Florida Blue
An Independent Licensee of the Blue Cross and Blue Shield Association

FLORIDA BLUE**
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE – Cover Page
BlueMedicare Supplement Plans A, B, C, D, F, G, K, L, M, N

Notice to buyer: These policies 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.

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state.

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 copayments.
- **Blood** – First three pints of blood each year.
- **Hospice** – Part A coinsurance

A	B	C	D	F	F*	G
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance		Basic, including 100% Part B coinsurance
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible
		Part B Deductible		Part B Deductible		
				Part B Excess (100%)		Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency

*Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as plan F after one has paid a calendar year $2,620 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2,620. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the plan. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

K	L	M	N
Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Foreign Travel Emergency	Foreign Travel Emergency
Out-of-pocket limit $5,240 paid at 100% after limit reached	Out-of-pocket limit $2,620 paid at 100% after limit reached		

**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.

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	$678.60	$806.00	$928.70	$861.60	$943.50	$871.20	$466.40	$664.50	$798.60	$782.70
65	$201.00	$238.80	$275.00	$255.20	$279.40	$258.10	$138.20	$196.80	$236.60	$231.90
66	$205.10	$244.20	$280.50	$262.00	$284.70	$264.80	$141.80	$201.90	$242.60	$238.20
67	$209.30	$250.10	$287.50	$269.20	$291.80	$271.80	$145.80	$207.40	$248.90	$244.90
68	$213.70	$256.10	$295.00	$276.70	$299.30	$279.40	$149.80	$213.20	$255.60	$251.80
69	$217.60	$261.50	$302.20	$283.90	$306.40	$286.50	$153.80	$218.90	$262.10	$258.60
70-71	$222.90	$269.60	$312.80	$294.30	$316.80	$296.90	$159.40	$226.90	$271.20	$268.40
72-74	$230.70	$281.00	$330.20	$311.90	$335.40	$314.50	$169.10	$240.60	$286.80	$285.30
75-79	$237.60	$295.10	$355.10	$337.80	$360.20	$340.40	$183.50	$260.80	$309.10	$310.50
80+	$233.60	$305.00	$398.60	$378.90	$403.80	$381.40	$206.20	$292.70	$342.70	$352.60

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 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	$746.00	$886.70	$1021.60	$947.90	$1037.60	$958.20	$513.30	$730.80	$878.20	$860.80
65	$221.00	$262.70	$302.60	$280.80	$307.30	$283.80	$152.10	$216.50	$260.20	$255.00
66	$225.60	$268.60	$308.50	$288.20	$313.20	$291.20	$156.00	$222.10	$266.80	$262.00
67	$230.30	$275.10	$316.40	$296.20	$321.10	$299.10	$160.30	$228.30	$273.90	$269.30
68	$235.10	$281.60	$324.50	$304.40	$329.30	$307.30	$164.90	$234.60	$281.20	$277.10
69	$239.30	$287.60	$332.40	$312.30	$337.10	$315.20	$169.10	$240.70	$288.40	$284.50
70-71	$245.20	$296.70	$344.00	$323.70	$348.60	$326.60	$175.40	$249.50	$298.40	$295.30
72-74	$253.70	$309.10	$363.30	$343.20	$368.90	$345.90	$186.20	$264.70	$315.40	$313.70
75-79	$261.40	$324.60	$390.70	$371.60	$396.20	$374.20	$201.90	$286.90	$340.00	$341.50
80+	$257.00	$335.50	$438.40	$416.90	$444.00	$419.50	$226.80	$321.90	$376.90	$387.90

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	$668.40	$793.90	$914.70	$848.60	$929.30	$858.20	$459.40	$654.50	$786.60	$770.90
65	$198.00	$235.20	$270.90	$251.40	$275.20	$254.20	$136.10	$193.90	$233.00	$228.40
66	$202.10	$240.60	$276.30	$258.10	$280.50	$260.80	$139.70	$198.90	$239.00	$234.60
67	$206.10	$246.30	$283.20	$265.10	$287.40	$267.80	$143.60	$204.30	$245.20	$241.20
68	$210.50	$252.20	$290.50	$272.60	$294.80	$275.20	$147.60	$210.00	$251.80	$248.00
69	$214.30	$257.60	$297.70	$279.60	$301.80	$282.20	$151.50	$215.60	$258.20	$254.70
70-71	$219.60	$265.60	$308.10	$289.90	$312.10	$292.40	$157.00	$223.50	$267.10	$264.40
72-74	$227.20	$276.80	$325.30	$307.20	$330.30	$309.70	$166.60	$237.00	$282.50	$281.00
75-79	$234.10	$290.60	$349.70	$332.70	$354.80	$335.30	$180.70	$256.80	$304.50	$305.90
80+	$230.10	$300.40	$392.70	$373.30	$397.70	$375.70	$203.10	$288.30	$337.60	$347.30

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	$734.80	$873.40	$1006.30	$933.70	$1022.00	$943.80	$505.60	$719.90	$865.10	$847.90
65	$217.70	$258.70	$298.10	$276.60	$302.70	$279.50	$149.80	$213.30	$256.30	$251.20
66	$222.20	$264.60	$303.90	$283.90	$308.50	$286.90	$153.70	$218.70	$262.80	$258.10
67	$226.80	$271.00	$311.60	$291.80	$316.30	$294.60	$157.90	$224.80	$269.80	$265.20
68	$231.50	$277.40	$319.60	$299.90	$324.30	$302.70	$162.40	$231.10	$277.00	$272.90
69	$235.70	$283.30	$327.40	$307.60	$332.00	$310.50	$166.60	$237.10	$284.00	$280.30
70-71	$241.50	$292.20	$338.80	$318.90	$343.30	$321.70	$172.80	$245.70	$293.90	$290.90
72-74	$249.90	$304.50	$357.80	$338.10	$363.40	$340.70	$183.40	$260.70	$310.70	$309.00
75-79	$257.50	$319.70	$384.80	$366.00	$390.30	$368.60	$198.90	$282.60	$334.90	$336.40
80+	$253.20	$330.40	$431.80	$410.60	$437.40	$413.20	$223.40	$317.10	$371.30	$382.10

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 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	$477.90	$567.40	$653.80	$607.10	$664.20	$613.40	$328.50	$467.90	$562.70	$551.20
65	$141.60	$168.20	$193.60	$179.90	$196.70	$181.80	$97.40	$138.50	$166.70	$163.30
66	$144.40	$172.00	$197.50	$184.50	$200.50	$186.50	$99.80	$142.30	$170.80	$167.70
67	$147.40	$176.10	$202.60	$189.50	$205.60	$191.40	$102.60	$146.20	$175.30	$172.40
68	$150.50	$180.30	$207.60	$194.80	$210.70	$196.70	$105.60	$150.10	$180.10	$177.30
69	$153.10	$184.20	$212.70	$200.00	$215.70	$201.80	$108.30	$154.10	$184.60	$182.20
70-71	$157.00	$189.90	$220.30	$207.20	$223.00	$209.00	$112.20	$159.80	$191.00	$188.90
72-74	$162.50	$198.00	$232.50	$219.60	$236.20	$221.40	$119.00	$169.30	$202.00	$200.90
75-79	$167.40	$207.80	$250.00	$238.00	$253.60	$239.70	$129.20	$183.70	$217.70	$218.70
80+	$164.50	$214.70	$280.70	$266.70	$284.40	$268.50	$145.10	$206.20	$241.30	$248.30

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.

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	$525.60	$624.50	$719.00	$667.80	$730.40	$674.50	$361.50	$514.50	$618.90	$606.30
65	$155.80	$185.00	$213.00	$197.90	$216.40	$199.90	$107.10	$152.40	$183.30	$179.60
66	$158.80	$189.10	$217.30	$202.90	$220.60	$205.00	$109.90	$156.40	$188.00	$184.50
67	$162.20	$193.80	$222.80	$208.50	$226.10	$210.60	$112.80	$160.80	$192.90	$189.80
68	$165.50	$198.30	$228.50	$214.30	$231.90	$216.40	$116.00	$165.20	$198.10	$195.10
69	$168.50	$202.60	$234.00	$220.10	$237.30	$222.00	$119.00	$169.40	$203.00	$200.40
70-71	$172.70	$208.90	$242.30	$228.00	$245.30	$230.00	$123.50	$175.80	$210.10	$207.90
72-74	$178.70	$217.70	$255.70	$241.60	$259.80	$243.60	$131.00	$186.40	$222.20	$220.90
75-79	$184.10	$228.60	$275.00	$261.60	$279.10	$263.60	$142.20	$202.00	$239.60	$240.50
80+	$180.90	$236.20	$308.70	$293.50	$312.80	$295.40	$159.70	$226.80	$265.30	$273.10

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 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 - 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	$470.70	$558.90	$643.90	$598.00	$654.20	$604.20	$323.60	$460.90	$554.30	$542.90
65	$139.50	$165.60	$190.70	$177.20	$193.80	$179.10	$95.90	$136.50	$164.20	$160.80
66	$142.20	$169.40	$194.50	$181.70	$197.50	$183.70	$98.40	$140.10	$168.30	$165.20
67	$145.20	$173.50	$199.50	$186.60	$202.50	$188.50	$101.10	$144.00	$172.70	$169.80
68	$148.20	$177.60	$204.50	$191.90	$207.50	$193.80	$104.00	$147.90	$177.40	$174.70
69	$150.80	$181.50	$209.50	$197.00	$212.40	$198.80	$106.60	$151.80	$181.80	$179.50
70-71	$154.60	$187.00	$217.00	$204.00	$219.70	$205.80	$110.50	$157.40	$188.10	$186.10
72-74	$160.10	$195.00	$229.00	$216.30	$232.70	$218.10	$117.20	$166.80	$199.00	$197.90
75-79	$164.90	$204.70	$246.20	$234.40	$249.80	$236.10	$127.20	$181.00	$214.40	$215.40
80+	$162.10	$211.50	$276.50	$262.70	$280.10	$264.50	$143.00	$203.10	$237.60	$244.60

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	$517.70	$615.10	$708.20	$657.80	$719.50	$664.40	$356.10	$506.80	$609.60	$597.20
65	$153.50	$182.20	$209.80	$194.90	$213.20	$196.90	$105.50	$150.10	$180.50	$176.90
66	$156.40	$186.30	$214.00	$199.90	$217.30	$201.90	$108.20	$154.10	$185.20	$181.70
67	$159.80	$190.90	$219.50	$205.40	$222.70	$207.40	$111.20	$158.40	$190.00	$186.90
68	$163.00	$195.30	$225.00	$211.10	$228.40	$213.20	$114.30	$162.70	$195.10	$192.20
69	$165.90	$199.50	$230.50	$216.70	$233.80	$218.60	$117.20	$166.90	$200.00	$197.40
70-71	$170.10	$205.70	$238.70	$224.60	$241.60	$226.50	$121.70	$173.20	$207.00	$204.80
72-74	$176.00	$214.40	$251.90	$238.00	$255.90	$239.90	$129.00	$183.60	$218.80	$217.60
75-79	$181.40	$225.10	$270.90	$257.70	$274.90	$259.70	$140.00	$199.00	$236.00	$236.90
80+	$178.20	$232.70	$304.10	$289.10	$308.10	$291.00	$157.30	$223.40	$261.40	$269.00

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	$450.50	$535.30	$616.80	$572.30	$626.30	$578.20	$309.60	$441.20	$530.40	$519.70
65	$133.40	$158.60	$182.60	$169.40	$185.50	$171.20	$91.70	$130.60	$157.10	$154.00
66	$136.20	$162.20	$186.30	$173.90	$188.90	$175.80	$94.10	$134.10	$161.00	$158.10
67	$139.00	$166.10	$190.90	$178.70	$193.80	$180.50	$96.80	$137.80	$165.40	$162.60
68	$141.90	$170.00	$195.90	$183.80	$198.70	$185.50	$99.50	$141.70	$169.80	$167.20
69	$144.50	$173.70	$200.70	$188.40	$203.40	$190.20	$102.10	$145.30	$174.00	$171.80
70-71	$148.00	$179.00	$207.60	$195.30	$210.20	$197.00	$105.90	$150.60	$180.20	$178.30
72-74	$153.10	$186.60	$219.20	$207.20	$222.70	$208.80	$112.30	$159.70	$190.40	$189.40
75-79	$157.80	$196.00	$235.60	$224.40	$239.10	$226.00	$121.90	$173.10	$205.20	$206.30
80+	$155.00	$202.50	$264.70	$251.50	$268.10	$253.20	$136.80	$194.40	$227.40	$234.10

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	$495.60	$588.90	$678.30	$629.40	$689.00	$636.30	$340.80	$485.60	$583.40	$571.90
65	$146.80	$174.40	$200.90	$186.50	$204.20	$188.50	$100.90	$143.90	$172.80	$169.30
66	$149.80	$178.40	$204.80	$191.30	$207.90	$193.30	$103.60	$147.40	$177.10	$174.00
67	$152.80	$182.60	$210.00	$196.60	$213.10	$198.50	$106.50	$151.40	$182.00	$178.80
68	$156.10	$186.90	$215.40	$202.10	$218.70	$204.20	$109.40	$155.90	$186.70	$183.90
69	$158.90	$191.10	$220.70	$207.30	$223.90	$209.20	$112.30	$159.90	$191.40	$188.90
70-71	$162.80	$196.90	$228.50	$214.90	$231.20	$216.70	$116.50	$165.70	$198.20	$196.10
72-74	$168.50	$205.10	$241.10	$227.90	$245.00	$229.60	$123.60	$175.70	$209.50	$208.40
75-79	$173.50	$215.50	$259.30	$246.80	$263.00	$248.50	$134.10	$190.40	$225.70	$226.90
80+	$170.60	$222.70	$291.10	$276.70	$295.00	$278.60	$150.60	$213.90	$250.30	$257.50

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 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	$443.70	$527.30	$607.50	$563.70	$616.90	$569.50	$305.00	$434.60	$522.50	$511.90
65	$131.40	$156.20	$179.90	$166.90	$182.70	$168.70	$90.40	$128.70	$154.70	$151.70
66	$134.10	$159.80	$183.50	$171.30	$186.10	$173.20	$92.70	$132.00	$158.60	$155.80
67	$136.90	$163.60	$188.00	$176.00	$190.90	$177.80	$95.30	$135.70	$162.90	$160.20
68	$139.80	$167.40	$192.90	$181.10	$195.80	$182.70	$98.00	$139.60	$167.20	$164.70
69	$142.30	$171.10	$197.60	$185.60	$200.40	$187.40	$100.60	$143.20	$171.40	$169.20
70-71	$145.80	$176.30	$204.50	$192.40	$207.10	$194.10	$104.30	$148.30	$177.50	$175.60
72-74	$150.80	$183.80	$215.90	$204.00	$219.40	$205.60	$110.60	$157.30	$187.60	$186.50
75-79	$155.50	$193.00	$232.10	$221.10	$235.50	$222.60	$120.10	$170.50	$202.20	$203.20
80+	$152.70	$199.40	$260.70	$247.70	$264.10	$249.40	$134.80	$191.50	$224.00	$230.60

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 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	$488.20	$580.10	$668.10	$619.90	$678.70	$626.80	$335.70	$478.30	$574.70	$563.40
65	$144.60	$171.80	$197.90	$183.70	$201.10	$185.70	$99.40	$141.70	$170.30	$166.80
66	$147.60	$175.70	$201.70	$188.40	$204.80	$190.40	$102.00	$145.20	$174.40	$171.40
67	$150.50	$179.90	$206.90	$193.70	$209.90	$195.50	$104.90	$149.20	$179.30	$176.10
68	$153.80	$184.10	$212.10	$199.10	$215.40	$201.10	$107.80	$153.60	$183.90	$181.20
69	$156.50	$188.20	$217.40	$204.20	$220.50	$206.00	$110.60	$157.60	$188.50	$186.10
70-71	$160.40	$194.00	$225.00	$211.70	$227.80	$213.50	$114.70	$163.20	$195.20	$193.10
72-74	$165.90	$202.10	$237.50	$224.50	$241.30	$226.20	$121.80	$173.10	$206.40	$205.30
75-79	$170.90	$212.20	$255.40	$243.10	$259.00	$244.80	$132.00	$187.60	$222.30	$223.50
80+	$168.00	$219.40	$286.80	$272.60	$290.50	$274.40	$148.30	$210.70	$246.60	$253.60

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 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	$543.50	$644.90	$743.10	$689.70	$754.90	$697.50	$373.10	$531.50	$638.90	$626.80
65	$160.90	$191.10	$220.20	$204.40	$223.60	$206.60	$110.50	$157.40	$189.30	$185.70
66	$164.20	$195.30	$224.40	$209.50	$227.70	$211.80	$113.50	$161.70	$194.20	$190.50
67	$167.50	$200.10	$230.20	$215.40	$233.50	$217.60	$116.60	$166.10	$199.30	$196.00
68	$170.90	$204.90	$236.10	$221.40	$239.40	$223.60	$119.90	$170.60	$204.70	$201.50
69	$174.10	$209.20	$241.80	$227.10	$245.30	$229.20	$123.10	$175.10	$209.80	$207.00
70-71	$178.40	$215.70	$250.30	$235.40	$253.40	$237.50	$127.70	$181.60	$217.10	$214.80
72-74	$184.70	$225.00	$264.30	$249.60	$268.40	$251.60	$135.30	$192.60	$229.40	$228.30
75-79	$190.20	$236.10	$284.20	$270.30	$288.20	$272.40	$146.80	$208.60	$247.30	$248.50
80+	$187.00	$244.10	$319.00	$303.30	$323.20	$305.20	$165.00	$234.20	$274.30	$282.20

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.

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	$597.50	$709.80	$817.50	$758.60	$830.10	$767.20	$410.80	$584.50	$703.10	$689.30
65	$177.00	$210.20	$242.20	$224.70	$245.90	$227.20	$121.70	$173.20	$208.30	$204.30
66	$180.60	$214.90	$246.80	$230.60	$250.60	$233.10	$124.80	$177.70	$213.60	$209.60
67	$184.20	$220.20	$253.20	$237.00	$256.90	$239.30	$128.30	$182.60	$219.20	$215.50
68	$188.10	$225.40	$259.70	$243.60	$263.40	$245.90	$131.80	$187.80	$225.20	$221.60
69	$191.50	$230.20	$266.10	$249.80	$269.80	$252.20	$135.30	$192.70	$230.80	$227.70
70-71	$196.30	$237.30	$275.40	$258.90	$278.80	$261.30	$140.30	$199.80	$238.80	$236.40
72-74	$203.10	$247.40	$290.60	$274.60	$295.30	$276.80	$148.90	$211.80	$252.40	$251.10
75-79	$209.20	$259.70	$312.50	$297.40	$317.10	$299.50	$161.40	$229.50	$272.20	$273.30
80+	$205.70	$268.50	$350.90	$333.50	$355.50	$335.70	$181.40	$257.60	$301.70	$310.30

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	$535.30	$635.30	$731.90	$679.30	$743.60	$687.00	$367.50	$523.50	$629.30	$617.40
65	$158.50	$188.20	$216.90	$201.30	$220.20	$203.50	$108.80	$155.00	$186.40	$183.00
66	$161.70	$192.40	$221.10	$206.40	$224.30	$208.70	$111.80	$159.20	$191.20	$187.70
67	$165.00	$197.10	$226.70	$212.10	$230.00	$214.30	$114.80	$163.60	$196.30	$193.00
68	$168.40	$201.80	$232.60	$218.10	$235.90	$220.20	$118.10	$168.00	$201.60	$198.50
69	$171.50	$206.00	$238.20	$223.70	$241.60	$225.80	$121.20	$172.50	$206.70	$203.90
70-71	$175.70	$212.40	$246.60	$231.90	$249.60	$234.00	$125.70	$178.90	$213.80	$211.60
72-74	$181.90	$221.60	$260.30	$245.80	$264.40	$247.80	$133.30	$189.70	$226.00	$224.80
75-79	$187.40	$232.60	$279.90	$266.30	$283.90	$268.30	$144.60	$205.50	$243.60	$244.80
80+	$184.20	$240.50	$314.30	$298.70	$318.40	$300.60	$162.50	$230.70	$270.20	$277.90

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.

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	$588.60	$699.10	$805.20	$747.20	$817.60	$755.70	$404.60	$575.80	$692.60	$679.00
65	$174.30	$207.10	$238.60	$221.40	$242.30	$223.80	$119.90	$170.60	$205.20	$201.20
66	$177.90	$211.70	$243.10	$227.10	$246.90	$229.60	$122.90	$175.10	$210.30	$206.50
67	$181.50	$216.90	$249.40	$233.40	$253.10	$235.70	$126.40	$179.90	$215.90	$212.20
68	$185.30	$222.00	$255.80	$239.90	$259.50	$242.30	$129.80	$184.90	$221.80	$218.30
69	$188.60	$226.70	$262.10	$246.00	$265.80	$248.40	$133.30	$189.80	$227.40	$224.30
70-71	$193.30	$233.80	$271.20	$255.10	$274.60	$257.40	$138.20	$196.80	$235.20	$232.80
72-74	$200.10	$243.70	$286.20	$270.50	$290.90	$272.70	$146.60	$208.70	$248.70	$247.30
75-79	$206.00	$255.80	$307.90	$293.00	$312.40	$295.10	$159.00	$226.10	$268.10	$269.20
80+	$202.60	$264.50	$345.60	$328.50	$350.20	$330.60	$178.60	$253.70	$297.20	$305.70

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.

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

Disclosures
Use this Outline to compare benefits and premiums among policies.

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.

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.

Notice
- This policy may not fully cover all of your medical costs.
- 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 the *Medicare and You* handbook for more details.

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

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

*A benefit period begins on the first day you receive services 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 $1,340	$0	$1,340 (Part A deductible)
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $670	$670 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 $167.50 a day	$0	Up to $167.50 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 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 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 A
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $183 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 $183 of Medicare Approved Amounts*	$0	$0	$183 (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 $183 of Medicare Approved Amounts*	$0	$0	$183 (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 $183 of Medicare Approved Amounts*	$0	$0	$183 (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 services 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 $1,340	$1,340 (Part A deductible)	$0
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $670	$670 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 $167.50 a day	$0	Up to $167.50 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 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 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 B
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $183 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 $183 of Medicare Approved Amounts*	$0	$0	$183 (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 $183 of Medicare Approved Amounts*	$0	$0	$183 (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 $183 of Medicare Approved Amounts*	$0	$0	$183 (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 services 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 $1,340	$1,340 (Part A deductible)	$0
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $670	$670 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 $167.50 a day	Up to $167.50 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 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 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 C
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $183 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 $183 of Medicare Approved Amounts*	$0	$183 (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 $183 of Medicare Approved Amounts*	$0	$183 (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 $183 of Medicare Approved Amounts*	$0	$183 (Part B deductible)	$0
- Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN C
OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN 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

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

*A benefit period begins on the first day you receive services 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 $1,340	$1,340 (Part A deductible)	$0
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $670	$670 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 $167.50 a day	Up to $167.50 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 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 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 D
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $183 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 $183 of Medicare Approved Amounts*	$0	$0	$183 (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 $183 of Medicare Approved Amounts*	$0	$0	$183 (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 $183 of Medicare Approved Amounts*	$0	$0	$183 (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 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 services 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 $1,340	$1,340 (Part A deductible)	$0
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $670	$670 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 $167.50 a day	Up to $167.50 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 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 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 F
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $183 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 $183 of Medicare Approved Amounts*	$0	$183 (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 $183 of Medicare Approved Amounts*	$0	$183 (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	100%	$0	$0
Durable medical equipment			
- First $183 of Medicare Approved Amounts*	$0	$183 (Part B deductible)	$0
- Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN F
OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN 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

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

*A benefit period begins on the first day you receive services 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 $1,340	$1,340 (Part A deductible)	$0
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $670	$670 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 $167.50 a day	Up to $167.50 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 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 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 G
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $183 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 $183 of Medicare Approved Amounts*	$0	$0	$183 (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 $183 of Medicare Approved Amounts*	$0	$0	$183 (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 $183 of Medicare Approved Amounts*	$0	$0	$183 (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 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

*You will pay half of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $5,240 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.

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

**A benefit period begins on the first day you receive services 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 $1,340	$670 (50% of Part A deductible)	$670 (50% of Part A deductible) ♦
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $670	$670 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 $167.50 a day	Up to $83.75 a day (50% of Part A coinsurance)	Up to $83.75 a day (50% of Part A coinsurance) ♦
101st day and after	$0	$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
BLOOD First 3 pints Additional amounts	 $0 100%	 50% $0	 50% ♦ $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.	50% Medicare copayment/coinsurance	50% 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 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 K
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

****Once you have been billed $183 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 $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B deductible)****♦
Preventive Benefits For Medicare covered services	Generally 80% 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 $5,240)*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
BLOOD			
First 3 pints	$0	50%	50%♦
Next $183 of Medicare Approved Amounts****	$0	$0	$183 (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 $5,240 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 Durable medical equipment	100%	$0	$0
- First $183 of Medicare Approved Amounts*****	$0	$0	$183 (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

*You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $2,620 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.

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

**A benefit period begins on the first day you receive services 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 $1,340	$1,005 (75% of Part A deductible)	$335 (25% of Part A deductible) ♦
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $670	$670 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 $167.50 a day	Up to $125.63 a day (75% of Part A coinsurance)	Up to $41.87 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 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 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 L
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

****Once you have been billed $183 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 $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B deductible)****♦
Preventive Benefits For Medicare covered services	Generally 80% 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 $2,620)*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
BLOOD			
First 3 pints	$0	75%	25%♦
Next $183 of Medicare Approved Amounts****	$0	$0	$183 (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 $2,620 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 Durable medical equipment	100%	$0	$0
- First $183 of Medicare Approved Amounts*****	$0	$0	$183 (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 services 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 $1,340	$670 (50% of Part A deductible)	$670 (50% of Part A deductible)
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $670	$670 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 $167.50 a day	Up to $167.50 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 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 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 M
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $183 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 $183 of Medicare Approved Amounts*	$0	$0	$183 (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 $183 of Medicare Approved Amounts*	$0	$0	$183 (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 $183 of Medicare Approved Amounts*	$0	$0	$183 (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 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 services 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 $1,340	$1,340 (Part A deductible)	$0
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $670	$670 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 $167.50 a day	Up to $167.50 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 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 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
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $183 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 $183 of Medicare Approved Amounts*	$0	$0	$183 (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 $183 of Medicare Approved Amounts*	$0	$0	$183 (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 MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment	100%	$0	$0
- First $183 of Medicare Approved Amounts*	$0	$0	$183 (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 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