Medicare Supplement Insurance plan benefits

(Outline of Coverage)

Plans A, F, Innovative F, Innovative G, N & Innovative N

Anthem Blue Cross and Blue Shield
Nevada 2024

This booklet includes:
2024 Premium Rates
2023 Medicare deductibles, copays and maximum out-of-pocket costs

Call toll-free 866-438-9969 with questions.
Administrative Office: P.O. Box 659816, San Antonio, TX 78265-9116

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Benefit Chart of Medicare Supplement Plans Sold for Effective Dates on or after January 1, 2020

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

Plans shown in gray are available for purchase to those age 65 and over.

Note: A "✓" means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G[1,4]	K[4]	L	M	N[4]	C	F[1,4]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓[1]
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply[3]	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2023[2]					$6,940[2]	$3,470[2]				

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of $2,700 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible. We do not offer **High Deductible Plans F** or **G**.

[2] Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

[3] Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that do not result in an inpatient admission.

[4] **Innovative F, G & N** include additional benefits not contained in other standardized Medicare Supplement Plans as outlined in the following pages.

Finding the right plan for you

Plans A, F, Innovative F, Innovative G, N & Innovative N | Effective January 1, 2024
Premiums can change.

Next steps

- Compare the individual plan pages
- Choose the plan that meets your needs

Find your premium

Premiums for the plan you choose are determined by several factors, including age, county you live in, tobacco use and gender. Premium may adjust in the future as a result of the cost of medical services and supplies.

How to find your premium

Step 1:
Find your county

Step 2:
Use the premium table that applies to you (non-tobacco / tobacco)

Start comparing premiums

How to save on your monthly premium

Pay yearly or with automatic bank draft

- Save up to $48 when you pay your premium for the year.
- Save $2 a month when you pay by automatic bank draft.

Household Discount Program

- Save 5% when more than one member in your household is enrolled in one of our Medicare Supplement insurance plans.‡

Ready to enroll?

Go to the Application section of this booklet.

‡ Available on coverage effective dates June 1, 2010 or after. Members must occupy the same housing unit.

Finding your monthly premium

Plans A, F, Innovative F, Innovative G, N & Innovative N | Effective January 1, 2024
Premiums can change.

Step 1: Determine your Rating Area | County Area Guide

Find the county you live in from the list below.

Got your Rating Area? Now you are ready to go to **Step 2**.

County	Area	County	Area	County	Area
Carson City	**2**	Eureka	**2**	Nye	**2**
Churchill	**2**	Humboldt	**2**	Pershing	**2**
Clark	**1**	Lander	**2**	Storey	**2**
Douglas	**2**	Lincoln	**2**	Washoe	**2**
Elko	**2**	Lyon	**2**	White Pine	**2**
Esmeralda	**2**	Mineral	**2**		

Finding your monthly premium

Plans A, F, Innovative F, Innovative G, N & Innovative N | Effective January 1, 2024
Premiums can change. Premium is based upon your tobacco usage, age, area, gender and plan.

Step 2: Find your premium

Table 1 | Non-tobacco
If you have not used tobacco products in the past 12 months, use this table.

Area 1

Age*	Male					
	Plan **A**	Plan **F**	Innovative **F**	Innovative **G**	Plan **N**	Innovative **N**
65	$169.71	$291.95	$241.34	$177.64	$220.38	$150.35
66	176.66	303.29	250.70	184.91	228.93	156.20
67	183.62	314.63	260.08	192.19	237.47	162.03
68	190.56	325.94	269.43	199.46	246.02	167.85
69	197.51	337.24	278.77	206.70	254.56	173.69
70	204.47	348.60	288.16	213.99	263.11	179.52
71	211.43	359.89	297.49	221.26	271.67	185.35
72	218.37	371.21	306.85	228.54	280.19	191.17
73	225.32	382.54	316.24	235.80	288.73	197.00
74	232.27	393.86	325.58	243.07	297.28	202.84
75	239.23	405.18	334.94	250.34	305.83	208.66
76	246.18	416.48	344.28	257.59	314.37	214.48
77	253.12	427.83	353.67	264.89	322.92	220.32
78	260.08	439.14	363.02	272.16	331.48	226.16
79	267.04	450.46	372.37	279.40	340.01	231.98
80	273.99	461.81	381.74	286.70	348.56	237.83
81	280.93	473.10	391.09	293.96	357.10	243.66
82	287.88	484.41	400.43	301.21	365.65	249.46
83	294.84	495.74	409.80	308.49	374.17	255.28
84+	301.80	507.07	419.15	315.74	382.73	261.13

*Attained age as of the coverage effective date.

(see next page for more areas) →

Finding your monthly premium

Plans A, F, Innovative F, Innovative G, N & Innovative N | Effective January 1, 2024
Premiums can change. Premium is based upon your tobacco usage, age, area, gender and plan.

Step 2: Find your premium *(continued)*

Table 1 | Non-tobacco
If you have not used tobacco products in the past 12 months, use this table.

Area 1

Age*	Female					
	Plan **A**	Plan **F**	Innovative **F**	Innovative **G**	Plan **N**	Innovative **N**
65	$157.45	$271.18	$224.16	$164.29	$204.67	$139.65
66	163.20	280.53	231.89	170.29	211.77	144.49
67	168.95	289.88	239.63	176.30	218.80	149.29
68	174.68	299.28	247.40	182.33	225.89	154.12
69	180.41	308.64	255.12	188.34	232.98	158.96
70	186.15	318.03	262.89	194.37	240.02	163.76
71	191.90	327.40	270.64	200.38	247.12	168.61
72	197.63	336.79	278.39	206.41	254.20	173.43
73	203.37	346.15	286.14	212.44	261.27	178.25
74	209.10	355.53	293.89	218.45	268.34	183.09
75	214.84	364.91	301.65	224.48	275.44	187.92
76	220.59	374.26	309.38	230.48	282.48	192.73
77	226.32	383.65	317.13	236.49	289.58	197.57
78	232.05	393.02	324.88	242.53	296.65	202.40
79	237.79	402.39	332.62	248.55	303.70	207.21
80	243.52	411.78	340.38	254.57	310.80	212.04
81	249.26	421.15	348.13	260.59	317.89	216.90
82	255.00	430.53	355.88	266.61	324.95	221.72
83	260.73	439.90	363.63	272.62	332.02	226.54
84+	266.47	449.29	371.41	278.66	339.12	231.38

*Attained age as of the coverage effective date.

(see next page for more areas) ➔

Finding your monthly premium

Plans A, F, Innovative F, Innovative G, N & Innovative N | Effective January 1, 2024
Premiums can change. Premium is based upon your tobacco usage, age, area, gender and plan.

Step 2: Find your premium *(continued)*

Table 1 | Non-tobacco
If you have not used tobacco products in the past 12 months, use this table.

Area 2

Age*	Male					
	Plan **A**	Plan **F**	Innovative **F**	Innovative **G**	Plan **N**	Innovative **N**
65	$151.38	$260.42	$215.28	$158.45	$196.58	$134.11
66	157.58	270.53	223.62	164.94	204.21	139.33
67	163.79	280.65	231.99	171.43	211.82	144.53
68	169.98	290.74	240.33	177.92	219.45	149.72
69	176.18	300.82	248.66	184.38	227.07	154.93
70	182.39	310.95	257.04	190.88	234.69	160.13
71	188.60	321.02	265.36	197.36	242.33	165.33
72	194.79	331.12	273.71	203.86	249.93	170.52
73	200.99	341.23	282.09	210.33	257.55	175.72
74	207.18	351.32	290.42	216.82	265.17	180.93
75	213.39	361.42	298.77	223.30	272.80	186.12
76	219.59	371.50	307.10	229.77	280.42	191.32
77	225.78	381.62	315.47	236.28	288.04	196.53
78	231.99	391.71	323.81	242.77	295.68	201.73
79	238.20	401.81	332.15	249.22	303.29	206.93
80	244.40	411.93	340.51	255.74	310.92	212.14
81	250.59	422.01	348.85	262.21	318.53	217.34
82	256.79	432.09	357.18	268.68	326.16	222.52
83	263.00	442.20	365.54	275.17	333.76	227.71
84+	269.21	452.31	373.88	281.64	341.40	232.93

*Attained age as of the coverage effective date.

(see next page for more areas) →

Finding your monthly premium

Plans A, F, Innovative F, Innovative G, N & Innovative N | Effective January 1, 2024
Premiums can change. Premium is based upon your tobacco usage, age, area, gender and plan.

Step 2: Find your premium *(continued)*

Table 1 | Non-tobacco
If you have not used tobacco products in the past 12 months, use this table.

Area 2

Age*	Female					
	Plan **A**	Plan **F**	Innovative **F**	Innovative **G**	Plan **N**	Innovative **N**
65	$140.45	$241.89	$199.95	$146.55	$182.57	$124.57
66	145.57	250.23	206.85	151.90	188.90	128.89
67	150.70	258.57	213.75	157.26	195.17	133.17
68	155.81	266.96	220.68	162.64	201.49	137.48
69	160.93	275.31	227.57	168.00	207.82	141.79
70	166.05	283.68	234.50	173.38	214.10	146.07
71	171.17	292.04	241.41	178.74	220.43	150.40
72	176.29	300.42	248.32	184.12	226.75	154.70
73	181.41	308.77	255.24	189.50	233.05	159.00
74	186.52	317.13	262.15	194.86	239.36	163.32
75	191.64	325.50	269.07	200.24	245.69	167.62
76	196.77	333.84	275.97	205.59	251.97	171.92
77	201.88	342.22	282.88	210.95	258.31	176.23
78	206.99	350.57	289.79	216.34	264.61	180.54
79	212.11	358.93	296.70	221.71	270.90	184.83
80	217.22	367.31	303.62	227.08	277.23	189.14
81	222.34	375.67	310.53	232.45	283.56	193.47
82	227.46	384.03	317.44	237.82	289.86	197.77
83	232.57	392.39	324.36	243.18	296.16	202.07
84+	237.69	400.77	331.30	248.56	302.50	206.39

*Attained age as of the coverage effective date.

(see next page for table 2) →

Finding your monthly premium

Plans A, F, Innovative F, Innovative G, N & Innovative N | Effective January 1, 2024
Premiums can change. Premium is based upon your tobacco usage, age, area, gender and plan.

Step 2: Find your premium

Table 2 | For tobacco users
If you have used tobacco products in the past 12 months, use this table.

Area 1

Age*	Male					
	Plan **A**	Plan **F**	Innovative **F**	Innovative **G**	Plan **N**	Innovative **N**
65	$190.08	$326.98	$270.30	$198.96	$246.83	$168.39
66	197.86	339.68	280.78	207.10	256.40	174.94
67	205.65	352.39	291.29	215.25	265.97	181.47
68	213.43	365.05	301.76	223.40	275.54	187.99
69	221.21	377.71	312.22	231.50	285.11	194.53
70	229.01	390.43	322.74	239.67	294.68	201.06
71	236.80	403.08	333.19	247.81	304.27	207.59
72	244.57	415.76	343.67	255.96	313.81	214.11
73	252.36	428.44	354.19	264.10	323.38	220.64
74	260.14	441.12	364.65	272.24	332.95	227.18
75	267.94	453.80	375.13	280.38	342.53	233.70
76	275.72	466.46	385.59	288.50	352.09	240.22
77	283.49	479.17	396.11	296.68	361.67	246.76
78	291.29	491.84	406.58	304.82	371.26	253.30
79	299.08	504.52	417.05	312.93	380.81	259.82
80	306.87	517.23	427.55	321.10	390.39	266.37
81	314.64	529.87	438.02	329.24	399.95	272.90
82	322.43	542.54	448.48	337.36	409.53	279.40
83	330.22	555.23	458.98	345.51	419.07	285.91
84+	338.02	567.92	469.45	353.63	428.66	292.47

*Attained age as of the coverage effective date.

(see next page for more areas) →

Finding your monthly premium

Plans A, F, Innovative F, Innovative G, N & Innovative N | Effective January 1, 2024
Premiums can change. Premium is based upon your tobacco usage, age, area, gender and plan.

Step 2: Find your premium *(continued)*

Table 2 | For tobacco users
If you have used tobacco products in the past 12 months, use this table.

Area 1

Age*	Female					
	Plan **A**	Plan **F**	Innovative **F**	Innovative **G**	Plan **N**	Innovative **N**
65	$176.34	$303.72	$251.06	$184.00	$229.23	$156.41
66	182.78	314.19	259.72	190.72	237.18	161.83
67	189.22	324.67	268.39	197.46	245.06	167.20
68	195.64	335.19	277.09	204.21	253.00	172.61
69	202.06	345.68	285.73	210.94	260.94	178.04
70	208.49	356.19	294.44	217.69	268.82	183.41
71	214.93	366.69	303.12	224.43	276.77	188.84
72	221.35	377.20	311.80	231.18	284.70	194.24
73	227.77	387.69	320.48	237.93	292.62	199.64
74	234.19	398.19	329.16	244.66	300.54	205.06
75	240.62	408.70	337.85	251.42	308.49	210.47
76	247.06	419.17	346.51	258.14	316.38	215.86
77	253.48	429.69	355.19	264.87	324.33	221.28
78	259.90	440.18	363.87	271.63	332.25	226.69
79	266.32	450.68	372.53	278.38	340.14	232.08
80	272.74	461.19	381.23	285.12	348.10	237.48
81	279.17	471.69	389.91	291.86	356.04	242.93
82	285.60	482.19	398.59	298.60	363.94	248.33
83	292.02	492.69	407.27	305.33	371.86	253.72
84+	298.45	503.20	415.98	312.10	379.81	259.15

*Attained age as of the coverage effective date.

(see next page for more areas) ➔

Finding your monthly premium

Plans A, F, Innovative F, Innovative G, N & Innovative N | Effective January 1, 2024
Premiums can change. Premium is based upon your tobacco usage, age, area, gender and plan.

Step 2: Find your premium *(continued)*

Table 2 | For tobacco users
If you have used tobacco products in the past 12 months, use this table.

Area 2

Age*	Male					
	Plan **A**	Plan **F**	Innovative **F**	Innovative **G**	Plan **N**	Innovative **N**
65	$169.55	$291.67	$241.11	$177.47	$220.17	$150.21
66	176.49	303.00	250.46	184.73	228.71	156.05
67	183.44	314.33	259.83	192.01	237.24	161.87
68	190.38	325.63	269.17	199.27	245.78	167.69
69	197.32	336.92	278.50	206.50	254.32	173.52
70	204.27	348.27	287.88	213.78	262.86	179.35
71	211.23	359.54	297.20	221.05	271.41	185.17
72	218.16	370.85	306.56	228.32	279.92	190.99
73	225.10	382.17	315.94	235.57	288.45	196.81
74	232.05	393.48	325.27	242.84	296.99	202.65
75	239.00	404.79	334.62	250.10	305.54	208.46
76	245.94	416.08	343.95	257.34	314.07	214.27
77	252.88	427.42	353.33	264.64	322.61	220.11
78	259.83	438.72	362.67	271.90	331.16	225.94
79	266.78	450.03	372.01	279.13	339.68	231.76
80	273.73	461.37	381.37	286.42	348.23	237.60
81	280.66	472.65	390.71	293.68	356.76	243.43
82	287.60	483.94	400.05	300.92	365.30	249.22
83	294.56	495.26	409.41	308.19	373.81	255.03
84+	301.51	506.58	418.75	315.44	382.36	260.88

*Attained age as of the coverage effective date.

(see next page for more areas) ➔

Finding your monthly premium

Plans A, F, Innovative F, Innovative G, N & Innovative N | Effective January 1, 2024
Premiums can change. Premium is based upon your tobacco usage, age, area, gender and plan.

Step 2: Find your premium *(continued)*

Table 2 | For tobacco users
If you have used tobacco products in the past 12 months, use this table.

Area 2

Age*	Female					
	Plan **A**	Plan **F**	Innovative **F**	Innovative **G**	Plan **N**	Innovative **N**
65	$157.30	$270.92	$223.94	$164.13	$204.47	$139.52
66	163.04	280.26	231.67	170.13	211.57	144.35
67	168.79	289.60	239.40	176.13	218.59	149.15
68	174.51	298.99	247.16	182.15	225.67	153.97
69	180.24	308.34	254.88	188.16	232.76	158.81
70	185.97	317.72	262.64	194.18	239.79	163.60
71	191.72	327.09	270.38	200.19	246.88	168.45
72	197.44	336.47	278.12	206.21	253.96	173.26
73	203.17	345.82	285.87	212.24	261.02	178.08
74	208.90	355.19	293.61	218.24	268.08	182.91
75	214.63	364.56	301.36	224.26	275.18	187.74
76	220.38	373.90	309.08	230.26	282.21	192.54
77	226.10	383.28	316.83	236.26	289.30	197.38
78	231.83	392.64	324.57	242.30	296.37	202.21
79	237.56	402.00	332.30	248.31	303.41	207.01
80	243.29	411.38	340.05	254.33	310.50	211.84
81	249.02	420.75	347.80	260.34	317.58	216.69
82	254.76	430.12	355.54	266.35	324.64	221.51
83	260.48	439.48	363.28	272.36	331.70	226.32
84+	266.21	448.86	371.05	278.39	338.79	231.16

*Attained age as of the coverage effective date.

Important plan disclosures

Plans A, F, Innovative F, Innovative G, N & Innovative N
Retain this outline for your records.

Right to return policy

We, Anthem, can only raise your premium if we raise the premium for all plans like yours in this State. We will recalculate your age each year and adjust your premium based on the new age band in January, up to the age cap.

Disclosures

Use this outline to compare benefits and premiums among policies.

Medicare deductibles and coinsurance amounts are effective as of January 1, 2023. Medicare may change their amounts annually.

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 Anthem.

Right to return policy

If you find that you are not satisfied with your policy, you may return it to us at our Administrative Office: P.O. 659816, San Antonio, TX 78265-9116. 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 Anthem 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.

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.

You may contact the Commissioner of Insurance or the Nevada State Health Insurance Assistance Program (SHIP) of the Aging and Disability Services Division of the Department of Health and Human Services for help in understanding your health insurance.

Plan A

Medicare (Part A) – Hospital Services – per benefit period

Services	Medicare pays	Plan pays	You pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,600	$0	$1,600 (Part A deductible)
61st thru 90th day	All but $400 a day	$400 a day	$0
91st day and after: ∘ While using 60 lifetime reserve days	All but $800 a day	$800 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 $200 a day	$0	Up to $200 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

* 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.

** 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

(continued)

Medicare (Part B) – Medical Services – per 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 $226 of Medicare Approved Amounts*	$0	$0	$226 (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 $226 of Medicare Approved Amounts*	$0	$0	$226 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Clinical Laboratory Services			
Tests for Diagnostic Services	100%	$0	$0

Parts A & B Services

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 $226 of Medicare approved amounts*	$0	$0	$226 (Part B deductible)
— Remainder of Medicare approved amounts	80%	20%	$0

* Once you have been billed $226 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.

Plan F

Medicare (Part A) – Hospital Services – per benefit period

Services	Medicare pays	Plan pays	You pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,600	$1,600 (Part A deductible)	$0
61st thru 90th day	All but $400 a day	$400 a day	$0
91st day and after: ∘ While using 60 lifetime reserve days	All but $800 a day	$800 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 $200 a day	Up to $200 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

* 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.

** 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 F

(continued)

Medicare (Part B) – Medical Services – per 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 $226 of Medicare Approved Amounts*	$0	$226 (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 $226 of Medicare Approved Amounts*	$0	$226 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
Clinical Laboratory Services			
Tests for Diagnostic Services	100%	$0	$0

Parts A & B Services

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 $226 of Medicare approved amounts*	$0	$226 (Part B deductible)	$0
— Remainder of Medicare approved amounts	80%	20%	$0

* Once you have been billed $226 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.

Plan F

(continued)

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

Innovative F

Medicare (Part A) – Hospital Services – per benefit period

Services	Medicare pays	Plan pays	You pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,600	$1,600 (Part A deductible)	$0
61st thru 90th day	All but $400 a day	$400 a day	$0
91st day and after: ∘ While using 60 lifetime reserve days	All but $800 a day	$800 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 $200 a day	Up to $200 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

* 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.

** 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.

Innovative F

(continued)

Medicare (Part B) – Medical Services – per 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 $226 of Medicare Approved Amounts*	$0	$226 (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 $226 of Medicare Approved Amounts*	$0	$226 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
Clinical Laboratory Services			
Tests for Diagnostic Services	100%	$0	$0

Parts A & B Services

Home Health Care — Medicare approved services			
° Medically necessary skilled care services and medical supplies	100%	$0	$0
° Durable medical equipment: — First $226 of Medicare approved amounts*	$0	$226 (Part B deductible)	$0
— Remainder of Medicare approved amounts	80%	20%	$0
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

* Once you have been billed $226 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.

Innovative F

(continued)

Innovative Benefits – not covered by Medicare or Standardized Medicare Supplement plans

Services	Medicare pays	Plan pays	You pay
Routine Vision Benefit Through Blue View Vision Access network you can maximize your benefits. You may receive covered benefits outside of the Blue View Vision Access network. You will need to pay the provider at the time of service and submit a claim for reimbursement.			
A. Routine Eye Exam (with dilation as needed) once every 12 months	$0	In Network: 100% after the Copayment Out of Network: Up to $35 allowance	In Network: $25 copay Out of Network: Any amounts remaining after the Plan pays
B. Eyeglass Frames – Allowance toward new frames once every 24 months	$0	In-Network: $150 allowance Out-of-Network: Up to $45 allowance	Any amounts remaining after the Plan pays
C. Lenses: Standard Plastic (CR39) – up to 55 mm in: Single Vision, Bifocal, Trifocal (FT 25-28), Lenticular (once every 12 months)	$0	In Network: 100% after the Copayment Out of Network: Single Vision: Up to $25 Bifocal: Up to $40 Trifocal or Lenticular: Up to $55	In Network: $25 copay Out of Network: Any amounts remaining after the Plan pays
° Contact Lenses (in place of eyeglass lenses) – once every 12 months — Elective (conventional/disposable)	$0	In Network: $150 allowance Out of Network: Up to $80 allowance	Any amounts remaining after the Plan pays
— Non-Elective	$0	In Network: All Costs Out of Network: Up to $210 allowance	
Routine Hearing Benefit Through Hearing Care Solutions network of providers, coverage is provided for an annual hearing exam and hearing aid(s). This is separate from diagnostic hearing examinations and related charges as covered by Medicare. Includes a 60-day evaluation period, returns subject to a $75 restocking fee per hearing aid.			
Hearing Exam – Coverage for up to (1) routine hearing exam every 12 months.	$0	100%	$0
Hearing Aid(s) – Includes fitting evaluation for a hearing aid(s).	$0	Coverage allowance up to $750 toward a hearing device(s) every year. Includes 1-year supply of batteries (up to 64 cells per hearing aid).	Amounts in excess of Allowance

Innovative G

Medicare (Part A) – Hospital Services – per benefit period

Services	Medicare pays	Plan pays	You pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,600	$1,600 (Part A deductible)	$0
61st thru 90th day	All but $400 a day	$400 a day	$0
91st day and after: ∘ While using 60 lifetime reserve days	All but $800 a day	$800 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 $200 a day	Up to $200 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

* 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.

** 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.

Innovative G

(continued)

Medicare (Part B) – Medical Services – per 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 $226 of Medicare Approved Amounts*	$0	$0	$226 (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 $226 of Medicare Approved Amounts*	$0	$0	$226 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Clinical Laboratory Services			
Tests for Diagnostic Services	100%	$0	$0

Parts A & B Services

Home Health Care — Medicare approved services			
° Medically necessary skilled care services and medical supplies	100%	$0	$0
° Durable medical equipment: — First $226 of Medicare approved amounts*	$0	$0	$226 (Part B deductible)
— Remainder of Medicare approved amounts	80%	20%	$0
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

* Once you have been billed $226 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.

Innovative G

(continued)

Innovative Benefits – not covered by Medicare or Standardized Medicare Supplement plans

Services	Medicare pays	Plan pays	You pay
Routine Vision Benefit Through Blue View Vision Access network you can maximize your benefits. You may receive covered benefits outside of the Blue View Vision Access network. You will need to pay the provider at the time of service and submit a claim for reimbursement.			
A. Routine Eye Exam (with dilation as needed) once every 12 months	$0	In Network: 100% after the Copayment Out of Network: Up to $35 allowance	In Network: $25 copay Out of Network: Any amounts remaining after the Plan pays
B. Eyeglass Frames – Allowance toward new frames once every 24 months	$0	In-Network: $150 allowance Out-of-Network: Up to $45 allowance	Any amounts remaining after the Plan pays
C. Lenses: Standard Plastic (CR39) – up to 55 mm in: Single Vision, Bifocal, Trifocal (FT 25-28), Lenticular (once every 12 months)	$0	In Network: 100% after the Copayment Out of Network: Single Vision: Up to $25 Bifocal: Up to $40 Trifocal or Lenticular: Up to $55	In Network: $25 copay Out of Network: Any amounts remaining after the Plan pays
° Contact Lenses (in place of eyeglass lenses) – once every 12 months — Elective (conventional/disposable)	$0	In Network: $150 allowance Out of Network: Up to $80 allowance	Any amounts remaining after the Plan pays
— Non-Elective	$0	In Network: All Costs Out of Network: Up to $210 allowance	
Routine Hearing Benefit Through Hearing Care Solutions network of providers, coverage is provided for an annual hearing exam and hearing aid(s). This is separate from diagnostic hearing examinations and related charges as covered by Medicare. Includes a 60-day evaluation period, returns subject to a $75 restocking fee per hearing aid.			
Hearing Exam – Coverage for up to (1) routine hearing exam every 12 months.	$0	100%	$0
Hearing Aid(s) – Includes fitting evaluation for a hearing aid(s).	$0	Coverage allowance up to $750 toward a hearing device(s) every year. Includes 1-year supply of batteries (up to 64 cells per hearing aid).	Amounts in excess of Allowance

Plan N

Medicare (Part A) – Hospital Services – per benefit period

Services	Medicare pays	Plan pays	You pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,600	$1,600 (Part A deductible)	$0
61st thru 90th day	All but $400 a day	$400 a day	$0
91st day and after: ∘ While using 60 lifetime reserve days	All but $800 a day	$800 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 $200 a day	Up to $200 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

* 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.

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

Plan N

(continued)

Medicare (Part B) – Medical Services – per 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 $226 of Medicare Approved Amounts*	$0	$0	$226 (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 co-payment 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 co-payment 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 $226 of Medicare Approved Amounts*	$0	$0	$226 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Clinical Laboratory Services			
Tests for Diagnostic Services	100%	$0	$0

* Once you have been billed $226 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.

Plan N

(continued)

Parts A & B Services

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 $226 of Medicare approved amounts*	$0	$0	$226 (Part B deductible)
— Remainder of Medicare approved amounts	80%	20%	$0

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

* Once you have been billed $226 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.

Innovative N

Medicare (Part A) – Hospital Services – per benefit period

Services	Medicare pays	Plan pays	You pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,600	$1,600 (Part A deductible)	$0
61st thru 90th day	All but $400 a day	$400 a day	$0
91st day and after: ∘ While using 60 lifetime reserve days	All but $800 a day	$800 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 $200 a day	Up to $200 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

* 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.

** 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.

Innovative N

(continued)

Medicare (Part B) – Medical Services – per 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 $226 of Medicare Approved Amounts*	$0	$0	$226 (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 co-payment 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 co-payment 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 $226 of Medicare Approved Amounts*	$0	$0	$226 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Clinical Laboratory Services			
Tests for Diagnostic Services	100%	$0	$0

* Once you have been billed $226 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.

Parts A & B Services

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 $226 of Medicare approved amounts*	$0	$0	$226 (Part B deductible)
— Remainder of Medicare approved amounts	80%	20%	$0
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

* Once you have been billed $226 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.

Innovative N

(continued)

Innovative Benefits – not covered by Medicare or Standardized Medicare Supplement plans

Services	Medicare pays	Plan pays	You pay
Routine Vision Benefit Through Blue View Vision Access network you can maximize your benefits. You may receive covered benefits outside of the Blue View Vision Access network. You will need to pay the provider at the time of service and submit a claim for reimbursement.			
A. Routine Eye Exam (with dilation as needed) once every 12 months	$0	In Network: 100% after the Copayment Out of Network: Up to $35 allowance	In Network: $25 copay Out of Network: Any amounts remaining after the Plan pays
B. Eyeglass Frames – Allowance toward new frames once every 24 months	$0	In-Network: $150 allowance Out-of-Network: Up to $45 allowance	Any amounts remaining after the Plan pays
C. Lenses: Standard Plastic (CR39) – up to 55 mm in: Single Vision, Bifocal, Trifocal (FT 25-28), Lenticular (once every 12 months)	$0	In Network: 100% after the Copayment Out of Network: Single Vision: Up to $25 Bifocal: Up to $40 Trifocal or Lenticular: Up to $55	In Network: $25 copay Out of Network: Any amounts remaining after the Plan pays
° Contact Lenses (in place of eyeglass lenses) – once every 12 months — Elective (conventional/disposable)	$0	In Network: $150 allowance Out of Network: Up to $80 allowance	Any amounts remaining after the Plan pays
— Non-Elective	$0	In Network: All Costs Out of Network: Up to $210 allowance	
Routine Hearing Benefit Through Hearing Care Solutions network of providers, coverage is provided for an annual hearing exam and hearing aid(s). This is separate from diagnostic hearing examinations and related charges as covered by Medicare. Includes a 60-day evaluation period, returns subject to a $75 restocking fee per hearing aid.			
Hearing Exam – Coverage for up to (1) routine hearing exam every 12 months.	$0	100%	$0
Hearing Aid(s) – Includes fitting evaluation for a hearing aid(s).	$0	Coverage allowance up to $750 toward a hearing device(s) every year. Includes 1-year supply of batteries (up to 64 cells per hearing aid).	Amounts in excess of Allowance

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