

Mountain State Blue Cross Blue Shield
700 Market Square
P.O. Box 1948
Parkersburg, West Virginia 26102

**Changes effective January 1, 2008*

Outline of Medicare Supplemental Coverage-Cover Page: Benefit Plans A, C, F and I

Medicare supplement insurance can be sold in only ten standard plans. This chart shows the benefits included in each plan. Every company must make available Plan A. Some plans may not be available in your state. **Mountain State Blue Cross Blue Shield offers benefit plans A, C, F and I.**

BASIC BENEFITS INCLUDED IN ALL PLANS.

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (20% of Medicare-approved expenses).

Blood: First three pints of blood each calendar year.

Benefit plans A, C, F and I are shaded below for your convenience.

A	B	C	D	E	F	G	H	I	J
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance
	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					

PREMIUM INFORMATION

Effective January 1, 2008

Mountain State Blue Cross Blue Shield can only raise your premium if we raise the premium for all policies like yours in this State.

The premiums for the Mountain State Medifil Medicare supplement are based on criteria established by Mountain State Blue Cross Blue Shield. Please carefully review the information below to determine the amount of premium which you will pay:

PLAN A

If you apply for Mountain State Medifil Plan A, your monthly premium for Mountain State Medifil Plan A coverage will be:

*Under 65	\$119.13
65 - 69	\$107.22
70 - 74	\$136.96
75 - 79	\$154.83
80+	\$184.18

PLAN C

If you apply for Mountain State Medifil Plan C, your monthly premium for Mountain State Medifil Plan C coverage will be:

*Under 65	\$174.94
65 - 69	\$157.42
70 - 74	\$201.14
75 - 79	\$227.37
80+	\$270.40

PLAN F

If you apply for Mountain State Medifil Plan F, your monthly premium for Mountain State Medifil Plan F coverage will be:

*Under 65	\$177.56
65 - 69	\$159.79
70 - 74	\$204.16
75 - 79	\$230.78
80+	\$274.49

PLAN I

If you apply for Mountain State Medifil Plan I, your monthly premium for Mountain State Medifil Plan I coverage will be:

*Under 65	\$165.20
65 - 69	\$147.44
70 - 74	\$191.81
75 - 79	\$218.42
80+	\$262.12

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

***Specific restrictions apply.**

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and Mountain State Blue Cross & Blue Shield.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to **Mountain State Blue Cross Blue Shield, 700 Market Square, P.O. Box 1948, Parkersburg, West Virginia 26102**. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

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

NOTICE

This policy may not fully cover all of your medical costs.

Mountain State Blue Cross Blue Shield is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or review The Medicare Handbook for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

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

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies</p> <ul style="list-style-type: none"> First 60 days 61st thru 90th day 91st day and after: <ul style="list-style-type: none"> - While using 60 lifetime reserve days - Once lifetime reserve days are used: <ul style="list-style-type: none"> - Additional 365 days - Beyond the Additional 365 days 	<ul style="list-style-type: none"> All but \$1,024.00 All but \$256.00 a day All but \$512.00 a day \$0 \$0 	<ul style="list-style-type: none"> \$0 \$256.00 a day \$512.00 a day 100% of Medicare Eligible Expenses \$0 	<ul style="list-style-type: none"> \$1,024.00 (Part A Deductible) \$0 \$0 \$0 All Costs
<p>SKILLED NURSING FACILITY CARE* You must meet Medicare 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</p> <ul style="list-style-type: none"> First 20 days 21st thru 100th day 101st day and after 	<ul style="list-style-type: none"> All approved amounts All but \$128.00 a day \$0 	<ul style="list-style-type: none"> \$0 \$0 \$0 	<ul style="list-style-type: none"> \$0 Up to \$128.00 a day All Costs
<p>BLOOD First 3 pints Additional amounts</p>	<ul style="list-style-type: none"> \$0 100% 	<ul style="list-style-type: none"> All Costs \$0 	<ul style="list-style-type: none"> \$0 \$0
<p>HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited coinsurance for outpatient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance</p>

PLAN A

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

* Once you have been billed \$135.00 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, Such as: Physician=s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$135.00 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts Part B Excess Charges (Above Medicare-Approved Amounts)	\$0 80% \$0	\$0 20% \$0	\$135.00 (Part B Deductible) \$0 All Costs
BLOOD First 3 pints Next \$135.00 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$135.00 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES – BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

Parts A and B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First \$135.00 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$135.00 (Part B Deductible) \$0
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PLAN C
Medicare (Part A) - Hospital Services - Per Benefit Period

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies</p> <ul style="list-style-type: none"> First 60 days 61st thru 90th day 91st day and after: <ul style="list-style-type: none"> - While using 60 lifetime reserve days - Once lifetime reserve days are used: <ul style="list-style-type: none"> - Additional 365 days - Beyond the Additional 365 days 	<ul style="list-style-type: none"> All but \$1,024.00 All but \$256.00 a day All but \$512.00 a day \$0 \$0 	<ul style="list-style-type: none"> \$1,024.00 (Part A Deductible) \$256.00 a day \$512.00 a day \$100% of Medicare Eligible Expenses \$0 	<ul style="list-style-type: none"> \$0 \$0 \$0 \$0 All Costs
<p>SKILLED NURSING FACILITY CARE* You must meet Medicare 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</p> <ul style="list-style-type: none"> First 20 days 21st thru 100th day 101st day after 	<ul style="list-style-type: none"> All approved amounts All but \$128.00 a day \$0 	<ul style="list-style-type: none"> \$0 Up to \$128.00 a day \$0 	<ul style="list-style-type: none"> \$0 \$0 All Costs
<p>BLOOD First 3 pints Additional amounts</p>	<ul style="list-style-type: none"> \$0 100% 	<ul style="list-style-type: none"> All Costs \$0 	<ul style="list-style-type: none"> \$0 \$0
<p>HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<ul style="list-style-type: none"> All but very limited coinsurance for outpatient drugs and inpatient respite care 	<ul style="list-style-type: none"> \$0 	<ul style="list-style-type: none"> Balance

PLAN C

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

* Once you have been billed \$135.00 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as: Physicians services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$135.00 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts Part B Excess Charges (Above Medicare-Approved Amounts)	\$0 80% \$0	\$135.00 (Part B Deductible) 20% \$0	\$0 \$0 All Costs
BLOOD First 3 pints Next \$135.00 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All Costs \$135.00 (Part B Deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES - BLOOD TEST FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

Parts A and B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First \$135.00 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	100% \$0 80%	\$0 \$135.00 (Part B Deductible) 20%	\$0 \$0 \$0
FOREIGN TRAVEL- NOT COVERED BY MEDICARE Medically necessary emergency care services during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges	\$0 \$0	\$0 80 % to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st 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	All but \$1,024.00 All but \$256.00 a day All but \$512.00 a day \$0 \$0	\$1,024.00 (Part A Deductible) \$256.00 a day \$512.00 a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0 All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$128.00 a day \$0	\$0 Up to \$128.00 a day \$0	\$0 \$0 All Costs
BLOOD First 3 pints Additional amounts	\$0 100%	All Costs \$0	\$0 \$0
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	Balance

PLAN F

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

* Once you have been billed \$135.00 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as: Physicians services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$135.00 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts Part B Excess Charges (Above Medicare-Approved Amounts)	\$0 80% \$0	\$135.00 (Part B Deductible) 20% 100%	\$0 \$0 \$0
BLOOD First 3 pints Next \$135.00 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All Costs \$135.00 (Part B Deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES - BLOOD TEST FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

Parts A and B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First \$135.00 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	100% \$0 80%	\$0 \$135.00 (Part B Deductible) 20%	\$0 \$0 \$0
FOREIGN TRAVEL- NOT COVERED BY MEDICARE Medically necessary emergency care services during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges	\$0 \$0	\$0 80 % to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>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</p>	<p>All but \$1,024.00 All but \$256.00 a day All but \$512.00 a day \$0 \$0</p>	<p>\$1,024.00 (Part A Deductible) \$256.00 a day \$512.00 a day 100% of Medicare Eligible Expenses \$0</p>	<p>\$0 \$0 \$0 \$0 All Costs</p>
<p>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</p>	<p>All approved amounts All but \$128.00 a day \$0</p>	<p>\$0 Up to \$128.00 a day \$0</p>	<p>\$0 \$0 All Costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$0 100%</p>	<p>All Costs \$0</p>	<p>\$0 \$0</p>
<p>HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited coinsurance for outpatient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance</p>

PLAN I

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

* Once you have been billed \$135.00 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as: Physicians services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$135.00 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts Part B Excess Charges (Above Medicare-Approved Amounts)	\$0 80% \$0	\$0 20% 100%	\$135.00 (Part B Deductible) \$0 \$0
BLOOD First 3 pints Next \$135.00 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$135.00 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES - BLOOD TEST FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

Parts A and B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First \$135.00 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan - Benefit for each visit - Number of visits covered (must be received within 8 weeks of last Medicare-Approved visit) - Calendar year maximum	100% \$0 80% \$0 \$0 \$0	\$0 \$0 20% Actual Charges to \$40 a visit Up to the number of Medicare approved visits, not to exceed 7 each week \$1,600	\$0 \$135.00 (Part B Deductible) \$0 Balance
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PLAN I

OTHER BENEFITS

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum