

**ROCKY MOUNTAIN HEALTH PLANS**  
**Underwritten by Rocky Mountain HealthCare Options, Inc.**  
**Outline of Medicare Supplement Coverage – Cover Page: 1 of 2**  
**Benefit Plans offered: A, C, F and G**

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.

See Outlines of Coverage sections for details about ALL plans

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

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

A	B	C	D	E	F	F*	G	H	I	J	J*
Basic Benefits	Basic Benefits	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	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 A Deductible	Part A
		Part B Deductible			Part B Deductible	Part B Deductible				Part B Deductible	Part B Deductible
					Part B Excess (100%)	Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	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	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery				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 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 – J, 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		
At-Home Recovery		
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 – J.

Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called “Excess Charges.” You will be responsible for paying excess charges.

\*\*\*The out-of-pocket annual limit will increase each year for inflation.

See Outlines of Coverage for details and exceptions.

**ROCKY MOUNTAIN HEALTH PLANS  
MONTHLY PREMIUM INFORMATION**

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**Metro**

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

**NON-TOBACCO MONTHLY PREMIUM**

FEMALE				MALE				
Plan A	Plan C	Plan F	Plan G	Attained Age Through	Plan A	Plan C	Plan F	Plan G
\$172.61	\$182.20	\$191.79	\$201.38	64	\$199.53	\$210.62	\$221.71	\$ 232.79
\$118.22	\$124.78	\$131.36	\$137.92	65	\$136.67	\$144.26	\$151.85	\$ 159.44
\$123.41	\$130.26	\$137.12	\$143.98	66-67	\$142.67	\$150.60	\$158.53	\$ 166.46
\$134.62	\$142.10	\$149.57	\$157.05	68-69	\$155.66	\$164.31	\$172.96	\$ 181.61
\$145.82	\$153.92	\$162.03	\$170.13	70-71	\$168.64	\$178.02	\$187.38	\$ 196.75
\$158.80	\$167.63	\$176.45	\$185.27	72-73	\$183.54	\$193.74	\$203.93	\$ 214.14
\$177.81	\$187.68	\$197.56	\$207.44	74-75	\$205.55	\$216.96	\$228.39	\$ 239.80
\$198.44	\$209.46	\$220.49	\$231.51	76-77	\$229.47	\$242.21	\$254.96	\$ 267.71
\$216.62	\$228.65	\$240.68	\$252.71	78-79	\$250.37	\$264.29	\$278.19	\$ 292.10
\$230.42	\$243.22	\$256.02	\$268.82	80 and Over	\$266.36	\$281.16	\$295.95	\$ 310.76

**TOBACCO MONTHLY PREMIUM**

FEMALE				MALE				
Plan A	Plan C	Plan F	Plan G	Attained Age Through	Plan A	Plan C	Plan F	Plan G
\$207.19	\$218.69	\$191.79	\$241.72	64	\$239.44	\$252.75	\$266.04	\$ 279.34
\$141.86	\$149.74	\$131.36	\$165.50	65	\$164.00	\$173.11	\$182.22	\$ 191.33
\$148.14	\$156.38	\$137.12	\$172.84	66-67	\$171.24	\$180.76	\$190.27	\$ 199.78
\$161.54	\$170.51	\$149.57	\$188.46	68-69	\$186.83	\$197.20	\$207.59	\$ 217.96
\$174.93	\$184.65	\$162.03	\$204.09	70-71	\$202.40	\$213.64	\$224.89	\$ 236.13
\$190.51	\$201.10	\$176.45	\$222.26	72-73	\$220.30	\$232.54	\$244.79	\$ 257.02
\$213.34	\$225.18	\$197.56	\$248.89	74-75	\$246.69	\$260.39	\$274.09	\$ 287.79
\$238.08	\$251.30	\$220.49	\$277.75	76-77	\$275.38	\$290.68	\$305.98	\$ 321.28
\$259.94	\$274.38	\$240.68	\$303.26	78-79	\$300.39	\$317.08	\$333.76	\$ 350.46
\$276.48	\$291.84	\$256.02	\$322.55	80 and Over	\$319.66	\$337.42	\$355.18	\$ 372.94

**ROCKY MOUNTAIN HEALTH PLANS  
MONTHLY PREMIUM INFORMATION**

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**Resort Counties**

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

**NON-TOBACCO MONTHLY PREMIUM**

FEMALE				MALE				
Plan A	Plan C	Plan F	Plan G	Attained Age	Plan A	Plan C	Plan F	Plan G
\$ 141.38	\$ 149.23	\$ 157.09	\$ 164.94	Through 64	\$ 163.43	\$ 172.51	\$ 181.59	\$ 190.66
\$ 96.83	\$ 102.20	\$ 107.59	\$ 112.96	65	\$ 111.94	\$ 118.16	\$ 124.37	\$ 130.59
\$ 101.08	\$ 106.69	\$ 112.31	\$ 117.92	66-67	\$ 116.86	\$ 123.35	\$ 129.84	\$ 136.34
\$ 110.26	\$ 116.38	\$ 122.51	\$ 128.63	68-69	\$ 127.50	\$ 134.58	\$ 141.66	\$ 148.75
\$ 119.44	\$ 126.07	\$ 132.71	\$ 139.35	70-71	\$ 138.12	\$ 145.80	\$ 153.48	\$ 161.15
\$ 130.07	\$ 137.30	\$ 144.52	\$ 151.75	72-73	\$ 150.33	\$ 158.68	\$ 167.03	\$ 175.39
\$ 145.63	\$ 153.72	\$ 161.81	\$ 169.90	74-75	\$ 168.35	\$ 177.70	\$ 187.06	\$ 196.41
\$ 162.53	\$ 171.56	\$ 180.59	\$ 189.62	76-77	\$ 187.94	\$ 198.38	\$ 208.83	\$ 219.27
\$ 177.42	\$ 187.27	\$ 197.13	\$ 206.98	78-79	\$ 205.07	\$ 216.46	\$ 227.85	\$ 239.24
\$ 188.73	\$ 199.21	\$ 209.69	\$ 220.18	80 and Over	\$ 218.16	\$ 230.28	\$ 242.40	\$ 254.53

**TOBACCO MONTHLY PREMIUM**

FEMALE				MALE				
Plan A	Plan C	Plan F	Plan G	Attained Age	Plan A	Plan C	Plan F	Plan G
\$ 169.70	\$ 179.12	\$ 188.55	\$ 197.98	Through 64	\$ 196.11	\$ 207.01	\$ 217.90	\$ 228.79
\$ 116.19	\$ 122.64	\$ 129.10	\$ 135.55	65	\$ 134.32	\$ 141.79	\$ 149.24	\$ 156.71
\$ 121.34	\$ 128.08	\$ 134.82	\$ 141.56	66-67	\$ 140.26	\$ 148.05	\$ 155.84	\$ 163.63
\$ 132.31	\$ 139.66	\$ 147.01	\$ 154.36	68-69	\$ 153.02	\$ 161.52	\$ 170.02	\$ 178.52
\$ 143.28	\$ 151.24	\$ 159.19	\$ 167.16	70-71	\$ 165.77	\$ 174.98	\$ 184.19	\$ 193.41
\$ 156.04	\$ 164.71	\$ 173.38	\$ 182.04	72-73	\$ 180.44	\$ 190.46	\$ 200.49	\$ 210.51
\$ 174.73	\$ 184.44	\$ 194.15	\$ 203.85	74-75	\$ 202.05	\$ 213.27	\$ 224.49	\$ 235.72
\$ 195.00	\$ 205.82	\$ 216.66	\$ 227.49	76-77	\$ 225.55	\$ 238.08	\$ 250.61	\$ 263.14
\$ 212.90	\$ 224.73	\$ 236.56	\$ 248.39	78-79	\$ 246.04	\$ 259.70	\$ 273.37	\$ 287.04
\$ 226.45	\$ 239.03	\$ 251.61	\$ 264.18	80 and Over	\$ 261.82	\$ 276.36	\$ 290.91	\$ 305.45

**ROCKY MOUNTAIN HEALTH PLANS  
MONTHLY PREMIUM INFORMATION**

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**Denver County**  
Denver County Only

**NON-TOBACCO MONTHLY PREMIUM**

FEMALE				MALE			
Plan A	Plan C	Plan F	Plan G	Plan A	Plan C	Plan F	Plan G
\$ 185.76	\$ 196.08	\$ 206.41	\$ 216.72	\$ 214.73	\$ 226.67	\$ 238.60	\$ 250.52
\$ 127.23	\$ 134.29	\$ 141.36	\$ 148.43	\$ 147.08	\$ 155.25	\$ 163.42	\$ 171.59
\$ 132.81	\$ 140.19	\$ 147.57	\$ 154.95	\$ 153.54	\$ 162.08	\$ 170.61	\$ 179.14
\$ 144.88	\$ 152.92	\$ 160.97	\$ 169.01	\$ 167.52	\$ 176.83	\$ 186.13	\$ 195.44
\$ 156.93	\$ 165.65	\$ 174.37	\$ 183.09	\$ 181.49	\$ 191.58	\$ 201.66	\$ 211.74
\$ 170.90	\$ 180.40	\$ 189.90	\$ 199.39	\$ 197.52	\$ 208.50	\$ 219.47	\$ 230.45
\$ 191.35	\$ 201.98	\$ 212.61	\$ 223.24	\$ 221.21	\$ 233.49	\$ 245.79	\$ 258.07
\$ 213.56	\$ 225.42	\$ 237.29	\$ 249.15	\$ 246.95	\$ 260.67	\$ 274.39	\$ 288.10
\$ 233.12	\$ 246.07	\$ 259.02	\$ 271.97	\$ 269.45	\$ 284.42	\$ 299.38	\$ 314.35
\$ 247.98	\$ 261.75	\$ 275.53	\$ 289.30	\$ 286.66	\$ 302.58	\$ 318.50	\$ 334.43

**TOBACCO MONTHLY PREMIUM**

FEMALE				MALE			
Plan A	Plan C	Plan F	Plan G	Plan A	Plan C	Plan F	Plan G
\$ 222.97	\$ 235.36	\$ 247.74	\$ 260.14	\$ 257.69	\$ 272.00	\$ 286.31	\$ 300.63
\$ 152.66	\$ 161.15	\$ 169.64	\$ 178.11	\$ 176.49	\$ 186.30	\$ 196.10	\$ 205.91
\$ 159.43	\$ 168.29	\$ 177.15	\$ 186.01	\$ 184.29	\$ 194.53	\$ 204.77	\$ 215.01
\$ 173.85	\$ 183.50	\$ 193.16	\$ 202.82	\$ 201.06	\$ 212.23	\$ 223.40	\$ 234.57
\$ 188.26	\$ 198.72	\$ 209.17	\$ 219.64	\$ 217.82	\$ 229.92	\$ 242.02	\$ 254.13
\$ 205.03	\$ 216.42	\$ 227.81	\$ 239.20	\$ 237.09	\$ 250.26	\$ 263.44	\$ 276.60
\$ 229.59	\$ 242.34	\$ 255.10	\$ 267.86	\$ 265.48	\$ 280.23	\$ 294.98	\$ 309.72
\$ 256.22	\$ 270.44	\$ 284.68	\$ 298.91	\$ 296.37	\$ 312.83	\$ 329.29	\$ 345.76
\$ 279.74	\$ 295.28	\$ 310.83	\$ 326.37	\$ 323.28	\$ 341.24	\$ 359.19	\$ 377.16
\$ 297.54	\$ 314.07	\$ 330.60	\$ 347.12	\$ 344.02	\$ 363.13	\$ 382.25	\$ 401.35

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**Front Range Counties**

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

**NON-TOBACCO MONTHLY PREMIUM**

FEMALE				MALE				
Plan A	Plan C	Plan F	Plan G	Attained Age	Plan A	Plan C	Plan F	Plan G
\$ 156.17	\$ 164.84	\$ 173.53	\$ 182.20	Through 64	\$ 180.53	\$ 190.56	\$ 200.59	\$ 210.62
\$ 106.96	\$ 112.90	\$ 118.85	\$ 124.78	65	\$ 123.65	\$ 130.52	\$ 137.39	\$ 144.26
\$ 111.65	\$ 117.86	\$ 124.06	\$ 130.26	66-67	\$ 129.09	\$ 136.26	\$ 143.43	\$ 150.60
\$ 121.80	\$ 128.56	\$ 135.33	\$ 142.09	68-69	\$ 140.84	\$ 148.67	\$ 156.48	\$ 164.31
\$ 131.94	\$ 139.26	\$ 146.59	\$ 153.93	70-71	\$ 152.58	\$ 161.06	\$ 169.54	\$ 178.01
\$ 143.68	\$ 151.67	\$ 159.65	\$ 167.63	72-73	\$ 166.06	\$ 175.28	\$ 184.51	\$ 193.74
\$ 160.87	\$ 169.80	\$ 178.74	\$ 187.68	74-75	\$ 185.97	\$ 196.30	\$ 206.63	\$ 216.96
\$ 179.54	\$ 189.52	\$ 199.49	\$ 209.47	76-77	\$ 207.61	\$ 219.15	\$ 230.68	\$ 242.21
\$ 195.99	\$ 206.87	\$ 217.76	\$ 228.65	78-79	\$ 226.53	\$ 239.12	\$ 251.69	\$ 264.28
\$ 208.48	\$ 220.06	\$ 231.64	\$ 243.22	80 and Over	\$ 241.00	\$ 254.38	\$ 267.77	\$ 281.16

**TOBACCO MONTHLY PREMIUM**

FEMALE				MALE				
Plan A	Plan C	Plan F	Plan G	Attained Age	Plan A	Plan C	Plan F	Plan G
\$ 187.45	\$ 197.87	\$ 208.28	\$ 218.70	Through 64	\$ 216.64	\$ 228.67	\$ 240.70	\$ 252.74
\$ 128.35	\$ 135.48	\$ 142.61	\$ 149.74	65	\$ 148.38	\$ 156.63	\$ 164.86	\$ 173.11
\$ 134.04	\$ 141.48	\$ 148.93	\$ 156.38	66-67	\$ 154.94	\$ 163.54	\$ 172.15	\$ 180.76
\$ 146.16	\$ 154.27	\$ 162.39	\$ 170.52	68-69	\$ 169.03	\$ 178.42	\$ 187.82	\$ 197.20
\$ 158.27	\$ 167.07	\$ 175.85	\$ 184.65	70-71	\$ 183.12	\$ 193.30	\$ 203.47	\$ 213.65
\$ 172.37	\$ 181.94	\$ 191.52	\$ 201.10	72-73	\$ 199.32	\$ 210.40	\$ 221.47	\$ 232.54
\$ 193.02	\$ 203.74	\$ 214.46	\$ 225.19	74-75	\$ 223.19	\$ 235.59	\$ 247.99	\$ 260.39
\$ 215.40	\$ 227.36	\$ 239.33	\$ 251.29	76-77	\$ 249.16	\$ 263.00	\$ 276.84	\$ 290.68
\$ 235.18	\$ 248.24	\$ 261.32	\$ 274.38	78-79	\$ 271.79	\$ 286.88	\$ 301.98	\$ 317.08
\$ 250.14	\$ 264.04	\$ 277.94	\$ 291.83	80 and Over	\$ 289.22	\$ 305.28	\$ 321.36	\$ 337.42

**ROCKY MOUNTAIN HEALTH PLANS  
MONTHLY PREMIUM INFORMATION**

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**Eastern Plains Counties**

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

**NON-TOBACCO MONTHLY PREMIUM**

FEMALE				MALE				
Plan A	Plan C	Plan F	Plan G	Attained Age	Plan A	Plan C	Plan F	Plan G
\$ 156.17	\$ 164.84	\$ 173.53	\$ 182.20	Through 64	\$ 180.53	\$ 190.56	\$ 200.59	\$ 210.62
\$ 106.96	\$ 112.90	\$ 118.85	\$ 124.78	65	\$ 123.65	\$ 130.52	\$ 137.39	\$ 144.26
\$ 111.65	\$ 117.86	\$ 124.06	\$ 130.26	66-67	\$ 129.09	\$ 136.26	\$ 143.43	\$ 150.60
\$ 121.80	\$ 128.56	\$ 135.33	\$ 142.09	68-69	\$ 140.84	\$ 148.67	\$ 156.48	\$ 164.31
\$ 131.94	\$ 139.26	\$ 146.59	\$ 153.93	70-71	\$ 152.58	\$ 161.06	\$ 169.54	\$ 178.01
\$ 143.68	\$ 151.67	\$ 159.65	\$ 167.63	72-73	\$ 166.06	\$ 175.28	\$ 184.51	\$ 193.74
\$ 160.87	\$ 169.80	\$ 178.74	\$ 187.68	74-75	\$ 185.97	\$ 196.30	\$ 206.63	\$ 216.96
\$ 179.54	\$ 189.52	\$ 199.49	\$ 209.47	76-77	\$ 207.61	\$ 219.15	\$ 230.68	\$ 242.21
\$ 195.99	\$ 206.87	\$ 217.76	\$ 228.65	78-79	\$ 226.53	\$ 239.12	\$ 251.69	\$ 264.28
\$ 208.48	\$ 220.06	\$ 231.64	\$ 243.22	80 and Over	\$ 241.00	\$ 254.38	\$ 267.77	\$ 281.16

**TOBACCO MONTHLY PREMIUM**

FEMALE				MALE				
Plan A	Plan C	Plan F	Plan G	Attained Age	Plan A	Plan C	Plan F	Plan G
\$ 187.45	\$ 197.87	\$ 208.28	\$ 218.70	Through 64	\$ 216.64	\$ 228.67	\$ 240.70	\$ 252.74
\$ 128.35	\$ 135.48	\$ 142.61	\$ 149.74	65	\$ 148.38	\$ 156.63	\$ 164.86	\$ 173.11
\$ 134.04	\$ 141.48	\$ 148.93	\$ 156.38	66-67	\$ 154.94	\$ 163.54	\$ 172.15	\$ 180.76
\$ 146.16	\$ 154.27	\$ 162.39	\$ 170.52	68-69	\$ 169.03	\$ 178.42	\$ 187.82	\$ 197.20
\$ 158.27	\$ 167.07	\$ 175.85	\$ 184.65	70-71	\$ 183.12	\$ 193.30	\$ 203.47	\$ 213.65
\$ 172.37	\$ 181.94	\$ 191.52	\$ 201.10	72-73	\$ 199.32	\$ 210.40	\$ 221.47	\$ 232.54
\$ 193.02	\$ 203.74	\$ 214.46	\$ 225.19	74-75	\$ 223.19	\$ 235.59	\$ 247.99	\$ 260.39
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**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				MALE				
Plan A	Plan C	Plan F	Plan G	Attained Age	Plan A	Plan C	Plan F	Plan G
\$ 156.17	\$ 164.84	\$ 173.53	\$ 182.20	Through 64	\$ 180.53	\$ 190.56	\$ 200.59	\$ 210.62
\$ 106.96	\$ 112.90	\$ 118.85	\$ 124.78	65	\$ 123.65	\$ 130.52	\$ 137.39	\$ 144.26
\$ 111.65	\$ 117.86	\$ 124.06	\$ 130.26	66-67	\$ 129.09	\$ 136.26	\$ 143.43	\$ 150.60
\$ 121.80	\$ 128.56	\$ 135.33	\$ 142.09	68-69	\$ 140.84	\$ 148.67	\$ 156.48	\$ 164.31
\$ 131.94	\$ 139.26	\$ 146.59	\$ 153.93	70-71	\$ 152.58	\$ 161.06	\$ 169.54	\$ 178.01
\$ 143.68	\$ 151.67	\$ 159.65	\$ 167.63	72-73	\$ 166.06	\$ 175.28	\$ 184.51	\$ 193.74
\$ 160.87	\$ 169.80	\$ 178.74	\$ 187.68	74-75	\$ 185.97	\$ 196.30	\$ 206.63	\$ 216.96
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\$ 195.99	\$ 206.87	\$ 217.76	\$ 228.65	78-79	\$ 226.53	\$ 239.12	\$ 251.69	\$ 264.28
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**TOBACCO MONTHLY PREMIUM**

FEMALE				MALE				
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\$ 134.04	\$ 141.48	\$ 148.93	\$ 156.38	66-67	\$ 154.94	\$ 163.54	\$ 172.15	\$ 180.76
\$ 146.16	\$ 154.27	\$ 162.39	\$ 170.52	68-69	\$ 169.03	\$ 178.42	\$ 187.82	\$ 197.20
\$ 158.27	\$ 167.07	\$ 175.85	\$ 184.65	70-71	\$ 183.12	\$ 193.30	\$ 203.47	\$ 213.65
\$ 172.37	\$ 181.94	\$ 191.52	\$ 201.10	72-73	\$ 199.32	\$ 210.40	\$ 221.47	\$ 232.54
\$ 193.02	\$ 203.74	\$ 214.46	\$ 225.19	74-75	\$ 223.19	\$ 235.59	\$ 247.99	\$ 260.39
\$ 215.40	\$ 227.36	\$ 239.33	\$ 251.29	76-77	\$ 249.16	\$ 263.00	\$ 276.84	\$ 290.68
\$ 235.18	\$ 248.24	\$ 261.32	\$ 274.38	78-79	\$ 271.79	\$ 286.88	\$ 301.98	\$ 317.08
\$ 250.14	\$ 264.04	\$ 277.94	\$ 291.83	80 and Over	\$ 289.22	\$ 305.28	\$ 321.36	\$ 337.42

### **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
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,068	\$0	\$1,068 (Part A Deductible)
61 <sup>st</sup> thru 90 <sup>th</sup> day	All but \$267 a day	\$267 a day	\$0
91 <sup>st</sup> day and after - While using 60 Lifetime Reserve days	All but \$534 a day	\$534 a day	\$0
- Once Lifetime Reserve days are used :		100% of Medicare Eligible Expenses	\$0 **
- Additional 365 days	\$0	\$0	\$0 **
- Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b>			
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	All approved amounts	\$0	\$0
21 <sup>st</sup> thru 100 <sup>th</sup> day	All but \$133.50 a day	\$0	Up to \$133.50 a day
101 <sup>st</sup> day and after	\$0	\$0	All costs

SERVICES	MEDICARE PAYS	RMHP PAYS	YOU PAY
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
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

\*\* 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 \$135 of Medicare Eligible Expenses 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	YOU PAY
<b>MEDICAL EXPENSES -</b>			
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 of Medicare Eligible Expenses*	\$0	\$0	\$135 (Part B Deductible)
Remainder of Medicare Eligible Expenses	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Eligible Expenses)	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next \$135 of Medicare Eligible Expenses*	\$0	\$0	\$135 (Part B Deductible)
Remainder of Medicare Eligible Expenses	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES -</b>			
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			
- Medically Necessary skilled care services and medical supplies	100%	\$0	\$0
- Durable medical equipment  First \$135 of Medicare Eligible Expenses*	\$0	\$0	\$135 (Part B Deductible)
Remainder of Medicare Eligible Expenses	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
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,068	\$1,068 (Part A Deductible)	\$0
61 <sup>st</sup> thru 90 <sup>th</sup> day	All but \$267 a day	\$267 a day	\$0
91 <sup>st</sup> day and after -While using 60 Lifetime Reserve days	All but \$534 a day	\$534 a day	\$0
- Once Lifetime Reserve days are used:		100% of Medicare Eligible Expenses	\$0 **
- Additional 365 days	\$0		
- Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b>			
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	All approved amounts	\$0	\$0
21 <sup>st</sup> thru 100 <sup>th</sup> day	All but \$133.50 a day	Up to \$133.50 a day	\$0
101 <sup>st</sup> day and after	\$0	\$0	All costs

SERVICES	MEDICARE PAYS	RMHP PAYS	YOU PAY
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
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

**\*\* 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 \$135 of Medicare Eligible Expenses 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
<b>MEDICAL EXPENSES -</b>			
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 of Medicare Eligible Expenses*	\$0	\$135 (Part B Deductible)	\$0
Remainder of Medicare Eligible Expenses	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Eligible Expenses)	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next \$135 of Medicare Eligible Expenses*	\$0	\$135 (Part B Deductible)	\$0
Remainder of Medicare Eligible Expenses	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES -</b>			
TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

### Medicare (Parts A and B)

SERVICES	MEDICARE PAYS	RMHP PAYS	YOU PAY
<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 Eligible Expenses*	\$0	\$135 (Part B Deductible)	\$0
Remainder of Medicare Eligible Expenses	80%	20%	\$0

### Other Benefits – Not Covered by Medicare

SERVICES	MEDICARE PAYS	RMHP PAYS	YOU PAY
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b>			
Medically Necessary emergency care services beginning during the first 60 days of each trip outside the USA  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

**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
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,068	\$1,068 (Part A Deductible)	\$0
61 <sup>st</sup> thru 90 <sup>th</sup> day	All but \$267 a day	\$267 a day	\$0
91 <sup>st</sup> day and after - While using 60 Lifetime Reserve days	All but \$534 a day	\$534 a day	\$0
- Once Lifetime Reserve days are used:			
- Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0 **
- Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b>			
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	All approved amounts	\$0	\$0
21 <sup>st</sup> thru 100 <sup>th</sup> day	All but \$133.50 a day	Up to \$133.50 a day	\$0
101 <sup>st</sup> day and after	\$0	\$0	All costs
<b>BLOOD</b>			

SERVICES	MEDICARE PAYS	RMHP PAYS	YOU PAY
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
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

\*\* 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 \$135 of Medicare Eligible Expenses 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
<b>MEDICAL EXPENSES -</b>			
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 of Medicare Eligible Expenses*	\$0	\$135 (Part B Deductible)	\$0
Remainder of Medicare Eligible Expenses	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Eligible Expenses)	\$0	100%	\$0
<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next \$135 of Medicare Eligible Expenses*	\$0	\$135 (Part B Deductible)	\$0
Remainder of Medicare Eligible Expenses	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES -</b>			
TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

## Medicare (Parts A and B)

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>RMHP PAYS</b>	<b>YOU PAY</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 Eligible Expenses*	\$0	\$135 (Part B Deductible)	\$0
Remainder of Medicare Eligible Expenses	80%	20%	\$0

**Other Benefits – Not Covered by Medicare**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>RMHP PAYS</b>	<b>YOU PAY</b>
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b>			
Medically Necessary emergency care services beginning during the first 60 days of each trip outside the USA			
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

**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
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,068	\$1,068 (Part A Deductible)	\$0
61 <sup>st</sup> thru 90 <sup>th</sup> day	All but \$267 a day	\$267 a day	\$0
91 <sup>st</sup> day and after - While using 60 Lifetime Reserve days	All but \$534 a day	\$534 a day	\$0
- Once Lifetime Reserve days are used:		100% of Medicare Eligible Expenses	\$0 **
- Additional 365 days	\$0		
- Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b>			
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	All approved amounts	\$0	\$0
21 <sup>st</sup> thru 100 <sup>th</sup> day	All but \$133.50 a day	Up to \$133.50 a day	\$0
101 <sup>st</sup> day and after	\$0	\$0	All costs
<b>BLOOD</b>			

SERVICES	MEDICARE PAYS	RMHP PAYS	YOU PAY
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
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

\*\* 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 \$135 of Medicare Eligible Expenses 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
<b>MEDICAL EXPENSES -</b>			
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 of Medicare Eligible Expenses*	\$0	\$0	\$135 (Part B Deductible)
Remainder of Medicare Eligible Expenses	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Eligible Expenses)	\$0	80%	20%
<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next \$135 of Medicare Eligible Expenses *	\$0	\$0	\$135 (Part B Deductible)
Remainder of Medicare Eligible Expenses	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES -</b>			
TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

### Medicare (Parts A and B)

SERVICES	MEDICARE PAYS	RMHP PAYS	YOU PAY
<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 Eligible Expenses*	\$0	\$0	\$135 (Part B Deductible)
Remainder of Medicare Eligible Expenses	80%	20%	\$0
<b>AT-HOME RECOVERY SERVICES – NOT COVERED BY MEDICARE</b>			
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	\$0	Actual charges to \$40 a 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	
Calendar year maximum	\$0	\$1,600	

**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			
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