Florida Blue | MEDICARE

FLORIDA BLUE**
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE – Cover Page
BlueMedicare Supplement Select Plans B, C, D, M
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	Select B	Select D	G[1]	K	L	Select M	N	Select C 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.

Disclosures

Use this Outline to compare benefits and premiums among policies.

Florida Blue has a procedure to respond to member grievance issues. If you are dissatisfied with our handling of a claim denial or are dissatisfied for any reason, you may submit a formal grievance. Grievances must be submitted in writing and contain the words “This is a Grievance” to ensure that we understand the purpose of the communication. Please clearly state the nature of your grievance and submit your written grievance to Florida Blue Attn: Medicare Appeals and Grievances Department P.O. Box 41629 Jacksonville, FL 32203-1629. Each grievance shall be processed within a maximum of 60 days after it is first received by Florida Blue.

For complete details on the grievance process, please refer to the Grievance Procedure subsection in Section 10: General Provisions of your plan.

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 C	Plan F	Select B	Select C	Select D	Select M
Under 65	$853.10	$1167.40	$1186.10	$853.80	$1022.00	$920.10	$914.10
65	$252.60	$345.60	$351.10	$283.00	$338.80	$305.00	$302.90
66	$257.80	$352.50	$357.80	$290.80	$346.20	$314.70	$312.50
67	$263.00	$361.30	$366.70	$299.00	$356.60	$324.90	$322.70
68	$268.50	$370.70	$376.20	$307.00	$366.90	$335.30	$333.10
69	$273.50	$379.80	$385.00	$314.60	$377.10	$345.50	$343.00
70-71	$280.20	$393.00	$398.10	$325.10	$391.80	$360.50	$357.90
72-74	$289.90	$415.00	$421.40	$339.70	$415.30	$384.00	$381.20
75-79	$298.60	$446.20	$452.60	$353.80	$448.30	$416.20	$413.10
80+	$293.50	$501.00	$507.40	$349.00	$493.60	$461.40	$456.90

NOTE: BlueMedicare Supplement Select plans include restricted network provisions. You must use hospitals that participate in a network program to receive full Medicare supplemental benefits.

You have the right to purchase any plan offered by Florida Blue, with or without restricted network provisions.

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 C	Plan F	Select B	Select C	Select D	Select M
Under 65	$937.80	$1284.30	$1304.30	$939.30	$1125.00	$1012.00	$1005.10
65	$277.70	$380.30	$386.20	$311.40	$372.70	$335.40	$333.10
66	$283.50	$387.70	$393.60	$320.00	$380.90	$346.20	$343.90
67	$289.40	$397.60	$403.50	$328.90	$392.30	$357.40	$355.10
68	$295.40	$407.80	$413.80	$337.80	$403.70	$368.80	$366.30
69	$300.80	$417.70	$423.60	$346.10	$414.70	$380.20	$377.40
70-71	$308.10	$432.30	$438.00	$357.60	$431.10	$396.50	$393.60
72-74	$318.90	$456.50	$463.60	$373.80	$457.00	$422.20	$419.40
75-79	$328.50	$490.90	$497.90	$389.10	$493.20	$457.70	$454.20
80+	$323.00	$550.90	$558.00	$384.00	$542.90	$507.40	$502.60

NOTE: BlueMedicare Supplement Select plans include restricted network provisions. You must use hospitals that participate in a network program to receive full Medicare supplemental benefits.

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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 C	Plan F	Select B	Select C	Select D	Select M
Under 65	$840.30	$1149.90	$1168.30	$841.00	$1006.70	$906.30	$900.30
65	$248.80	$340.50	$345.90	$278.70	$333.70	$300.40	$298.40
66	$253.90	$347.20	$352.50	$286.50	$341.00	$310.00	$307.90
67	$259.10	$355.90	$361.20	$294.50	$351.20	$320.10	$317.90
68	$264.50	$365.10	$370.50	$302.40	$361.40	$330.30	$328.10
69	$269.40	$374.10	$379.20	$309.90	$371.50	$340.30	$337.90
70-71	$276.00	$387.20	$392.20	$320.20	$386.00	$355.10	$352.50
72-74	$285.60	$408.80	$415.10	$334.60	$409.10	$378.20	$375.50
75-79	$294.20	$439.50	$445.90	$348.50	$441.50	$409.90	$406.90
80+	$289.10	$493.50	$499.80	$343.80	$486.20	$454.50	$450.00

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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 C	Plan F	Select B	Select C	Select D	Select M
Under 65	$923.70	$1265.10	$1284.80	$925.20	$1108.10	$996.80	$990.00
65	$273.60	$374.60	$380.40	$306.70	$367.20	$330.40	$328.10
66	$279.30	$381.90	$387.70	$315.20	$375.20	$341.00	$338.70
67	$285.10	$391.60	$397.40	$323.90	$386.40	$352.10	$349.80
68	$291.00	$401.70	$407.60	$332.70	$397.60	$363.30	$360.80
69	$296.30	$411.40	$417.20	$340.90	$408.50	$374.50	$371.80
70-71	$303.50	$425.80	$431.50	$352.20	$424.60	$390.60	$387.70
72-74	$314.10	$449.70	$456.70	$368.20	$450.20	$415.80	$413.10
75-79	$323.60	$483.60	$490.40	$383.20	$485.80	$450.90	$447.40
80+	$318.20	$542.70	$549.70	$378.20	$534.70	$499.80	$495.10

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You have the right to purchase any plan offered by Florida Blue, with or without restricted network provisions.

This Chart displays premiums for the following counties, classified as Area 2, for Plans A, C, F: 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 and the following counties for plans Select B, Select C, Select D, Select M: Bay, Charlotte, Clay, Collier, Duval, Escambia, Hernando, Highlands, Hillsborough, Indian River, Lee, Manatee, Okaloosa, Okeechobee, Orange, Osceola, Pasco, Pinellas, Saint John's, Saint Lucie, Santa Rosa, Sarasota, Seminole.

MONTHLY PREMIUM - NON TOBACCO USER

Age At Enrollment	Plan A	Plan C	Plan F	Select B	Select C	Select D	Select M
Under 65	$600.70	$821.80	$835.00	$578.10	$691.90	$622.90	$618.80
65	$178.00	$243.30	$247.20	$191.50	$229.30	$206.40	$205.00
66	$181.50	$248.10	$252.00	$196.90	$234.40	$213.00	$211.50
67	$185.20	$254.60	$258.30	$202.30	$241.40	$220.00	$218.50
68	$189.10	$260.90	$264.80	$207.70	$248.40	$227.00	$225.50
69	$192.40	$267.30	$271.00	$213.00	$255.30	$233.80	$232.20
70-71	$197.30	$276.80	$280.30	$220.10	$265.30	$243.90	$242.30
72-74	$204.20	$292.20	$296.90	$229.90	$281.10	$259.80	$257.90
75-79	$210.40	$314.20	$318.70	$239.40	$303.50	$281.80	$279.60
80+	$206.80	$352.70	$357.40	$236.30	$334.30	$312.30	$309.20

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This Chart displays premiums for the following counties, classified as Area 2, for Plans A, C, F: 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 and the following counties for plans Select B, Select C, Select D, Select M: Bay, Charlotte, Clay, Collier, Duval, Escambia, Hernando, Highlands, Hillsborough, Indian River, Lee, Manatee, Okaloosa, Okeechobee, Orange, Osceola, Pasco, Pinellas, Saint John's, Saint Lucie, Santa Rosa, Sarasota, Seminole.

MONTHLY PREMIUM - TOBACCO USER

Age At Enrollment	Plan A	Plan C	Plan F	Select B	Select C	Select D	Select M
Under 65	$660.70	$903.90	$918.20	$635.70	$761.30	$685.50	$680.90
65	$195.80	$267.70	$272.00	$210.60	$252.30	$227.10	$225.70
66	$199.50	$273.10	$277.20	$216.60	$257.90	$234.30	$232.80
67	$203.80	$280.00	$284.20	$222.60	$265.60	$242.00	$240.40
68	$208.00	$287.10	$291.40	$228.70	$273.20	$249.60	$247.80
69	$211.70	$294.10	$298.20	$234.30	$280.80	$257.30	$255.50
70-71	$217.10	$304.50	$308.30	$242.10	$291.80	$268.40	$266.50
72-74	$224.60	$321.40	$326.50	$252.90	$309.30	$285.90	$283.80
75-79	$231.40	$345.60	$350.70	$263.30	$334.00	$309.90	$307.60
80+	$227.40	$388.00	$393.00	$259.90	$367.60	$343.40	$340.10

NOTE: BlueMedicare Supplement Select plans include restricted network provisions. You must use hospitals that participate in a network program to receive full Medicare supplemental benefits.

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This Chart displays premiums for the following counties, classified as Area 2, for Plans A, C, F: 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 and the following counties for plans Select B, Select C, Select D, Select M: Bay, Charlotte, Clay, Collier, Duval, Escambia, Hernando, Highlands, Hillsborough, Indian River, Lee, Manatee, Okaloosa, Okeechobee, Orange, Osceola, Pasco, Pinellas, Saint John's, Saint Lucie, Santa Rosa, Sarasota, Seminole.

AUTOMATIC PAYMENT OPTION MONTHLY PREMIUM - NON TOBACCO USER

Age At Enrollment	Plan A	Plan C	Plan F	Select B	Select C	Select D	Select M
Under 65	$591.70	$809.50	$822.40	$569.40	$681.60	$613.50	$609.50
65	$175.30	$239.70	$243.50	$188.70	$225.90	$203.30	$201.90
66	$178.70	$244.40	$248.30	$194.00	$230.90	$209.80	$208.30
67	$182.40	$250.80	$254.50	$199.30	$237.80	$216.70	$215.20
68	$186.30	$257.00	$260.80	$204.60	$244.70	$223.60	$222.10
69	$189.60	$263.30	$267.00	$209.80	$251.40	$230.30	$228.70
70-71	$194.30	$272.70	$276.10	$216.80	$261.30	$240.20	$238.60
72-74	$201.20	$287.80	$292.40	$226.40	$276.80	$255.90	$254.00
75-79	$207.20	$309.50	$313.90	$235.80	$299.00	$277.60	$275.40
80+	$203.70	$347.40	$352.10	$232.80	$329.20	$307.60	$304.60

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This Chart displays premiums for the following counties, classified as Area 2, for Plans A, C, F: 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 and the following counties for plans Select B, Select C, Select D, Select M: Bay, Charlotte, Clay, Collier, Duval, Escambia, Hernando, Highlands, Hillsborough, Indian River, Lee, Manatee, Okaloosa, Okeechobee, Orange, Osceola, Pasco, Pinellas, Saint John's, Saint Lucie, Santa Rosa, Sarasota, Seminole.

AUTOMATIC PAYMENT OPTION MONTHLY PREMIUM - TOBACCO USER

Age At Enrollment	Plan A	Plan C	Plan F	Select B	Select C	Select D	Select M
Under 65	$650.80	$890.30	$904.40	$626.10	$749.90	$675.30	$670.70
65	$192.90	$263.70	$267.90	$207.50	$248.60	$223.70	$222.30
66	$196.50	$269.00	$273.10	$213.40	$254.00	$230.70	$229.30
67	$200.80	$275.80	$279.90	$219.30	$261.60	$238.40	$236.80
68	$204.90	$282.80	$287.00	$225.30	$269.10	$245.80	$244.10
69	$208.50	$289.70	$293.80	$230.70	$276.60	$253.40	$251.70
70-71	$213.80	$300.00	$303.70	$238.50	$287.50	$264.30	$262.50
72-74	$221.20	$316.60	$321.60	$249.10	$304.70	$281.60	$279.60
75-79	$227.90	$340.50	$345.50	$259.30	$329.00	$305.30	$303.00
80+	$224.00	$382.10	$387.20	$256.00	$362.10	$338.30	$335.00

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You have the right to purchase any plan offered by Florida Blue, with or without restricted network provisions.

This Chart displays premiums for the following counties, classified as Area 3, for Plans A, C, F: 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 and the following counties for plans Select B, Select C, Select D, Select M: Leon, Alachua, Bradford, Citrus, Columbia, Flagler, Hamilton, Lake, Marion, Polk, Putnam, Sumter, Suwannee, Volusia.

MONTHLY PREMIUM - NON TOBACCO USER

Age At Enrollment	Plan A	Plan C	Plan F	Select B	Select C	Select D	Select M
Under 65	$566.30	$775.40	$787.40	$545.60	$652.60	$587.10	$583.50
65	$167.70	$229.50	$233.20	$180.80	$216.30	$194.60	$193.40
66	$171.10	$234.10	$237.40	$185.60	$221.10	$200.90	$199.70
67	$174.60	$239.80	$243.60	$191.00	$227.60	$207.40	$206.10
68	$178.40	$246.10	$249.80	$196.10	$234.10	$214.00	$212.70
69	$181.60	$252.20	$255.60	$200.70	$240.70	$220.60	$219.10
70-71	$186.00	$260.90	$264.20	$207.60	$250.30	$230.00	$228.30
72-74	$192.40	$275.50	$279.90	$216.90	$265.30	$245.20	$243.30
75-79	$198.30	$296.10	$300.50	$226.00	$286.20	$265.70	$263.70
80+	$194.80	$332.70	$336.90	$222.90	$315.20	$294.60	$291.70

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This Chart displays premiums for the following counties, classified as Area 3, for Plans A, C, F: 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 and the following counties for plans Select B, Select C, Select D, Select M: Leon, Alachua, Bradford, Citrus, Columbia, Flagler, Hamilton, Lake, Marion, Polk, Putnam, Sumter, Suwannee, Volusia.

MONTHLY PREMIUM - TOBACCO USER

Age At Enrollment	Plan A	Plan C	Plan F	Select B	Select C	Select D	Select M
Under 65	$623.00	$852.70	$866.20	$599.90	$718.00	$645.70	$642.10
65	$184.50	$252.40	$256.60	$198.80	$237.90	$214.00	$212.80
66	$188.30	$257.40	$261.30	$204.20	$243.30	$221.00	$219.50
67	$192.00	$264.00	$267.80	$210.10	$250.40	$228.10	$226.70
68	$196.20	$270.60	$274.80	$215.60	$257.60	$235.40	$234.00
69	$199.70	$277.30	$281.40	$220.90	$264.90	$242.60	$240.80
70-71	$204.60	$287.10	$290.60	$228.30	$275.40	$253.10	$251.20
72-74	$211.70	$303.10	$307.90	$238.60	$291.80	$269.70	$267.50
75-79	$218.00	$325.80	$330.50	$248.50	$314.90	$292.30	$290.10
80+	$214.40	$365.90	$370.70	$245.20	$346.70	$324.10	$320.90

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This Chart displays premiums for the following counties, classified as Area 3, for Plans A, C, F: 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 and the following counties for plans Select B, Select C, Select D, Select M: Leon, Alachua, Bradford, Citrus, Columbia, Flagler, Hamilton, Lake, Marion, Polk, Putnam, Sumter, Suwannee, Volusia.

AUTOMATIC PAYMENT OPTION MONTHLY PREMIUM - NON TOBACCO USER

Age At Enrollment	Plan A	Plan C	Plan F	Select B	Select C	Select D	Select M
Under 65	$557.80	$763.70	$775.60	$537.40	$642.80	$578.30	$574.80
65	$165.10	$226.10	$229.70	$178.10	$213.10	$191.70	$190.50
66	$168.60	$230.60	$233.90	$182.80	$217.80	$197.90	$196.70
67	$172.00	$236.20	$239.90	$188.10	$224.10	$204.30	$203.00
68	$175.70	$242.40	$246.00	$193.10	$230.60	$210.80	$209.50
69	$178.90	$248.40	$251.80	$197.70	$237.10	$217.30	$215.80
70-71	$183.20	$257.00	$260.30	$204.50	$246.50	$226.60	$224.90
72-74	$189.60	$271.30	$275.70	$213.70	$261.30	$241.50	$239.70
75-79	$195.40	$291.60	$296.00	$222.60	$281.90	$261.80	$259.80
80+	$191.90	$327.70	$331.90	$219.50	$310.40	$290.20	$287.30

NOTE: BlueMedicare Supplement Select plans include restricted network provisions. You must use hospitals that participate in a network program to receive full Medicare supplemental benefits.

You have the right to purchase any plan offered by Florida Blue, with or without restricted network provisions.

This Chart displays premiums for the following counties, classified as Area 3, for Plans A, C, F: 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 and the following counties for plans Select B, Select C, Select D, Select M: Leon, Alachua, Bradford, Citrus, Columbia, Flagler, Hamilton, Lake, Marion, Polk, Putnam, Sumter, Suwannee, Volusia.

AUTOMATIC PAYMENT OPTION MONTHLY PREMIUM - TOBACCO USER

Age At Enrollment	Plan A	Plan C	Plan F	Select B	Select C	Select D	Select M
Under 65	$613.70	$839.90	$853.20	$590.90	$707.20	$636.00	$632.40
65	$181.80	$248.60	$252.70	$195.90	$234.30	$210.80	$209.60
66	$185.50	$253.50	$257.40	$201.20	$239.70	$217.70	$216.20
67	$189.20	$260.00	$263.80	$206.90	$246.70	$224.70	$223.30
68	$193.20	$266.60	$270.70	$212.40	$253.70	$231.90	$230.50
69	$196.70	$273.20	$277.10	$217.50	$260.90	$238.90	$237.20
70-71	$201.60	$282.80	$286.20	$224.90	$271.20	$249.30	$247.40
72-74	$208.50	$298.50	$303.30	$235.10	$287.50	$265.60	$263.50
75-79	$214.70	$320.90	$325.60	$244.80	$310.20	$287.90	$285.70
80+	$211.20	$360.40	$365.10	$241.50	$341.50	$319.20	$316.00

NOTE: BlueMedicare Supplement Select plans include restricted network provisions. You must use hospitals that participate in a network program to receive full Medicare supplemental benefits.

You have the right to purchase any plan offered by Florida Blue, with or without restricted network provisions.

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. You may be eligible for a guaranteed issue plan through any other Medicare Supplement Insurer or the Blue Cross and Blue Shield plan serving the area where you now reside. For further information, please contact the Medicare Supplement insurer or the Blue Cross and Blue Shield plan serving your new area of residence.

MONTHLY PREMIUM - NON TOBACCO USER

Age At Enrollment	Plan A	Plan C	Plan F	Select B	Select C	Select D	Select M
Under 65	$683.20	$934.20	$949.00	$657.20	$786.10	$707.40	$702.90
65	$202.20	$276.70	$281.00	$217.80	$260.50	$234.40	$232.90
66	$206.40	$282.00	$286.20	$223.80	$266.30	$242.10	$240.40
67	$210.50	$289.30	$293.40	$229.90	$274.40	$250.00	$248.40
68	$214.80	$296.80	$300.90	$236.20	$282.20	$257.70	$256.10
69	$218.80	$303.90	$308.30	$242.10	$290.10	$265.70	$263.90
70-71	$224.20	$314.60	$318.50	$250.20	$301.50	$277.30	$275.40
72-74	$232.10	$332.10	$337.30	$261.20	$319.50	$295.30	$293.20
75-79	$239.00	$357.20	$362.20	$272.20	$344.90	$320.10	$317.80
80+	$235.00	$400.90	$406.20	$268.50	$379.60	$355.00	$351.50

NOTE: BlueMedicare Supplement Select plans include restricted network provisions. You must use hospitals that participate in a network program to receive full Medicare supplemental benefits.

You have the right to purchase any plan offered by Florida Blue, with or without restricted network provisions.

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. You may be eligible for a guaranteed issue plan through any other Medicare Supplement Insurer or the Blue Cross and Blue Shield plan serving the area where you now reside. For further information, please contact the Medicare Supplement insurer or the Blue Cross and Blue Shield plan serving your new area of residence.

MONTHLY PREMIUM - TOBACCO USER

Age At Enrollment	Plan A	Plan C	Plan F	Select B	Select C	Select D	Select M
Under 65	$751.20	$1027.70	$1043.50	$722.90	$864.70	$778.40	$773.30
65	$222.40	$304.40	$309.10	$239.70	$286.60	$257.90	$256.30
66	$227.00	$310.20	$315.00	$246.10	$293.00	$266.30	$264.40
67	$231.50	$318.20	$322.90	$252.90	$301.90	$275.10	$273.20
68	$236.40	$326.40	$331.00	$259.80	$310.50	$283.50	$281.80
69	$240.60	$334.40	$339.10	$266.30	$319.10	$292.30	$290.20
70-71	$246.70	$346.00	$350.30	$275.20	$331.50	$305.00	$302.80
72-74	$255.20	$365.20	$371.10	$287.50	$351.60	$324.90	$322.50
75-79	$262.90	$392.80	$398.50	$299.30	$379.30	$352.20	$349.60
80+	$258.50	$441.00	$446.70	$295.30	$417.60	$390.40	$386.60

NOTE: BlueMedicare Supplement Select plans include restricted network provisions. You must use hospitals that participate in a network program to receive full Medicare supplemental benefits.

You have the right to purchase any plan offered by Florida Blue, with or without restricted network provisions.

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. You may be eligible for a guaranteed issue plan through any other Medicare Supplement Insurer or the Blue Cross and Blue Shield plan serving the area where you now reside. For further information, please contact the Medicare Supplement insurer or the Blue Cross and Blue Shield plan serving your new area of residence.

AUTOMATIC PAYMENT OPTION MONTHLY PREMIUM - NON TOBACCO USER

Age At Enrollment	Plan A	Plan C	Plan F	Select B	Select C	Select D	Select M
Under 65	$672.90	$920.10	$934.80	$647.30	$774.30	$696.70	$692.40
65	$199.20	$272.50	$276.70	$214.50	$256.60	$230.90	$229.50
66	$203.30	$277.80	$281.90	$220.40	$262.30	$238.50	$236.80
67	$207.40	$284.90	$289.00	$226.40	$270.20	$246.30	$244.70
68	$211.60	$292.30	$296.40	$232.60	$278.00	$253.90	$252.30
69	$215.50	$299.30	$303.70	$238.50	$285.70	$261.80	$259.90
70-71	$220.80	$309.90	$313.70	$246.40	$296.90	$273.10	$271.20
72-74	$228.60	$327.10	$332.30	$257.30	$314.70	$290.90	$288.80
75-79	$235.50	$351.80	$356.80	$268.10	$339.70	$315.30	$313.00
80+	$231.50	$394.90	$400.10	$264.50	$373.90	$349.60	$346.20

NOTE: BlueMedicare Supplement Select plans include restricted network provisions. You must use hospitals that participate in a network program to receive full Medicare supplemental benefits.

You have the right to purchase any plan offered by Florida Blue, with or without restricted network provisions.

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. You may be eligible for a guaranteed issue plan through any other Medicare Supplement Insurer or the Blue Cross and Blue Shield plan serving the area where you now reside. For further information, please contact the Medicare Supplement insurer or the Blue Cross and Blue Shield plan serving your new area of residence.

AUTOMATIC PAYMENT OPTION MONTHLY PREMIUM - TOBACCO USER

Age At Enrollment	Plan A	Plan C	Plan F	Select B	Select C	Select D	Select M
Under 65	$739.90	$1012.30	$1027.80	$712.10	$851.70	$766.70	$761.70
65	$219.10	$299.80	$304.40	$236.10	$282.30	$254.00	$252.40
66	$223.60	$305.50	$310.20	$242.40	$288.60	$262.30	$260.50
67	$228.10	$313.40	$318.00	$249.10	$297.40	$271.00	$269.10
68	$232.80	$321.50	$326.10	$255.90	$305.80	$279.30	$277.60
69	$237.00	$329.40	$334.00	$262.30	$314.30	$287.90	$285.90
70-71	$243.00	$340.90	$345.10	$271.10	$326.50	$300.40	$298.20
72-74	$251.40	$359.70	$365.50	$283.20	$346.30	$320.10	$317.60
75-79	$258.90	$386.90	$392.60	$294.80	$373.60	$346.90	$344.30
80+	$254.60	$434.40	$440.00	$290.90	$411.40	$384.50	$380.80

NOTE: BlueMedicare Supplement Select plans include restricted network provisions. You must use hospitals that participate in a network program to receive full Medicare supplemental benefits.

You have the right to purchase any plan offered by Florida Blue, with or without restricted network provisions.

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

SELECT 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	
		PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
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	$0	$1,632 (Part A deductible)
61st thru 90th day	All but $408 a day	$408 a day	$0	$0	$408 a day
91st day and after:					
--While using 60 lifetime reserve days	All but $816	$816 a day	$0	$0	$816 a day
--Once lifetime reserve days are used:					
--Additional 365 days	$0	100% of Medicare Eligible Expenses	$0	$0**	All costs
--Beyond the Additional 365 days	$0	$0	$0	All costs	All costs
EMERGENCY ADMISSIONS	Same as any other admission	Same as any other admission	Same as admission to participating hospital	All costs beyond lifetime maximum benefit	All costs beyond lifetime maximum benefit

**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.

SELECT B
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD
(continued)

*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
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

SELECT 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

SELECT B
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR
(continued)

*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
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

SELECT 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	
		PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
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	$0	$1,632 (Part A deductible)
61st thru 90th day	All but $408 a day	$408 a day	$0	$0	$408 a day
91st day and after:					
--While using 60 lifetime reserve days	All but $816	$816 a day	$0	$0	$816 a day
--Once lifetime reserve days are used:					
--Additional 365 days	$0	100% of Medicare Eligible Expenses	$0	$0**	All costs
--Beyond the Additional 365 days	$0	$0	$0	All costs	All costs
EMERGENCY ADMISSIONS	Same as any other admission	Same as any other admission	Same as admission to participating hospital	All costs beyond lifetime maximum benefit	All costs beyond lifetime maximum benefit

**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.**

SELECT C+
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD
(continued)

*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
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

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

SELECT 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

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

SELECT C+
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR
(continued)

*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
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	$240 (Part B deductible)	$0
- Remainder of Medicare Approved Amounts	80%	20%	$0

SELECT 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

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

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 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.

SELECT 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	
		PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
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	$0	$1,632 (Part A deductible)
61st thru 90th day	All but $408 a day	$408 a day	$0	$0	$408 a day
91st day and after:					
--While using 60 lifetime reserve days	All but $816	$816 a day	$0	$0	$816 a day
--Once lifetime reserve days are used:					
--Additional 365 days	$0	100% of Medicare Eligible Expenses	$0	$0**	All costs
--Beyond the Additional 365 days	$0	$0	$0	All costs	All costs
EMERGENCY ADMISSIONS	Same as any other admission	Same as any other admission	Same as admission to participating hospital	All costs beyond lifetime maximum benefit	All costs beyond lifetime maximum benefit

**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.

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

*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
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

SELECT 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

SELECT D
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR
(continued)

*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
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

SELECT 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 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 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.

SELECT 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	
		PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies					
First 60 days	All but $1,632	$816 (50% Part A deductible)	$0	$816	$1,632 (Part A deductible)
61st thru 90th day	All but $408 a day	$408 a day	$0	$0	$408 a day
91st day and after:					
--While using 60 lifetime reserve days	All but $816	$816 a day	$0	$0	$816 a day
--Once lifetime reserve days are used:					
--Additional 365 days	$0	100% of Medicare Eligible Expenses	$0	$0**	All costs
--Beyond the Additional 365 days	$0	$0	$0	All costs	All costs
EMERGENCY ADMISSIONS	Same as any other admission	Same as any other admission	Same as admission to participating hospital	All costs beyond lifetime maximum benefit	All costs beyond lifetime maximum benefit

****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.

SELECT M
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD
(continued)

*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
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

SELECT 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

SELECT M
MEDICARE (PARTS A & 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
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

SELECT 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