NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued.

# Outline of Medicare Supplement Coverage

## By Reason of Age – Cover Page:
## Benefit Plans A, C, G, High Deductible G and N

PREMERA | BLUE CROSS

**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[1] | K[2] | L[2] | M | N[3] | C | F[1] |
| 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 | | | | | $7,220 | $3,610 | | | | |

[1]Plan F and G also have a high deductible option which require first paying a plan deductible of $2,870 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.

[2]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.

[3]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

## 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.

## NEW SPOUSAL DISCOUNT

You may be eligible for a discount on your premium if you qualify for our spousal discount. Eligibility requires both beneficiaries to be enrolled in a standard Washington Individual Premera Blue Cross Medicare Supplement plan (effective 2010 and later) and have the same address. You also must be married or a state-registered domestic partner. You can request the discount by visiting **ms.premera.com,** then select **Coverage and Benefits**. Download and complete the form and then send it back to us to apply for the discount. Mail the completed form to PO Box 327, MS 295, Seattle, Washington 98111, or fax it to 425-918-5278.

## 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.

### Monthly Subscription Charges Per Person

| | Standard Rate (Effective 4/1/25-3/31/26) | | With Spousal Discount (Effective 4/1/25-3/31/26) | |
|---|---|---|---|---|
| **Plan** | **AFT** | **Paper Bill** | **AFT** | **Paper Bill** |
| Plan A | $200 | $205 | $180 | $185 |
| Plan C | $273 | $278 | $245 | $250 |
| Plan G | $238 | $243 | $214 | $219 |
| Plan G High Deductible | $59 | $64 | $53 | $58 |
| Plan N | $187 | $192 | $168 | $173 |

# 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 |
|---|---|---|---|
| **HOSPITALIZATION*** Semi-private room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $1,676 | $0 | $1,676 (Part A Deductible) |
| 61st through 90th day | All but $419 a day | $419 a day | $0 |
| 91st day and after: (while using 60 lifetime reserve days) | All but $838 a day | $838 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 |
| **SKILLED NURSING FACILITY CARE*** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st through 100th day | All but $209.50 a day | $0 | Up to $209.50 a day |
| 101st day and after | $0 | $0 | All costs |
| **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 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 $257 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 |
|---|---|---|---|
| **MEDICAL EXPENSES** In or out of the Hospital and Outpatient Hospital Treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. | | | |
| First $257 of Medicare approved amounts* | $0 | $0 | $257 (Part B Deductible) |
| Remainder of Medicare approved amounts | Generally 80% | Generally 20% | $0 |
| **Part B Excess Charges** (above Medicare approved amounts) | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $257 of Medicare approved amounts* | $0 | $0 | $257 (Part B Deductible) |
| Remainder of Medicare approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES** | | | |
| Tests for diagnostic services | 100% | $0 | $0 |

## MEDICARE (PARTS A & B)

| SERVICES | MEDICARE PAYS | PLAN A PAYS | YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE** - Medicare approved services | | | |
| **Medically Necessary Skilled Care Services and Medical Supplies** | 100% | $0 | $0 |
| **Durable Medical Equipment** | | | |
| First $257 of Medicare approved amounts* | $0 | $0 | $257 (Part B Deductible) |
| Remainder of Medicare approved amounts | 80% | 20% | $0 |

## C 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 |
|---|---|---|---|
| **HOSPITALIZATION*** Semi-private room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $1,676 | $1,676 (Part A Deductible) | $0 |
| 61st through 90th day | All but $419 a day | $419 a day | $0 |
| 91st day and after: (while using 60 lifetime reserve days) | All but $838 a day | $838 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 |
| **SKILLED NURSING FACILITY CARE*** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st through 100th day | All but $209.50 a day | Up to $209.50 a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **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 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 $257 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 |
|---|---|---|---|
| **MEDICAL EXPENSES** In or out of the Hospital and Outpatient Hospital Treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. | | | |
| First $257 of Medicare approved amounts* | $0 | $257 | $0 |
| Remainder of Medicare approved amounts | Generally 80% | Generally 20% | $0 |
| **Part B Excess Charges** (above Medicare approved amounts) | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $257 of Medicare approved amounts* | $0 | $257 (Part B Deductible) | $0 |
| Remainder of Medicare approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES** | | | |
| Tests for diagnostic services | 100% | $0 | $0 |

### MEDICARE (PARTS A & B)

| SERVICES | MEDICARE PAYS | PLAN C PAYS | YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE** - Medicare approved services | | | |
| **Medically Necessary Skilled Care Services and Medical Supplies** | 100% | $0 | $0 |
| **Durable Medical Equipment** | | | |
| First $257 of Medicare approved amounts* | $0 | $257 (Part B Deductible) | $0 |
| Remainder of Medicare approved amounts | 80% | 20% | $0 |

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

| SERVICES | MEDICARE PAYS | PLAN C PAYS | YOU PAY |
|---|---|---|---|
| **FOREIGN TRAVEL** - Not covered by Medicare<br>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 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 |
|---|---|---|---|
| **HOSPITALIZATION*** Semi-private room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $1,676 | $1,676 (Part A Deductible) | $0 |
| 61st through 90th day | All but $419 a day | $419 a day | $0 |
| 91st day and after: (while using 60 lifetime reserve days) | All but $838 a day | $838 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 |
| **SKILLED NURSING FACILITY CARE*** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st through 100th day | All but $209.50 a day | Up to $209.50 a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **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 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 $257 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 |
|---|---|---|---|
| **MEDICAL EXPENSES** In or out of the Hospital and Outpatient Hospital Treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. | | | |
| First $257 of Medicare approved amounts* | $0 | $0 | $257 (Part B Deductible) |
| Remainder of Medicare approved amounts | Generally 80% | Generally 20% | $0 |
| **Part B Excess Charges** (above Medicare approved amounts) | $0 | 100% | $0 |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $257 of Medicare approved amounts* | $0 | $0 | $257 (Part B Deductible) |
| Remainder of Medicare approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES** | | | |
| Tests for diagnostic services | 100% | $0 | $0 |

### MEDICARE (PARTS A & B)

| SERVICES | MEDICARE PAYS | PLAN G PAYS | YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE** - Medicare approved services | | | |
| **Medically Necessary Skilled Care Services and Medical Supplies** | 100% | $0 | $0 |
| **Durable Medical Equipment** | | | |
| First $257 of Medicare approved amounts* | $0 | $0 | $257 (Part B Deductible) |
| Remainder of Medicare approved amounts | 80% | 20% | $0 |

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

| SERVICES | MEDICARE PAYS | PLAN G PAYS | YOU PAY |
|---|---|---|---|
| **FOREIGN TRAVEL** - Not covered by Medicare<br>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 $2,870 deductible. Benefits from the High Deductible Plan G will not begin until out-of-pocket expenses are $2,870. 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 $2,870 DEDUCTIBLE**, PLAN G PAYS | IN ADDITION TO $2,870 DEDUCTIBLE**, YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** Semi-private room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $1,676 | $1,676 (Part A Deductible) | $0 |
| 61st through 90th day | All but $419 a day | $419 a day | $0 |
| 91st day and after: (while using 60 lifetime reserve days) | All but $838 a day | $838 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 |
| **SKILLED NURSING FACILITY CARE*** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st through 100th day | All but $209.50 a day | Up to $209.50 a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **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 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 $257 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 $2,870 deductible. Benefits from the High Deductible Plan G will not begin until out-of-pocket expenses are $2,870. 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 $2,870 DEDUCTIBLE**, PLAN G PAYS | IN ADDITION TO $2,870 DEDUCTIBLE**, YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES** In or out of the Hospital and Outpatient Hospital Treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. | | | |
| First $257 of Medicare approved amounts* | $0 | $0 | $257 (Unless Part B deductible has been met) |
| Remainder of Medicare approved amounts | Generally 80% | Generally 20% | $0 |
| **Part B Excess Charges** (above Medicare approved amounts) | $0 | 100% | $0 |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $257 of Medicare approved amounts* | $0 | $0 | $257 (Unless Part B deductible has been met) |
| Remainder of Medicare approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES** | | | |
| Tests for diagnostic services | 100% | $0 | $0 |

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

*Once you have been billed $257 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 $2,870 deductible. Benefits from the High Deductible Plan G will not begin until out-of-pocket expenses are $2,870. 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 $2,870 DEDUCTIBLE**, PLAN G PAYS | IN ADDITION TO $2,870 DEDUCTIBLE**, YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE** - Medicare approved services | | | |
| **Medically Necessary Skilled Care Services and Medical Supplies** | 100% | $0 | $0 |
| **Durable Medical Equipment** | | | |
| First $257 of Medicare approved amounts* | $0 | $0 | $257 (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 $2,870 DEDUCTIBLE**, PLAN G PAYS | IN ADDITION TO $2,870 DEDUCTIBLE**, YOU PAY |
|---|---|---|---|
| **FOREIGN TRAVEL** - Not covered by Medicare<br>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 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 |
|---|---|---|---|
| **HOSPITALIZATION*** Semi-private room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $1,676 | $1,676 (Part A Deductible) | $0 |
| 61st through 90th day | All but $419 a day | $419 a day | $0 |
| 91st day and after: (while using 60 lifetime reserve days) | All but $838 a day | $838 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 |
| **SKILLED NURSING FACILITY CARE*** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st through 100th day | All but $209.50 a day | Up to $209.50 a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **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 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 $257 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 |
|---|---|---|---|
| **MEDICAL EXPENSES**<br>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 $257 of Medicare approved amounts* | $0 | $0 | $257 (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 |
| **Part B Excess Charges** (above Medicare approved amounts) | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $257 of Medicare approved amounts* | $0 | $0 | $257 (Part B Deductible) |
| Remainder of Medicare approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES** | | | |
| Tests for diagnostic services | 100% | $0 | $0 |

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

*Once you have been billed $257 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 |
|---|---|---|---|
| **HOME HEALTH CARE** - Medicare approved services | | | |
| **Medically Necessary Skilled Care Services and Medical Supplies** | 100% | $0 | $0 |
| **Durable Medical Equipment** | | | |
| First $257 of Medicare approved amounts* | $0 | $0 | $257 (Part B Deductible) |
| Remainder of Medicare approved amounts | 80% | 20% | $0 |

### OTHER BENEFITS - NOT COVERED BY MEDICARE

| SERVICES | MEDICARE PAYS | PLAN N PAYS | YOU PAY |
|---|---|---|---|
| **FOREIGN TRAVEL** - Not covered by Medicare<br>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 |

## Notice of availability and nondiscrimination **800-722-1471 | TTY: 711**

Call for free language assistance services and appropriate auxiliary aids and services.
Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.
呼吁提供免费的语言援助服务和适当的辅助设备及服务。
呼籲提供免費的語言援助服務和適當的輔助設備及服務。
Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.
무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.
Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.
Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.
Звертайтесь за безкоштовною мовною підтримкою та відповідними додатковими послугами.
សូមហៅទូរសព្ទទៅសេវាជំនួយភាសាដោយឥតគិតថ្លៃ ព្រមទាំងសេវាកម្ម និងជំនួយចាំបាច់ដែលសមរម្យផ្សេងៗ។
無料言語支援サービスと適切な補助器具及びサービスをお求めください。
ለነፃ የቋንቋ እርዳታ አገልግሎቶች እና ተገቢ ድጋፍ ሰጪ አጋዥ መሳሪያዎችን እና አገልግሎቶችን ለማግኘት በስልክ ቁጥር
Tajaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaajiloota barbaachisaa ta'an argachuuf bilbilaa.
મુફત ભાષા સહાયિતા સેવાવાં અને ઉચિત સહાયિક ચીજાં અને સેવાવાં વાસતે કાલ કરો।
Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.
ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.
Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.
Appelez pour obtenir des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés.
Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.
Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.
Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.
اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.
برای خدمات کمک زبانی رایگان و کمک‌ها و خدمات امدادی مقتضی، تماس بگیرید.

**Discrimination is against the law.** Premera Blue Cross (Premera) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes. Premera does not exclude people or treat them less favorably because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. Premera provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language assistance services to people whose primary language is not English, which may include qualified interpreters and information written in other languages. If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, TTY: 711, Fax: 425-918-5592, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

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