

# Outline of Coverage

## State of New Hampshire Retiree Over 65

### Medicare Complementary Coverage

The State of New Hampshire requires every insurance company selling health insurance to an individual covered by Medicare to provide the following information.

Medicare Benefits may be changed by Federal Law.

<b>Inpatient Hospital Benefits</b>	<b>Medicare A Pays</b>	<b>Medicomp Three Pays</b>	<b>You Pay</b>
First 60 days of Medicare benefit period	Full cost after \$1,184 Benefit Period Deductible	Deductible \$1,184	<b>No Balance</b>
Next 30 days (61 <sup>st</sup> through 90 <sup>th</sup> days)	Full cost except for coinsurance of \$296 per day	Coinsurance \$296 per day	<b>No Balance</b>
Next 60 days of one-time lifetime reserve days (91 <sup>st</sup> through 150 <sup>th</sup> days)	Full cost except for coinsurance of \$592 per day	Coinsurance \$592 per day	<b>No Balance</b>
After 150 days of continuous confinement	Nothing	90% of covered services Lifetime Maximum: 365 days	Remaining Balance**
<b>Skilled Nursing Facility Benefits</b>	<b>Remember:</b> Skilled Nursing Facility confinement must follow a hospitalization, must be medically necessary. <b>Custodial care is not covered.</b>		
First 20 days of benefit period	Full cost	Nothing	<b>No Balance</b>
Next 80 days (21 <sup>st</sup> through 100 <sup>th</sup> days)	Full cost except for coinsurance of \$148.00 per day	Coinsurance \$148.00 per day	<b>No Balance</b>
After 100 days of continuous confinement	Nothing	Nothing	Full Cost
<b>Medical Service Benefits</b>	<b>Medicare B Pays</b>	<b>Medicomp Three Pays</b>	<b>You Pay</b>
Physician Services, Hospital Outpatient, Prosthetic Devices, Durable Medical Equipment, Immunosuppressive Drugs and Other Covered Services	80% of Medicare approved charges after \$147 annual deductible	20% of Medicare approved charges	\$147 deductible
Certain hospital outpatient services	Full cost except for the hospital outpatient copayment	Hospital outpatient copayment	<b>No Balance</b>
<b>Specific Benefits</b>	<b>Medicare Pays</b>	<b>Medicomp Three Pays</b>	<b>You Pay</b>
Blood (for New Hampshire residents NH Red Cross replaces blood free of charge but hospitals do charge for this administration)	Full cost after 3 pints	First 3 pints of blood for non-residents and applicable coinsurance for administrative charges	Nothing
Non-inpatient Psychiatric Services*	80% of Medicare approved charges after psychiatric reduction, if applicable	Psychiatric reduction and 20% of Medicare approved charges	Remaining Balance**

\*Please refer to Medicare Handbook for psychiatric maximums and exceptions

\*\* Balances are eligible for consideration under the Major Medical portion of this plan. Please see "Additional Benefits" on Page 2 of this Outline.

<p><b>Additional Benefits</b></p>	<p>Major Medical, the second component of Medicomp Three, provides additional coverage for eligible balances remaining after Medicare and Medicomp have processed claims.</p> <p>Major Medical benefits are paid at 100% of the allowable charge.</p>
<p><b>Exclusions and Limitations</b></p>	<p>Services and supplies not covered by Medicare or Medicomp include but are not limited to: dental services, routine foot care, prescriptions drugs, eye glasses and hearing aids: service and supplies which are not medically necessary; and charges in excess of Medicare allowed charges. <b>It is important to read and understand Article vi of your Medicomp Three Medicare Complementary Contract which describes in detail those services and supplies not covered by Medicomp.</b></p>

**Anthem Blue Cross and Blue Shield Customer Service**

3000 Goffs Falls Road  
Manchester, NH 03111-0001  
1-800-225-2666