Florida Blue | MEDICARE

**FLORIDA BLUE****
**OUTLINE OF MEDICARE SUPPLEMENT COVERAGE – Cover Page**
**BlueMedicare Supplement Plans A, B, C, D, F, G, K, L, M, N**
**Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2024**

**Notice to buyer**: This policy may not cover all of the costs associated with medical care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.

| Benefits | Plans Available to All Applicants | | | | | | | | Medicare first eligible before 2020 only+ | |
|---|---|---|---|---|---|---|---|---|---|---|
| | A | B | D | G[1] | K | L | M | N | 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[3] | ✔ | ✔ |
| Blood (first 3 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 in 2024 [2] | | | | | $7,060 [2] | $3,530 [2] | | | | |

**Note**: A ✓ means 100% of the benefit is paid. **+Only applicants first eligible for Medicare before January 1, 2020 may purchase Plans C, F, and high deductible F**. This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available. Every company must make Plan A available.

**Florida Blue is a trade name for Blue Cross and Blue Shield of Florida, Inc., an Independent Licensee of the Blue Cross and Blue Shield Association.

1 - Plans F and G also have a high deductible option which require first paying a plan deductible of $2,800 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 Plans F and G do not cover the separate Foreign travel emergency deductible. High deductible Plan G does not cover the Medicare Part B deductible. However, high deductible Plans 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 co-payment 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.

## Basic Benefits

**Hospitalization -** Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

**Medical Expenses -** Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or co-payments.

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

**Hospice -** Part A coinsurance.

## Premium Information

We, Florida Blue, can only raise your premium if we raise the premium for all policies like yours in the state of Florida.

## Read Your Policy Very Carefully

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

## Right to Return Policy

If you find that you are not satisfied with your policy, you may return it to Florida Blue, Post Office Box 1798, Jacksonville FL 32231-1798. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

## Notice

- Neither Florida Blue, nor its agents are connected with Medicare.
- This Outline of Coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details. Use this outline to compare benefits and premiums among policies.

## Policy Replacement

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

## Complete Answers Are Very Important

When you fill out the application for the new policy, and it is NOT an "Open Enrollment or Guaranteed Issue status application," be sure to answer truthfully and completely all questions about your medical and health history. The policy is issued on the basis that the answers to all questions and all information shown in the application are correct and complete. The company may cancel your policy and refuse to pay any claims if you make misstatements, leave out or falsify important information. Review the application carefully before you sign it. Be certain that all information has been properly recorded. To review "Open Enrollment" timeframes please go to the following link on the Medicare.gov website:

https://www.medicare.gov/supplement-other-insurance/when-can-i-buy-medigap/when-can-i-buy-medigap.html

This Chart displays premiums for the following counties, classified as Area 1: Broward, Miami-Dade, and Palm Beach.

**MONTHLY PREMIUM - NON TOBACCO USER**

| Age At Enrollment | Plan A | Plan B | Plan C | Plan D | Plan F | Plan G | Plan K | Plan L | Plan M | Plan N |
|---|---|---|---|---|---|---|---|---|---|---|
| Under 65 | $853.10 | $1013.20 | $1167.40 | $1083.10 | $1186.10 | $1043.00 | $366.10 | $681.30 | $1003.90 | $859.70 |
| 65 | $252.60 | $300.10 | $345.60 | $320.70 | $351.10 | $308.90 | $108.50 | $201.70 | $297.30 | $254.60 |
| 66 | $257.80 | $306.90 | $352.50 | $329.30 | $357.80 | $316.90 | $111.30 | $206.90 | $304.90 | $261.50 |
| 67 | $263.00 | $314.30 | $361.30 | $338.30 | $366.70 | $325.30 | $114.40 | $212.50 | $312.80 | $268.90 |
| 68 | $268.50 | $321.80 | $370.70 | $347.80 | $376.20 | $334.40 | $117.60 | $218.50 | $321.30 | $276.50 |
| 69 | $273.50 | $328.60 | $379.80 | $356.80 | $385.00 | $342.90 | $120.70 | $224.30 | $329.40 | $284.00 |
| 70-71 | $280.20 | $338.80 | $393.00 | $369.90 | $398.10 | $355.30 | $125.10 | $232.50 | $340.80 | $294.80 |
| 72-74 | $289.90 | $353.10 | $415.00 | $392.00 | $421.40 | $376.40 | $132.70 | $246.60 | $360.40 | $313.30 |
| 75-79 | $298.60 | $370.80 | $446.20 | $424.50 | $452.60 | $407.30 | $144.00 | $267.20 | $388.50 | $341.00 |
| 80+ | $293.50 | $383.30 | $501.00 | $476.20 | $507.40 | $456.40 | $161.80 | $300.00 | $430.70 | $387.20 |

NOTE: BlueMedicare Supplement Plan K, L, M and N policies include additional out-of-pocket expenses that must be satisfied before some policy benefits are paid. Under Plans K and L, you must satisfy the Annual Out-of-Pocket limit to receive full Medicare supplemental benefits.

You have the right to purchase any policy offered by Florida Blue, with or without the additional Annual Out-of-Pocket Limit.

This Chart displays premiums for the following counties, classified as Area 1: Broward, Miami-Dade, and Palm Beach.

**MONTHLY PREMIUM - TOBACCO USER**

| Age At Enrollment | Plan A | Plan B | Plan C | Plan D | Plan F | Plan G | Plan K | Plan L | Plan M | Plan N |
|---|---|---|---|---|---|---|---|---|---|---|
| Under 65 | $937.80 | $1114.70 | $1284.30 | $1191.60 | $1304.30 | $1147.10 | $403.00 | $749.30 | $1104.00 | $945.60 |
| 65 | $277.70 | $330.10 | $380.30 | $352.90 | $386.20 | $339.60 | $119.30 | $221.90 | $327.00 | $280.00 |
| 66 | $283.50 | $337.60 | $387.70 | $362.20 | $393.60 | $348.60 | $122.40 | $227.60 | $335.30 | $287.70 |
| 67 | $289.40 | $345.80 | $397.60 | $372.30 | $403.50 | $358.00 | $125.80 | $233.90 | $344.20 | $295.70 |
| 68 | $295.40 | $353.90 | $407.80 | $382.60 | $413.80 | $367.80 | $129.40 | $240.50 | $353.40 | $304.20 |
| 69 | $300.80 | $361.40 | $417.70 | $392.50 | $423.60 | $377.20 | $132.70 | $246.70 | $362.40 | $312.40 |
| 70-71 | $308.10 | $372.80 | $432.30 | $406.80 | $438.00 | $390.90 | $137.60 | $255.60 | $375.00 | $324.20 |
| 72-74 | $318.90 | $388.50 | $456.50 | $431.30 | $463.60 | $414.00 | $146.10 | $271.30 | $396.40 | $344.50 |
| 75-79 | $328.50 | $407.90 | $490.90 | $467.00 | $497.90 | $447.90 | $158.50 | $294.00 | $427.30 | $375.00 |
| 80+ | $323.00 | $421.60 | $550.90 | $523.90 | $558.00 | $502.10 | $177.90 | $329.90 | $473.70 | $425.90 |

NOTE: BlueMedicare Supplement Plan K, L, M and N policies include additional out-of-pocket expenses that must be satisfied before some policy benefits are paid. Under Plans K and L, you must satisfy the Annual Out-of-Pocket limit to receive full Medicare supplemental benefits.

You have the right to purchase any policy offered by Florida Blue, with or without the additional Annual Out-of-Pocket Limit.

This Chart displays premiums for the following counties, classified as Area 1: Broward, Miami-Dade, and Palm Beach.

**AUTOMATIC PAYMENT OPTION MONTHLY PREMIUM - NON TOBACCO USER**

| Age At Enrollment | Plan A | Plan B | Plan C | Plan D | Plan F | Plan G | Plan K | Plan L | Plan M | Plan N |
|---|---|---|---|---|---|---|---|---|---|---|
| Under 65 | $840.30 | $998.00 | $1149.90 | $1066.80 | $1168.30 | $1027.40 | $360.60 | $671.10 | $988.80 | $846.80 |
| 65 | $248.80 | $295.60 | $340.50 | $315.90 | $345.90 | $304.30 | $106.80 | $198.70 | $292.80 | $250.80 |
| 66 | $253.90 | $302.30 | $347.20 | $324.40 | $352.50 | $312.20 | $109.60 | $203.80 | $300.40 | $257.60 |
| 67 | $259.10 | $309.60 | $355.90 | $333.20 | $361.20 | $320.50 | $112.70 | $209.30 | $308.10 | $264.90 |
| 68 | $264.50 | $317.00 | $365.10 | $342.60 | $370.50 | $329.40 | $115.80 | $215.20 | $316.40 | $272.40 |
| 69 | $269.40 | $323.70 | $374.10 | $351.40 | $379.20 | $337.80 | $118.90 | $220.90 | $324.50 | $279.70 |
| 70-71 | $276.00 | $333.70 | $387.20 | $364.30 | $392.20 | $350.00 | $123.20 | $229.00 | $335.70 | $290.30 |
| 72-74 | $285.60 | $347.80 | $408.80 | $386.10 | $415.10 | $370.70 | $130.70 | $242.90 | $355.00 | $308.60 |
| 75-79 | $294.20 | $365.30 | $439.50 | $418.10 | $445.90 | $401.20 | $141.80 | $263.20 | $382.70 | $335.90 |
| 80+ | $289.10 | $377.50 | $493.50 | $469.10 | $499.80 | $449.60 | $159.40 | $295.50 | $424.20 | $381.40 |

NOTE: BlueMedicare Supplement Plan K, L, M and N policies include additional out-of-pocket expenses that must be satisfied before some policy benefits are paid. Under Plans K and L, you must satisfy the Annual Out-of-Pocket limit to receive full Medicare supplemental benefits.

You have the right to purchase any policy offered by Florida Blue, with or without the additional Annual Out-of-Pocket Limit.

This Chart displays premiums for the following counties, classified as Area 1: Broward, Miami-Dade, and Palm Beach.

**AUTOMATIC PAYMENT OPTION MONTHLY PREMIUM - TOBACCO USER**

| Age At Enrollment | Plan A | Plan B | Plan C | Plan D | Plan F | Plan G | Plan K | Plan L | Plan M | Plan N |
|---|---|---|---|---|---|---|---|---|---|---|
| Under 65 | $923.70 | $1098.00 | $1265.10 | $1173.70 | $1284.80 | $1129.90 | $396.90 | $738.10 | $1087.50 | $931.40 |
| 65 | $273.60 | $325.20 | $374.60 | $347.60 | $380.40 | $334.50 | $117.50 | $218.60 | $322.10 | $275.80 |
| 66 | $279.30 | $332.50 | $381.90 | $356.80 | $387.70 | $343.30 | $120.60 | $224.20 | $330.30 | $283.40 |
| 67 | $285.10 | $340.60 | $391.60 | $366.70 | $397.40 | $352.60 | $123.90 | $230.40 | $339.00 | $291.30 |
| 68 | $291.00 | $348.60 | $401.70 | $376.90 | $407.60 | $362.30 | $127.40 | $236.90 | $348.10 | $299.70 |
| 69 | $296.30 | $356.00 | $411.40 | $386.60 | $417.20 | $371.60 | $130.70 | $243.00 | $356.90 | $307.70 |
| 70-71 | $303.50 | $367.20 | $425.80 | $400.70 | $431.50 | $385.00 | $135.60 | $251.80 | $369.30 | $319.40 |
| 72-74 | $314.10 | $382.70 | $449.70 | $424.90 | $456.70 | $407.80 | $143.90 | $267.20 | $390.40 | $339.30 |
| 75-79 | $323.60 | $401.80 | $483.60 | $460.00 | $490.40 | $441.20 | $156.10 | $289.60 | $420.90 | $369.40 |
| 80+ | $318.20 | $415.20 | $542.70 | $516.00 | $549.70 | $494.60 | $175.30 | $325.00 | $466.60 | $419.50 |

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You have the right to purchase any policy offered by Florida Blue, with or without the additional Annual Out-of-Pocket Limit.

This Chart displays premiums for the following counties, classified as Area 2: Bay, Brevard, Charlotte, Clay, Collier, DeSoto, Duval, Escambia, Glades, Gulf, Hardee, Hendry, Hernando, Highlands, Hillsborough, Holmes, Indian River, Lee, Manatee, Martin, Monroe, Nassau, Okaloosa, Okeechobee, Orange, Osceola, Pasco, Pinellas, St. Johns, St. Lucie, Santa Rosa, Sarasota, Seminole, Walton, and Washington.

**MONTHLY PREMIUM - NON TOBACCO USER**

| Age At Enrollment | Plan A | Plan B | Plan C | Plan D | Plan F | Plan G | Plan K | Plan L | Plan M | Plan N |
|---|---|---|---|---|---|---|---|---|---|---|
| Under 65 | $600.70 | $713.30 | $821.80 | $763.20 | $835.00 | $734.40 | $257.90 | $479.70 | $707.40 | $605.50 |
| 65 | $178.00 | $211.30 | $243.30 | $226.10 | $247.20 | $217.60 | $76.40 | $142.00 | $209.40 | $179.30 |
| 66 | $181.50 | $216.10 | $248.10 | $231.80 | $252.00 | $223.20 | $78.40 | $145.80 | $214.70 | $184.20 |
| 67 | $185.20 | $221.40 | $254.60 | $238.10 | $258.30 | $229.10 | $80.50 | $149.80 | $220.30 | $189.30 |
| 68 | $189.10 | $226.60 | $260.90 | $244.80 | $264.80 | $235.40 | $82.90 | $153.90 | $226.30 | $194.70 |
| 69 | $192.40 | $231.50 | $267.30 | $251.40 | $271.00 | $241.60 | $85.00 | $157.90 | $231.90 | $200.10 |
| 70-71 | $197.30 | $238.60 | $276.80 | $260.30 | $280.30 | $250.10 | $88.10 | $163.80 | $240.00 | $207.50 |
| 72-74 | $204.20 | $248.80 | $292.20 | $276.00 | $296.90 | $265.00 | $93.40 | $173.50 | $253.90 | $220.60 |
| 75-79 | $210.40 | $261.10 | $314.20 | $299.00 | $318.70 | $286.80 | $101.30 | $188.30 | $273.60 | $240.10 |
| 80+ | $206.80 | $269.80 | $352.70 | $335.20 | $357.40 | $321.40 | $113.90 | $211.30 | $303.20 | $272.60 |

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You have the right to purchase any policy offered by Florida Blue, with or without the additional Annual Out-of-Pocket Limit.

This Chart displays premiums for the following counties, classified as Area 2: Bay, Brevard, Charlotte, Clay, Collier, DeSoto, Duval, Escambia, Glades, Gulf, Hardee, Hendry, Hernando, Highlands, Hillsborough, Holmes, Indian River, Lee, Manatee, Martin, Monroe, Nassau, Okaloosa, Okeechobee, Orange, Osceola, Pasco, Pinellas, St. Johns, St. Lucie, Santa Rosa, Sarasota, Seminole, Walton, and Washington.

**MONTHLY PREMIUM - TOBACCO USER**

| Age At Enrollment | Plan A | Plan B | Plan C | Plan D | Plan F | Plan G | Plan K | Plan L | Plan M | Plan N |
|---|---|---|---|---|---|---|---|---|---|---|
| Under 65 | $660.70 | $785.10 | $903.90 | $839.60 | $918.20 | $807.50 | $283.80 | $527.60 | $778.10 | $666.10 |
| 65 | $195.80 | $232.50 | $267.70 | $248.70 | $272.00 | $239.30 | $84.00 | $156.20 | $230.30 | $197.20 |
| 66 | $199.50 | $237.70 | $273.10 | $255.00 | $277.20 | $245.40 | $86.20 | $160.30 | $236.20 | $202.60 |
| 67 | $203.80 | $243.60 | $280.00 | $262.10 | $284.20 | $252.00 | $88.60 | $164.80 | $242.40 | $208.40 |
| 68 | $208.00 | $249.20 | $287.10 | $269.30 | $291.40 | $259.00 | $91.10 | $169.30 | $249.00 | $214.30 |
| 69 | $211.70 | $254.60 | $294.10 | $276.50 | $298.20 | $265.70 | $93.40 | $173.60 | $255.10 | $220.10 |
| 70-71 | $217.10 | $262.50 | $304.50 | $286.60 | $308.30 | $275.20 | $96.90 | $180.20 | $264.10 | $228.30 |
| 72-74 | $224.60 | $273.60 | $321.40 | $303.60 | $326.50 | $291.50 | $102.80 | $191.00 | $279.20 | $242.60 |
| 75-79 | $231.40 | $287.30 | $345.60 | $328.80 | $350.70 | $315.50 | $111.50 | $207.00 | $301.00 | $264.10 |
| 80+ | $227.40 | $296.90 | $388.00 | $368.80 | $393.00 | $353.50 | $125.30 | $232.40 | $333.50 | $299.90 |

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You have the right to purchase any policy offered by Florida Blue, with or without the additional Annual Out-of-Pocket Limit.

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**AUTOMATIC PAYMENT OPTION MONTHLY PREMIUM - NON TOBACCO USER**

| Age At Enrollment | Plan A | Plan B | Plan C | Plan D | Plan F | Plan G | Plan K | Plan L | Plan M | Plan N |
|---|---|---|---|---|---|---|---|---|---|---|
| Under 65 | $591.70 | $702.60 | $809.50 | $751.70 | $822.40 | $723.40 | $254.00 | $472.50 | $696.80 | $596.40 |
| 65 | $175.30 | $208.20 | $239.70 | $222.70 | $243.50 | $214.30 | $75.30 | $139.80 | $206.30 | $176.60 |
| 66 | $178.70 | $212.90 | $244.40 | $228.30 | $248.30 | $219.80 | $77.20 | $143.60 | $211.40 | $181.40 |
| 67 | $182.40 | $218.00 | $250.80 | $234.50 | $254.50 | $225.60 | $79.30 | $147.60 | $217.00 | $186.50 |
| 68 | $186.30 | $223.20 | $257.00 | $241.10 | $260.80 | $231.90 | $81.60 | $151.60 | $222.90 | $191.80 |
| 69 | $189.60 | $228.10 | $263.30 | $247.60 | $267.00 | $237.90 | $83.70 | $155.50 | $228.50 | $197.10 |
| 70-71 | $194.30 | $235.10 | $272.70 | $256.40 | $276.10 | $246.30 | $86.70 | $161.30 | $236.40 | $204.40 |
| 72-74 | $201.20 | $245.10 | $287.80 | $271.90 | $292.40 | $261.00 | $92.00 | $170.90 | $250.10 | $217.30 |
| 75-79 | $207.20 | $257.20 | $309.50 | $294.60 | $313.90 | $282.50 | $99.80 | $185.40 | $269.50 | $236.50 |
| 80+ | $203.70 | $265.80 | $347.40 | $330.20 | $352.10 | $316.60 | $112.20 | $208.10 | $298.60 | $268.60 |

NOTE: BlueMedicare Supplement Plan K, L, M and N policies include additional out-of-pocket expenses that must be satisfied before some policy benefits are paid. Under Plans K and L, you must satisfy the Annual Out-of-Pocket limit to receive full Medicare supplemental benefits.

You have the right to purchase any policy offered by Florida Blue, with or without the additional Annual Out-of-Pocket Limit.

This Chart displays premiums for the following counties, classified as Area 2: Bay, Brevard, Charlotte, Clay, Collier, DeSoto, Duval, Escambia, Glades, Gulf, Hardee, Hendry, Hernando, Highlands, Hillsborough, Holmes, Indian River, Lee, Manatee, Martin, Monroe, Nassau, Okaloosa, Okeechobee, Orange, Osceola, Pasco, Pinellas, St. Johns, St. Lucie, Santa Rosa, Sarasota, Seminole, Walton, and Washington.

**AUTOMATIC PAYMENT OPTION MONTHLY PREMIUM - TOBACCO USER**

| Age At Enrollment | Plan A | Plan B | Plan C | Plan D | Plan F | Plan G | Plan K | Plan L | Plan M | Plan N |
|---|---|---|---|---|---|---|---|---|---|---|
| Under 65 | $650.80 | $773.30 | $890.30 | $827.00 | $904.40 | $795.40 | $279.50 | $519.60 | $766.40 | $656.10 |
| 65 | $192.90 | $229.00 | $263.70 | $245.00 | $267.90 | $235.70 | $82.80 | $153.80 | $226.90 | $194.20 |
| 66 | $196.50 | $234.10 | $269.00 | $251.20 | $273.10 | $241.70 | $84.90 | $157.90 | $232.70 | $199.50 |
| 67 | $200.80 | $239.90 | $275.80 | $258.10 | $279.90 | $248.20 | $87.20 | $162.30 | $238.80 | $205.30 |
| 68 | $204.90 | $245.50 | $282.80 | $265.30 | $287.00 | $255.10 | $89.70 | $166.70 | $245.20 | $211.00 |
| 69 | $208.50 | $250.80 | $289.70 | $272.40 | $293.80 | $261.70 | $92.00 | $171.00 | $251.30 | $216.80 |
| 70-71 | $213.80 | $258.50 | $300.00 | $282.30 | $303.70 | $271.10 | $95.50 | $177.50 | $260.10 | $224.90 |
| 72-74 | $221.20 | $269.50 | $316.60 | $299.00 | $321.60 | $287.20 | $101.20 | $188.10 | $275.00 | $238.90 |
| 75-79 | $227.90 | $282.90 | $340.50 | $323.80 | $345.50 | $310.80 | $109.90 | $203.90 | $296.50 | $260.10 |
| 80+ | $224.00 | $292.40 | $382.10 | $363.30 | $387.20 | $348.20 | $123.50 | $228.90 | $328.50 | $295.40 |

NOTE: BlueMedicare Supplement Plan K, L, M and N policies include additional out-of-pocket expenses that must be satisfied before some policy benefits are paid. Under Plans K and L, you must satisfy the Annual Out-of-Pocket limit to receive full Medicare supplemental benefits.

You have the right to purchase any policy offered by Florida Blue, with or without the additional Annual Out-of-Pocket Limit.

This Chart displays premiums for the following counties, classified as Area 3: Alachua, Baker, Bradford, Calhoun, Citrus, Columbia, Dixie, Flagler, Franklin, Gadsden, Gilchrist, Hamilton, Jackson, Jefferson, Lafayette, Lake, Leon, Levy, Liberty, Madison, Marion, Polk, Putnam, Sumter, Suwannee, Taylor, Union, Volusia, and Wakulla.

**MONTHLY PREMIUM - NON TOBACCO USER**

| Age At Enrollment | Plan A | Plan B | Plan C | Plan D | Plan F | Plan G | Plan K | Plan L | Plan M | Plan N |
|---|---|---|---|---|---|---|---|---|---|---|
| Under 65 | $566.30 | $672.90 | $775.40 | $719.40 | $787.40 | $692.20 | $243.00 | $452.40 | $666.80 | $570.90 |
| 65 | $167.70 | $199.30 | $229.50 | $212.90 | $233.20 | $204.90 | $72.00 | $133.90 | $197.40 | $169.10 |
| 66 | $171.10 | $203.80 | $234.10 | $218.60 | $237.40 | $210.40 | $73.80 | $137.40 | $202.30 | $173.70 |
| 67 | $174.60 | $208.80 | $239.80 | $224.60 | $243.60 | $216.00 | $75.90 | $141.20 | $207.80 | $178.60 |
| 68 | $178.40 | $213.60 | $246.10 | $231.00 | $249.80 | $222.00 | $78.10 | $145.20 | $213.30 | $183.60 |
| 69 | $181.60 | $218.30 | $252.20 | $236.80 | $255.60 | $227.70 | $80.10 | $149.00 | $218.70 | $188.60 |
| 70-71 | $186.00 | $225.00 | $260.90 | $245.50 | $264.20 | $235.80 | $83.10 | $154.30 | $226.50 | $195.80 |
| 72-74 | $192.40 | $234.50 | $275.50 | $260.30 | $279.90 | $249.80 | $88.10 | $163.70 | $239.30 | $207.90 |
| 75-79 | $198.30 | $246.30 | $296.10 | $282.00 | $300.50 | $270.50 | $95.70 | $177.30 | $257.90 | $226.50 |
| 80+ | $194.80 | $254.40 | $332.70 | $316.00 | $336.90 | $303.00 | $107.40 | $199.20 | $285.80 | $257.10 |

NOTE: BlueMedicare Supplement Plan K, L, M and N policies include additional out-of-pocket expenses that must be satisfied before some policy benefits are paid. Under Plans K and L, you must satisfy the Annual Out-of-Pocket limit to receive full Medicare supplemental benefits.

You have the right to purchase any policy offered by Florida Blue, with or without the additional Annual Out-of-Pocket Limit.

This Chart displays premiums for the following counties, classified as Area 3: Alachua, Baker, Bradford, Calhoun, Citrus, Columbia, Dixie, Flagler, Franklin, Gadsden, Gilchrist, Hamilton, Jackson, Jefferson, Lafayette, Lake, Leon, Levy, Liberty, Madison, Marion, Polk, Putnam, Sumter, Suwannee, Taylor, Union, Volusia, and Wakulla.

**MONTHLY PREMIUM - TOBACCO USER**

| Age At Enrollment | Plan A | Plan B | Plan C | Plan D | Plan F | Plan G | Plan K | Plan L | Plan M | Plan N |
|---|---|---|---|---|---|---|---|---|---|---|
| Under 65 | $623.00 | $740.40 | $852.70 | $791.20 | $866.20 | $761.80 | $267.50 | $497.90 | $733.50 | $628.30 |
| 65 | $184.50 | $219.20 | $252.40 | $234.40 | $256.60 | $225.60 | $79.20 | $147.40 | $217.20 | $185.90 |
| 66 | $188.30 | $224.20 | $257.40 | $240.40 | $261.30 | $231.30 | $81.30 | $151.00 | $222.60 | $191.10 |
| 67 | $192.00 | $229.50 | $264.00 | $247.10 | $267.80 | $237.60 | $83.50 | $155.20 | $228.70 | $196.40 |
| 68 | $196.20 | $234.90 | $270.60 | $254.00 | $274.80 | $244.40 | $85.90 | $159.80 | $234.60 | $202.00 |
| 69 | $199.70 | $240.10 | $277.30 | $260.50 | $281.40 | $250.40 | $88.10 | $163.90 | $240.50 | $207.50 |
| 70-71 | $204.60 | $247.50 | $287.10 | $270.10 | $290.60 | $259.40 | $91.40 | $169.80 | $249.10 | $215.30 |
| 72-74 | $211.70 | $257.80 | $303.10 | $286.40 | $307.90 | $274.80 | $97.00 | $180.10 | $263.30 | $228.90 |
| 75-79 | $218.00 | $270.80 | $325.80 | $310.20 | $330.50 | $297.40 | $105.20 | $195.10 | $283.60 | $249.10 |
| 80+ | $214.40 | $279.90 | $365.90 | $347.80 | $370.70 | $333.40 | $118.20 | $219.20 | $314.60 | $282.70 |

NOTE: BlueMedicare Supplement Plan K, L, M and N policies include additional out-of-pocket expenses that must be satisfied before some policy benefits are paid. Under Plans K and L, you must satisfy the Annual Out-of-Pocket limit to receive full Medicare supplemental benefits.

You have the right to purchase any policy offered by Florida Blue, with or without the additional Annual Out-of-Pocket Limit.

This Chart displays premiums for the following counties, classified as Area 3: Alachua, Baker, Bradford, Calhoun, Citrus, Columbia, Dixie, Flagler, Franklin, Gadsden, Gilchrist, Hamilton, Jackson, Jefferson, Lafayette, Lake, Leon, Levy, Liberty, Madison, Marion, Polk, Putnam, Sumter, Suwannee, Taylor, Union, Volusia, and Wakulla.

**AUTOMATIC PAYMENT OPTION MONTHLY PREMIUM - NON TOBACCO USER**

| Age At Enrollment | Plan A | Plan B | Plan C | Plan D | Plan F | Plan G | Plan K | Plan L | Plan M | Plan N |
|---|---|---|---|---|---|---|---|---|---|---|
| Under 65 | $557.80 | $662.80 | $763.70 | $708.60 | $775.60 | $681.80 | $239.40 | $445.60 | $656.80 | $562.30 |
| 65 | $165.10 | $196.30 | $226.10 | $209.70 | $229.70 | $201.90 | $70.90 | $131.90 | $194.40 | $166.60 |
| 66 | $168.60 | $200.80 | $230.60 | $215.30 | $233.90 | $207.30 | $72.70 | $135.30 | $199.30 | $171.00 |
| 67 | $172.00 | $205.60 | $236.20 | $221.20 | $239.90 | $212.80 | $74.80 | $139.10 | $204.70 | $175.90 |
| 68 | $175.70 | $210.40 | $242.40 | $227.50 | $246.00 | $218.70 | $76.90 | $143.10 | $210.10 | $180.80 |
| 69 | $178.90 | $215.00 | $248.40 | $233.20 | $251.80 | $224.20 | $78.90 | $146.70 | $215.40 | $185.80 |
| 70-71 | $183.20 | $221.60 | $257.00 | $241.80 | $260.30 | $232.30 | $81.90 | $152.00 | $223.10 | $192.80 |
| 72-74 | $189.60 | $231.00 | $271.30 | $256.40 | $275.70 | $246.10 | $86.80 | $161.20 | $235.70 | $204.80 |
| 75-79 | $195.40 | $242.60 | $291.60 | $277.80 | $296.00 | $266.40 | $94.20 | $174.70 | $254.10 | $223.10 |
| 80+ | $191.90 | $250.60 | $327.70 | $311.30 | $331.90 | $298.50 | $105.80 | $196.20 | $281.50 | $253.20 |

NOTE: BlueMedicare Supplement Plan K, L, M and N policies include additional out-of-pocket expenses that must be satisfied before some policy benefits are paid. Under Plans K and L, you must satisfy the Annual Out-of-Pocket limit to receive full Medicare supplemental benefits.

You have the right to purchase any policy offered by Florida Blue, with or without the additional Annual Out-of-Pocket Limit.

This Chart displays premiums for the following counties, classified as Area 3: Alachua, Baker, Bradford, Calhoun, Citrus, Columbia, Dixie, Flagler, Franklin, Gadsden, Gilchrist, Hamilton, Jackson, Jefferson, Lafayette, Lake, Leon, Levy, Liberty, Madison, Marion, Polk, Putnam, Sumter, Suwannee, Taylor, Union, Volusia, and Wakulla.

**AUTOMATIC PAYMENT OPTION MONTHLY PREMIUM - TOBACCO USER**

| Age At Enrollment | Plan A | Plan B | Plan C | Plan D | Plan F | Plan G | Plan K | Plan L | Plan M | Plan N |
|---|---|---|---|---|---|---|---|---|---|---|
| Under 65 | $613.70 | $729.20 | $839.90 | $779.30 | $853.20 | $750.40 | $263.50 | $490.40 | $722.50 | $618.90 |
| 65 | $181.80 | $215.90 | $248.60 | $230.80 | $252.70 | $222.20 | $78.00 | $145.20 | $214.00 | $183.10 |
| 66 | $185.50 | $220.80 | $253.50 | $236.80 | $257.40 | $227.90 | $80.10 | $148.80 | $219.20 | $188.20 |
| 67 | $189.20 | $226.10 | $260.00 | $243.40 | $263.80 | $234.00 | $82.30 | $152.90 | $225.30 | $193.40 |
| 68 | $193.20 | $231.40 | $266.60 | $250.20 | $270.70 | $240.70 | $84.60 | $157.40 | $231.10 | $198.90 |
| 69 | $196.70 | $236.50 | $273.20 | $256.60 | $277.10 | $246.60 | $86.80 | $161.50 | $236.90 | $204.40 |
| 70-71 | $201.60 | $243.80 | $282.80 | $266.10 | $286.20 | $255.50 | $90.00 | $167.30 | $245.40 | $212.10 |
| 72-74 | $208.50 | $253.90 | $298.50 | $282.20 | $303.30 | $270.70 | $95.50 | $177.40 | $259.30 | $225.40 |
| 75-79 | $214.70 | $266.70 | $320.90 | $305.50 | $325.60 | $293.00 | $103.60 | $192.20 | $279.40 | $245.40 |
| 80+ | $211.20 | $275.70 | $360.40 | $342.60 | $365.10 | $328.40 | $116.40 | $215.90 | $309.90 | $278.50 |

NOTE: BlueMedicare Supplement Plan K, L, M and N policies include additional out-of-pocket expenses that must be satisfied before some policy benefits are paid. Under Plans K and L, you must satisfy the Annual Out-of-Pocket limit to receive full Medicare supplemental benefits.

You have the right to purchase any policy offered by Florida Blue, with or without the additional Annual Out-of-Pocket Limit.

This Chart displays Out of state premiums. If your primary residence changes to one that is not in the state of Florida, that is, you move permanently out of state, your Premium for this plan will be adjusted to the Premium shown below.

**MONTHLY PREMIUM - NON TOBACCO USER**

| Age At Enrollment | Plan A | Plan B | Plan C | Plan D | Plan F | Plan G | Plan K | Plan L | Plan M | Plan N |
|---|---|---|---|---|---|---|---|---|---|---|
| Under 65 | $683.20 | $810.80 | $934.20 | $867.00 | $949.00 | $835.00 | $292.80 | $545.00 | $803.20 | $688.50 |
| 65 | $202.20 | $240.10 | $276.70 | $256.90 | $281.00 | $247.30 | $86.70 | $161.30 | $237.80 | $204.00 |
| 66 | $206.40 | $245.50 | $282.00 | $263.30 | $286.20 | $253.50 | $89.10 | $165.70 | $244.00 | $209.20 |
| 67 | $210.50 | $251.50 | $289.30 | $270.60 | $293.40 | $260.40 | $91.50 | $170.20 | $250.40 | $215.20 |
| 68 | $214.80 | $257.50 | $296.80 | $278.30 | $300.90 | $267.60 | $94.10 | $174.80 | $257.30 | $221.30 |
| 69 | $218.80 | $262.90 | $303.90 | $285.40 | $308.30 | $274.30 | $96.60 | $179.40 | $263.70 | $227.40 |
| 70-71 | $224.20 | $271.00 | $314.60 | $295.80 | $318.50 | $284.30 | $100.20 | $186.10 | $272.80 | $235.90 |
| 72-74 | $232.10 | $282.70 | $332.10 | $313.60 | $337.30 | $301.10 | $106.20 | $197.30 | $288.30 | $250.60 |
| 75-79 | $239.00 | $296.80 | $357.20 | $339.70 | $362.20 | $326.00 | $115.20 | $213.80 | $310.80 | $272.90 |
| 80+ | $235.00 | $306.80 | $400.90 | $381.10 | $406.20 | $365.30 | $129.40 | $240.00 | $344.70 | $309.90 |

NOTE: BlueMedicare Supplement Plan K, L, M and N policies include additional out-of-pocket expenses that must be satisfied before some policy benefits are paid. Under Plans K and L, you must satisfy the Annual Out-of-Pocket limit to receive full Medicare supplemental benefits.

You have the right to purchase any policy offered by Florida Blue, with or without the additional Annual Out-of-Pocket Limit.

This Chart displays Out of state premiums. If your primary residence changes to one that is not in the state of Florida, that is, you move permanently out of state, your Premium for this plan will be adjusted to the Premium shown below.

**MONTHLY PREMIUM - TOBACCO USER**

| Age At Enrollment | Plan A | Plan B | Plan C | Plan D | Plan F | Plan G | Plan K | Plan L | Plan M | Plan N |
|---|---|---|---|---|---|---|---|---|---|---|
| Under 65 | $751.20 | $892.30 | $1027.70 | $953.60 | $1043.50 | $918.40 | $322.50 | $599.30 | $883.90 | $757.20 |
| 65 | $222.40 | $264.20 | $304.40 | $282.40 | $309.10 | $271.90 | $95.50 | $177.50 | $261.80 | $224.30 |
| 66 | $227.00 | $270.10 | $310.20 | $289.80 | $315.00 | $278.90 | $97.90 | $182.20 | $268.40 | $230.20 |
| 67 | $231.50 | $276.70 | $318.20 | $297.80 | $322.90 | $286.40 | $100.70 | $187.20 | $275.50 | $236.60 |
| 68 | $236.40 | $283.20 | $326.40 | $306.10 | $331.00 | $294.40 | $103.40 | $192.40 | $283.00 | $243.40 |
| 69 | $240.60 | $289.30 | $334.40 | $313.90 | $339.10 | $301.90 | $106.20 | $197.40 | $290.10 | $250.10 |
| 70-71 | $246.70 | $298.20 | $346.00 | $325.40 | $350.30 | $312.70 | $110.10 | $204.80 | $300.10 | $259.50 |
| 72-74 | $255.20 | $311.00 | $365.20 | $345.10 | $371.10 | $331.30 | $116.80 | $217.10 | $317.30 | $275.70 |
| 75-79 | $262.90 | $326.40 | $392.80 | $373.80 | $398.50 | $358.50 | $126.70 | $235.20 | $342.00 | $300.10 |
| 80+ | $258.50 | $337.50 | $441.00 | $419.20 | $446.70 | $401.70 | $142.30 | $263.90 | $379.10 | $340.70 |

NOTE: BlueMedicare Supplement Plan K, L, M and N policies include additional out-of-pocket expenses that must be satisfied before some policy benefits are paid. Under Plans K and L, you must satisfy the Annual Out-of-Pocket limit to receive full Medicare supplemental benefits.

You have the right to purchase any policy offered by Florida Blue, with or without the additional Annual Out-of-Pocket Limit.

This Chart displays Out of state premiums. If your primary residence changes to one that is not in the state of Florida, that is, you move permanently out of state, your Premium for this plan will be adjusted to the Premium shown below.

**AUTOMATIC PAYMENT OPTION MONTHLY PREMIUM - NON TOBACCO USER**

| Age At Enrollment | Plan A | Plan B | Plan C | Plan D | Plan F | Plan G | Plan K | Plan L | Plan M | Plan N |
|---|---|---|---|---|---|---|---|---|---|---|
| Under 65 | $672.90 | $798.60 | $920.10 | $854.00 | $934.80 | $822.50 | $288.40 | $536.80 | $791.10 | $678.20 |
| 65 | $199.20 | $236.50 | $272.50 | $253.00 | $276.70 | $243.60 | $85.40 | $158.90 | $234.30 | $200.90 |
| 66 | $203.30 | $241.80 | $277.80 | $259.30 | $281.90 | $249.70 | $87.70 | $163.20 | $240.30 | $206.10 |
| 67 | $207.40 | $247.70 | $284.90 | $266.60 | $289.00 | $256.50 | $90.10 | $167.70 | $246.70 | $212.00 |
| 68 | $211.60 | $253.70 | $292.30 | $274.10 | $296.40 | $263.60 | $92.70 | $172.20 | $253.40 | $218.00 |
| 69 | $215.50 | $258.90 | $299.30 | $281.10 | $303.70 | $270.20 | $95.10 | $176.70 | $259.70 | $224.00 |
| 70-71 | $220.80 | $267.00 | $309.90 | $291.40 | $313.70 | $280.00 | $98.70 | $183.30 | $268.70 | $232.40 |
| 72-74 | $228.60 | $278.50 | $327.10 | $308.90 | $332.30 | $296.60 | $104.60 | $194.40 | $284.00 | $246.90 |
| 75-79 | $235.50 | $292.30 | $351.80 | $334.70 | $356.80 | $321.10 | $113.50 | $210.60 | $306.20 | $268.80 |
| 80+ | $231.50 | $302.20 | $394.90 | $375.40 | $400.10 | $359.80 | $127.50 | $236.40 | $339.50 | $305.20 |

NOTE: BlueMedicare Supplement Plan K, L, M and N policies include additional out-of-pocket expenses that must be satisfied before some policy benefits are paid. Under Plans K and L, you must satisfy the Annual Out-of-Pocket limit to receive full Medicare supplemental benefits.

You have the right to purchase any policy offered by Florida Blue, with or without the additional Annual Out-of-Pocket Limit.

This Chart displays Out of state premiums. If your primary residence changes to one that is not in the state of Florida, that is, you move permanently out of state, your Premium for this plan will be adjusted to the Premium shown below.

**AUTOMATIC PAYMENT OPTION MONTHLY PREMIUM - TOBACCO USER**

| Age At Enrollment | Plan A | Plan B | Plan C | Plan D | Plan F | Plan G | Plan K | Plan L | Plan M | Plan N |
|---|---|---|---|---|---|---|---|---|---|---|
| Under 65 | $739.90 | $878.90 | $1012.30 | $939.30 | $1027.80 | $904.70 | $317.60 | $590.30 | $870.60 | $745.90 |
| 65 | $219.10 | $260.30 | $299.80 | $278.20 | $304.40 | $267.80 | $94.10 | $174.80 | $257.90 | $221.00 |
| 66 | $223.60 | $266.10 | $305.50 | $285.50 | $310.20 | $274.70 | $96.40 | $179.40 | $264.30 | $226.70 |
| 67 | $228.10 | $272.50 | $313.40 | $293.40 | $318.00 | $282.10 | $99.20 | $184.40 | $271.30 | $233.10 |
| 68 | $232.80 | $279.00 | $321.50 | $301.50 | $326.10 | $289.90 | $101.90 | $189.50 | $278.70 | $239.70 |
| 69 | $237.00 | $284.90 | $329.40 | $309.20 | $334.00 | $297.30 | $104.60 | $194.50 | $285.70 | $246.30 |
| 70-71 | $243.00 | $293.80 | $340.90 | $320.50 | $345.10 | $308.00 | $108.50 | $201.70 | $295.60 | $255.60 |
| 72-74 | $251.40 | $306.30 | $359.70 | $339.90 | $365.50 | $326.40 | $115.10 | $213.80 | $312.50 | $271.60 |
| 75-79 | $258.90 | $321.50 | $386.90 | $368.20 | $392.60 | $353.10 | $124.80 | $231.70 | $336.90 | $295.60 |
| 80+ | $254.60 | $332.40 | $434.40 | $412.90 | $440.00 | $395.70 | $140.20 | $260.00 | $373.40 | $335.60 |

NOTE: BlueMedicare Supplement Plan K, L, M and N policies include additional out-of-pocket expenses that must be satisfied before some policy benefits are paid. Under Plans K and L, you must satisfy the Annual Out-of-Pocket limit to receive full Medicare supplemental benefits.

You have the right to purchase any policy offered by Florida Blue, with or without the additional Annual Out-of-Pocket Limit.

**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 PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** | | | |
| Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $1,632 | $0 | $1,632 (Part A deductible) |
| 61st thru 90th day | All but $408 a day | $408 a day | $0 |
| 91st day and after: | | | |
| --While using 60 lifetime reserve days | All but $816 | $816 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 thru 100th day | All but $204 a day | $0 | Up to $204 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 insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

## PLAN A
## MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $240 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 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 $240 of Medicare Approved Amounts* | $0 | $0 | $240 (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 $240 of Medicare Approved Amounts* | $0 | $0 | $240 (Part B deductible) |
| Remainder of Medicare Approved Amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES –** TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

## PLAN A PARTS A and B

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE** | | | |
| MEDICARE APPROVED SERVICES | | | |
| Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| Durable medical equipment | | | |
| - First $240 of Medicare Approved Amounts* | $0 | $0 | $240 (Part B deductible) |
| - Remainder of Medicare Approved Amounts | 80% | 20% | $0 |

**PLAN B**
**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 PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** | | | |
| Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $1,632 | $1,632 (Part A deductible) | $0 |
| 61st thru 90th day | All but $408 a day | $408 a day | $0 |
| 91st day and after: | | | |
| --While using 60 lifetime reserve days | All but $816 | $816 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 thru 100th day | All but $204 a day | $0 | Up to $204 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 insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

## PLAN B
## MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $240 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 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 $240 of Medicare Approved Amounts* | $0 | $0 | $240 (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 $240 of Medicare Approved Amounts* | $0 | $0 | $240 (Part B deductible) |
| Remainder of Medicare Approved Amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES –** TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

## PLAN B PARTS A and B

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE** | | | |
| MEDICARE APPROVED SERVICES | | | |
| Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| Durable medical equipment | | | |
| - First $240 of Medicare Approved Amounts* | $0 | $0 | $240 (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 PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** | | | |
| Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $1,632 | $1,632 (Part A deductible) | $0 |
| 61st thru 90th day | All but $408 a day | $408 a day | $0 |
| 91st day and after: | | | |
| --While using 60 lifetime reserve days | All but $816 | $816 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 thru 100th day | All but $204 a day | Up to $204 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 insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

+**Only applicants first eligible for Medicare before January 1, 2020 may purchase Plans C, F, and high deductible F.**

## PLAN C+
## MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $240 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 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 $240 of Medicare Approved Amounts* | $0 | $240 (Part B deductible) | $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 $240 of Medicare Approved Amounts* | $0 | $240 (Part B deductible) | $0 |
| Remainder of Medicare Approved Amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES –** TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

## PLAN C+ PARTS A and B

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE** MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment | 100% | $0 | $0 |
| - First $240 of Medicare Approved Amounts* | $0 | $240 (Part B deductible) | $0 |
| - Remainder of Medicare Approved Amounts | 80% | 20% | $0 |

**+Only applicants first eligible for Medicare before January 1, 2020 may purchase Plans C, F, and high deductible F.**

**PLAN C[+]**
**OTHER BENEFITS – NOT COVERED BY MEDICARE**

| SERVICES | MEDICARE PAYS | PLAN 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 |

**[+]Only applicants first eligible for Medicare before January 1, 2020 may purchase Plans C, F, and high deductible F.**

**PLAN D**
**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 PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** | | | |
| Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $1,632 | $1,632 (Part A deductible) | $0 |
| 61st thru 90th day | All but $408 a day | $408 a day | $0 |
| 91st day and after: | | | |
| --While using 60 lifetime reserve days | All but $816 | $816 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 thru 100th day | All but $204 a day | Up to $204 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 insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

## PLAN D
## MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $240 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 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 $240 of Medicare Approved Amounts* | $0 | $0 | $240 (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 $240 of Medicare Approved Amounts* | $0 | $0 | $240 (Part B deductible) |
| Remainder of Medicare Approved Amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES –** TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

### PLAN D PARTS A and B

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE** MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment | 100% | $0 | $0 |
| - First $240 of Medicare Approved Amounts* | $0 | $0 | $240 (Part B deductible) |
| - Remainder of Medicare Approved Amounts | 80% | 20% | $0 |

**PLAN D**
**OTHER BENEFITS – NOT COVERED BY MEDICARE**

| SERVICES | MEDICARE PAYS | PLAN 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 |

## 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 PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** | | | |
| Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $1,632 | $1,632 (Part A deductible) | $0 |
| 61st thru 90th day | All but $408 a day | $408 a day | $0 |
| 91st day and after: | | | |
| --While using 60 lifetime reserve days | All but $816 | $816 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 thru 100th day | All but $204 a day | Up to $204 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 insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

+**Only applicants first eligible for Medicare before January 1, 2020 may purchase Plans C, F, and high deductible F.**

## PLAN F+
## MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $240 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 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 $240 of Medicare Approved Amounts* | $0 | $240 (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 $240 of Medicare Approved Amounts* | $0 | $240 (Part B deductible) | $0 |
| Remainder of Medicare Approved Amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES –** TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

## PLAN F+ PARTS A and B

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE** MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment | 100% | $0 | $0 |
| - First $240 of Medicare Approved Amounts* | $0 | $240 (Part B deductible) | $0 |
| - Remainder of Medicare Approved Amounts | 80% | 20% | $0 |

**+Only applicants first eligible for Medicare before January 1, 2020 may purchase Plans C, F, and high deductible F.**

**PLAN F[+]**
**OTHER BENEFITS – NOT COVERED BY MEDICARE**

| SERVICES | MEDICARE PAYS | PLAN 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 |

**[+]Only applicants first eligible for Medicare before January 1, 2020 may purchase Plans C, F, and high deductible F.**

**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 PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** | | | |
| Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $1,632 | $1,632 (Part A deductible) | $0 |
| 61st thru 90th day | All but $408 a day | $408 a day | $0 |
| 91st day and after: | | | |
| --While using 60 lifetime reserve days | All but $816 | $816 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 thru 100th day | All but $204 a day | Up to $204 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 insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

## PLAN G
## MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $240 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 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 $240 of Medicare Approved Amounts* | $0 | $0 | $240 (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 $240 of Medicare Approved Amounts* | $0 | $0 | $240 (Part B deductible) |
| Remainder of Medicare Approved Amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES –** TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

### PLAN G PARTS A and B

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE** MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment | 100% | $0 | $0 |
| - First $240 of Medicare Approved Amounts* | $0 | $0 | $240 (Part B deductible) |
| - Remainder of Medicare Approved Amounts | 80% | 20% | $0 |

**PLAN G**
**OTHER BENEFITS – NOT COVERED BY MEDICARE**

| SERVICES | MEDICARE PAYS | PLAN 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 |

**PLAN K**
**MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD**

*You will pay half of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $7,060 each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach your annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

**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 PAYS | YOU PAY* |
|---|---|---|---|
| **HOSPITALIZATION**** | | | |
| Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $1,632 | $816 (50% of Part A deductible) | $816 (50% of Part A deductible) ♦ |
| 61st thru 90th day | All but $408 a day | $408 a day | $0 |
| 91st day and after: | | | |
| --While using 60 lifetime reserve days | All but $816 | $816 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 thru 100th day | All but $204 a day | Up to $102.00 a day (50% of Part A coinsurance) | Up to $102.00 a day (50% of Part A coinsurance) ♦ |
| 101st day and after | $0 | $0 | All costs |

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY* |
|---|---|---|---|
| **BLOOD**<br>First 3 pints<br>Additional amounts | <br>$0<br>100% | <br>50%<br>$0 | <br>50% ♦<br>$0 |
| **HOSPICE CARE**<br>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. | 50% of copayment/coinsurance | 50% of copayment/coinsurance ♦ |

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

## PLAN K
## MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

****Once you have been billed $240 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 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 $240 of Medicare Approved Amounts**** | $0 | $0 | $240 (Part B deductible)****♦ |
| Preventive Benefits For Medicare covered services | Generally 75% or more of Medicare approved amounts | Remainder of Medicare approved amounts | All costs above Medicare approved amounts |
| Remainder of Medicare Approved Amounts | Generally 80% | Generally 10% | Generally 10% ♦ |
| Part B Excess Charges (Above Medicare Approved Amounts) | $0 | $0 | All costs (and they do not count toward annual out-of-pocket limit of $7,060)* |

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY* |
|---|---|---|---|
| **BLOOD** | | | |
| First 3 pints | $0 | 50% | 50%♦ |
| Next $240 of Medicare Approved Amounts**** | $0 | $0 | $240 (Part B deductible)****♦ |
| Remainder of Medicare Approved Amounts | Generally 80% | Generally 10% | Generally 10% ♦ |
| **CLINICAL LABORATORY SERVICES –** TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $7,060 per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

**PLAN K**
**PARTS A and B**

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY* |
|---|---|---|---|
| **HOME HEALTH CARE** MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| Durable medical equipment - First $240 of Medicare Approved Amounts***** | $0 | $0 | $240 (Part B deductible)♦ |
| - Remainder of Medicare Approved Amounts | 80% | 10% | 10% ♦ |

*****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare.*

**PLAN L**
**MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD**

*You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $3,530 each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach your annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

**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 PAYS | YOU PAY* |
|---|---|---|---|
| **HOSPITALIZATION**** | | | |
| Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $1,632 | $1,224 (75% of Part A deductible) | $408 (25% of Part A deductible) ♦ |
| 61st thru 90th day | All but $408 a day | $408 a day | $0 |
| 91st day and after: | | | |
| --While using 60 lifetime reserve days | All but $816 | $816 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 thru 100th day | All but $204 a day | Up to $153.00 a day (75% of Part A coinsurance) | Up to $51 a day (25% of Part A coinsurance) ♦ |
| 101st day and after | $0 | $0 | All costs |

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY* |
|---|---|---|---|
| **BLOOD** | | | |
| First 3 pints | $0 | 75% | 25% ♦ |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE**<br>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. | 75% Medicare copayment/coinsurance | 25% Medicare copayment/coinsurance ♦ |

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

## PLAN L
## MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

****Once you have been billed $240 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 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 $240 of Medicare Approved Amounts**** | $0 | $0 | $240 (Part B deductible)****♦ |
| Preventive Benefits For Medicare covered services | Generally 75% or more of Medicare approved amounts | Remainder of Medicare approved amounts | All costs above Medicare approved amounts |
| Remainder of Medicare Approved Amounts | Generally 80% | Generally 15% | Generally 5% ♦ |
| Part B Excess Charges (Above Medicare Approved Amounts) | $0 | $0 | All costs (and they do not count toward annual out-of-pocket limit of $3,530)* |

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY* |
|---|---|---|---|
| **BLOOD** | | | |
| First 3 pints | $0 | 75% | 25%♦ |
| Next $240 of Medicare Approved Amounts**** | $0 | $0 | $240 (Part B deductible)****♦ |
| Remainder of Medicare Approved Amounts | Generally 80% | Generally 15% | Generally 5% ♦ |
| **CLINICAL LABORATORY SERVICES –** TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $3,530 per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

**PLAN L**
**PARTS A and B**

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY* |
|---|---|---|---|
| **HOME HEALTH CARE** MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| Durable medical equipment - First $240 of Medicare Approved Amounts***** | $0 | $0 | $240 (Part B deductible)♦ |
| - Remainder of Medicare Approved Amounts | 80% | 15% | 5% ♦ |

*****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare.*

**PLAN M**
**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 PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** | | | |
| Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $1,632 | $816 (50% of Part A deductible) | $816 (50% of Part A deductible) |
| 61st thru 90th day | All but $408 a day | $408 a day | $0 |
| 91st day and after: | | | |
| --While using 60 lifetime reserve days | All but $816 | $816 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 thru 100th day | All but $204 a day | Up to $204 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 insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

## PLAN M
## MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $240 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 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 $240 of Medicare Approved Amounts* | $0 | $0 | $240 (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 $240 of Medicare Approved Amounts* | $0 | $0 | $240 (Part B deductible) |
| Remainder of Medicare Approved Amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES –** TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

### PLAN M PARTS A and B

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE** MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment | 100% | $0 | $0 |
| - First $240 of Medicare Approved Amounts* | $0 | $0 | $240 (Part B deductible) |
| - Remainder of Medicare Approved Amounts | 80% | 20% | $0 |

**PLAN M**
**OTHER BENEFITS – NOT COVERED BY MEDICARE**

| SERVICES | MEDICARE PAYS | PLAN 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 |

**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 PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** | | | |
| Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $1,632 | $1,632 (Part A deductible) | $0 |
| 61st thru 90th day | All but $408 a day | $408 a day | $0 |
| 91st day and after: | | | |
| --While using 60 lifetime reserve days | All but $816 | $816 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 thru 100th day | All but $204 a day | Up to $204 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 insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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

*Once you have been billed $240 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 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 $240 of Medicare Approved Amounts* | $0 | $0 | $240 (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 insured 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 insured 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 $240 of Medicare Approved Amounts* | $0 | $0 | $240 (Part B deductible) |
| Remainder of Medicare Approved Amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES –** TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

**PLAN N PARTS A and B**

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE**<br>MEDICARE APPROVED SERVICES<br>Medically necessary skilled care services and medical supplies<br>Durable medical equipment | 100% | $0 | $0 |
| - First $240 of Medicare Approved Amounts* | $0 | $0 | $240 (Part B deductible) |
| - Remainder of Medicare Approved Amounts | 80% | 20% | $0 |

**PLAN N**
**OTHER BENEFITS – NOT COVERED BY MEDICARE**

| SERVICES | MEDICARE PAYS | PLAN 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 |