocket maximum: All copays, coinsurance and deductibles listed in this benefit chart are accrued toward the medical out-of- pocket maximum of **$2,198** with the exception of the wig, routine hearing services, vision, foreign travel emergency copays or coinsurance amount.

This marketing literature provides a general discussion and overview of the plan offered by Anthem Blue Cross and Blue Shield. The legal rights and responsibilities between Anthem Blue Cross and Blue Shield and its insureds are contained in the legal policies, which you should consult for full information. If there is any conflict between this marketing literature and Anthem Blue Cross and Blue Shield's legal policies, the legal policies shall govern.