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, F, G, and N

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA
An Independent Licensee of the Blue Cross Blue Shield Association

See Outlines of Coverage sections for details about all plans. This chart shows the benefits included in each of the standard Medicare supplement plans. 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 Blue Shield of Alaska (Premera) are highlighted below.

Benefits	Plans Available to All Applicants								Medicare eligible before 2020	
	A	B	D	G*	K**	L**	M	N***	C	F*
Medicare Part A coinsurance and Hospital coverage (up to an additional 365 days after Medicare benefits are used up)	X	X	X	X	X	X	X	X	X	X
Medicare Part B coinsurance or copayment	X	X	X	X	50%	75%	X	X copays apply	X	X
Blood (first three pints)	X	X	X	X	50%	75%	X	X	X	X
Part A hospice care coinsurance or copayment	X	X	X	X	50%	75%	X	X	X	X
Skilled nursing facility coinsurance			X	X	50%	75%	X	X	X	X
Medicare Part A deductible		X	X	X	50%	75%	50%	X	X	X
Medicare Part B deductible									X	X
Medicare Part B excess charges				X						X
Foreign travel emergency (up to plan limits)			X	X			X	X	X	X
Out-of-pocket limit					$7,220	$3,610				

*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.

**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.

***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.

We base your subscription charge rate on your age as of April 1. For instance, if you are already 66 on April 1, 2025, we will charge you the rate for a subscriber who is age 66. If, on April 1, 2025, you have not turned 66 yet, we will charge you the rate for a subscriber who is age 65.

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

Plan A, F, G and N - Effective 4/1/2024-3/31/2025

	Plan A		Plan F		Plan G		Plan N	
Age on 4/1/24	AFT	Paper	AFT	Paper	AFT	Paper	AFT	Paper
65	$162	$167	$232	$237	$155	$160	$171	$176
66	$162	$167	$232	$237	$163	$168	$171	$176
67	$162	$167	$232	$237	$174	$179	$171	$176
68	$162	$167	$232	$237	$186	$191	$171	$176
69	$162	$167	$232	$237	$210	$215	$171	$176
70-74	$197	$202	$284	$289	$222	$227	$206	$211
75+	$245	$250	$353	$358	$296	$301	$259	$264

Plan A, F, G and N - Effective 4/1/2025-3/31/2026

	Plan A		Plan F		Plan G		Plan N	
Age on 4/1/25	AFT	Paper	AFT	Paper	AFT	Paper	AFT	Paper
65	$180	$185	$257	$262	$172	$177	$189	$194
66	$180	$185	$257	$262	$180	$185	$189	$194
67	$180	$185	$257	$262	$193	$198	$189	$194
68	$180	$185	$257	$262	$206	$211	$189	$194
69	$180	$185	$257	$262	$232	$237	$189	$194
70-74	$218	$223	$314	$319	$246	$251	$228	$233
75+	$271	$276	$391	$396	$327	$332	$286	$291

Plan G High Deductible (HD), Plan F High Deductible (HD) – Effective 4/1/2024-3/31/2025

	*Plan G HD		*Plan F HD	
Age on 4/1/24	AFT	Paper	AFT	Paper
65	$53	$58	$80	$85
66	$57	$62	$80	$85
67	$59	$64	$80	$85
68	$62	$67	$80	$85
69	$66	$71	$80	$85
70-74	$76	$81	$99	$104
75+	$97	$102	$125	$130

*As of 4/1/2024 closed to new sales

Plan G High Deductible (HD), Plan F High Deductible (HD) – Effective 4/1/2025-3/31/2026

	*Plan G HD		*Plan F HD	
Age on 4/1/25	AFT	Paper	AFT	Paper
65	$59	$64	$89	$94
66	$63	$68	$89	$94
67	$65	$70	$89	$94
68	$69	$74	$89	$94
69	$73	$78	$89	$94
70-74	$84	$89	$110	$115
75+	$107	$112	$138	$143

*As of 4/1/2024 closed to new sales

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 of 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, WA 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 of 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 of 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

PLAN F:
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 F 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.

F PLAN F (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 F 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 (Part B Deductible)	$0
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	$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 F 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

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

SERVICES	MEDICARE PAYS	PLAN F 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

F HIGH DEDUCTIBLE PLAN F: 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 F after one has paid a calendar year $2,870 deductible. Benefits from the High Deductible Plan F will not begin until out of pocket expenses are $2,870. Out-of-pocket expenses for this deductible are expenses ordinarily paid by the plan. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,870 DEDUCTIBLE**, PLAN F 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.

F HIGH DEDUCTIBLE PLAN F (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 F after one has paid a calendar year $2,870 deductible. Benefits from the High Deductible Plan F will not begin until out of pocket expenses are $2,870. Out-of-pocket expenses for this deductible are expenses ordinarily paid by the plan. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,870 DEDUCTIBLE**, PLAN F 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	$257 (Part B Deductible)	$0
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	$257 (Part B Deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Tests for diagnostic services	100%	$0	$0

F HIGH DEDUCTIBLE PLAN F (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 F after one has paid a calendar year $2,870 deductible. Benefits from the High Deductible Plan F will not begin until out of pocket expenses are $2,870. Out-of-pocket expenses for this deductible are expenses ordinarily paid by the plan. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,870 DEDUCTIBLE**, PLAN F 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	$257 (Part B Deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,870 DEDUCTIBLE**, PLAN F PAYS	IN ADDITION TO $2,870 DEDUCTIBLE**, 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

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 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 include expenses for the Medicare Part B deductible, and expenses ordinarily paid by the plan. 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 include expenses for the Medicare Part B deductible, and expenses ordinarily paid by the plan. 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 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.

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 DEDUCTIBL,E** 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

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.

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 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 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 **800-508-4722 | TTY: 711**

Call for free language assistance services and appropriate auxiliary aids and services.
Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.
Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.
무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.
Hu thov kev pab txhais lus pub dawb thiab lwm yam khoom pab dawb thiab kev pab cuam ua tsim nyog.
Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.
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。
Vala‘au mo auaunaga tau fesoasoani mo gagana e leai ni totogi ma fesoasoani fa‘aopo‘opo talafeagai ma auaunaga.
ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.
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。
Tumawag para kadagiti libre a serbisio iti tulong iti pagsasao ken dagiti nakanada nga aid ken serbisio iti komunikasion.
Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.
Звертайтесь за безкоштовною мовною підтримкою та відповідними додатковими послугами.
ติดต่อขอบริการช่วยเหลือด้านภาษาฟรีพร้อมความช่วยเหลือและบริการอื่น ๆ เพิ่มเติม
Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.
Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.
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.
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.

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