

# Outline of Medicare Supplement Coverage

## By Reason of Age – Cover Page:

### Benefit Plans A, C, G, High Deductible G and N



See **Outlines of Coverage** sections for detail about all plans. This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan A available. Some plans may not be available in your state. Only applicants first eligible for Medicare before 2020 may purchase Plans C, F and high deductible F.

**Plans offered by Premera Blue Cross (Premera) are highlighted below.**

**Note:** A ✓ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G <sup>1</sup>	K <sup>2</sup>	L <sup>2</sup>	M	N <sup>3</sup>	C	F <sup>1</sup>
Medicare Part A coinsurance and Hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit					\$6,940	\$3,470				

<sup>1</sup>Plan F and G also have a high deductible option which require first paying a plan deductible of \$2,700 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

<sup>2</sup>Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

<sup>3</sup>Plan N pays 100% of the Part B coinsurance, except for a copayment of up to \$20 for some office visits and up to a \$50 copayment for emergency room visits that do not result in an inpatient admission.

# SUBSCRIPTION CHARGES AND PAYMENT INFORMATION

(Rates effective April 1, 2023)

## SUBSCRIPTION CHARGE INFORMATION

We (Premera) can only raise your subscription charges if we raise the subscription charges for all contracts like yours in this state.

## PAYMENT MODE OPTIONS

Monthly payment by Automatic Funds Transfer (AFT). Rates shown reflect a \$5 monthly discount for AFT payments compared to the Paper Bill Option.

**OR**

If you prefer us to bill you, Premera will send you a paper bill in the mail each month.

<b>AFT Payment Option</b>	
<b>Monthly Subscription Charges Per Person</b>	
<b>Plan</b>	<b>Rate</b>
Plan A	\$167
Plan C	\$228
Plan G	\$199
Plan G*	\$49
Plan N	\$165
*High Deductible Plan G	

<b>Paper Bill Payment Option</b>	
<b>Monthly Subscription Charges Per Person</b>	
<b>Plan</b>	<b>Rate</b>
Plan A	\$172
Plan C	\$233
Plan G	\$204
Plan G*	\$54
Plan N	\$170
*High Deductible Plan G	

## DISCLOSURES

Use this outline to compare benefits and subscription charges among contracts.

### READ YOUR CONTRACT VERY CAREFULLY

This is only an outline describing your contract's most important features. The contract is your insurance contract. You must read the contract itself to understand all the rights and duties of both you and your Medicare supplement carrier.

### RIGHT TO RETURN CONTRACT

If you find that you are not satisfied with your contract, you may return it to PO Box 327, MS 295, Seattle, Washington 98111. If you send the contract back to us within 30 days after you receive it, we will treat the contract as if it had never been issued and return all your payments.

### POLICY REPLACEMENT

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

### NOTICE

This contract may not fully cover all your medical costs. Neither Premera nor its producers 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 and You* for more details.

### COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new contract, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your contract 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.

**A 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 A PAYS	YOU PAY
<b>HOSPITALIZATION*</b>			
Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,600	\$0	\$1,600 (Part A Deductible)
61 <sup>st</sup> through 90 <sup>th</sup> day	All but \$400 a day	\$400 a day	\$0
91 <sup>st</sup> day and after: (while using 60 lifetime reserve days)	All but \$800 a day	\$800 a day	\$0
Once lifetime reserve days are used:	\$0	100% of Medicare eligible expenses	\$0**
• Additional 365 days	\$0	\$0	All costs
• 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> through 100 <sup>th</sup> day	All but \$200 a day	\$0	Up to \$200 a day
101 <sup>st</sup> day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment / coinsurance for outpatient drugs and inpatient respite care	Medicare copayment / coinsurance	\$0

\*\*NOTICE: When your Medicare Part A hospital benefits are exhausted, the carrier 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 plan'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.

**A PLAN A (continued):  
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

\*Once you have been billed \$226 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 A 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 \$226 of Medicare approved amounts*	\$0	\$0	\$226 (Part B Deductible)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (above Medicare approved amounts)	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next \$226 of Medicare approved amounts*	\$0	\$0	\$226 (Part B Deductible)
Remainder of Medicare approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES</b>			
Tests for diagnostic services	100%	\$0	\$0

**MEDICARE (PARTS A & B)**

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
<b>HOME HEALTH CARE - Medicare approved services</b>			
<b>Medically Necessary Skilled Care Services and Medical Supplies</b>	100%	\$0	\$0
<b>Durable Medical Equipment</b>			
First \$226 of Medicare approved amounts*	\$0	\$0	\$226 (Part B Deductible)
Remainder of Medicare approved amounts	80%	20%	\$0



**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 C PAYS	YOU PAY
<b>HOSPITALIZATION*</b>			
Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,600	\$1,600 (Part A Deductible)	\$0
61 <sup>st</sup> through 90 <sup>th</sup> day	All but \$400 a day	\$400 a day	\$0
91 <sup>st</sup> day and after: (while using 60 lifetime reserve days)	All but \$800 a day	\$800 a day	\$0
Once lifetime reserve days are used:	\$0	100% of Medicare eligible expenses	\$0**
• Additional 365 days	\$0	\$0	All costs
• 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> through 100 <sup>th</sup> day	All but \$200 a day	Up to \$200 a day	\$0
101 <sup>st</sup> day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment / coinsurance for outpatient drugs and inpatient respite care	Medicare copayment / coinsurance	\$0

\*\*NOTICE: When your Medicare Part A hospital benefits are exhausted, the carrier 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 plan'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.

**C PLAN C (continued):  
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

\*Once you have been billed \$226 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 C 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 \$226 of Medicare approved amounts*	\$0	\$226	\$0
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (above Medicare approved amounts)	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next \$226 of Medicare approved amounts*	\$0	\$226 (Part B Deductible)	\$0
Remainder of Medicare approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES</b>			
Tests for diagnostic services	100%	\$0	\$0

**MEDICARE (PARTS A & B)**

SERVICES	MEDICARE PAYS	PLAN C PAYS	YOU PAY
<b>HOME HEALTH CARE - Medicare approved services</b>			
<b>Medically Necessary Skilled Care Services and Medical Supplies</b>	100%	\$0	\$0
<b>Durable Medical Equipment</b>			
First \$226 of Medicare approved amounts*	\$0	\$226 (Part B Deductible)	\$0
Remainder of Medicare approved amounts	80%	20%	\$0



**PLAN C (continued):  
OTHER BENEFITS - NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN C PAYS	YOU PAY
<b>FOREIGN TRAVEL</b> - 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





**PLAN G:  
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 G PAYS	YOU PAY
<b>HOSPITALIZATION*</b>			
Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,600	\$1,600 (Part A Deductible)	\$0
61 <sup>st</sup> through 90 <sup>th</sup> day	All but \$400 a day	\$400 a day	\$0
91 <sup>st</sup> day and after: (while using 60 lifetime reserve days)	All but \$800 a day	\$800 a day	\$0
Once lifetime reserve days are used:	\$0	100% of Medicare eligible expenses	\$0***
• Additional 365 days	\$0	\$0	All costs
• 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> through 100 <sup>th</sup> day	All but \$200 a day	Up to \$200 a day	\$0
101 <sup>st</sup> day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment / coinsurance for outpatient drugs and inpatient respite care	Medicare copayment / coinsurance	\$0

\*\*\*NOTICE: When your Medicare Part A hospital benefits are exhausted, the carrier 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 plan'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.

**G PLAN G (continued):  
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

\*Once you have been billed \$226 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 G 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 \$226 of Medicare approved amounts*	\$0	\$0	\$226 (Part B Deductible)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (above Medicare approved amounts)	\$0	100%	\$0
<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next \$226 of Medicare approved amounts*	\$0	\$0	\$226 (Part B Deductible)
Remainder of Medicare approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES</b>			
Tests for diagnostic services	100%	\$0	\$0

**MEDICARE (PARTS A & B)**

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
<b>HOME HEALTH CARE - Medicare approved services</b>			
<b>Medically Necessary Skilled Care Services and Medical Supplies</b>	100%	\$0	\$0
<b>Durable Medical Equipment</b>			
First \$226 of Medicare approved amounts*	\$0	\$0	\$226 (Part B Deductible)
Remainder of Medicare approved amounts	80%	20%	\$0



**PLAN G (continued):  
OTHER BENEFITS - NOT COVERED BY MEDICARE**

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SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
<b>FOREIGN TRAVEL</b> - 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

## G HIGH DEDUCTIBLE PLAN G: 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.

\*\*This high deductible plan pays the same benefits as Plan G after one has paid a calendar year \$2,700 deductible. Benefits from the High Deductible Plan G will not begin until out of pocket expenses are \$2,700. Out-of-pocket expenses for this deductible are expenses for the Part B deductible, and expenses that would normally be paid by the contract. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,700 DEDUCTIBLE**, PLAN G PAYS	IN ADDITION TO \$2,700 DEDUCTIBLE**, YOU PAY
<b>HOSPITALIZATION*</b>			
Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,600	\$1,600 (Part A Deductible)	\$0
61 <sup>st</sup> through 90 <sup>th</sup> day	All but \$400 a day	\$400 a day	\$0
91 <sup>st</sup> day and after: (while using 60 lifetime reserve days)	All but \$800 a day	\$800 a day	\$0
Once lifetime reserve days are used:	\$0	100% of Medicare eligible expenses	\$0***
• Additional 365 days	\$0	\$0	All costs
• 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> through 100 <sup>th</sup> day	All but \$200 a day	Up to \$200 a day	\$0
101 <sup>st</sup> day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment / coinsurance for outpatient drugs and inpatient respite care	Medicare copayment / coinsurance	\$0

\*\*\*NOTICE: When your Medicare Part A hospital benefits are exhausted, the carrier 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 plan'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.

**G**

**HIGH DEDUCTIBLE PLAN G (continued):  
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

\*Once you have been billed \$226 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.

\*\*This high deductible plan pays the same benefits as Plan G after one has paid a calendar year \$2,700 deductible. Benefits from the High Deductible Plan G will not begin until out of pocket expenses are \$2,700. Out-of-pocket expenses for this deductible are expenses for the Part B deductible, and expenses that would normally be paid by the contract. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,700 DEDUCTIBLE**, PLAN G PAYS	IN ADDITION TO \$2,700 DEDUCTIBLE**, 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 \$226 of Medicare approved amounts*	\$0	\$0	\$226 (Unless Part B deductible has been met)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (above Medicare approved amounts)	\$0	100%	\$0
<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next \$226 of Medicare approved amounts*	\$0	\$0	\$226 (Unless Part B deductible has been met)
Remainder of Medicare approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES</b>			
Tests for diagnostic services	100%	\$0	\$0

**G**

**HIGH DEDUCTIBLE PLAN G (continued):  
MEDICARE (PARTS A & B)**

\*Once you have been billed \$226 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.

\*\*This high deductible plan pays the same benefits as Plan G after one has paid a calendar year \$2,700 deductible. Benefits from the High Deductible Plan G will not begin until out of pocket expenses are \$2,700. Out-of-pocket expenses for this deductible are expenses for the Part B deductible, and expenses that would ordinarily be paid by the contract. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,700 DEDUCTIBLE**, PLAN G PAYS	IN ADDITION TO \$2,700 DEDUCTIBLE**, YOU PAY
<b>HOME HEALTH CARE - Medicare approved services</b>			
<b>Medically Necessary Skilled Care Services and Medical Supplies</b>	100%	\$0	\$0
<b>Durable Medical Equipment</b>			
First \$226 of Medicare approved amounts*	\$0	\$0	\$226 (Unless Part B deductible has been met)
Remainder of Medicare approved amounts	80%	20%	\$0

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,700 DEDUCTIBLE**, PLAN G PAYS	IN ADDITION TO \$2,700 DEDUCTIBLE**, 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

**N PLAN N:  
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 N PAYS	YOU PAY
<b>HOSPITALIZATION*</b>			
Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1600	\$1,600 (Part A Deductible)	\$0
61 <sup>st</sup> through 90 <sup>th</sup> day	All but \$400 a day	\$400 a day	\$0
91 <sup>st</sup> day and after: (while using 60 lifetime reserve days)	All but \$800 a day	\$800 a day	\$0
Once lifetime reserve days are used:	\$0	100% of Medicare eligible expenses	\$0**
• Additional 365 days	\$0	\$0	All costs
• 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> through 100 <sup>th</sup> day	All but \$200 a day	Up to \$200 a day	\$0
101 <sup>st</sup> day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment / coinsurance for outpatient drugs and inpatient respite care	Medicare copayment / coinsurance	\$0

\*\*NOTICE: When your Medicare Part A hospital benefits are exhausted, the carrier 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 plan'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.

**N PLAN N (continued):  
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

\*Once you have been billed \$226 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 N 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 \$226 of Medicare approved amounts*	\$0	\$0	\$226 (Part B Deductible)
Remainder of Medicare approved amounts	Generally 80%	Balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the member is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense	Up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the member is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense
<b>Part B Excess Charges</b> (above Medicare approved amounts)	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next \$226 of Medicare approved amounts*	\$0	\$0	\$226 (Part B Deductible)
Remainder of Medicare approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES</b>			
Tests for diagnostic services	100%	\$0	\$0



**N**

**PLAN N (continued):  
MEDICARE (PARTS A & B)**

\*Once you have been billed \$226 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 N PAYS	YOU PAY
<b>HOME HEALTH CARE - Medicare approved services</b>			
<b>Medically Necessary Skilled Care Services and Medical Supplies</b>	100%	\$0	\$0
<b>Durable Medical Equipment</b>			
First \$226 of Medicare approved amounts*	\$0	\$0	\$226 (Part B Deductible)
Remainder of Medicare approved amounts	80%	20%	\$0

**PLAN N (continued):  
OTHER BENEFITS - NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN N 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