# Highmark Blue Cross Blue Shield

## Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2026

### Medigap Blue - Benefit Plans A, B, C, D, F, High Deductible F, G, High Deductible G and N

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.

**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.

**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[4] | K | L | M | N | C | F[1] |
| Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Medicare Part B coinsurance or copayment | ✓ | ✓ | ✓ | ✓ | 50% | 75% | ✓ | ✓ Copays apply[3] | ✓ | ✓ |
| Blood (first 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 2025[2] | | | | | $8,000[2] | $4,000[2] | | | | |

1 Plan F has a high deductible option, which requires first paying a plan deductible of $2,950 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 F counts your payment of the Medicare Part B deductible toward meeting the plan deductible.
2 Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.
3 Plan N pays 100% of the Part B coinsurance, except for a 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 Plan G has a high deductible option, which requires first paying a plan deductible of $2,950 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 counts your payment of the Medicare Part B deductible toward meeting the plan deductible.

# Medigap Blue Plans A, B, C, D, F, High Deductible F, G, High Deductible G and N
## MONTHLY SUBSCRIPTION RATES EFFECTIVE JULY 1, 2025 THROUGH JUNE 30, 2026

**Southwest PA Region**
(Allegheny, Fayette, Greene, Indiana Washington, Westmoreland counties)

| Age | Plan A | | Plan B | | Plan C | | Plan D (Male) | | Plan D (Female) | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Preferred | Standard | Preferred | Standard | Preferred | Standard | Preferred | Standard | Preferred | Standard |
| <65 | $143.95 | $172.75 | $179.55 | $215.40 | $262.95 | $315.65 | $172.15 | $258.20 | $155.60 | $233.40 |
| 65 | $143.95 | $172.75 | $179.55 | $215.40 | $262.95 | $315.65 | $172.15 | $258.20 | $155.60 | $233.40 |
| 66 | $150.05 | $180.05 | $187.35 | $224.75 | $274.60 | $329.50 | $172.15 | $258.20 | $155.60 | $233.40 |
| 67 | $155.95 | $187.10 | $194.80 | $233.75 | $285.75 | $342.95 | $172.15 | $258.20 | $155.60 | $233.40 |
| 68 | $162.00 | $194.40 | $202.60 | $243.05 | $297.35 | $356.85 | $177.30 | $266.00 | $160.25 | $240.35 |
| 69 | $167.85 | $201.45 | $210.15 | $252.05 | $308.50 | $370.25 | $182.60 | $273.95 | $165.00 | $247.60 |
| 70 | $174.00 | $208.75 | $217.85 | $261.40 | $320.10 | $384.15 | $188.10 | $282.20 | $170.00 | $254.95 |
| 71 | $179.95 | $216.05 | $225.50 | $270.65 | $331.70 | $397.95 | $193.70 | $290.65 | $175.10 | $262.70 |
| 72 | $185.80 | $223.05 | $232.90 | $279.65 | $342.95 | $411.55 | $199.55 | $299.35 | $180.35 | $270.55 |
| 73 | $191.95 | $230.30 | $240.80 | $289.00 | $354.45 | $425.25 | $205.60 | $308.30 | $185.80 | $278.65 |
| 74 | $197.85 | $237.35 | $248.30 | $297.95 | $365.75 | $438.80 | $211.70 | $317.60 | $191.30 | $287.05 |
| 75 | $205.05 | $246.05 | $257.45 | $308.90 | $379.40 | $455.30 | $218.05 | $327.15 | $197.10 | $295.60 |
| 76 | $211.45 | $253.70 | $265.75 | $318.80 | $391.55 | $470.00 | $224.65 | $336.90 | $203.00 | $304.55 |
| 77 | $217.90 | $261.55 | $273.85 | $328.65 | $403.80 | $484.60 | $231.35 | $347.00 | $209.10 | $313.65 |
| 78 | $224.25 | $269.15 | $282.20 | $338.75 | $416.10 | $499.45 | $238.30 | $357.40 | $215.40 | $323.10 |
| 79 | $230.65 | $276.80 | $290.50 | $348.60 | $428.50 | $514.05 | $245.40 | $368.15 | $221.80 | $332.75 |
| 80 | $233.90 | $280.65 | $294.40 | $353.35 | $434.35 | $521.20 | $252.75 | $379.20 | $228.45 | $342.70 |
| 81 | $239.00 | $286.85 | $301.05 | $361.20 | $444.25 | $533.20 | $260.35 | $390.60 | $235.35 | $352.95 |
| 82 | $244.15 | $292.90 | $307.70 | $369.20 | $454.05 | $544.65 | $268.25 | $402.30 | $242.35 | $363.55 |
| 83 | $249.30 | $299.20 | $314.15 | $376.95 | $463.85 | $556.60 | $276.20 | $414.30 | $249.65 | $374.50 |
| 84 | $254.45 | $305.25 | $320.65 | $384.80 | $473.60 | $568.35 | $284.50 | $426.75 | $257.15 | $385.70 |
| 85 | $260.50 | $312.55 | $328.40 | $394.20 | $485.10 | $582.15 | $293.05 | $439.60 | $264.85 | $397.30 |
| 86 | $260.50 | $312.55 | $328.40 | $394.20 | $485.10 | $582.15 | $293.05 | $439.60 | $264.85 | $397.30 |
| 87 | $260.50 | $312.55 | $328.40 | $394.20 | $485.10 | $582.15 | $293.05 | $439.60 | $264.85 | $397.30 |
| 88 | $260.50 | $312.55 | $328.40 | $394.20 | $485.10 | $582.15 | $293.05 | $439.60 | $264.85 | $397.30 |
| 89 | $260.50 | $312.55 | $328.40 | $394.20 | $485.10 | $582.15 | $293.05 | $439.60 | $264.85 | $397.30 |
| 90+ | $260.50 | $312.55 | $328.40 | $394.20 | $485.10 | $582.15 | $293.05 | $439.60 | $264.85 | $397.30 |

# Medigap Blue Plans A, B, C, D, F, High Deductible F, G, High Deductible G and N

## MONTHLY SUBSCRIPTION RATES EFFECTIVE JULY 1, 2025 THROUGH JUNE 30, 2026

**Southwest PA Region**

(Allegheny, Fayette, Greene, Indiana Washington, Westmoreland counties)

| Age | Plan F | | Plan F (HD) | | Plan G (Male) | | Plan G (Female) | | Plan G (HD) (Male) | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Preferred | Standard | Preferred | Standard | Preferred | Standard | Preferred | Standard | Preferred | Standard |
| **<65** | $263.45 | $316.15 | $119.75 | $143.70 | $179.80 | $269.80 | $162.55 | $243.85 | $87.70 | $131.55 |
| **65** | $263.45 | $316.15 | $119.75 | $143.70 | $179.80 | $269.80 | $162.55 | $243.85 | $87.70 | $131.55 |
| **66** | $275.00 | $330.00 | $124.65 | $149.45 | $179.80 | $269.80 | $162.55 | $243.85 | $87.70 | $131.55 |
| **67** | $286.30 | $343.55 | $129.10 | $154.95 | $179.80 | $269.80 | $162.55 | $243.85 | $87.70 | $131.55 |
| **68** | $297.85 | $357.45 | $133.80 | $160.55 | $185.20 | $277.90 | $167.40 | $251.15 | $90.35 | $135.55 |
| **69** | $308.95 | $370.90 | $138.50 | $166.20 | $190.75 | $286.15 | $172.45 | $258.70 | $93.05 | $139.60 |
| **70** | $320.80 | $384.85 | $143.20 | $171.80 | $196.45 | $294.80 | $177.65 | $266.50 | $95.85 | $143.80 |
| **71** | $332.10 | $398.60 | $147.85 | $177.40 | $202.40 | $303.65 | $182.95 | $274.45 | $98.75 | $148.15 |
| **72** | $343.50 | $412.20 | $152.35 | $182.85 | $208.40 | $312.75 | $188.40 | $282.70 | $101.65 | $152.50 |
| **73** | $355.00 | $425.95 | $157.10 | $188.50 | $214.70 | $322.10 | $194.05 | $291.20 | $104.75 | $157.15 |
| **74** | $366.35 | $439.60 | $161.60 | $193.90 | $221.10 | $331.75 | $199.85 | $299.90 | $107.85 | $161.80 |
| **75** | $380.05 | $456.00 | $167.20 | $200.75 | $227.75 | $341.75 | $205.90 | $308.95 | $111.10 | $166.65 |
| **76** | $392.25 | $470.75 | $172.20 | $206.60 | $234.60 | $352.00 | $212.05 | $318.20 | $114.45 | $171.70 |
| **77** | $404.65 | $485.45 | $177.15 | $212.65 | $241.65 | $362.50 | $218.45 | $327.75 | $117.90 | $176.85 |
| **78** | $416.80 | $500.10 | $182.15 | $218.55 | $248.85 | $373.40 | $224.95 | $337.55 | $121.40 | $182.10 |
| **79** | $429.25 | $515.05 | $187.20 | $224.65 | $256.30 | $384.65 | $231.70 | $347.65 | $125.05 | $187.60 |
| **80** | $435.20 | $522.20 | $189.65 | $227.45 | $264.05 | $396.20 | $238.70 | $358.05 | $128.80 | $193.20 |
| **81** | $444.95 | $533.80 | $193.55 | $232.20 | $271.95 | $408.10 | $245.80 | $368.85 | $132.65 | $199.00 |
| **82** | $454.75 | $545.60 | $197.60 | $237.05 | $280.10 | $420.25 | $253.20 | $379.90 | $136.65 | $205.00 |
| **83** | $464.75 | $557.75 | $201.50 | $241.85 | $288.50 | $432.90 | $260.85 | $391.30 | $140.75 | $211.15 |
| **84** | $474.45 | $569.45 | $205.50 | $246.70 | $297.20 | $445.85 | $268.65 | $403.05 | $145.00 | $217.50 |
| **85** | $486.10 | $583.30 | $210.30 | $252.30 | $306.20 | $459.25 | $276.70 | $415.10 | $149.35 | $224.00 |
| **86** | $486.10 | $583.30 | $210.30 | $252.30 | $306.20 | $459.25 | $276.70 | $415.10 | $153.85 | $230.80 |
| **87** | $486.10 | $583.30 | $210.30 | $252.30 | $306.20 | $459.25 | $276.70 | $415.10 | $158.45 | $237.70 |
| **88** | $486.10 | $583.30 | $210.30 | $252.30 | $306.20 | $459.25 | $276.70 | $415.10 | $163.20 | $244.80 |
| **89** | $486.10 | $583.30 | $210.30 | $252.30 | $306.20 | $459.25 | $276.70 | $415.10 | $168.10 | $252.15 |
| **90+** | $486.10 | $583.30 | $210.30 | $252.30 | $306.20 | $459.25 | $276.70 | $415.10 | $173.15 | $259.75 |

# Medigap Blue Plans A, B, C, D, F, High Deductible F, G, High Deductible G and N

## MONTHLY SUBSCRIPTION RATES EFFECTIVE JULY 1, 2025 THROUGH JUNE 30, 2026

### Southwest PA Region

(Allegheny, Fayette, Greene, Indiana Washington, Westmoreland counties)

| Age | Plan G (HD) (Female) | | Plan N | |
|---|---|---|---|---|
| | Preferred | Standard | Preferred | Standard |
| **<65** | $79.35 | $119.05 | $140.00 | $167.95 |
| **65** | $79.35 | $119.05 | $140.00 | $167.95 |
| **66** | $79.35 | $119.05 | $146.00 | $175.15 |
| **67** | $79.35 | $119.05 | $151.65 | $181.95 |
| **68** | $81.75 | $122.65 | $157.65 | $189.10 |
| **69** | $84.20 | $126.30 | $163.30 | $195.95 |
| **70** | $86.70 | $130.05 | $169.30 | $203.05 |
| **71** | $89.35 | $134.05 | $175.15 | $210.15 |
| **72** | $92.00 | $138.00 | $180.90 | $217.05 |
| **73** | $94.75 | $142.15 | $186.80 | $224.15 |
| **74** | $97.60 | $146.40 | $192.60 | $231.10 |
| **75** | $100.55 | $150.85 | $199.65 | $239.65 |
| **76** | $103.55 | $155.35 | $205.90 | $247.20 |
| **77** | $106.65 | $160.00 | $212.30 | $254.65 |
| **78** | $109.85 | $164.80 | $218.45 | $262.10 |
| **79** | $113.15 | $169.75 | $224.70 | $269.55 |
| **80** | $116.55 | $174.85 | $227.75 | $273.30 |
| **81** | $120.00 | $180.00 | $232.85 | $279.35 |
| **82** | $123.65 | $185.50 | $237.80 | $285.40 |
| **83** | $127.35 | $191.05 | $242.90 | $291.55 |
| **84** | $131.15 | $196.75 | $247.90 | $297.50 |
| **85** | $135.10 | $202.65 | $253.95 | $304.65 |
| **86** | $139.20 | $208.80 | $253.95 | $304.65 |
| **87** | $143.35 | $215.00 | $253.95 | $304.65 |
| **88** | $147.65 | $221.50 | $253.95 | $304.65 |
| **89** | $152.10 | $228.15 | $253.95 | $304.65 |
| **90+** | $156.65 | $235.00 | $253.95 | $304.65 |

# Medigap Blue Plans A, B, C, D, F, High Deductible F, G, High Deductible G and N
## MONTHLY SUBSCRIPTION RATES EFFECTIVE JULY 1, 2025 THROUGH JUNE 30, 2026

**Northwest PA Region**

(Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Cameron, Centre, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Huntingdon, Jefferson, Lawrence, McKean, Mercer, Potter, Somerset, Venango, and Warren counties.)

| Age | Plan A | | Plan B | | Plan C | | Plan D (Male) | | Plan D (Female) | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Preferred | Standard | Preferred | Standard | Preferred | Standard | Preferred | Standard | Preferred | Standard |
| **<65** | $117.65 | $141.20 | $146.40 | $175.55 | $214.00 | $256.90 | $148.35 | $222.55 | $134.05 | $201.05 |
| **65** | $117.65 | $141.20 | $146.40 | $175.55 | $214.00 | $256.90 | $148.35 | $222.55 | $134.05 | $201.05 |
| **66** | $122.55 | $147.10 | $152.75 | $183.20 | $223.45 | $268.20 | $148.35 | $222.55 | $134.05 | $201.05 |
| **67** | $127.35 | $152.85 | $158.70 | $190.50 | $232.40 | $278.95 | $148.35 | $222.55 | $134.05 | $201.05 |
| **68** | $132.20 | $158.65 | $164.90 | $197.95 | $241.65 | $289.95 | $152.85 | $229.25 | $138.10 | $207.15 |
| **69** | $137.00 | $164.35 | $171.00 | $205.20 | $250.55 | $300.80 | $157.40 | $236.00 | $142.25 | $213.35 |
| **70** | $141.85 | $170.25 | $177.20 | $212.55 | $260.00 | $312.15 | $162.05 | $243.20 | $146.50 | $219.75 |
| **71** | $146.60 | $175.95 | $183.50 | $220.15 | $269.30 | $323.20 | $166.95 | $250.45 | $150.95 | $226.30 |
| **72** | $151.50 | $181.90 | $189.55 | $227.50 | $278.25 | $334.05 | $172.00 | $257.95 | $155.45 | $233.15 |
| **73** | $156.35 | $187.60 | $195.85 | $235.00 | $287.85 | $345.40 | $177.15 | $265.70 | $160.15 | $240.10 |
| **74** | $161.05 | $193.25 | $201.80 | $242.25 | $296.80 | $356.05 | $182.50 | $273.60 | $164.85 | $247.35 |
| **75** | $166.85 | $200.25 | $209.20 | $251.10 | $307.70 | $369.20 | $187.95 | $281.90 | $169.90 | $254.75 |
| **76** | $171.95 | $206.35 | $215.85 | $259.00 | $317.65 | $381.20 | $193.55 | $290.35 | $175.00 | $262.35 |
| **77** | $177.15 | $212.65 | $222.45 | $267.00 | $327.50 | $393.05 | $199.40 | $299.05 | $180.20 | $270.30 |
| **78** | $182.45 | $218.90 | $229.10 | $274.95 | $337.30 | $404.80 | $205.30 | $307.95 | $185.65 | $278.35 |
| **79** | $187.60 | $225.15 | $235.70 | $282.85 | $347.30 | $416.70 | $211.50 | $317.25 | $191.15 | $286.75 |
| **80** | $190.15 | $228.20 | $239.00 | $286.70 | $352.10 | $422.55 | $217.85 | $326.75 | $196.85 | $295.30 |
| **81** | $194.20 | $233.05 | $244.20 | $293.00 | $359.95 | $432.00 | $224.35 | $336.60 | $202.85 | $304.15 |
| **82** | $198.30 | $238.00 | $249.55 | $299.40 | $367.85 | $441.40 | $231.15 | $346.65 | $208.95 | $313.35 |
| **83** | $202.45 | $243.00 | $254.90 | $305.80 | $375.80 | $451.05 | $238.05 | $357.05 | $215.15 | $322.70 |
| **84** | $206.65 | $248.00 | $260.10 | $312.15 | $383.75 | $460.45 | $245.25 | $367.75 | $221.65 | $332.45 |
| **85** | $211.60 | $253.90 | $266.25 | $319.50 | $393.15 | $471.70 | $252.55 | $378.85 | $228.25 | $342.40 |
| **86** | $211.60 | $253.90 | $266.25 | $319.50 | $393.15 | $471.70 | $252.55 | $378.85 | $228.25 | $342.40 |
| **87** | $211.60 | $253.90 | $266.25 | $319.50 | $393.15 | $471.70 | $252.55 | $378.85 | $228.25 | $342.40 |
| **88** | $211.60 | $253.90 | $266.25 | $319.50 | $393.15 | $471.70 | $252.55 | $378.85 | $228.25 | $342.40 |
| **89** | $211.60 | $253.90 | $266.25 | $319.50 | $393.15 | $471.70 | $252.55 | $378.85 | $228.25 | $342.40 |
| **90+** | $211.60 | $253.90 | $266.25 | $319.50 | $393.15 | $471.70 | $252.55 | $378.85 | $228.25 | $342.40 |

# Medigap Blue Plans A, B, C, D, F, High Deductible F, G, High Deductible G and N
## MONTHLY SUBSCRIPTION RATES EFFECTIVE JULY 1, 2025 THROUGH JUNE 30, 2026

**Northwest PA Region**

(Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Cameron, Centre, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Huntingdon, Jefferson, Lawrence, McKean, Mercer, Potter, Somerset, Venango, and Warren counties.)

| Age | Plan F | | Plan F (HD) | | Plan G (Male) | | Plan G (Female) | | Plan G (HD) (Male) | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Preferred | Standard | Preferred | Standard | Preferred | Standard | Preferred | Standard | Preferred | Standard |
| <65 | $214.55 | $257.45 | $98.50 | $118.25 | $155.10 | $232.60 | $140.20 | $210.25 | $74.55 | $111.80 |
| 65 | $214.55 | $257.45 | $98.50 | $118.25 | $155.10 | $232.60 | $140.20 | $210.25 | $74.55 | $111.80 |
| 66 | $223.75 | $268.50 | $102.40 | $122.85 | $155.10 | $232.60 | $140.20 | $210.25 | $74.55 | $111.80 |
| 67 | $232.80 | $279.35 | $106.20 | $127.45 | $155.10 | $232.60 | $140.20 | $210.25 | $74.55 | $111.80 |
| 68 | $242.20 | $290.65 | $110.00 | $131.95 | $159.75 | $239.50 | $144.40 | $216.55 | $76.80 | $115.20 |
| 69 | $251.20 | $301.45 | $113.60 | $136.35 | $164.50 | $246.80 | $148.70 | $223.05 | $79.10 | $118.65 |
| 70 | $260.55 | $312.60 | $117.35 | $140.90 | $169.45 | $254.20 | $153.15 | $229.75 | $81.45 | $122.20 |
| 71 | $269.80 | $323.75 | $121.20 | $145.40 | $174.50 | $261.75 | $157.75 | $236.60 | $83.95 | $125.95 |
| 72 | $279.05 | $334.85 | $124.90 | $149.80 | $179.75 | $269.65 | $162.55 | $243.65 | $86.40 | $129.60 |
| 73 | $288.20 | $345.85 | $128.70 | $154.40 | $185.15 | $277.70 | $167.35 | $251.05 | $89.05 | $133.60 |
| 74 | $297.35 | $356.85 | $132.25 | $158.70 | $190.75 | $286.05 | $172.45 | $258.55 | $91.65 | $137.50 |
| 75 | $308.35 | $370.05 | $136.80 | $164.15 | $196.45 | $294.65 | $177.65 | $266.30 | $94.45 | $141.70 |
| 76 | $318.20 | $381.75 | $140.75 | $168.90 | $202.35 | $303.45 | $182.90 | $274.30 | $97.30 | $145.95 |
| 77 | $328.05 | $393.70 | $144.95 | $173.90 | $208.35 | $312.55 | $188.40 | $282.55 | $100.20 | $150.30 |
| 78 | $337.95 | $405.65 | $148.75 | $178.65 | $214.65 | $321.95 | $194.00 | $291.00 | $103.20 | $154.80 |
| 79 | $347.85 | $417.50 | $152.85 | $183.40 | $221.05 | $331.60 | $199.85 | $299.80 | $106.30 | $159.45 |
| 80 | $352.65 | $423.15 | $154.90 | $185.80 | $227.70 | $341.60 | $205.85 | $308.70 | $109.50 | $164.25 |
| 81 | $360.70 | $432.90 | $158.00 | $189.70 | $234.55 | $351.85 | $212.05 | $318.05 | $112.75 | $169.15 |
| 82 | $368.55 | $442.25 | $161.25 | $193.50 | $241.60 | $362.35 | $218.45 | $327.60 | $116.15 | $174.25 |
| 83 | $376.50 | $451.80 | $164.50 | $197.45 | $248.85 | $373.20 | $224.95 | $337.45 | $119.65 | $179.50 |
| 84 | $384.35 | $461.15 | $167.70 | $201.25 | $256.30 | $384.45 | $231.70 | $347.50 | $123.25 | $184.90 |
| 85 | $393.80 | $472.45 | $171.45 | $205.80 | $264.00 | $395.95 | $238.70 | $357.90 | $126.95 | $190.45 |
| 86 | $393.80 | $472.45 | $171.45 | $205.80 | $264.00 | $395.95 | $238.70 | $357.90 | $130.75 | $196.15 |
| 87 | $393.80 | $472.45 | $171.45 | $205.80 | $264.00 | $395.95 | $238.70 | $357.90 | $134.70 | $202.05 |
| 88 | $393.80 | $472.45 | $171.45 | $205.80 | $264.00 | $395.95 | $238.70 | $357.90 | $138.70 | $208.05 |
| 89 | $393.80 | $472.45 | $171.45 | $205.80 | $264.00 | $395.95 | $238.70 | $357.90 | $142.90 | $214.35 |
| 90+ | $393.80 | $472.45 | $171.45 | $205.80 | $264.00 | $395.95 | $238.70 | $357.90 | $147.20 | $220.80 |

# Medigap Blue Plans A, B, C, D, F, High Deductible F, G, High Deductible G and N
## MONTHLY SUBSCRIPTION RATES EFFECTIVE JULY 1, 2025 THROUGH JUNE 30, 2026

### Northwest PA Region

(Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Cameron, Centre, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Huntingdon, Jefferson, Lawrence, McKean, Mercer, Potter, Somerset, Venango, and Warren counties.)

| Age | Plan G (HD) (Female) | | Plan N | |
|---|---|---|---|---|
| | Preferred | Standard | Preferred | Standard |
| <65 | $67.45 | $101.20 | $114.45 | $137.40 |
| 65 | $67.45 | $101.20 | $114.45 | $137.40 |
| 66 | $67.45 | $101.20 | $119.10 | $142.95 |
| 67 | $67.45 | $101.20 | $123.85 | $148.65 |
| 68 | $69.50 | $104.25 | $128.60 | $154.30 |
| 69 | $71.55 | $107.30 | $133.20 | $159.90 |
| 70 | $73.70 | $110.55 | $138.05 | $165.65 |
| 71 | $75.95 | $113.95 | $142.70 | $171.25 |
| 72 | $78.20 | $117.30 | $147.40 | $176.90 |
| 73 | $80.55 | $120.85 | $152.15 | $182.55 |
| 74 | $82.95 | $124.45 | $156.85 | $188.15 |
| 75 | $85.45 | $128.20 | $162.35 | $194.90 |
| 76 | $88.00 | $132.00 | $167.40 | $200.95 |
| 77 | $90.65 | $136.00 | $172.55 | $206.95 |
| 78 | $93.35 | $140.05 | $177.55 | $213.05 |
| 79 | $96.20 | $144.30 | $182.65 | $219.20 |
| 80 | $99.05 | $148.60 | $185.10 | $222.10 |
| 81 | $102.00 | $153.00 | $189.15 | $226.95 |
| 82 | $105.10 | $157.65 | $193.15 | $231.80 |
| 83 | $108.25 | $162.40 | $197.25 | $236.75 |
| 84 | $111.50 | $167.25 | $201.30 | $241.50 |
| 85 | $114.85 | $172.30 | $206.20 | $247.40 |
| 86 | $118.30 | $177.45 | $206.20 | $247.40 |
| 87 | $121.85 | $182.80 | $206.20 | $247.40 |
| 88 | $125.50 | $188.25 | $206.20 | $247.40 |
| 89 | $129.30 | $193.95 | $206.20 | $247.40 |
| 90+ | $133.15 | $199.75 | $206.20 | $247.40 |

# Medigap Blue Plans A, B, C, D, F, High Deductible F, G, High Deductible G and N

## MONTHLY SUBSCRIPTION RATES EFFECTIVE JULY 1, 2025 THROUGH JUNE 30, 2026

### Northeastern Pennsylvania (NEPA) Region

(Wayne, Pike, Monroe, Carbon, Luzerne, Lackawanna, Wyoming, Susquehanna, Bradford, Sullivan, Lycoming, Clinton and Tioga counties)

| Age | Plan A | | Plan B | | Plan C | | Plan D (Male) | | Plan D (Female) | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Preferred | Standard | Preferred | Standard | Preferred | Standard | Preferred | Standard | Preferred | Standard |
| **<65** | $98.95 | $149.70 | $134.55 | $203.95 | $191.60 | $290.75 | $141.10 | $211.70 | $128.25 | $192.35 |
| **65** | $98.95 | $149.70 | $134.55 | $203.95 | $191.60 | $290.75 | $141.10 | $211.70 | $128.25 | $192.35 |
| **66** | $102.00 | $154.50 | $138.85 | $210.30 | $197.70 | $300.00 | $141.10 | $211.70 | $128.25 | $192.35 |
| **67** | $105.15 | $158.90 | $143.00 | $216.60 | $203.60 | $308.85 | $141.10 | $211.70 | $128.25 | $192.35 |
| **68** | $108.20 | $163.70 | $147.20 | $222.95 | $209.75 | $318.05 | $145.40 | $218.15 | $132.15 | $198.20 |
| **69** | $111.25 | $168.15 | $151.45 | $229.25 | $215.65 | $327.00 | $149.75 | $224.65 | $136.05 | $204.10 |
| **70** | $115.45 | $174.75 | $158.05 | $239.30 | $225.85 | $342.60 | $154.20 | $231.35 | $140.15 | $210.20 |
| **71** | $119.85 | $181.30 | $164.55 | $249.25 | $236.15 | $358.00 | $158.85 | $238.25 | $144.35 | $216.55 |
| **72** | $124.10 | $187.70 | $171.10 | $259.20 | $246.05 | $373.40 | $163.60 | $245.50 | $148.65 | $223.00 |
| **73** | $127.50 | $192.85 | $175.95 | $266.60 | $253.30 | $384.35 | $168.55 | $252.85 | $153.15 | $229.75 |
| **74** | $130.95 | $197.95 | $180.85 | $273.90 | $260.45 | $395.00 | $173.55 | $260.45 | $157.75 | $236.65 |
| **75** | $135.50 | $204.95 | $187.80 | $284.45 | $271.05 | $411.10 | $178.80 | $268.25 | $162.50 | $243.75 |
| **76** | $139.65 | $211.20 | $193.90 | $293.70 | $280.25 | $425.15 | $184.15 | $276.25 | $167.30 | $251.00 |
| **77** | $143.40 | $216.85 | $199.15 | $301.60 | $288.20 | $437.05 | $189.65 | $284.55 | $172.40 | $258.55 |
| **78** | $147.95 | $223.70 | $206.05 | $312.20 | $298.80 | $453.15 | $195.40 | $293.10 | $177.55 | $266.35 |
| **79** | $152.70 | $231.00 | $213.55 | $323.50 | $310.50 | $470.85 | $201.25 | $301.85 | $182.85 | $274.35 |
| **80** | $154.80 | $234.10 | $216.70 | $328.35 | $315.40 | $478.25 | $207.25 | $310.95 | $188.35 | $282.55 |
| **81** | $156.60 | $236.75 | $218.60 | $331.10 | $317.45 | $481.40 | $213.50 | $320.35 | $194.00 | $291.00 |
| **82** | $162.45 | $245.80 | $228.70 | $346.45 | $333.95 | $506.80 | $219.85 | $329.85 | $199.75 | $299.80 |
| **83** | $168.45 | $254.95 | $238.75 | $361.90 | $350.55 | $532.20 | $226.50 | $339.75 | $205.85 | $308.75 |
| **84** | $174.50 | $264.05 | $248.85 | $377.30 | $367.15 | $557.50 | $233.20 | $349.95 | $211.95 | $318.05 |
| **85** | $180.85 | $273.75 | $259.35 | $393.40 | $384.55 | $584.10 | $240.25 | $360.45 | $218.35 | $327.50 |
| **86** | $180.85 | $273.75 | $259.35 | $393.40 | $384.55 | $584.10 | $240.25 | $360.45 | $218.35 | $327.50 |
| **87** | $180.85 | $273.75 | $259.35 | $393.40 | $384.55 | $584.10 | $240.25 | $360.45 | $218.35 | $327.50 |
| **88** | $180.85 | $273.75 | $259.35 | $393.40 | $384.55 | $584.10 | $240.25 | $360.45 | $218.35 | $327.50 |
| **89** | $180.85 | $273.75 | $259.35 | $393.40 | $384.55 | $584.10 | $240.25 | $360.45 | $218.35 | $327.50 |
| **90+** | $180.85 | $273.75 | $259.35 | $393.40 | $384.55 | $584.10 | $240.25 | $360.45 | $218.35 | $327.50 |

# Medigap Blue Plans A, B, C, D, F, High Deductible F, G, High Deductible G and N

## MONTHLY SUBSCRIPTION RATES EFFECTIVE JULY 1, 2025 THROUGH JUNE 30, 2026

**Northeastern Pennsylvania (NEPA) Region**

(Wayne, Pike, Monroe, Carbon, Luzerne, Lackawanna, Wyoming, Susquehanna, Bradford, Sullivan, Lycoming, Clinton and Tioga counties)

| Age | Plan F | | Plan F (HD) | | Plan G (Male) | | Plan G (Female) | | Plan G (HD) (Male) | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Preferred | Standard | Preferred | Standard | Preferred | Standard | Preferred | Standard | Preferred | Standard |
| **<65** | $230.25 | $276.35 | $101.35 | $121.65 | $146.55 | $219.85 | $133.15 | $199.80 | $61.20 | $91.80 |
| **65** | $230.25 | $276.35 | $101.35 | $121.65 | $146.55 | $219.85 | $133.15 | $199.80 | $61.20 | $91.80 |
| **66** | $234.95 | $282.00 | $102.80 | $123.35 | $146.55 | $219.85 | $133.15 | $199.80 | $61.20 | $91.80 |
| **67** | $239.50 | $287.35 | $104.10 | $124.95 | $146.55 | $219.85 | $133.15 | $199.80 | $61.20 | $91.80 |
| **68** | $244.55 | $293.50 | $105.75 | $126.90 | $150.90 | $226.45 | $137.15 | $205.80 | $63.05 | $94.60 |
| **69** | $249.50 | $299.40 | $107.35 | $128.85 | $155.50 | $233.25 | $141.30 | $211.95 | $64.95 | $97.45 |
| **70** | $254.50 | $305.50 | $109.00 | $130.80 | $160.15 | $240.20 | $145.60 | $218.30 | $66.90 | $100.35 |
| **71** | $259.75 | $311.65 | $110.65 | $132.75 | $165.00 | $247.40 | $149.90 | $224.90 | $68.90 | $103.35 |
| **72** | $264.70 | $317.60 | $112.20 | $134.65 | $169.90 | $254.80 | $154.40 | $231.65 | $70.95 | $106.45 |
| **73** | $276.50 | $331.80 | $117.30 | $140.75 | $175.00 | $262.50 | $159.05 | $238.50 | $73.10 | $109.65 |
| **74** | $288.20 | $345.75 | $122.35 | $146.90 | $180.25 | $270.40 | $163.80 | $245.70 | $75.30 | $112.95 |
| **75** | $300.85 | $361.00 | $127.65 | $153.20 | $185.65 | $278.45 | $168.75 | $253.10 | $77.55 | $116.35 |
| **76** | $312.80 | $375.45 | $132.85 | $159.45 | $191.20 | $286.80 | $173.75 | $260.70 | $79.85 | $119.80 |
| **77** | $325.00 | $389.95 | $138.05 | $165.65 | $197.00 | $295.35 | $178.95 | $268.50 | $82.30 | $123.45 |
| **78** | $339.00 | $406.80 | $144.30 | $173.15 | $202.90 | $304.25 | $184.40 | $276.55 | $84.75 | $127.15 |
| **79** | $353.10 | $423.70 | $150.55 | $180.65 | $208.95 | $313.45 | $189.90 | $284.80 | $87.30 | $130.95 |
| **80** | $364.75 | $437.75 | $156.00 | $187.20 | $215.20 | $322.80 | $195.60 | $293.35 | $89.90 | $134.85 |
| **81** | $377.90 | $453.55 | $161.90 | $194.25 | $221.65 | $332.50 | $201.45 | $302.20 | $92.60 | $138.90 |
| **82** | $391.00 | $469.30 | $167.85 | $201.50 | $228.30 | $342.45 | $207.50 | $311.35 | $95.40 | $143.10 |
| **83** | $414.85 | $497.80 | $179.30 | $215.15 | $235.20 | $352.75 | $213.70 | $320.55 | $98.25 | $147.40 |
| **84** | $438.55 | $526.30 | $190.70 | $228.85 | $242.20 | $363.35 | $220.15 | $330.25 | $101.20 | $151.80 |
| **85** | $463.70 | $556.40 | $202.65 | $243.15 | $249.45 | $374.25 | $226.75 | $340.10 | $104.20 | $156.30 |
| **86** | $463.70 | $556.40 | $202.65 | $243.15 | $249.45 | $374.25 | $226.75 | $340.10 | $107.35 | $161.05 |
| **87** | $463.70 | $556.40 | $202.65 | $243.15 | $249.45 | $374.25 | $226.75 | $340.10 | $110.55 | $165.85 |
| **88** | $463.70 | $556.40 | $202.65 | $243.15 | $249.45 | $374.25 | $226.75 | $340.10 | $113.90 | $170.85 |
| **89** | $463.70 | $556.40 | $202.65 | $243.15 | $249.45 | $374.25 | $226.75 | $340.10 | $117.30 | $175.95 |
| **90+** | $463.70 | $556.40 | $202.65 | $243.15 | $249.45 | $374.25 | $226.75 | $340.10 | $120.80 | $181.20 |

# Medigap Blue Plans A, B, C, D, F, High Deductible F, G, High Deductible G and N
## MONTHLY SUBSCRIPTION RATES EFFECTIVE JULY 1, 2025 THROUGH JUNE 30, 2026

**Northeastern Pennsylvania (NEPA) Region**

(Wayne, Pike, Monroe, Carbon, Luzerne, Lackawanna, Wyoming, Susquehanna, Bradford, Sullivan, Lycoming, Clinton and Tioga counties)

| Age | Plan G (HD) (Female) | | Plan N | |
|---|---|---|---|---|
| | Preferred | Standard | Preferred | Standard |
| **<65** | $55.40 | $83.10 | $114.15 | $137.05 |
| **65** | $55.40 | $83.10 | $114.15 | $137.05 |
| **66** | $55.40 | $83.10 | $115.70 | $138.85 |
| **67** | $55.40 | $83.10 | $117.20 | $140.60 |
| **68** | $57.05 | $85.60 | $119.05 | $142.80 |
| **69** | $58.75 | $88.15 | $120.80 | $144.95 |
| **70** | $60.55 | $90.85 | $122.60 | $147.10 |
| **71** | $62.35 | $93.55 | $124.50 | $149.40 |
| **72** | $64.20 | $96.30 | $126.20 | $151.50 |
| **73** | $66.15 | $99.25 | $132.05 | $158.45 |
| **74** | $68.10 | $102.15 | $138.00 | $165.60 |
| **75** | $70.15 | $105.25 | $144.15 | $172.95 |
| **76** | $72.25 | $108.40 | $150.20 | $180.20 |
| **77** | $74.45 | $111.70 | $156.20 | $187.45 |
| **78** | $76.70 | $115.05 | $163.45 | $196.10 |
| **79** | $79.00 | $118.50 | $170.65 | $204.80 |
| **80** | $81.35 | $122.05 | $177.10 | $212.55 |
| **81** | $83.80 | $125.70 | $184.05 | $220.85 |
| **82** | $86.30 | $129.45 | $190.90 | $229.15 |
| **83** | $88.90 | $133.35 | $204.40 | $245.35 |
| **84** | $91.55 | $137.35 | $217.85 | $261.40 |
| **85** | $94.30 | $141.45 | $231.85 | $278.25 |
| **86** | $97.10 | $145.65 | $231.85 | $278.25 |
| **87** | $100.05 | $150.10 | $231.85 | $278.25 |
| **88** | $103.05 | $154.60 | $231.85 | $278.25 |
| **89** | $106.15 | $159.25 | $231.85 | $278.25 |
| **90+** | $109.30 | $163.95 | $231.85 | $278.25 |

## TRANSFER OF COVERAGE

Subscribers moving into the Highmark Blue Cross Blue Shield 42-county service area who are currently enrolled in a Blue Cross and Blue Shield Medicare Supplement or Medicare Advantage program may transfer their coverage to a Highmark Blue Cross Blue Shield Medigap Blue Plan at a coverage level equal to or lesser than their current program.

## PREMIUM INFORMATION

We, Highmark Blue Cross Blue Shield, can only raise your premium if we raise the premium for all policies like yours in the Commonwealth of Pennsylvania. Premiums for these attained age plans are billed at the age which a member has attained on the first day of enrollment in any given calendar year in accordance with the premium schedule on the previous pages.

The Company may change subscription rates with the approval of the Pennsylvania Insurance Department.

## DISCLOSURES

Use this outline to compare benefits and premiums among policies.

## READ YOUR POLICY VERY CAREFULLY

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

## RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to Highmark Blue Cross Blue Shield at 120 Fifth Avenue, Pittsburgh, Pennsylvania 15222-3099. 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.

Highmark Blue Cross Blue Shield and its agents are not 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 complete 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.

**MEDIGAP BLUE PLAN A**
**MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** | | | |
| Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $1,736 | $0 | $1,736 (Part A deductible) |
| 61st thru 90th day | All but $434 a day | $434 a day | $0 |
| 91st day and after: | | | |
| —While using 60 lifetime reserve days | All but $868 a day | $868 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 $217 a day | $0 | Up to $217 a day |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** | | | |
| You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/ coinsurance | $0 |

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

**MEDIGAP BLUE PLAN A**
**MEDICARE (PART A)—MEDICAL SERVICES—PER CALENDAR YEAR**

* Once you have been billed $283of 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 $283of Medicare Approved Amounts* | $0 | $0 | $283(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 $283of Medicare Approved Amounts* | $0 | $0 | $283(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 | 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 $283of Medicare Approved Amounts* | $0 | $0 | $283(Part B deductible) |
| Remainder of Medicare Approved Amounts | 80% | 20% | $0 |

**MEDIGAP BLUE PLAN B**
**MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** | | | |
| Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $1,736 | $1,736 (Part A deductible) | $0 |
| 61st thru 90th day | All but $434 a day | $434 a day | $0 |
| 91st day and after: | | | |
| —While using 60 lifetime reserve days | All but $868 a day | $868a 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 $217 a day | $0 | Up to $217 a day |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** | | | |
| You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/ coinsurance | $0 |

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

**MEDIGAP BLUE PLAN B**
**MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

* Once you have been billed $283of 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 $283of Medicare Approved Amounts* | $0 | $0 | $283(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 $283of Medicare Approved Amounts* | $0 | $0 | $283(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 | 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 $283of Medicare Approved Amounts* | $0 | $0 | $283(Part B deductible) |
| Remainder of Medicare Approved Amounts | 80% | 20% | $0 |

**MEDIGAP BLUE PLAN C**
**MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** | | | |
| Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $1,736 | $1,736 (Part A deductible) | $0 |
| 61st thru 90th day | All but $434 a day | $434 a day | $0 |
| 91st day and after: | | | |
| —While using 60 lifetime reserve days | All but $868 a day | $868 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 $217 a day | Up to $217 a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** | | | |
| You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/ coinsurance | $0 |

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

**MEDIGAP BLUE PLAN C**
**MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

* Once you have been billed $283of 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 $283of Medicare Approved Amounts* | $0 | $283(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 $283of Medicare Approved Amounts* | $0 | $283(Part B deductible) | $0 |
| Remainder of Medicare Approved Amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES—** TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

**MEDIGAP BLUE PLAN C**

**PARTS A & B**

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE**<br>MEDICARE APPROVED SERVICES<br>—Medically necessary skilled care services and medical supplies<br>—Durable medical equipment | 100% | $0 | $0 |
| First $283of Medicare Approved Amounts* | $0 | $283(Part B deductible) | $0 |
| 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**<br>Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA | | | |
| First $250 each calendar year | $0 | $0 | $250 |
| Remainder of charges | $0 | 80% to a lifetime maximum benefit of $50,000 | 20% and amounts over the $50,000 lifetime maximum |

**MEDIGAP BLUE PLAN D**
**MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** | | | |
| Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $1,736 | $1,736 (Part A deductible) | $0 |
| 61st thru 90th day | All but $434 a day | $434 a day | $0 |
| 91st day and after: | | | |
| —While using 60 lifetime reserve days | All but $868 a day | $868 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 $217 a day | Up to $217 a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** | | | |
| You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/ coinsurance | $0 |

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

**MEDIGAP BLUE PLAN D**
**MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

* Once you have been billed $283of 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 $283of Medicare Approved Amounts* | $0 | $0 | $283(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 $283of Medicare Approved Amounts* | $0 | $0 | $283(Part B deductible) |
| Remainder of Medicare Approved Amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES—** TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

**MEDIGAP BLUE PLAN D**
**PARTS A & 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 $283of Medicare Approved Amounts* | $0 | $0 | $283(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 |

**MEDIGAP BLUE PLAN F**
**MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** | | | |
| Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $1,736 | $1,736 (Part A deductible) | $0 |
| 61st thru 90th day | All but $434 a day | $434 a day | $0 |
| 91st day and after: | | | |
| —While using 60 lifetime reserve days | All but $868 a day | $868 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 $217 a day | Up to $217 a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** | | | |
| You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/ coinsurance | $0 |

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

**MEDIGAP BLUE PLAN F**
**MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

* Once you have been billed $283of 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 $283of Medicare Approved Amounts* | $0 | $283(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 $283of Medicare Approved Amounts* | $0 | $283(Part B deductible) | $0 |
| Remainder of Medicare Approved Amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES—** TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

**MEDIGAP BLUE PLAN F**

**PARTS A & B**

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE**<br>MEDICARE APPROVED SERVICES<br>—Medically necessary skilled care services and medical supplies<br>—Durable medical equipment | 100% | $0 | $0 |
| First $283of Medicare Approved Amounts* | $0 | $283(Part B deductible) | $0 |
| 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**<br>Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA | | | |
| First $250 each calendar year | $0 | $0 | $250 |
| Remainder of charges | $0 | 80% to a lifetime maximum benefit of $50,000 | 20% and amounts over the $50,000 lifetime maximum |

**MEDIGAP BLUE HIGH DEDUCTIBLE PLAN F**
**MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

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

****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,950 deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $2,950. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.**

| SERVICES | MEDICARE PAYS | AFTER YOU PAY $2,950 DEDUCTIBLE** PLAN PAYS | IN ADDITION TO $2,950 DEDUCTIBLE** YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** | | | |
| Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $1,736 | $1,736 (Part A deductible) | $0 |
| 61st thru 90th day | All but $434 a day | $434 a day | $0 |
| 91st day and after: | | | |
| —While using 60 lifetime reserve days | All but $868 a day | $868 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 $217 a day | Up to $217 a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** | | | |
| You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/ coinsurance | $0 |

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

**MEDIGAP BLUE HIGH DEDUCTIBLE PLAN F**
**MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

* Once you have been billed $283of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,950 deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $2,950. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.**

| SERVICES | MEDICARE PAYS | AFTER YOU PAY $2,950 DEDUCTIBLE** PLAN PAYS | IN ADDITION TO $2,950 DEDUCTIBLE** 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 $283of Medicare Approved Amounts* | $0 | $283(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 $283of Medicare Approved Amounts* | $0 | $283(Part B deductible) | $0 |
| Remainder of Medicare Approved Amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES—** TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

**MEDIGAP BLUE HIGH DEDUCTIBLE PLAN F**

**PARTS A & B**

| SERVICES | MEDICARE PAYS | AFTER YOU PAY $2,950 DEDUCTIBLE** PLAN PAYS | IN ADDITION TO $2,950 DEDUCTIBLE** YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE** | | | |
| MEDICARE APPROVED SERVICES | | | |
| —Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| —Durable medical equipment | | | |
| First $283of Medicare Approved Amounts* | $0 | $283(Part B deductible) | $0 |
| Remainder of Medicare Approved Amounts | 80% | 20% | $0 |

**OTHER BENEFITS—NOT COVERED BY MEDICARE**

| SERVICES | MEDICARE PAYS | AFTER YOU PAY $2,950 deductible** PLAN PAYS | IN ADDITION TO $2,950 deductible** 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 |

**MEDIGAP BLUE PLAN G**
**MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** | | | |
| Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $1,736 | $1,736 (Part A deductible) | $0 |
| 61st thru 90th day | All but $434 a day | $434 a day | $0 |
| 91st day and after: | | | |
| —While using 60 lifetime reserve days | All but $868 a day | $868 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 $217 a day | Up to $217 a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** | | | |
| You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/ coinsurance | $0 |

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

**MEDIGAP BLUE PLAN G**
**MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

* Once you have been billed $283of 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 $283of Medicare Approved Amounts* | $0 | $0 | $283(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 $283of Medicare Approved Amounts* | $0 | $0 | $283(Part B deductible) |
| Remainder of Medicare Approved Amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES—** TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

**MEDIGAP BLUE PLAN G**

**PARTS A & B**

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE**<br>MEDICARE APPROVED SERVICES<br>—Medically necessary skilled care services and medical supplies<br>—Durable medical equipment | 100% | $0 | $0 |
| First $283of Medicare Approved Amounts* | $0 | $0 | $283(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**<br>Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA | | | |
| First $250 each calendar year | $0 | $0 | $250 |
| Remainder of charges | $0 | 80% to a lifetime maximum benefit of $50,000 | 20% and amounts over the $50,000 lifetime maximum |

**MEDIGAP BLUE HIGH DEDUCTIBLE PLAN G**
**MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

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

****This high deductible plan pays the same benefits as Plan G after one has paid a calendar year $2,950 deductible. Benefits from the high deductible plan G will not begin until out-of-pocket expenses are $2,950. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.**

| SERVICES | MEDICARE PAYS | AFTER YOU PAY $2,950 DEDUCTIBLE** PLAN PAYS | IN ADDITION TO $2,950 DEDUCTIBLE** YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** | | | |
| Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $1,736 | $1,736 (Part A deductible) | $0 |
| 61st thru 90th day | All but $434 a day | $434 a day | $0 |
| 91st day and after: | | | |
| —While using 60 lifetime reserve days | All but $868 a day | $868 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 $217 a day | Up to $217 a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** | | | |
| You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/ coinsurance | $0 |

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

**MEDIGAP BLUE HIGH DEDUCTIBLE PLAN G**
**MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

* Once you have been billed $283 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.

****This high deductible plan pays the same benefits as Plan G after one has paid a calendar year $2,950 deductible. Benefits from the high deductible plan G will not begin until out-of-pocket expenses are $2,950. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.**

| SERVICES | MEDICARE PAYS | AFTER YOU PAY $2,950 DEDUCTIBLE** PLAN PAYS | IN ADDITION TO $2,950 DEDUCTIBLE** 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 $283 of Medicare Approved Amounts* | $0 | $283 (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 $283 of Medicare Approved Amounts* | $0 | $283 (Part B deductible) | $0 |
| Remainder of Medicare Approved Amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES—** TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

**MEDIGAP BLUE HIGH DEDUCTIBLE PLAN G**

**PARTS A & B**

| SERVICES | MEDICARE PAYS | AFTER YOU PAY $2,950 DEDUCTIBLE** PLAN PAYS | IN ADDITION TO $2,950 DEDUCTIBLE** YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE** | | | |
| MEDICARE APPROVED SERVICES | | | |
| —Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| —Durable medical equipment | | | |
| First $283 of Medicare Approved Amounts* | $0 | $283 (Part B deductible) | $0 |
| Remainder of Medicare Approved Amounts | 80% | 20% | $0 |

**OTHER BENEFITS—NOT COVERED BY MEDICARE**

| SERVICES | MEDICARE PAYS | AFTER YOU PAY $2,950 DEDUCTIBLE** PLAN PAYS | IN ADDITION TO $2,950 DEDUCTIBLE** 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 $50,000lifetime maximum |

**MEDIGAP BLUE PLAN N**
**MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** | | | |
| Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $1,736 | $1,736 (Part A deductible) | $0 |
| 61st thru 90th day | All but $434 a day | $434 a day | $0 |
| 91st day and after: | | | |
| —While using 60 lifetime reserve days | All but $868 a day | $868 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 $217 a day | Up to $217 a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** | | | |
| You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/ coinsurance | $0 |

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

**MEDIGAP BLUE PLAN N**
**MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

* Once you have been billed $283of 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 $283of Medicare Approved Amounts* | $0 | $0 | $283(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 emergency room visit copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense | Up to $20 per office visit and up to $50 per emergency room visit. The emergency room visit 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 $283of Medicare Approved Amounts* | $0 | $0 | $283(Part B deductible) |
| Remainder of Medicare Approved Amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES—** TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

**MEDIGAP BLUE PLAN N**

**PARTS A & B**

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE**<br>MEDICARE APPROVED SERVICES<br>—Medically necessary skilled care services and medical supplies<br>—Durable medical equipment | 100% | $0 | $0 |
| First $283of Medicare Approved Amounts* | $0 | $0 | $283(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**<br>Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA | | | |
| First $250 each calendar year | $0 | $0 | $250 |
| Remainder of charges | $0 | 80% to a lifetime maximum benefit of $50,000 | 20% and amounts over the $50,000 lifetime maximum |

Fifth Avenue Place, 120 Fifth Avenue, Pittsburgh, PA 15222-3099



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**Discrimination is Against the Law**

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Plan will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Plan will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at

https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

**Pennsylvania, Delaware, West Virginia, and New York: 1-844-679-6930 (TTY:711)**

We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call the number provided for your state of residence. Someone who speaks English can help you. This is a free service.

Tenemos servicios gratis de interpretación para responder cualquier pregunta que pueda tener sobre nuestro plan médico o de medicamentos. Para obtener un intérprete, simplemente llame al número correspondiente a su estado de residencia. Alguien que hable español puede ayudarlo. Este servicio es gratis.

我们免费提供口译服务，为您解答有关我们健康计划或药物计划的任何疑问。如需口译服务，只需拨打您所在州相应的电话号码即可。说中文的工作人员可为您提供帮助。此项服务免费。

我們免費提供口譯服務，爲您解答有關我們健康計畫或藥物計畫的任何疑問。若要獲得口譯服務，只需撥打您所在州的電話號碼即可。講漢語的工作人員可爲您提供協助。此項服務免費。

Mayroon kaming mga libreng serbisyo ng interpreter para sagutin ang anumang tanong na posibleng mayroon ka tungkol sa aming planong pangkalusugan o plano sa gamot. Para kumuha ng interpreter, tawagan lang ang numerong ibinigay para sa estadong tinitirhan mo. May taong nagsasalita ng Tagalog na makakatulong sa iyo. Isa itong libreng serbisyo.