

Outline of Coverage

Benefit Chart of Medicare Supplement Plans Sold on or After June 1, 2010.



This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state. Medicare Supplement Plans A, F, G, N, and Select F are currently being offered by Blue Cross & Blue Shield of Rhode Island.

Basic Benefits:

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

Plan A	Plan B	Plan C	Plan D	Plan F		Plan G	Plan K	Plan L	Plan M	Plan N
				F	F*					
Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER
		Skilled nursing facility co-insurance	Skilled nursing facility co-insurance	Skilled nursing facility co-insurance	Skilled nursing facility co-insurance	Skilled nursing facility co-insurance	50% Skilled nursing facility co-insurance	75% Skilled nursing facility co-insurance	Skilled nursing facility co-insurance	Skilled nursing facility co-insurance
	Part A deductible	Part A deductible	Part A deductible	Part A deductible	Part A deductible	Part A deductible	50% Part A deductible	75% Part A deductible	50% Part A deductible	Part A deductible
		Part B deductible		Part B deductible						
				Part B excess (100%)	Part B excess (100%)					
		Foreign travel emergency	Foreign travel emergency	Foreign travel emergency	Foreign travel emergency	Foreign travel emergency			Foreign travel emergency	Foreign travel emergency
*Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2,370 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed \$2,370. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.							Out-of-pocket limit \$6,220; paid at 100% after limit reached	Out-of-pocket limit \$3,110; paid at 100% after limit reached		

Monthly Subscriber Fees

Monthly subscriber fees are based on how a member enrolls in Plan 65. Monthly subscriber fees vary by age for existing members and for new members eligible for Medicare due to attaining age 65 or retired new members over age 65 who were enrolled in active commercial group coverage.

If you are age 65 and over and enrolled in Medicare due to disability or end-stage renal disease (ESRD), the Plan 65 A subscriber fee is the Base Rate, regardless of your age at enrollment.

For enrollment on or after July 1, 2021, if you are under age 65 and enrolled in Medicare due to disability or ESRD, the Plan 65 A subscriber fee is \$332.62 for non-tobacco users and \$369.58 for tobacco users. Your Plan 65 A subscriber fee will change to the Base Rate when you turn 65.

Rate Level	Plan 65 A	Plan 65 F	Plan 65 Select F	Plan 65 G	Plan 65 Select G	Plan 65 N
Age 65-67						
Non-Tobacco*	\$188.52	\$175.96	\$131.51	\$130.43	\$114.89	\$109.77
Tobacco*	\$209.47	\$195.51	\$146.12	\$144.92	\$127.66	\$121.97
Age 68-70						
Non-Tobacco*	\$226.23	\$211.15	\$157.81	\$156.61	\$137.87	\$131.72
Tobacco*	\$251.37	\$234.61	\$175.34	\$173.90	\$153.19	\$146.35
Age 71-72						
Non-Tobacco*	\$261.04	\$243.64	\$182.09	\$180.59	\$159.08	\$151.98
Tobacco*	\$290.04	\$270.71	\$202.32	\$200.65	\$176.76	\$168.87
Base Rate						
Non-Tobacco*	\$290.04	\$270.70	\$202.32	\$200.66	\$176.76	\$168.88
Tobacco*	\$322.27	\$300.78	\$224.80	\$222.95	\$196.40	\$187.64

After age 72, the subscriber pays the Base Rate.

*Members enrolling on or after May 1, 2016, with no tobacco use within the last 12 months, may be eligible for the non-tobacco rate by submitting an attestation form. The non-tobacco rate becomes effective on the first of the month following receipt of the attestation, if received by the 1st day of the prior month (For example, if we receive your form on or by April 1, your new rate will be effective on May 1). We may discontinue this rate in our discretion concurrent with a filed and approved rate change. We will provide prior written notice of such discontinuance.

Members who opt to pay their bill using electronic funds transfer are eligible for a discount off their rate of \$2 per month. The electronic funds transfer discount becomes effective on the next monthly bill if the electronic funds transfer form is received by the 13th day of the prior month. Please call our Medicare Concierge Team for more information on monthly subscriber fees.

Premium Information

We, Blue Cross & Blue Shield of Rhode Island can only raise your subscriber fee if we raise the subscriber fee for all policies like yours in this state.

Disclosures

Use this outline to compare benefits and subscriber fees among subscriber agreements.

Read your Subscriber Agreement Very Carefully

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

Right to Return Agreement

If you find that you are not satisfied with your agreement, you may return it to 500 Exchange Street, Providence, RI 02903. If you send the agreement back to us within 30 days after you receive it, we will treat the agreement as if it had never been issued and return all of your payments.

Agreement Replacement

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

Notice

The subscriber agreement may not fully cover all of your medical costs. Blue Cross & Blue Shield of Rhode Island is 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 completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. **Review the application carefully before you sign it. Be certain that all information has been properly recorded.**

Plan 65 Select Disclosure Statement

Plan 65 Select is a Medicare Select Benefit Plan. The following information is provided in order to make a full and fair disclosure of the provisions, restrictions and limitations of a Medicare Select Benefit Plan.

Outline of Coverage

The Outline of Medicare Supplement Coverage which accompanies this Disclosure Statement allows you to compare the benefits and premiums of all open Medicare Supplement Plans offered by Blue Cross & Blue Shield of Rhode Island.

Plan 65 Select Hospital Network Listing

A Plan 65 Select Hospital Network listing is included with your enrollment package. This listing contains all the hospitals participating in the Plan 65 Select Hospital Network. All hospital hours of operation are 24 hours a day, 7 days a week.

Limited Benefit Reductions

Generally, Plan 65 Select benefits are paid in full as long as the Medicare Part A Eligible Expenses are received from Plan 65 Select Hospital Network Providers. Benefit reductions are limited to the Medicare Part A deductibles and copayments for services rendered by hospitals who are NOT participants in the Plan 65 Select Hospital Network.

Emergency Care and Coverage Outside the Network

Emergency and urgently needed care will be covered at hospitals who are not participants in the Plan 65 Select Hospital Network. In addition, all Medicare Part A eligible services which are not available through Plan 65 Select Hospital Network providers will be covered outside the network without a benefit reduction.

Referrals

There are no limitations on referrals to Plan 65 Select Hospital Network. Other than the benefit reductions listed above, there are no limitations on referrals to other providers.

Right to Purchase

At the time of initial purchase, you have the right to choose any other Medicare Supplement Benefit Plan that we offer, instead of Plan 65 Select. Once enrolled in Plan 65 Select, you may request a transfer to a Medicare Supplement Benefit Plan that does not have a restricted network and we will give you an opportunity to choose a plan which has comparable or lesser benefits.

Grievance Procedures

You may submit a written objection to us if you disagree with any aspect of our performance relative to the delivery of health care services, claim payments and handling, and related services. A grievance committee will review your request. Grievances will be fully investigated in a timely manner. If necessary, the committee will obtain the opinion of outside consultants regarding the claim. If a grievance is found to be valid, corrective actions will be taken promptly. All concerned parties will be notified in writing of the review decision. Any and all other legal and equitable remedies will be available to you upon decision of an appeal. See your Subscriber Agreement for details.

Quality Assurance Programs

All Plan 65 Network Hospitals are licensed by the appropriate state regulatory authority and accredited by the applicable accreditation organization and/or Medicare certified.

Plan Benefit Tables: Plan A

Medicare Part A: Hospital Services per Benefit Period^(*)				
Service		Medicare Pays	Plan Pays	You Pay
Hospitalization** Semiprivate room and board, general nursing and miscellaneous services and supplies	First 60 days	All but \$1,484	\$0	\$1,484 (Part A deductible)
	Days 61 thru 90	All but \$371 per day	\$371 per day	\$0
	Days 91 and after while using 60 lifetime reserve days	All but \$742 per day	\$742 per day	\$0
	Once lifetime reserve days are used, an additional 365 days	\$0	100% of Medicare eligible expenses (**)	\$0 ^(**)
	Beyond the additional 365 days	\$0	\$0	100%
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
	Days 21 thru 100	All but \$185.50 per day	\$0	Up to \$185.50 per day
	Days 101 and after	\$0	\$0	100%
Blood	First 3 pints	\$0	100%	\$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 or coinsurance for outpatient drugs and inpatient respite care	Medicare copayment or coinsurance for outpatient drugs and inpatient respite care	\$0

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

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

Plan Benefit Tables: Plan A (continued)

Medicare Part B: Medical Services per Calendar Year^(*)				
Service		Medicare Pays	Plan Pays	You Pay
Medical Expenses INCLUDES TREATMENT 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 \$203 of Medicare-approved amounts ^(*)	\$0	\$0	\$203 (Part B deductible)
	Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)		\$0	\$0	100%
Blood	First 3 pints	\$0	100%	\$0
	Next \$203 of Medicare-approved amounts ^(*)	\$0	\$0	\$203 (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services	Tests for diagnostic services	100%	\$0	\$0
Medicare Parts A and B				
Service		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 Medicare-approved Services	First \$203 of Medicare-approved amounts ^(*)	\$0	\$0	\$203 (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	\$0

^(*) Once you have been billed \$203 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Plan Benefit Tables: Plan F and Plan Select F

Medicare Part A: Hospital Services per Benefit Period^(*)				
Service		Medicare Pays	Plan Pays	You Pay
Hospitalization** Semiprivate room and board, general nursing and miscellaneous services and supplies	First 60 days	All but \$1,484	\$1,484 (Part A deductible) ⁽⁺⁺⁾	\$0
	Days 61 thru 90	All but \$371 per day	\$371 per day	\$0
	Days 91 and after while using 60 lifetime reserve days	All but \$742 per day	\$742 per day	\$0
	Once lifetime reserve days are used, an additional 365 days	\$0	100% of Medicare eligible expenses ^(**)	\$0 ^(**)
	Beyond the additional 365 days	\$0	\$0	100%
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
	Days 21 thru 100	All but \$185.50 per day	Up to \$185.50 per day	\$0
	Days 101 and after	\$0	\$0	100%
Blood	First 3 pints	\$0	100%	\$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 or coinsurance for outpatient drugs and inpatient respite care	Medicare copayment or coinsurance for outpatient drugs and inpatient respite care	\$0

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

(**) 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.

(++) If you choose the Plan 65 Select version of Plan F, you must use a Plan 65 Select Hospital Network for Medicare Part A benefits, unless the services are required for Emergency treatment or the services are not available within the Plan 65 Select Hospital Network.

Plan Benefit Tables: Plan F and Plan Select F (continued)

Medicare Part B: Medical Services per Calendar Year^(*)				
Service		Medicare Pays	Plan Pays	You Pay
Medical Expenses INCLUDES TREATMENT 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 \$203 of Medicare-approved amounts ^(*)	\$0	\$203 (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	100%	\$0
	Next \$203 of Medicare-approved amounts ^(*)	\$0	\$203 (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 and B				
Service		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 Medicare-approved Services	First \$203 of Medicare-approved amounts ^(*)	\$0	\$203 (Part B deductible)	\$0
	Remainder of Medicare-approved amounts	80%	20%	\$0

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^(*) Once you have been billed \$203 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Plan Benefit Tables: Plan F and Plan Select F (continued)

Other Benefits not Covered by Medicare				
Service		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 of 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 Benefit Tables: Plan G and Plan Select G

Medicare Part A: Hospital Services per Benefit Period^(*)				
Service		Medicare Pays	Plan Pays	You Pay
Hospitalization** Semiprivate room and board, general nursing and miscellaneous services and supplies	First 60 days	All but \$1,484	\$1,484 (Part A deductible) ⁽⁺⁺⁾	\$0
	Days 61 thru 90	All but \$371 per day	\$371 per day	\$0
	Days 91 and after while using 60 lifetime reserve days	All but \$742 per day	\$742 per day	\$0
	Once lifetime reserve days are used, an additional 365 days	\$0	100% of Medicare eligible expenses ^(**)	\$0 ^(**)
	Beyond the additional 365 days	\$0	\$0	100%
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
	Days 21 thru 100	All but \$185.50 per day	Up to \$185.50 per day	\$0
	Days 101 and after	\$0	\$0	100%
Blood	First 3 pints	\$0	100%	\$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 or coinsurance for outpatient drugs and inpatient respite care	Medicare copayment or coinsurance for outpatient drugs and inpatient respite care	\$0

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

^(**) 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.

⁽⁺⁺⁾ If you choose the Plan 65 Select version of Plan G, you must use a Plan 65 Select Hospital Network for Medicare Part A benefits, unless the services are required for Emergency treatment or the services are not available within the Plan 65 Select Hospital Network.

Plan Benefit Tables: Plan G and Plan Select G (continued)

Medicare Part B: Medical Services per Calendar Year^(*)				
Service		Medicare Pays	Plan Pays	You Pay
Medical Expenses INCLUDES TREATMENT 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 \$203 of Medicare-approved amounts ^(*)	\$0	\$0	\$203 (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	100%	\$0
	Next \$203 of Medicare-approved amounts ^(*)	\$0	\$0	\$203 (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services	Tests for diagnostic services	100%	\$0	\$0
Medicare Parts A and B				
Service		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 Medicare-approved Services	First \$203 of Medicare-approved amounts ^(*)	\$0	\$0	\$203 (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	\$0

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^(*) Once you have been billed \$203 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Plan Benefit Tables: Plan G and Plan Select G (continued)

Other Benefits not Covered by Medicare				
Service		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 of 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 Benefit Tables: Plan N

Medicare Part A: Hospital Services per Benefit Period^(*)				
Service		Medicare Pays	Plan Pays	You Pay
Hospitalization** Semiprivate room and board, general nursing and miscellaneous services and supplies	First 60 days	All but \$1,484	\$1,484 (Part A deductible)	\$0
	Days 61 thru 90	All but \$371 per day	\$371 per day	\$0
	Days 91 and after while using 60 lifetime reserve days	All but \$742 per day	\$742 per day	\$0
	Once lifetime reserve days are used, an additional 365 days	\$0	100% of Medicare eligible expenses (**)	\$0 ^(**)
	Beyond the additional 365 days	\$0	\$0	100%
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
	Days 21 thru 100	All but \$185.50 per day	Up to \$185.50 per day	\$0
	Days 101 and after	\$0	\$0	100%
Blood	First 3 pints	\$0	100%	\$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 or coinsurance for outpatient drugs and inpatient respite care	Medicare copayment or coinsurance for outpatient drugs and inpatient respite care	\$0

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

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

Plan Benefit Tables: Plan N (continued)

Medicare Part B: Medical Services per Calendar Year^(*)				
Service		Medicare Pays	Plan Pays	You Pay
Medical Expenses INCLUDES TREATMENT 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 \$203 of Medicare-approved amounts ^(*)	\$0	\$0	\$203 (Part B <i>deductible</i>)
	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 you are admitted to any hospital and the emergency visit is covered as a <i>Medicare Part A</i> expense.	Up to \$20 per office visit and up to \$50 per emergency room visit. The co- payment of up to \$50 is waived if you are admitted to any hospital and the emergency visit is covered as a <i>Medicare Part A</i> expense.
Part B Excess Charges (Above Medicare Approved Amounts)		\$0	\$0	100%
Blood	First 3 pints	\$0	100%	\$0
	Next \$203 of Medicare-approved amounts ^(*)	\$0	\$0	\$203 (Part B deductible)
	Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services	Tests for diagnostic services	100%	\$0	\$0
Medicare Parts A and B				
Service		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 Medicare-approved Services	First 203 of Medicare-approved amounts ^(*)	\$0	\$0
	Remainder of Medicare-approved amounts	80%	20%	\$0

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(*) Once you have been billed \$203 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Plan Benefit Tables: Plan N (continued)

Other Benefits not Covered by Medicare				
Service		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 of 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