Highmark Blue Cross Blue Shield

Benefit Chart of Medicare Supplement Plans Sold on or After January 1, 2010 Including Revisions Effective January 1, 2024

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make available Plans "A & B" and either "D" or "G". Only applicants first eligible for Medicare before January 1, 2020 may purchase C, F and high deductible F+. Highmark Blue Cross Blue Shield offers those plans marked with an asterisk in New York State. Some plans may not be available in your state.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A*	B*	D	G*[1]	K[2]	L[2]	M	N*[3]	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%	✔	✔ copay applies[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 2024					$7,060	$3,530				

1. Plans F and G also have a high deductible option which require first paying a plan deductible of $2,800 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G is only available on or after January 1, 2020, and does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

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

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

PREMIUM INFORMATION

Highmark Blue Cross Blue Shield can only raise your premium if we raise the premium for all policies like yours in this state.

Service Area
Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Orleans, Niagara, and Wyoming counties

PLAN TYPE	MONTHLY PREMIUM	QUARTERLY PREMIUM	SEMIANNUAL PREMIUM	ANNUAL PREMIUM
Plan A	$273.74	$821.22	$1,642.44	$3,284.88
Plan B	$229.92	$689.76	$1,379.52	$2,759.04
Plan C	$285.65	$856.95	$1,713.90	$3,427.80
Plan F	$541.54	$1,624.62	$3,249.24	$6,498.48
Plan F*	$121.15	$363.45	$726.90	$1,453.80
Plan G	$332.92	$998.76	$1,997.52	$3,995.04
Plan N	$230.89	$692.67	$1,385.34	$2,770.68

Rates effective 01/01/2024

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, Attention: Consumer Sales, PO Box 15013, Albany, New York 12212-5012. 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 Highmark Blue Cross Blue Shield, nor its agents are connected with Medicare.

This **Outline of Coverage** does not give all the details of Medicare coverage. Contact your local Social Security office or consult "Medicare and You" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

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 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 A PAYS	WITH PLAN A YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,632	$0	$1,632 (Part A deductible)
61st through 90th day	All but $408 a day	$408 a day	$0
91st day and after:	All but $816 a day	$816 a day	$0
While using 60 Lifetime Reserve days			
Once Lifetime Reserve days are used:			
- Additional 365 days (lifetime)	$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 three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $204 a day	$0	Up to $204 a day
101st day and after	$0	$0	All costs
BLOOD (per calendar year)			
First three pints	$0	Three pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayments/coinsurance	$0
You must meet Medicare’s requirements, including a doctor’s certification of terminal illness			

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

* Once you have been billed $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN A PAYS	WITH PLAN A YOU PAY
MEDICAL EXPENSES			
IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-approved amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First three pints	$0	All costs	$0
Next $240 of Medicare-approved amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE PARTS A & B

HOME HEALTH CARE	100%	$0	$0
MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies			
Durable medical equipment			
First $240 of Medicare-approved amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN B

MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD

* A benefit period begins on the first day you receive 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 B PAYS	WITH PLAN B YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A deductible)	$0
61st through 90th day	All but $408 a day	$408 a day	$0
91st day and after:	All but $816 a day	$816 a day	$0
While using 60 Lifetime Reserve days			
Once Lifetime Reserve days are used:			
- Additional 365 days (lifetime)	$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 through 100th day	All but $204 a day	$0	Up to $204 a day
101st day and after	$0	$0	All costs
BLOOD (per calendar year)			
First three pints	$0	Three pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayments/coinsurance	$0
You must meet Medicare's requirements, including a doctor's certification of terminal illness			

PLAN B

MEDICARE (PART B) MEDICAL SERVICES PER CALENDAR YEAR

* Once you have been billed $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN B PAYS	WITH PLAN B YOU PAY
MEDICAL EXPENSES			
IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-approved amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First three pints	$0	All costs	$0
Next $240 of Medicare-approved amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE PARTS A & B

HOME HEALTH CARE	100%	$0	$0
MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies			
Durable medical equipment			
First $240 of Medicare-approved amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN C

MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD

* A benefit period begins on the first day you receive 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 C PAYS	WITH PLAN C YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A deductible)	$0
61st through 90th day	All but $408 a day	$408 a day	$0
91st day and after:	All but $816 a day	$816 a day	$0
While using 60 Lifetime Reserve days			
Once Lifetime Reserve days are used:			
- Additional 365 days (lifetime)	$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 three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD (per calendar year)			
First three pints	$0	Three 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 copayments/coinsurance	$0

PLAN C

MEDICARE (PART B) MEDICAL SERVICES PER CALENDAR YEAR

* Once you have been billed $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendaryear.

SERVICES	MEDICARE PAYS	PLAN C PAYS	WITH PLAN C YOU PAY
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-approved amounts*	$0	$240 (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First three pints	$0	All costs	$0
Next $240 of Medicare-approved amounts*	$0	$240 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
MEDICARE PARTS A & B			
HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $240 of Medicare-approved amounts*	$0	$240 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
OTHER BENEFITS NOT COVERED BY MEDICARE			
FOREIGN TRAVEL NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN F

MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN F PAYS	WITH PLAN F YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A deductible)	$0
61st through 90th day	All but $408 a day	$408 a day	$0
91st day and after:	All but $816 a day	$816 a day	$0
While using 60 Lifetime Reserve days			
Once Lifetime Reserve days are used:			
- Additional 365 days (lifetime)	$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 three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD (per calendar year)			
First three pints	$0	Three 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 copayments/coinsurance	$0

PLAN F

MEDICARE (PART B) MEDICAL SERVICES PER CALENDAR YEAR

* Once you have been billed $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN F PAYS	WITH PLAN F YOU PAY
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-approved amounts*	$0	$240 (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (above Medicare-approved amounts)	$0	All costs	$0
BLOOD			
First three pints	$0	All costs	$0
Next $240 of Medicare-approved amounts*	$0	$240 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment	100%	$0	$0
First $240 of Medicare-approved amounts*	$0	$240 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS NOT COVERED BY MEDICARE

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

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 $2,800 deductible. Benefits from the high-deductible F plan will not begin until out-of-pocket expenses are $2,800. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by this policy. This includes Medicare deductibles for Part A & Part B, but does not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	PLAN F+ PAYS	WITH PLAN F+ YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A deductible)	$0
61st through 90th day	All but $408 a day	$408 a day	$0
91st day and after:	All but $816 a day	$816 a day	$0
While using 60 Lifetime Reserve days			
Once Lifetime Reserve days are used:			
- Additional 365 days (lifetime)	$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 three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD (per calendar year)			
First three pints	$0	Three 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 copayments/coinsurance	$0

HIGH-DEDUCTIBLE PLAN F

MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD

* Once you have been billed $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

** **This high-deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,800 deductible. Benefits from the high-deductible F plan will not begin until out-of-pocket expenses are $2,800. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by this policy. This includes Medicare deductibles for Part A & Part B, but does not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	PLAN F+ PAYS	WITH PLAN F+ YOU PAY
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-approved amounts*	$0	$240 (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (above Medicare-approved amounts)	$0	All costs	$0
BLOOD			
First three pints	$0	All costs	$0
Next $240 of Medicare-approved amounts*	$0	$240 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

HIGH-DEDUCTIBLE PLAN F

MEDICARE (PART B) MEDICAL SERVICES PER CALENDAR YEAR

* Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

** **This high-deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,800 deductible. Benefits from the high-deductible F plan will not begin until out-of-pocket expenses are $2,800. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by this policy. This includes Medicare deductibles for Part A & Part B, but does not include the plan's separate foreign travel emergency deductible.**

MEDICARE PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment	100%	$0	$0
First $240 of Medicare-approved amounts*	$0	$240 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS NOT COVERED BY MEDICARE

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

PLAN G

MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD

*A benefit period begins on the first day you receive 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 G PAYS	WITH PLAN G YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A deductible)	$0
61st through 90th day	All but $408 a day	$408 a day	$0
91st day and after:	All but $816 a day	$816 a day	$0
While using 60 Lifetime Reserve days			
Once Lifetime Reserve days are used:			
- Additional 365 days (lifetime)	$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 three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD (per calendar year)			
First three pints	$0	Three 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 copayments/coinsurance	$0

PLAN G

MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD

* Once you have been billed $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN G PAYS	WITH PLAN G YOU PAY
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-approved amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (above Medicare-approved amounts)	$0	All costs	$0
BLOOD			
First three pints	$0	All costs	$0
Next $240 of Medicare-approved amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment	100%	$0	$0
First $240 of Medicare-approved amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS NOT COVERED BY MEDICARE

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

PLAN N

MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD

*A benefit period begins on the first day you receive 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 N PAYS	WITH PLAN N YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A deductible)	$0
61st through 90th day	All but $408 a day	$408 a day	$0
91st day and after:	All but $816 a day	$816 a day	$0
While using 60 Lifetime Reserve days			
Once Lifetime Reserve days are used:			
- Additional 365 days (lifetime)	$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 three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD (per calendar year)			
First three pints	$0	Three 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 copayments/coinsurance	$0

PLAN N

MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD

* Once you have been billed $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN N PAYS	WITH PLAN N YOU PAY
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-approved amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered a Medicare Part A expense.
Part B excess charges (above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First three pints	$0	All costs	$0
Next $240 of Medicare-approved amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

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MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD

MEDICARE PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment	100%	$0	$0
First $240 of Medicare-approved amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS NOT COVERED BY MEDICARE

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

Mailing address: PO Box 15013, Albany, New York 12212-5012

Physical address: 257 West Genesee Street, Buffalo, New York 14202

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HIGHMARK

An Independent Licensee of the Blue Cross and Blue Shield Association

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.