Florida Blue

An Independent Licensee of the Blue Cross and Blue Shield Association

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

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

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

Basic Benefits:

- **Hospitalization** – Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses** – Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.
- **Blood** – First three pints of blood each year.
- **Hospice** – Part A coinsurance

A	Select B	Select C	C	Select D	F	F*	G	K	L	Select M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance		Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance		Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible		Part A Deductible	Part A Deductible		Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible						
					Part B Excess (100%)		Part B Excess (100%)				
		Foreign Travel Emergency		Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
								Out-of-pocket limit $5,560 paid at 100% after limit reached	Out-of-pocket limit $2,780 paid at 100% after limit reached		

*Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as plan F after one has paid a calendar year $2,780 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2,780. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the plan. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

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

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

MONTHLY PREMIUM - NON TOBACCO USER

Age At Enrollment	Plan A	Plan C	Plan F	Select B	Select C	Select D	Select M
Under 65	$715.80	$979.60	$995.30	$697.50	$834.90	$751.70	$746.70
65	$211.90	$290.00	$294.60	$239.90	$287.20	$258.50	$256.80
66	$216.30	$295.70	$300.20	$246.60	$293.50	$266.80	$265.00
67	$220.70	$303.20	$307.70	$253.50	$302.30	$275.50	$273.60
68	$225.30	$311.00	$315.60	$260.30	$311.10	$284.20	$282.40
69	$229.50	$318.70	$323.10	$266.70	$319.70	$292.90	$290.80
70-71	$235.10	$329.80	$334.10	$275.60	$332.20	$305.60	$303.40
72-74	$243.30	$348.20	$353.60	$288.00	$352.10	$325.50	$323.20
75-79	$250.60	$374.40	$379.80	$299.90	$380.00	$352.80	$350.20
80+	$246.30	$420.40	$425.80	$295.90	$418.50	$391.10	$387.30

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 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	$786.90	$1077.70	$1094.50	$767.30	$919.00	$826.70	$821.10
65	$233.00	$319.10	$324.10	$264.00	$316.00	$284.40	$282.40
66	$237.90	$325.30	$330.20	$271.30	$322.90	$293.50	$291.50
67	$242.80	$333.60	$338.60	$278.80	$332.60	$303.00	$301.10
68	$247.90	$342.20	$347.20	$286.30	$342.20	$312.70	$310.60
69	$252.40	$350.50	$355.40	$293.40	$351.60	$322.30	$320.00
70-71	$258.60	$362.70	$367.50	$303.20	$365.40	$336.20	$333.70
72-74	$267.50	$383.10	$389.00	$316.90	$387.40	$357.90	$355.60
75-79	$275.60	$411.90	$417.80	$329.90	$418.10	$388.10	$385.10
80+	$271.00	$462.30	$468.20	$325.50	$460.20	$430.20	$426.10

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 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	$705.10	$964.90	$980.30	$687.10	$822.40	$740.40	$735.50
65	$208.70	$285.70	$290.20	$236.30	$282.90	$254.70	$253.00
66	$213.10	$291.30	$295.70	$242.90	$289.10	$262.80	$261.00
67	$217.40	$298.60	$303.00	$249.70	$297.80	$271.30	$269.50
68	$221.90	$306.40	$310.90	$256.40	$306.40	$280.00	$278.20
69	$226.00	$313.90	$318.20	$262.70	$314.90	$288.50	$286.40
70-71	$231.50	$324.80	$329.10	$271.50	$327.20	$301.00	$298.90
72-74	$239.60	$343.00	$348.30	$283.60	$346.80	$320.60	$318.30
75-79	$246.80	$368.80	$374.10	$295.40	$374.30	$347.50	$345.00
80+	$242.60	$414.10	$419.40	$291.40	$412.20	$385.30	$381.50

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 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	$775.10	$1061.50	$1078.10	$755.80	$905.20	$814.30	$808.80
65	$229.60	$314.30	$319.20	$260.00	$311.30	$280.10	$278.20
66	$234.30	$320.40	$325.30	$267.20	$318.10	$289.10	$287.20
67	$239.20	$328.60	$333.50	$274.60	$327.60	$298.50	$296.50
68	$244.20	$337.00	$342.00	$282.10	$337.10	$308.00	$305.90
69	$248.60	$345.20	$350.10	$289.00	$346.30	$317.50	$315.20
70-71	$254.70	$357.30	$362.00	$298.60	$360.00	$331.10	$328.70
72-74	$263.50	$377.30	$383.20	$312.10	$381.60	$352.50	$350.20
75-79	$271.50	$405.80	$411.50	$324.90	$411.80	$382.20	$379.30
80+	$267.00	$455.30	$461.20	$320.60	$453.30	$423.70	$419.70

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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 - NON TOBACCO USER

Age At Enrollment	Plan A	Plan C	Plan F	Select B	Select C	Select D	Select M
Under 65	$504.10	$689.60	$700.60	$472.20	$565.20	$508.80	$505.50
65	$149.30	$204.20	$207.40	$162.40	$194.40	$175.00	$173.80
66	$152.30	$208.20	$211.50	$167.00	$198.70	$180.60	$179.30
67	$155.40	$213.60	$216.80	$171.50	$204.70	$186.50	$185.30
68	$158.70	$218.90	$222.10	$176.10	$210.60	$192.40	$191.20
69	$161.50	$224.30	$227.40	$180.60	$216.40	$198.20	$196.90
70-71	$165.50	$232.30	$235.20	$186.60	$224.90	$206.80	$205.40
72-74	$171.40	$245.20	$249.10	$194.90	$238.30	$220.20	$218.60
75-79	$176.50	$263.60	$267.40	$202.90	$257.30	$238.90	$237.00
80+	$173.50	$296.00	$299.90	$200.30	$283.40	$264.70	$262.10

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MONTHLY PREMIUM - TOBACCO USER

Age At Enrollment	Plan A	Plan C	Plan F	Select B	Select C	Select D	Select M
Under 65	$554.40	$758.50	$770.50	$519.30	$621.90	$560.00	$556.30
65	$164.30	$224.60	$228.20	$178.60	$213.90	$192.50	$191.30
66	$167.40	$229.10	$232.60	$183.60	$218.60	$198.60	$197.40
67	$171.00	$235.00	$238.40	$188.70	$225.20	$205.20	$203.80
68	$174.50	$240.90	$244.50	$193.90	$231.60	$211.60	$210.10
69	$177.70	$246.80	$250.20	$198.60	$238.00	$218.10	$216.60
70-71	$182.10	$255.50	$258.70	$205.30	$247.40	$227.50	$225.90
72-74	$188.40	$269.70	$273.90	$214.40	$262.20	$242.40	$240.60
75-79	$194.20	$290.00	$294.30	$223.20	$283.10	$262.70	$260.80
80+	$190.80	$325.50	$329.80	$220.40	$311.70	$291.20	$288.30

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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	$496.50	$679.30	$690.10	$465.20	$556.80	$501.20	$497.90
65	$147.10	$201.10	$204.30	$160.00	$191.50	$172.40	$171.20
66	$150.00	$205.10	$208.30	$164.50	$195.70	$177.90	$176.60
67	$153.10	$210.40	$213.50	$169.00	$201.60	$183.70	$182.50
68	$156.30	$215.60	$218.80	$173.50	$207.40	$189.50	$188.30
69	$159.00	$220.90	$224.00	$177.90	$213.20	$195.30	$193.90
70-71	$163.00	$228.80	$231.70	$183.80	$221.60	$203.70	$202.30
72-74	$168.80	$241.50	$245.40	$192.00	$234.70	$216.90	$215.30
75-79	$173.90	$259.70	$263.40	$199.90	$253.40	$235.30	$233.50
80+	$170.90	$291.50	$295.40	$197.30	$279.10	$260.70	$258.20

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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	$546.10	$747.10	$758.90	$511.50	$612.60	$551.60	$547.90
65	$161.80	$221.30	$224.80	$175.90	$210.70	$189.70	$188.40
66	$164.90	$225.70	$229.10	$180.90	$215.30	$195.60	$194.40
67	$168.50	$231.40	$234.90	$185.90	$221.80	$202.10	$200.70
68	$171.90	$237.30	$240.80	$191.00	$228.10	$208.40	$206.90
69	$175.00	$243.10	$246.50	$195.60	$234.50	$214.90	$213.40
70-71	$179.40	$251.70	$254.80	$202.20	$243.70	$224.10	$222.50
72-74	$185.60	$265.60	$269.80	$211.20	$258.30	$238.70	$237.00
75-79	$191.30	$285.70	$289.90	$219.80	$278.90	$258.80	$256.90
80+	$187.90	$320.60	$324.80	$217.00	$307.00	$286.80	$284.00

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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 - NON TOBACCO USER

Age At Enrollment	Plan A	Plan C	Plan F	Select B	Select C	Select D	Select M
Under 65	$475.20	$650.60	$660.70	$445.70	$533.10	$479.60	$476.70
65	$140.70	$192.60	$195.60	$153.20	$183.40	$165.00	$164.00
66	$143.60	$196.40	$199.20	$157.30	$187.50	$170.30	$169.30
67	$146.50	$201.20	$204.40	$161.90	$192.90	$175.90	$174.80
68	$149.70	$206.50	$209.60	$166.20	$198.50	$181.40	$180.30
69	$152.40	$211.60	$214.50	$170.20	$204.00	$187.00	$185.70
70-71	$156.10	$218.90	$221.70	$176.00	$212.20	$195.00	$193.50
72-74	$161.50	$231.10	$234.80	$183.90	$224.90	$207.90	$206.30
75-79	$166.40	$248.40	$252.20	$191.60	$242.60	$225.30	$223.60
80+	$163.50	$279.10	$282.70	$189.00	$267.20	$249.80	$247.30

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MONTHLY PREMIUM - TOBACCO USER

Age At Enrollment	Plan A	Plan C	Plan F	Select B	Select C	Select D	Select M
Under 65	$522.80	$715.50	$726.80	$490.10	$586.60	$527.50	$524.50
65	$154.80	$211.80	$215.30	$168.60	$201.70	$181.40	$180.40
66	$158.00	$216.00	$219.20	$173.10	$206.30	$187.40	$186.10
67	$161.10	$221.50	$224.70	$178.10	$212.30	$193.40	$192.20
68	$164.60	$227.10	$230.60	$182.80	$218.40	$199.60	$198.40
69	$167.50	$232.70	$236.10	$187.20	$224.60	$205.60	$204.20
70-71	$171.70	$240.90	$243.80	$193.50	$233.50	$214.50	$212.90
72-74	$177.70	$254.30	$258.30	$202.30	$247.40	$228.60	$226.80
75-79	$182.90	$273.40	$277.30	$210.70	$266.90	$247.80	$245.90
80+	$179.90	$307.00	$311.00	$207.90	$293.90	$274.70	$272.00

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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	$468.00	$640.90	$650.80	$439.00	$525.10	$472.40	$469.50
65	$138.60	$189.70	$192.70	$150.90	$180.70	$162.50	$161.50
66	$141.40	$193.50	$196.20	$155.00	$184.70	$167.70	$166.80
67	$144.30	$198.20	$201.30	$159.50	$190.00	$173.20	$172.10
68	$147.40	$203.40	$206.40	$163.70	$195.50	$178.70	$177.60
69	$150.10	$208.40	$211.30	$167.60	$201.00	$184.20	$183.00
70-71	$153.70	$215.60	$218.40	$173.30	$209.00	$192.10	$190.60
72-74	$159.00	$227.70	$231.30	$181.10	$221.60	$204.80	$203.20
75-79	$163.90	$244.70	$248.40	$188.70	$239.00	$221.90	$220.20
80+	$161.00	$274.90	$278.50	$186.10	$263.20	$246.00	$243.60

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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	$515.00	$704.80	$715.90	$482.70	$577.80	$519.50	$516.60
65	$152.50	$208.60	$212.10	$166.00	$198.70	$178.70	$177.70
66	$155.60	$212.70	$215.90	$170.50	$203.20	$184.50	$183.30
67	$158.70	$218.20	$221.40	$175.40	$209.10	$190.50	$189.30
68	$162.10	$223.70	$227.10	$180.00	$215.10	$196.60	$195.40
69	$165.00	$229.20	$232.50	$184.40	$221.20	$202.60	$201.10
70-71	$169.10	$237.30	$240.20	$190.60	$230.00	$211.30	$209.70
72-74	$175.00	$250.50	$254.50	$199.30	$243.70	$225.20	$223.40
75-79	$180.20	$269.30	$273.20	$207.60	$262.90	$244.10	$242.20
80+	$177.20	$302.40	$306.40	$204.80	$289.50	$270.60	$267.90

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 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	$573.30	$783.90	$796.30	$536.80	$642.20	$577.80	$574.20
65	$169.70	$232.10	$235.70	$184.60	$220.80	$198.70	$197.50
66	$173.20	$236.60	$240.10	$189.70	$225.80	$205.30	$203.80
67	$176.60	$242.70	$246.20	$194.90	$232.60	$211.90	$210.60
68	$180.20	$249.00	$252.50	$200.20	$239.30	$218.50	$217.10
69	$183.60	$255.00	$258.70	$205.30	$245.90	$225.30	$223.70
70-71	$188.10	$263.90	$267.20	$212.10	$255.60	$235.10	$233.50
72-74	$194.70	$278.70	$283.10	$221.50	$270.90	$250.40	$248.50
75-79	$200.60	$299.70	$304.00	$230.70	$292.40	$271.40	$269.40
80+	$197.20	$336.40	$340.80	$227.60	$321.80	$300.90	$298.00

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 - TOBACCO USER

Age At Enrollment	Plan A	Plan C	Plan F	Select B	Select C	Select D	Select M
Under 65	$630.30	$862.30	$875.60	$590.60	$706.40	$635.90	$631.70
65	$186.60	$255.40	$259.30	$203.20	$243.00	$218.60	$217.30
66	$190.50	$260.20	$264.30	$208.60	$248.40	$225.80	$224.20
67	$194.30	$267.00	$270.90	$214.40	$255.90	$233.20	$231.60
68	$198.30	$273.80	$277.80	$220.20	$263.20	$240.40	$238.90
69	$201.90	$280.60	$284.50	$225.80	$270.50	$247.80	$246.10
70-71	$207.00	$290.40	$294.00	$233.30	$281.00	$258.50	$256.70
72-74	$214.20	$306.40	$311.40	$243.70	$298.10	$275.50	$273.40
75-79	$220.60	$329.60	$334.40	$253.70	$321.60	$298.60	$296.40
80+	$216.90	$370.00	$374.90	$250.40	$354.10	$331.00	$327.70

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	$564.70	$772.10	$784.40	$528.80	$632.50	$569.20	$565.60
65	$167.10	$228.70	$232.20	$181.90	$217.50	$195.70	$194.50
66	$170.60	$233.10	$236.50	$186.90	$222.40	$202.20	$200.70
67	$174.00	$239.10	$242.50	$192.00	$229.10	$208.80	$207.40
68	$177.50	$245.30	$248.70	$197.20	$235.70	$215.20	$213.90
69	$180.90	$251.10	$254.80	$202.20	$242.20	$221.90	$220.30
70-71	$185.30	$260.00	$263.20	$208.90	$251.70	$231.50	$230.00
72-74	$191.80	$274.50	$278.80	$218.10	$266.80	$246.60	$244.80
75-79	$197.60	$295.20	$299.40	$227.30	$288.00	$267.30	$265.40
80+	$194.20	$331.40	$335.70	$224.20	$317.00	$296.40	$293.50

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.

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	$620.90	$849.40	$862.50	$581.70	$695.80	$626.30	$622.20
65	$183.80	$251.60	$255.50	$200.10	$239.30	$215.30	$214.00
66	$187.60	$256.30	$260.30	$205.50	$244.70	$222.40	$220.80
67	$191.40	$263.00	$266.90	$211.20	$252.10	$229.70	$228.10
68	$195.40	$269.70	$273.60	$216.90	$259.30	$236.80	$235.30
69	$198.90	$276.40	$280.20	$222.40	$266.50	$244.10	$242.40
70-71	$203.90	$286.00	$289.50	$229.80	$276.80	$254.70	$252.80
72-74	$211.00	$301.80	$306.70	$240.10	$293.60	$271.30	$269.30
75-79	$217.30	$324.60	$329.40	$249.90	$316.70	$294.10	$291.90
80+	$213.60	$364.50	$369.20	$246.60	$348.80	$326.00	$322.80

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.

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

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

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 Attention: Grievance & Appeals, Medicare Member Services Department, Florida Blue, 8400 NW 33rd St. Suite 100, Miami FL 33122-1932. 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.

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

Notice
- This policy may not fully cover all of your medical costs.
- Neither Florida Blue, nor its agents are connected with Medicare.
- This Outline of Coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the *Medicare and You* handbook for more details.

Complete Answers Are Very Important
When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical
Review the application carefully before you sign it. Be certain that all information has been properly recorded.

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

*A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,364	$0	$1,364 (Part A deductible)
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $682	$682 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 $170.50 a day	$0	Up to $170.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	$0

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

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

*Once you have been billed $185 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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS		YOU PAY	
		PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and					
First 60 days	All but $1,364	$1,364 (Part A deductible)	$0	$0	$1,364 (Part A deductible)
61st thru 90th day	All but $341 a day	$341 a day	$0	$0	$341 a day
91st day and after:					
--While using 60 lifetime reserve days	All but $682	$682 a day	$0	$0	$682 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 B
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD
(continued)

*A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 $170.50 a day	$0	Up to $170.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	$0

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

*Once you have been billed $185 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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 $185 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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS		YOU PAY	
		PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and					
First 60 days	All but $1,364	$1,364 (Part A deductible)	$0	$0	$1,364 (Part A deductible)
61st thru 90th day	All but $341 a day	$341 a day	$0	$0	$341 a day
91st day and after:					
--While using 60 lifetime reserve days	All but $682	$682 a day	$0	$0	$682 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 C
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD
(continued)

*A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 $170.50 a day	Up to $170.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	$0

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

*Once you have been billed $185 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 $185 of Medicare Approved Amounts*	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$185 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

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

*Once you have been billed $185 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 $185 of Medicare Approved Amounts*	$0	$185 (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

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

*A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,364	$1,364 (Part A deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $682	$682 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 $170.50 a day	Up to $170.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	$0

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

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

*Once you have been billed $185 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 $185 of Medicare Approved Amounts*	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$185 (Part B deductible)	$0
- Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN C
OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

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

*A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS		YOU PAY	
		PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and					
First 60 days	All but $1,364	$1,364 (Part A deductible)	$0	$0	$1,364 (Part A deductible)
61st thru 90th day	All but $341 a day	$341 a day	$0	$0	$341 a day
91st day and after:					
--While using 60 lifetime reserve days	All but $682	$682 a day	$0	$0	$682 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 D
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD
(continued)

*A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 $170.50 a day	Up to $170.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	$0

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

*Once you have been billed $185 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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 $185 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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,364	$1,364 (Part A deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $682	$682 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 $170.50 a day	Up to $170.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	$0

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

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

*Once you have been billed $185 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 $185 of Medicare Approved Amounts*	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$185 (Part B deductible)	$0
- Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN F
OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

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

*A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS		YOU PAY	
		PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and					
First 60 days	All but $1,364	$682 (50% Part A deductible)	$0	$682	$1,364 (Part A deductible)
61st thru 90th day	All but $341 a day	$341 a day	$0	$0	$341 a day
91st day and after:					
--While using 60 lifetime reserve days	All but $682	$682 a day	$0	$0	$682 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 services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 $170.50 a day	Up to $170.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	$0

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

*Once you have been billed $185 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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 $185 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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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