

ROCKY MOUNTAIN HEALTH PLANS

Underwritten by Rocky Mountain HealthCare Options, Inc.

Outline of Medicare Supplement Coverage – Cover Page: 1 of 2

Benefit Chart of Medicare Supplement Plans sold for Effective Dates on or after June 1, 2010.

Benefit Plans offered: A, C, F, G and N

These charts show the benefits included in each of the standard Medicare supplement plans. Every company, including Rocky Mountain Health Plans, must make available Plan “A.” Some plans may not be available in Colorado. Plans E, H, I, and J are no longer available for sale.

See Outlines of Coverage sections for details about ALL plans

Basic Benefits for Plan A, B, C, D, F, G, K, L, M and N:

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

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N requires insureds to pay a portion of Part B coinsurance or copayments.

Blood: First three pints of blood each year.

Hospice: Part A coinsurance

A	B	C	D	F	F*	G	M	N
Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance		Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits except \$20 copay office visit \$50 copay ER visit
		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	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible				
				Part B Excess (100%)		Part B Excess (100%)		
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency

* Plan F has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2,000 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed \$2,000. Out-of-pocket expenses for this deductible 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.

ROCKY MOUNTAIN HEALTH PLANS

Outline of Medicare Supplement Coverage – Cover Page: 2 of 2

Basic Benefits for Plans K and L include similar services as plans A – G, M and N, but cost-sharing for the basic benefits is at different levels.

	K**	L**
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
Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
Preventive Care NOT covered by Medicare		
Out-of-Pocket Annual Limit	\$4,620 Out-of-Pocket Annual Limit***	\$2,310 Out-of-Pocket Annual Limit***

** Plans K and L provide for different cost-sharing for items and services than Plans A – G, M and N.

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.

**ROCKY MOUNTAIN HEALTH PLANS
MONTHLY PREMIUM INFORMATION**

Your Premium is based on several specific factors including your age, sex, and geographic location. A change in one or more of these factors may result in an increase in your Premium. Changes may also be made for other reasons, provided that we make the same change for all Policies like yours in the same classification of coverage. No change in Premium will be made because of the number of claims you file or because of a change in your health status.

Metro Counties

Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Douglas, Elbert, Gilpin, Jefferson, Park, Washington

NON-TOBACCO MONTHLY PREMIUM

FEMALE					Attained Age	MALE				
Plan A	Plan C	Plan F	Plan G	Plan N		Plan A	Plan C	Plan F	Plan G	Plan N
\$ 130.89	\$ 191.30	\$ 201.37	\$ 211.44	\$ 134.92	Through 64	\$ 151.31	\$ 221.14	\$ 232.78	\$ 244.42	\$ 155.96
\$ 89.65	\$ 131.02	\$ 137.92	\$ 144.81	\$ 92.40	65	\$ 103.64	\$ 151.47	\$ 159.44	\$ 167.41	\$ 106.82
\$ 93.58	\$ 136.78	\$ 143.97	\$ 151.17	\$ 96.46	66-67	\$ 108.20	\$ 158.13	\$ 166.46	\$ 174.78	\$ 111.53
\$ 102.08	\$ 149.20	\$ 157.05	\$ 164.90	\$ 105.22	68-69	\$ 118.04	\$ 172.52	\$ 181.60	\$ 190.68	\$ 121.67
\$ 110.58	\$ 161.62	\$ 170.12	\$ 178.63	\$ 113.98	70-71	\$ 127.89	\$ 186.91	\$ 196.75	\$ 206.59	\$ 131.82
\$ 120.43	\$ 176.01	\$ 185.27	\$ 194.53	\$ 124.13	72-73	\$ 139.18	\$ 203.42	\$ 214.13	\$ 224.83	\$ 143.47
\$ 134.83	\$ 197.06	\$ 207.43	\$ 217.80	\$ 138.98	74-75	\$ 155.87	\$ 227.81	\$ 239.80	\$ 251.79	\$ 160.66
\$ 150.48	\$ 219.93	\$ 231.51	\$ 243.08	\$ 155.11	76-77	\$ 174.00	\$ 254.31	\$ 267.70	\$ 281.08	\$ 179.36
\$ 164.26	\$ 240.08	\$ 252.71	\$ 265.35	\$ 169.32	78-79	\$ 189.86	\$ 277.49	\$ 292.09	\$ 306.70	\$ 195.70
\$ 174.73	\$ 255.38	\$ 268.82	\$ 282.26	\$ 180.11	80 and Over	\$ 201.99	\$ 295.21	\$ 310.75	\$ 326.29	\$ 208.20

TOBACCO MONTHLY PREMIUM

FEMALE					Attained Age	MALE				
Plan A	Plan C	Plan F	Plan G	Plan N		Plan A	Plan C	Plan F	Plan G	Plan N
\$ 157.11	\$ 229.63	\$ 241.71	\$ 253.80	\$ 161.95	Through 64	\$ 181.57	\$ 265.37	\$ 279.34	\$ 293.31	\$ 187.16
\$ 107.57	\$ 157.22	\$ 165.50	\$ 173.77	\$ 110.88	65	\$ 124.36	\$ 181.76	\$ 191.33	\$ 200.89	\$ 128.19
\$ 112.34	\$ 164.19	\$ 172.83	\$ 181.47	\$ 115.80	66-67	\$ 129.86	\$ 189.79	\$ 199.78	\$ 209.77	\$ 133.85
\$ 122.50	\$ 179.04	\$ 188.46	\$ 197.88	\$ 126.27	68-69	\$ 141.67	\$ 207.06	\$ 217.95	\$ 228.85	\$ 146.03
\$ 132.65	\$ 193.88	\$ 204.08	\$ 214.29	\$ 136.74	70-71	\$ 153.48	\$ 224.32	\$ 236.13	\$ 247.94	\$ 158.21
\$ 144.47	\$ 211.15	\$ 222.26	\$ 233.37	\$ 148.91	72-73	\$ 167.06	\$ 244.17	\$ 257.02	\$ 269.87	\$ 172.20
\$ 161.78	\$ 236.44	\$ 248.89	\$ 261.33	\$ 166.75	74-75	\$ 187.06	\$ 273.40	\$ 287.79	\$ 302.18	\$ 192.82
\$ 180.53	\$ 263.86	\$ 277.74	\$ 291.63	\$ 186.09	76-77	\$ 208.83	\$ 305.21	\$ 321.27	\$ 337.34	\$ 215.25
\$ 197.12	\$ 288.09	\$ 303.25	\$ 318.42	\$ 203.18	78-79	\$ 227.79	\$ 332.93	\$ 350.45	\$ 367.97	\$ 234.80
\$ 209.66	\$ 306.42	\$ 322.55	\$ 338.67	\$ 216.11	80 and Over	\$ 242.40	\$ 354.28	\$ 372.93	\$ 391.58	\$ 249.86

Resort Counties

Chaffee, Eagle, Garfield, Gunnison, Lake, Pitkin, Routt, Summit

NON-TOBACCO MONTHLY PREMIUM

FEMALE					Attained Age	MALE				
Plan A	Plan C	Plan F	Plan G	Plan N		Plan A	Plan C	Plan F	Plan G	Plan N
\$ 112.57	\$ 164.52	\$ 173.18	\$ 181.84	\$ 116.03	Through 64	\$ 130.13	\$ 190.18	\$ 200.19	\$ 210.20	\$ 134.13
\$ 77.09	\$ 112.68	\$ 118.61	\$ 124.54	\$ 79.47	65	\$ 89.13	\$ 130.26	\$ 137.12	\$ 143.97	\$ 91.87
\$ 80.48	\$ 117.63	\$ 123.82	\$ 130.01	\$ 82.96	66-67	\$ 93.05	\$ 135.99	\$ 143.15	\$ 150.31	\$ 95.91
\$ 87.79	\$ 128.31	\$ 135.06	\$ 141.81	\$ 90.49	68-69	\$ 101.52	\$ 148.37	\$ 156.18	\$ 163.99	\$ 104.64
\$ 95.10	\$ 138.99	\$ 146.31	\$ 153.62	\$ 98.02	70-71	\$ 109.98	\$ 160.74	\$ 169.20	\$ 177.66	\$ 113.37
\$ 103.57	\$ 151.37	\$ 159.33	\$ 167.30	\$ 106.75	72-73	\$ 119.70	\$ 174.94	\$ 184.15	\$ 193.36	\$ 123.38
\$ 115.95	\$ 169.47	\$ 178.39	\$ 187.31	\$ 119.52	74-75	\$ 134.05	\$ 195.91	\$ 206.23	\$ 216.54	\$ 138.17
\$ 129.41	\$ 189.14	\$ 199.10	\$ 209.05	\$ 133.39	76-77	\$ 149.64	\$ 218.71	\$ 230.22	\$ 241.73	\$ 154.25
\$ 141.27	\$ 206.47	\$ 217.33	\$ 228.20	\$ 145.61	78-79	\$ 163.28	\$ 238.64	\$ 251.20	\$ 263.76	\$ 168.30
\$ 150.27	\$ 219.62	\$ 231.18	\$ 242.74	\$ 154.89	80 and Over	\$ 173.71	\$ 253.88	\$ 267.24	\$ 280.61	\$ 179.05

TOBACCO MONTHLY PREMIUM

FEMALE					Attained Age	MALE				
Plan A	Plan C	Plan F	Plan G	Plan N		Plan A	Plan C	Plan F	Plan G	Plan N
\$ 135.12	\$ 197.48	\$ 207.87	\$ 218.27	\$ 139.27	Through 64	\$ 156.15	\$ 228.22	\$ 240.23	\$ 252.24	\$ 160.96
\$ 92.51	\$ 135.21	\$ 142.33	\$ 149.45	\$ 95.36	65	\$ 106.95	\$ 156.31	\$ 164.54	\$ 172.77	\$ 110.24
\$ 96.61	\$ 141.20	\$ 148.64	\$ 156.07	\$ 99.59	66-67	\$ 111.68	\$ 163.22	\$ 171.81	\$ 180.40	\$ 115.11
\$ 105.35	\$ 153.97	\$ 162.07	\$ 170.18	\$ 108.59	68-69	\$ 121.84	\$ 178.07	\$ 187.44	\$ 196.81	\$ 125.59
\$ 114.08	\$ 166.74	\$ 175.51	\$ 184.29	\$ 117.59	70-71	\$ 132.00	\$ 192.92	\$ 203.07	\$ 213.23	\$ 136.06
\$ 124.24	\$ 181.59	\$ 191.14	\$ 200.70	\$ 128.07	72-73	\$ 143.67	\$ 209.98	\$ 221.03	\$ 232.09	\$ 148.09
\$ 139.13	\$ 203.34	\$ 214.04	\$ 224.74	\$ 143.41	74-75	\$ 160.87	\$ 235.12	\$ 247.50	\$ 259.87	\$ 165.82
\$ 155.26	\$ 226.92	\$ 238.86	\$ 250.80	\$ 160.04	76-77	\$ 179.59	\$ 262.48	\$ 276.29	\$ 290.11	\$ 185.12
\$ 169.52	\$ 247.76	\$ 260.80	\$ 273.84	\$ 174.74	78-79	\$ 195.90	\$ 286.32	\$ 301.39	\$ 316.46	\$ 201.93
\$ 180.30	\$ 263.52	\$ 277.39	\$ 291.26	\$ 185.85	80 and Over	\$ 208.47	\$ 304.68	\$ 320.72	\$ 336.76	\$ 214.88

Denver County
Denver County Only

NON-TOBACCO MONTHLY PREMIUM

FEMALE					Attained Age	MALE				
Plan A	Plan C	Plan F	Plan G	Plan N		Plan A	Plan C	Plan F	Plan G	Plan N
\$ 147.91	\$ 216.17	\$ 227.55	\$ 238.93	\$ 152.46	Through 64	\$ 170.98	\$ 249.89	\$ 263.04	\$ 276.20	\$ 176.24
\$ 101.30	\$ 148.05	\$ 155.84	\$ 163.64	\$ 104.42	65	\$ 117.11	\$ 171.16	\$ 180.17	\$ 189.18	\$ 120.71
\$ 105.75	\$ 154.56	\$ 162.69	\$ 170.83	\$ 109.00	66-67	\$ 122.26	\$ 178.69	\$ 188.09	\$ 197.50	\$ 126.02
\$ 115.35	\$ 168.59	\$ 177.46	\$ 186.34	\$ 118.90	68-69	\$ 133.39	\$ 194.95	\$ 205.21	\$ 215.47	\$ 137.49
\$ 124.95	\$ 182.63	\$ 192.24	\$ 201.85	\$ 128.80	70-71	\$ 144.51	\$ 211.21	\$ 222.33	\$ 233.44	\$ 148.96
\$ 136.08	\$ 198.89	\$ 209.35	\$ 219.82	\$ 140.27	72-73	\$ 157.28	\$ 229.87	\$ 241.96	\$ 254.06	\$ 162.12
\$ 152.36	\$ 222.68	\$ 234.40	\$ 246.12	\$ 157.05	74-75	\$ 176.13	\$ 257.42	\$ 270.97	\$ 284.52	\$ 181.55
\$ 170.04	\$ 248.52	\$ 261.60	\$ 274.68	\$ 175.27	76-77	\$ 196.63	\$ 287.38	\$ 302.50	\$ 317.63	\$ 202.68
\$ 185.62	\$ 271.29	\$ 285.57	\$ 299.84	\$ 191.33	78-79	\$ 214.54	\$ 313.56	\$ 330.07	\$ 346.57	\$ 221.14
\$ 197.45	\$ 288.57	\$ 303.76	\$ 318.95	\$ 203.52	80 and Over	\$ 228.24	\$ 333.59	\$ 351.15	\$ 368.70	\$ 235.27

TOBACCO MONTHLY PREMIUM

FEMALE					Attained Age	MALE				
Plan A	Plan C	Plan F	Plan G	Plan N		Plan A	Plan C	Plan F	Plan G	Plan N
\$ 177.54	\$ 259.48	\$ 273.13	\$ 286.79	\$ 183.00	Through 64	\$ 205.17	\$ 299.87	\$ 315.65	\$ 331.44	\$ 211.49
\$ 121.56	\$ 177.66	\$ 187.01	\$ 196.36	\$ 125.30	65	\$ 140.53	\$ 205.39	\$ 216.20	\$ 227.01	\$ 144.85
\$ 126.95	\$ 185.54	\$ 195.30	\$ 205.07	\$ 130.85	66-67	\$ 146.74	\$ 214.46	\$ 225.75	\$ 237.04	\$ 151.25
\$ 138.42	\$ 202.31	\$ 212.96	\$ 223.61	\$ 142.68	68-69	\$ 160.09	\$ 233.97	\$ 246.29	\$ 258.60	\$ 165.01
\$ 149.90	\$ 219.08	\$ 230.61	\$ 242.14	\$ 154.51	70-71	\$ 173.44	\$ 253.49	\$ 266.83	\$ 280.17	\$ 178.77
\$ 163.25	\$ 238.60	\$ 251.15	\$ 263.71	\$ 168.27	72-73	\$ 188.78	\$ 275.91	\$ 290.43	\$ 304.95	\$ 194.59
\$ 182.81	\$ 267.18	\$ 281.24	\$ 295.30	\$ 188.43	74-75	\$ 211.38	\$ 308.94	\$ 325.20	\$ 341.46	\$ 217.89
\$ 204.00	\$ 298.16	\$ 313.85	\$ 329.54	\$ 210.28	76-77	\$ 235.97	\$ 344.89	\$ 363.04	\$ 381.19	\$ 243.23
\$ 222.74	\$ 325.54	\$ 342.68	\$ 359.81	\$ 229.59	78-79	\$ 257.40	\$ 376.21	\$ 396.01	\$ 415.81	\$ 265.33
\$ 236.91	\$ 346.25	\$ 364.48	\$ 382.70	\$ 244.20	80 and Over	\$ 273.92	\$ 400.34	\$ 421.41	\$ 442.48	\$ 282.35

Front Range Counties

Crowley, El Paso, Fremont, Grand, Jackson, Larimer, Lincoln, Logan, Morgan, Pueblo, Teller, Weld

NON-TOBACCO MONTHLY PREMIUM

FEMALE					Attained Age	MALE				
Plan A	Plan C	Plan F	Plan G	Plan N		Plan A	Plan C	Plan F	Plan G	Plan N
\$ 124.35	\$ 181.74	\$ 191.30	\$ 200.87	\$ 128.17	Through 64	\$ 143.74	\$ 210.09	\$ 221.14	\$ 232.20	\$ 148.17
\$ 85.16	\$ 124.47	\$ 131.02	\$ 137.57	\$ 87.78	65	\$ 98.45	\$ 143.89	\$ 151.47	\$ 159.04	\$ 101.48
\$ 88.90	\$ 129.94	\$ 136.78	\$ 143.61	\$ 91.64	66-67	\$ 102.79	\$ 150.23	\$ 158.13	\$ 166.04	\$ 105.95
\$ 96.98	\$ 141.74	\$ 149.20	\$ 156.66	\$ 99.96	68-69	\$ 112.14	\$ 163.90	\$ 172.52	\$ 181.15	\$ 115.59
\$ 105.05	\$ 153.54	\$ 161.62	\$ 169.70	\$ 108.28	70-71	\$ 121.49	\$ 177.57	\$ 186.91	\$ 196.26	\$ 125.23
\$ 114.40	\$ 167.21	\$ 176.01	\$ 184.81	\$ 117.92	72-73	\$ 132.22	\$ 193.25	\$ 203.42	\$ 213.59	\$ 136.29
\$ 128.09	\$ 187.21	\$ 197.06	\$ 206.91	\$ 132.03	74-75	\$ 148.08	\$ 216.42	\$ 227.81	\$ 239.20	\$ 152.63
\$ 142.96	\$ 208.93	\$ 219.93	\$ 230.93	\$ 147.35	76-77	\$ 165.30	\$ 241.60	\$ 254.31	\$ 267.03	\$ 170.39
\$ 156.05	\$ 228.07	\$ 240.08	\$ 252.08	\$ 160.85	78-79	\$ 180.37	\$ 263.61	\$ 277.49	\$ 291.36	\$ 185.92
\$ 165.99	\$ 242.61	\$ 255.38	\$ 268.14	\$ 171.10	80 and Over	\$ 191.89	\$ 280.45	\$ 295.21	\$ 309.97	\$ 197.79

TOBACCO MONTHLY PREMIUM

FEMALE					Attained Age	MALE				
Plan A	Plan C	Plan F	Plan G	Plan N		Plan A	Plan C	Plan F	Plan G	Plan N
\$ 149.26	\$ 218.14	\$ 229.63	\$ 241.11	\$ 153.85	Through 64	\$ 172.49	\$ 252.10	\$ 265.37	\$ 278.64	\$ 177.80
\$ 102.20	\$ 149.36	\$ 157.22	\$ 165.08	\$ 105.34	65	\$ 118.15	\$ 172.67	\$ 181.76	\$ 190.85	\$ 121.78
\$ 106.72	\$ 155.98	\$ 164.19	\$ 172.40	\$ 110.01	66-67	\$ 123.36	\$ 180.30	\$ 189.79	\$ 199.28	\$ 127.16
\$ 116.37	\$ 170.08	\$ 179.04	\$ 187.99	\$ 119.95	68-69	\$ 134.59	\$ 196.70	\$ 207.06	\$ 217.41	\$ 138.73
\$ 126.02	\$ 184.19	\$ 193.88	\$ 203.57	\$ 129.90	70-71	\$ 145.81	\$ 213.11	\$ 224.32	\$ 235.54	\$ 150.30
\$ 137.25	\$ 200.59	\$ 211.15	\$ 221.70	\$ 141.47	72-73	\$ 158.71	\$ 231.96	\$ 244.17	\$ 256.37	\$ 163.59
\$ 153.69	\$ 224.62	\$ 236.44	\$ 248.26	\$ 158.42	74-75	\$ 177.71	\$ 259.73	\$ 273.40	\$ 287.07	\$ 183.18
\$ 171.51	\$ 250.66	\$ 263.86	\$ 277.05	\$ 176.78	76-77	\$ 198.39	\$ 289.95	\$ 305.21	\$ 320.47	\$ 204.49
\$ 187.26	\$ 273.69	\$ 288.09	\$ 302.50	\$ 193.02	78-79	\$ 216.40	\$ 316.28	\$ 332.93	\$ 349.57	\$ 223.06
\$ 199.17	\$ 291.10	\$ 306.42	\$ 321.74	\$ 205.30	80 and Over	\$ 230.28	\$ 336.57	\$ 354.28	\$ 372.00	\$ 237.37

Eastern Plains Counties

Baca, Bent, Cheyenne, Custer, Huerfano, Kiowa, Kit Carson, Las Animas, Otero, Phillips, Prowers, Sedgwick, Yuma

NON-TOBACCO MONTHLY PREMIUM

FEMALE					Attained Age	MALE				
Plan A	Plan C	Plan F	Plan G	Plan N		Plan A	Plan C	Plan F	Plan G	Plan N
\$ 124.35	\$ 181.74	\$ 191.30	\$ 200.87	\$ 128.17	Through 64	\$ 143.74	\$ 210.09	\$ 221.14	\$ 232.20	\$ 148.17
\$ 85.16	\$ 124.47	\$ 131.02	\$ 137.57	\$ 87.78	65	\$ 98.45	\$ 143.89	\$ 151.47	\$ 159.04	\$ 101.48
\$ 88.90	\$ 129.94	\$ 136.78	\$ 143.61	\$ 91.64	66-67	\$ 102.79	\$ 150.23	\$ 158.13	\$ 166.04	\$ 105.95
\$ 96.98	\$ 141.74	\$ 149.20	\$ 156.66	\$ 99.96	68-69	\$ 112.14	\$ 163.90	\$ 172.52	\$ 181.15	\$ 115.59
\$ 105.05	\$ 153.54	\$ 161.62	\$ 169.70	\$ 108.28	70-71	\$ 121.49	\$ 177.57	\$ 186.91	\$ 196.26	\$ 125.23
\$ 114.40	\$ 167.21	\$ 176.01	\$ 184.81	\$ 117.92	72-73	\$ 132.22	\$ 193.25	\$ 203.42	\$ 213.59	\$ 136.29
\$ 128.09	\$ 187.21	\$ 197.06	\$ 206.91	\$ 132.03	74-75	\$ 148.08	\$ 216.42	\$ 227.81	\$ 239.20	\$ 152.63
\$ 142.96	\$ 208.93	\$ 219.93	\$ 230.93	\$ 147.35	76-77	\$ 165.30	\$ 241.60	\$ 254.31	\$ 267.03	\$ 170.39
\$ 156.05	\$ 228.07	\$ 240.08	\$ 252.08	\$ 160.85	78-79	\$ 180.37	\$ 263.61	\$ 277.49	\$ 291.36	\$ 185.92
\$ 165.99	\$ 242.61	\$ 255.38	\$ 268.14	\$ 171.10	80 and Over	\$ 191.89	\$ 280.45	\$ 295.21	\$ 309.97	\$ 197.79

TOBACCO MONTHLY PREMIUM

FEMALE					Attained Age	MALE				
Plan A	Plan C	Plan F	Plan G	Plan N		Plan A	Plan C	Plan F	Plan G	Plan N
\$ 149.26	\$ 218.14	\$ 229.63	\$ 241.11	\$ 153.85	Through 64	\$ 172.49	\$ 252.10	\$ 265.37	\$ 278.64	\$ 177.80
\$ 102.20	\$ 149.36	\$ 157.22	\$ 165.08	\$ 105.34	65	\$ 118.15	\$ 172.67	\$ 181.76	\$ 190.85	\$ 121.78
\$ 106.72	\$ 155.98	\$ 164.19	\$ 172.40	\$ 110.01	66-67	\$ 123.36	\$ 180.30	\$ 189.79	\$ 199.28	\$ 127.16
\$ 116.37	\$ 170.08	\$ 179.04	\$ 187.99	\$ 119.95	68-69	\$ 134.59	\$ 196.70	\$ 207.06	\$ 217.41	\$ 138.73
\$ 126.02	\$ 184.19	\$ 193.88	\$ 203.57	\$ 129.90	70-71	\$ 145.81	\$ 213.11	\$ 224.32	\$ 235.54	\$ 150.30
\$ 137.25	\$ 200.59	\$ 211.15	\$ 221.70	\$ 141.47	72-73	\$ 158.71	\$ 231.96	\$ 244.17	\$ 256.37	\$ 163.59
\$ 153.69	\$ 224.62	\$ 236.44	\$ 248.26	\$ 158.42	74-75	\$ 177.71	\$ 259.73	\$ 273.40	\$ 287.07	\$ 183.18
\$ 171.51	\$ 250.66	\$ 263.86	\$ 277.05	\$ 176.78	76-77	\$ 198.39	\$ 289.95	\$ 305.21	\$ 320.47	\$ 204.49
\$ 187.26	\$ 273.69	\$ 288.09	\$ 302.50	\$ 193.02	78-79	\$ 216.40	\$ 316.28	\$ 332.93	\$ 349.57	\$ 223.06
\$ 199.17	\$ 291.10	\$ 306.42	\$ 321.74	\$ 205.30	80 and Over	\$ 230.28	\$ 336.57	\$ 354.28	\$ 372.00	\$ 237.37

Western Slope Counties

Alamosa, Archuleta, Conejos, Costilla, Delta, Delores, Hinsdale, La Plata, Mesa, Mineral, Moffat, Montezuma, Montrose, Ouray, Rio Blanco, Rio Grande, Saguache, San Juan, San Miguel

NON-TOBACCO MONTHLY PREMIUM

FEMALE					Attained Age	MALE				
Plan A	Plan C	Plan F	Plan G	Plan N		Plan A	Plan C	Plan F	Plan G	Plan N
\$ 124.35	\$ 181.74	\$ 191.30	\$ 200.87	\$ 128.17	Through 64	\$ 143.74	\$ 210.09	\$ 221.14	\$ 232.20	\$ 148.17
\$ 85.16	\$ 124.47	\$ 131.02	\$ 137.57	\$ 87.78	65	\$ 98.45	\$ 143.89	\$ 151.47	\$ 159.04	\$ 101.48
\$ 88.90	\$ 129.94	\$ 136.78	\$ 143.61	\$ 91.64	66-67	\$ 102.79	\$ 150.23	\$ 158.13	\$ 166.04	\$ 105.95
\$ 96.98	\$ 141.74	\$ 149.20	\$ 156.66	\$ 99.96	68-69	\$ 112.14	\$ 163.90	\$ 172.52	\$ 181.15	\$ 115.59
\$ 105.05	\$ 153.54	\$ 161.62	\$ 169.70	\$ 108.28	70-71	\$ 121.49	\$ 177.57	\$ 186.91	\$ 196.26	\$ 125.23
\$ 114.40	\$ 167.21	\$ 176.01	\$ 184.81	\$ 117.92	72-73	\$ 132.22	\$ 193.25	\$ 203.42	\$ 213.59	\$ 136.29
\$ 128.09	\$ 187.21	\$ 197.06	\$ 206.91	\$ 132.03	74-75	\$ 148.08	\$ 216.42	\$ 227.81	\$ 239.20	\$ 152.63
\$ 142.96	\$ 208.93	\$ 219.93	\$ 230.93	\$ 147.35	76-77	\$ 165.30	\$ 241.60	\$ 254.31	\$ 267.03	\$ 170.39
\$ 156.05	\$ 228.07	\$ 240.08	\$ 252.08	\$ 160.85	78-79	\$ 180.37	\$ 263.61	\$ 277.49	\$ 291.36	\$ 185.92
\$ 165.99	\$ 242.61	\$ 255.38	\$ 268.14	\$ 171.10	80 and Over	\$ 191.89	\$ 280.45	\$ 295.21	\$ 309.97	\$ 197.79

TOBACCO MONTHLY PREMIUM

FEMALE					Attained Age	MALE				
Plan A	Plan C	Plan F	Plan G	Plan N		Plan A	Plan C	Plan F	Plan G	Plan N
\$ 149.26	\$ 218.14	\$ 229.63	\$ 241.11	\$ 153.85	Through 64	\$ 172.49	\$ 252.10	\$ 265.37	\$ 278.64	\$ 177.80
\$ 102.20	\$ 149.36	\$ 157.22	\$ 165.08	\$ 105.34	65	\$ 118.15	\$ 172.67	\$ 181.76	\$ 190.85	\$ 121.78
\$ 106.72	\$ 155.98	\$ 164.19	\$ 172.40	\$ 110.01	66-67	\$ 123.36	\$ 180.30	\$ 189.79	\$ 199.28	\$ 127.16
\$ 116.37	\$ 170.08	\$ 179.04	\$ 187.99	\$ 119.95	68-69	\$ 134.59	\$ 196.70	\$ 207.06	\$ 217.41	\$ 138.73
\$ 126.02	\$ 184.19	\$ 193.88	\$ 203.57	\$ 129.90	70-71	\$ 145.81	\$ 213.11	\$ 224.32	\$ 235.54	\$ 150.30
\$ 137.25	\$ 200.59	\$ 211.15	\$ 221.70	\$ 141.47	72-73	\$ 158.71	\$ 231.96	\$ 244.17	\$ 256.37	\$ 163.59
\$ 153.69	\$ 224.62	\$ 236.44	\$ 248.26	\$ 158.42	74-75	\$ 177.71	\$ 259.73	\$ 273.40	\$ 287.07	\$ 183.18
\$ 171.51	\$ 250.66	\$ 263.86	\$ 277.05	\$ 176.78	76-77	\$ 198.39	\$ 289.95	\$ 305.21	\$ 320.47	\$ 204.49
\$ 187.26	\$ 273.69	\$ 288.09	\$ 302.50	\$ 193.02	78-79	\$ 216.40	\$ 316.28	\$ 332.93	\$ 349.57	\$ 223.06
\$ 199.17	\$ 291.10	\$ 306.42	\$ 321.74	\$ 205.30	80 and Over	\$ 230.28	\$ 336.57	\$ 354.28	\$ 372.00	\$ 237.37

PREMIUM INFORMATION

The premium for this policy will change. Because the premium rate is based upon your attained age, the premium will increase as you age until you reach age 80. The premium may also change for reasons other than attained age. However, such premium change cannot be made unless we make the same change to all policies like yours issued to persons living in the same geographic area of Colorado.

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 Rocky Mountain Health Plans.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to Rocky Mountain HealthCare Options, Inc., P.O. Box 10600, Grand Junction, CO 81502-5600. 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

The policy may not fully cover all your medical costs.

Neither Rocky Mountain HealthCare Options, Inc. 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 "Medicare & You" 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. Rocky Mountain Health Plans 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.

RENEWABILITY

This policy is guaranteed renewable for life. We have the right to change the renewal premiums for this policy in accordance with our table of premium rates applicable to all policies of this form and class.

**ROCKY MOUNTAIN HEALTH PLANS
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE – PLAN A**

Underwritten by Rocky Mountain HealthCare Options, Inc.

Medicare (Part A) Hospital Services – Per Benefit Period*

* A Benefit Period begins on the first day you receive services as an inpatient in a Hospital or Skilled Nursing Facility and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 days in a row.

SERVICES	MEDICARE PAYS	RMHP PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
<ul style="list-style-type: none"> • First 60 days 	All but \$1,156	\$0	\$1,156 (Part A Deductible)
<ul style="list-style-type: none"> • 61st thru 90th day 	All but \$289/ day	\$289/day	\$0
<ul style="list-style-type: none"> • 91st day and after: While using 60 lifetime reserve days 	All but \$578/ day	\$578/ day	\$0
Once lifetime reserve days are used:			
<ul style="list-style-type: none"> • Additional 365 days 	\$0	100% of Medicare eligible expenses	\$0**
<ul style="list-style-type: none"> • Beyond the additional 365 days 	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
<ul style="list-style-type: none"> • First 20 days 	All approved amounts	\$0	\$0
<ul style="list-style-type: none"> • 21st thru 100th day 	All but \$144.50/ day	\$0	Up to \$144.50/ day
<ul style="list-style-type: none"> • 101st day and after 	\$0	\$0	All costs

SERVICES	MEDICARE PAYS	RMHP PAYS	YOU PAY
BLOOD			
• First 3 pints	\$0	3 pints	\$0
• Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copay/ coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, RMHP 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.

PLAN A

Medicare (Part B) Medical Services – Per Calendar Year

* Once you have been billed \$140 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	RMHP 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			
<ul style="list-style-type: none"> • First \$140 of Medicare-approved amounts* 	\$0	\$0	\$140 (Part B Deductible)
<ul style="list-style-type: none"> • Remainder of Medicare-approved amounts 	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare-approved amounts)	\$0	\$0	All Costs
BLOOD			
<ul style="list-style-type: none"> • First 3 pints 	\$0	All costs	\$0
<ul style="list-style-type: none"> • Next \$140 of Medicare-approved amounts 	\$0	\$0	\$140 (Part B Deductible)
<ul style="list-style-type: none"> • Remainder of Medicare-approved amounts 	80%	20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

Medicare (Parts A and B)

SERVICES	MEDICARE PAYS	RMHP PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES <ul style="list-style-type: none"> • Medically necessary skilled care services and medical supplies • Durable medical equipment 	100%	\$0	\$0
<ul style="list-style-type: none"> • First \$140 of Medicare-approved amounts 	\$0	\$0	\$140 (Part B Deductible)
<ul style="list-style-type: none"> • Remainder of Medicare-approved amounts 	80%	20%	\$0

**ROCKY MOUNTAIN HEALTH PLANS
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE – PLAN C**

Underwritten by Rocky Mountain HealthCare Options, Inc.

Medicare (Part A) Hospital Services – Per Benefit Period*

* A Benefit Period begins on the first day you receive services as an inpatient in a Hospital or Skilled Nursing Facility and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 days in a row.

SERVICES	MEDICARE PAYS	RMHP PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
<ul style="list-style-type: none"> • First 60 days 	All but \$1,156	\$1,156 (Part A Deductible)	\$0
<ul style="list-style-type: none"> • 61st thru 90th day 	All but \$289/ day	\$289/day	\$0
<ul style="list-style-type: none"> • 91st day and after: While using 60 lifetime reserve days 	All but \$578/ day	\$578/ day	\$0
Once lifetime reserve days are used:			
<ul style="list-style-type: none"> • Additional 365 days 	\$0	100% of Medicare eligible expenses	\$0**
<ul style="list-style-type: none"> • Beyond the additional 365 days 	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
<ul style="list-style-type: none"> • First 20 days 	All approved amounts	\$0	\$0
<ul style="list-style-type: none"> • 21st thru 100th day 	All but \$144.50/ day	Up to \$144.50/ day	\$0
<ul style="list-style-type: none"> • 101st day and after 	\$0	\$0	All costs

SERVICES	MEDICARE PAYS	RMHP PAYS	YOU PAY
BLOOD			
• First 3 pints	\$0	3 pints	\$0
• Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copay/ coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, RMHP 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.

PLAN C

Medicare (Part B) Medical Services – Per Calendar Year

* Once you have been billed \$140 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	RMHP 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			
<ul style="list-style-type: none"> • First \$140 of Medicare-approved amounts* 	\$0	\$140 (Part B Deductible)	\$0
<ul style="list-style-type: none"> • Remainder of Medicare-approved amounts 	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare-approved amounts)	\$0	\$0	All Costs
BLOOD			
<ul style="list-style-type: none"> • First 3 pints 	\$0	All costs	\$0
<ul style="list-style-type: none"> • Next \$140 of Medicare-approved amounts 	\$0	\$140 (Part B Deductible)	\$0
<ul style="list-style-type: none"> • Remainder of Medicare-approved amounts 	80%	20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

Medicare (Parts A and B)

SERVICES	MEDICARE PAYS	RMHP PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
<ul style="list-style-type: none"> • Medically necessary skilled care services and medical supplies • Durable medical equipment 	100%	\$0	\$0
<ul style="list-style-type: none"> • First \$140 of Medicare-approved amounts 	\$0	\$140 (Part B Deductible)	\$0
<ul style="list-style-type: none"> • Remainder of Medicare-approved amounts 	80%	20%	\$0

Other Benefits – Not Covered by Medicare

SERVICES	MEDICARE PAYS	RMHP PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
<ul style="list-style-type: none"> • First \$250 each calendar year 	\$0	\$0	\$250
<ul style="list-style-type: none"> • Remainder of Charges 	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

**ROCKY MOUNTAIN HEALTH PLANS
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE – PLAN F**

Underwritten by Rocky Mountain HealthCare Options, Inc.

Medicare (Part A) Hospital Services – Per Benefit Period*

* A Benefit Period begins on the first day you receive services as an inpatient in a Hospital or Skilled Nursing Facility and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 days in a row.

SERVICES	MEDICARE PAYS	RMHP PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
<ul style="list-style-type: none"> • First 60 days 	All but \$1,156	\$1,156 (Part A Deductible)	\$0
<ul style="list-style-type: none"> • 61st thru 90th day 	All but \$289/ day	\$289/day	\$0
<ul style="list-style-type: none"> • 91st day and after: While using 60 lifetime reserve days 	All but \$578/ day	\$578/ day	\$0
Once lifetime reserve days are used:			
<ul style="list-style-type: none"> • Additional 365 days 	\$0	100% of Medicare eligible expenses	\$0**
<ul style="list-style-type: none"> • Beyond the additional 365 days 	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
<ul style="list-style-type: none"> • First 20 days 	All approved amounts	\$0	\$0
<ul style="list-style-type: none"> • 21st thru 100th day 	All but \$144.50/ day	Up to \$144.50/ day	\$0
<ul style="list-style-type: none"> • 101st day and after 	\$0	\$0	All costs

SERVICES	MEDICARE PAYS	RMHP PAYS	YOU PAY
BLOOD			
• First 3 pints	\$0	3 pints	\$0
• Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copay/ coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, RMHP 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.

PLAN F

Medicare (Part B) Medical Services – Per Calendar Year

* Once you have been billed \$140 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	RMHP 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			
<ul style="list-style-type: none"> • First \$140 of Medicare-approved amounts* 	\$0	\$140 (Part B Deductible)	\$0
<ul style="list-style-type: none"> • Remainder of Medicare-approved amounts 	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare-approved amounts)	\$0	100%	\$0
BLOOD			
<ul style="list-style-type: none"> • First 3 pints 	\$0	All costs	\$0
<ul style="list-style-type: none"> • Next \$140 of Medicare-approved amounts 	\$0	\$140 (Part B Deductible)	\$0
<ul style="list-style-type: none"> • Remainder of Medicare-approved amounts 	80%	20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

Medicare (Parts A and B)

SERVICES	MEDICARE PAYS	RMHP PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
<ul style="list-style-type: none"> • Medically necessary skilled care services and medical supplies • Durable medical equipment 	100%	\$0	\$0
<ul style="list-style-type: none"> • First \$140 of Medicare-approved amounts 	\$0	\$140 (Part B Deductible)	\$0
<ul style="list-style-type: none"> • Remainder of Medicare-approved amounts 	80%	20%	\$0

Other Benefits – Not Covered by Medicare

SERVICES	MEDICARE PAYS	RMHP PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
<ul style="list-style-type: none"> • First \$250 each calendar year 	\$0	\$0	\$250
<ul style="list-style-type: none"> • Remainder of Charges 	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

**ROCKY MOUNTAIN HEALTH PLANS
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE – PLAN G**

Underwritten by Rocky Mountain HealthCare Options, Inc.

Medicare (Part A) Hospital Services – Per Benefit Period*

* A Benefit Period begins on the first day you receive services as an inpatient in a Hospital or Skilled Nursing Facility and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 days in a row.

SERVICES	MEDICARE PAYS	RMHP PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
<ul style="list-style-type: none"> • First 60 days 	All but \$1,156	\$1,156 (Part A Deductible)	\$0
<ul style="list-style-type: none"> • 61st thru 90th day 	All but \$289/ day	\$289/day	\$0
<ul style="list-style-type: none"> • 91st day and after: While using 60 lifetime reserve days 	All but \$578/ day	\$578/ day	\$0
Once lifetime reserve days are used:			
<ul style="list-style-type: none"> • Additional 365 days 	\$0	100% of Medicare eligible expenses	\$0**
<ul style="list-style-type: none"> • Beyond the additional 365 days 	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
<ul style="list-style-type: none"> • First 20 days 	All approved amounts	\$0	\$0
<ul style="list-style-type: none"> • 21st thru 100th day 	All but \$144.50/ day	Up to \$144.50/ day	\$0
<ul style="list-style-type: none"> • 101st day and after 	\$0	\$0	All costs

SERVICES	MEDICARE PAYS	RMHP PAYS	YOU PAY
BLOOD			
• First 3 pints	\$0	3 pints	\$0
• Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copay/ coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, RMHP 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.

PLAN G

Medicare (Part B) Medical Services – Per Calendar Year

* Once you have been billed \$140 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	RMHP 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			
<ul style="list-style-type: none"> • First \$140 of Medicare-approved amounts* 	\$0	\$0	\$140 (Part B Deductible)
<ul style="list-style-type: none"> • Remainder of Medicare-approved amounts 	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare-approved amounts)	\$0	100%	\$0
BLOOD			
<ul style="list-style-type: none"> • First 3 pints 	\$0	All costs	\$0
<ul style="list-style-type: none"> • Next \$140 of Medicare-approved amounts 	\$0	\$0	\$140 (Part B Deductible)
<ul style="list-style-type: none"> • Remainder of Medicare-approved amounts 	80%	20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

Medicare (Parts A and B)

SERVICES	MEDICARE PAYS	RMHP PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
<ul style="list-style-type: none"> • Medically necessary skilled care services and medical supplies • Durable medical equipment 	100%	\$0	\$0
<ul style="list-style-type: none"> • First \$140 of Medicare-approved amounts 	\$0	\$0	\$140 (Part B Deductible)
<ul style="list-style-type: none"> • Remainder of Medicare-approved amounts 	80%	20%	\$0

Other Benefits – Not Covered by Medicare

SERVICES	MEDICARE PAYS	RMHP PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
<ul style="list-style-type: none"> • First \$250 each calendar year 	\$0	\$0	\$250
<ul style="list-style-type: none"> • Remainder of Charges 	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

**ROCKY MOUNTAIN HEALTH PLANS
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE – PLAN N**

Underwritten by Rocky Mountain HealthCare Options, Inc.

Medicare (Part A) Hospital Services – Per Benefit Period*

* A Benefit Period begins on the first day you receive services as an inpatient in a Hospital or Skilled Nursing Facility and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 days in a row.

SERVICES	MEDICARE PAYS	RMHP PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
<ul style="list-style-type: none"> • First 60 days 	All but \$1,156	\$1,156 (Part A Deductible)	\$0
<ul style="list-style-type: none"> • 61st thru 90th day 	All but \$289/ day	\$289/day	\$0
<ul style="list-style-type: none"> • 91st day and after: While using 60 lifetime reserve days 	All but \$578/ day	\$578/ day	\$0
Once lifetime reserve days are used:			
<ul style="list-style-type: none"> • Additional 365 days 	\$0	100% of Medicare eligible expenses	\$0**
<ul style="list-style-type: none"> • Beyond the additional 365 days 	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
<ul style="list-style-type: none"> • First 20 days 	All approved amounts	\$0	\$0
<ul style="list-style-type: none"> • 21st thru 100th day 	All but \$144.50/ day	Up to \$144.50/ day	\$0
<ul style="list-style-type: none"> • 101st day and after 	\$0	\$0	All costs

SERVICES	MEDICARE PAYS	RMHP PAYS	YOU PAY
BLOOD			
• First 3 pints	\$0	3 pints	\$0
• Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copay/ coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, RMHP 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.

PLAN N

Medicare (Part B) Medical Services – Per Calendar Year

* Once you have been billed \$140 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	RMHP 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			
<ul style="list-style-type: none"> • First \$140 of Medicare-approved amounts* 	\$0	\$0	\$140 (Part B Deductible)
<ul style="list-style-type: none"> • Remainder of Medicare-approved amounts 	Generally 80%	Balance, other than \$20 per office visit and \$50 per emergency room visit. The copayment of \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	\$20 per office visit \$50 per emergency room visit. The copayment of \$50 is waived if the insured is admitted to the hospital and the emergency room visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare-approved amounts)	\$0	\$0	All Costs
BLOOD			
<ul style="list-style-type: none"> • First 3 pints 	\$0	All costs	\$0
<ul style="list-style-type: none"> • Next \$140 of Medicare-approved amounts 	\$0	\$0	\$140 (Part B Deductible)
<ul style="list-style-type: none"> • Remainder of Medicare-approved amounts 	80%	20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

Medicare (Parts A and B)

SERVICES	MEDICARE PAYS	RMHP PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES <ul style="list-style-type: none"> • Medically necessary skilled care services and medical supplies • Durable medical equipment 	100%	\$0	\$0
<ul style="list-style-type: none"> • First \$140 of Medicare-approved amounts 	\$0	\$0	\$140 (Part B Deductible)
<ul style="list-style-type: none"> • Remainder of Medicare-approved amounts 	80%	20%	\$0

Other Benefits – Not Covered by Medicare

SERVICES	MEDICARE PAYS	RMHP PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
<ul style="list-style-type: none"> • First \$250 each calendar year 	\$0	\$0	\$250
<ul style="list-style-type: none"> • Remainder of Charges 	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum