Blue Cross and Blue Shield of Nebraska

Medicare Supplement Outline of Coverage

Benefit Plans: A, B, C, F, G, L and N

Rates Valid: April 1, 2024, through March 31, 2025
For Plans Effective: Jan. 1, 2024, through Dec. 31, 2024

BlueCross BlueShield Nebraska

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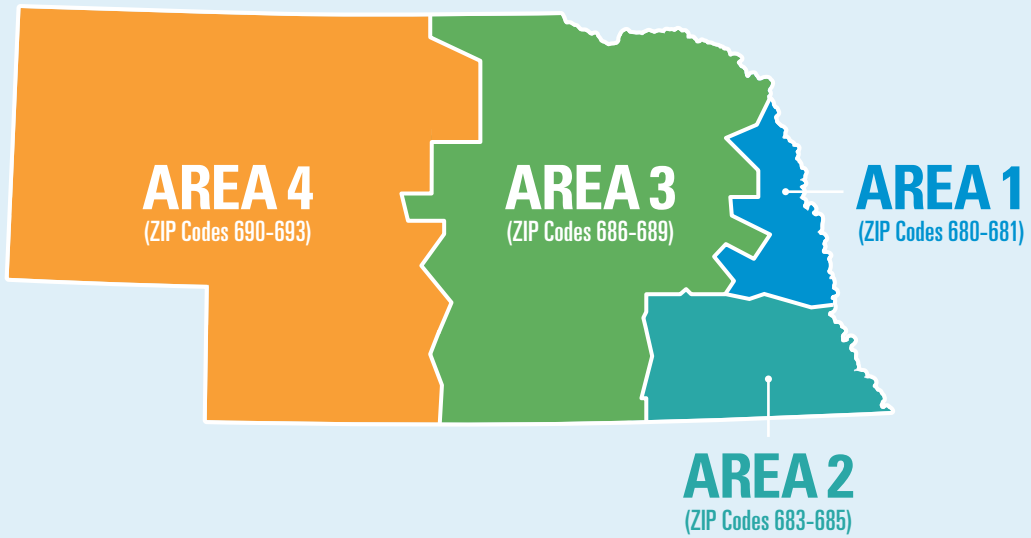
RATE ZONES | Based on ZIP Code



Benefit Chart of Medicare Supplement Plans

For Plans Effective: April 1, 2024, through March 31, 2025

This chart shows the benefits included in each of the standard Medicare Supplement plans. Some plans may not be available. Only applicants' first eligible for Medicare before 2020 may purchase Plans C, F and high deductible F.

Note: a ✔ means 100% of the benefit is paid

									Medicare first eligible before 2020 only	
	Plan A	**Plan B**	**Plan D**	**Plan G[1]**	**Plan K**	**Plan L**	**Plan M**	**Plan N**	**Plan C**	**Plan 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%	✔	✔[3] copays apply	✔	✔
Blood (first three pints)	✔	✔	✔	✔	50%	75%	✔	✔	✔	✔
Part A hospice care coinsurance or copayment	✔	✔	✔	✔	50%	75%	✔	✔	✔	✔
Skilled nursing facility care 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[2]					$7,060[2]	$3,530[2]				

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 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 copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that do not result in inpatient admission.

Blue Cross and Blue Shield of Nebraska only offers Plans A, B, C, F, G, L and N.

MONTHLY PREMIUMS | PREFERRED – Non-Tobacco User

AREA 1 (ZIP Codes 680-681)

Age	Plan A		Plan B		Plan G		Plan L		Plan N	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
65	197.73	171.94	247.96	215.62	179.50	156.09	137.40	119.48	128.77	111.98
66	197.73	171.94	247.96	215.62	179.50	156.09	137.40	119.48	128.77	111.98
67	197.73	171.94	247.96	215.62	179.50	156.09	137.40	119.48	128.77	111.98
68	208.60	181.39	261.60	227.48	189.37	164.67	144.96	126.06	135.85	118.13
69	219.48	190.86	275.24	239.34	199.24	173.25	152.51	132.62	142.94	124.30
70	230.35	200.31	288.88	251.20	209.12	181.84	160.07	139.19	150.02	130.45
71	240.24	208.91	301.28	261.98	218.08	189.64	166.94	145.17	156.46	136.05
72	250.13	217.50	313.68	272.76	227.07	197.45	173.82	151.15	162.90	141.65
73	260.02	226.10	326.08	283.55	236.03	205.25	180.69	157.12	169.34	147.25
74	269.90	234.70	338.47	294.32	245.01	213.06	187.56	163.10	175.77	152.85
75	279.79	243.30	350.87	305.10	253.98	220.86	194.42	169.06	182.22	158.45
76	288.69	251.04	362.03	314.81	262.07	227.89	200.60	174.44	188.01	163.49
77	297.59	258.77	373.19	324.51	270.14	234.91	206.79	179.82	193.80	168.52
78	306.48	266.50	384.34	334.21	278.23	241.94	212.97	185.19	199.60	173.57
79	315.38	274.25	395.51	343.92	286.30	248.96	219.16	190.57	205.39	178.60
80	324.28	281.98	406.66	353.62	294.37	255.98	225.34	195.95	211.19	183.64
81	331.20	288.00	415.34	361.16	300.66	261.44	230.15	200.13	215.69	187.56
82	338.12	294.02	424.02	368.71	306.94	266.90	234.96	204.32	220.20	191.48
83	345.04	300.04	432.70	376.26	313.22	272.37	239.77	208.50	224.71	195.40
84	351.96	306.05	441.38	383.81	319.50	277.83	244.58	212.68	229.22	199.32
85	358.89	312.08	450.06	391.35	325.78	283.29	249.38	216.86	233.72	203.23
86	361.85	314.65	453.78	394.59	328.48	285.64	251.45	218.65	235.65	204.92
87	364.82	317.23	457.50	397.82	331.17	287.97	253.51	220.45	237.59	206.60
88	367.78	319.81	461.21	401.05	333.87	290.32	255.57	222.23	239.52	208.28
89	370.75	322.39	464.94	404.29	336.56	292.66	257.63	224.03	241.45	209.96
90+	373.71	324.97	468.65	407.52	339.25	295.00	259.70	225.82	243.38	211.63

Plan C		Plan F	
Male	Female	Male	Female
230.16	200.14	255.90	222.52
230.16	200.14	255.90	222.52
230.16	200.14	255.90	222.52
242.82	211.15	269.97	234.75
255.47	222.15	284.05	247.00
268.13	233.16	298.12	259.24
279.64	243.16	310.91	270.36
291.15	253.18	323.71	281.49
302.66	263.18	336.50	292.61
314.16	273.18	349.29	303.73
325.67	283.20	362.10	314.87
336.03	292.20	373.61	324.88
346.39	301.21	385.13	334.89
356.74	310.21	396.64	344.91
367.10	319.22	408.16	354.92
377.46	328.23	419.67	364.93
385.51	335.23	428.63	372.72
393.57	342.24	437.58	380.50
401.62	349.24	446.54	388.29
409.68	356.24	455.50	396.08
417.74	363.25	464.45	403.87
421.19	366.25	468.29	407.21
424.64	369.26	472.12	410.54
428.10	372.26	475.97	413.89
431.55	375.26	479.80	417.22
435.00	378.26	483.64	420.56

Only available to those Medicare eligible prior to Jan. 1, 2020

Rates valid through March 31, 2025. Premium is based on your gender and age as of April 1, 2024. Premium payment may be made monthly.

MONTHLY PREMIUMS | PREFERRED – Non-Tobacco User

AREA 1 (ZIP Codes 680-681) – Household Discount Applied*

Age	Plan A		Plan B		Plan G		Plan L		Plan N	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
65	168.07	146.15	210.77	183.28	152.57	132.68	116.79	101.56	109.45	95.18
66	168.07	146.15	210.77	183.28	152.57	132.68	116.79	101.56	109.45	95.18
67	168.07	146.15	210.77	183.28	152.57	132.68	116.79	101.56	109.45	95.18
68	177.31	154.18	222.36	193.36	160.96	139.97	123.22	107.15	115.47	100.41
69	186.56	162.23	233.95	203.44	169.35	147.26	129.63	112.73	121.50	105.65
70	195.80	170.26	245.55	213.52	177.75	154.56	136.06	118.31	127.52	110.88
71	204.20	177.57	256.09	222.68	185.37	161.19	141.90	123.39	132.99	115.64
72	212.61	184.87	266.63	231.85	193.01	167.83	147.75	128.48	138.46	120.40
73	221.02	192.18	277.17	241.02	200.63	174.46	153.59	133.55	143.94	125.16
74	229.41	199.49	287.70	250.17	208.26	181.10	159.43	138.63	149.40	129.92
75	237.82	206.80	298.24	259.33	215.88	187.73	165.26	143.70	154.89	134.68
76	245.39	213.38	307.73	267.59	222.76	193.71	170.51	148.27	159.81	138.97
77	252.95	219.95	317.21	275.83	229.62	199.67	175.77	152.85	164.73	143.24
78	260.51	226.52	326.69	284.08	236.50	205.65	181.02	157.41	169.66	147.53
79	268.07	233.11	336.18	292.33	243.35	211.62	186.29	161.98	174.58	151.81
80	275.64	239.68	345.66	300.58	250.21	217.58	191.54	166.56	179.51	156.09
81	281.52	244.80	353.04	306.99	255.56	222.22	195.63	170.11	183.34	159.43
82	287.40	249.92	360.42	313.40	260.90	226.86	199.72	173.67	187.17	162.76
83	293.28	255.03	367.79	319.82	266.24	231.51	203.80	177.22	191.00	166.09
84	299.17	260.14	375.17	326.24	271.57	236.16	207.89	180.78	194.84	169.42
85	305.06	265.27	382.55	332.65	276.91	240.80	211.97	184.33	198.66	172.75
86	307.57	267.45	385.71	335.40	279.21	242.79	213.73	185.85	200.30	174.18
87	310.10	269.65	388.87	338.15	281.49	244.77	215.48	187.38	201.95	175.61
88	312.61	271.84	392.03	340.89	283.79	246.77	217.23	188.90	203.59	177.04
89	315.14	274.03	395.20	343.65	286.08	248.76	218.99	190.43	205.23	178.47
90+	317.65	276.22	398.35	346.39	288.36	250.75	220.74	191.95	206.87	179.89

Plan C		Plan F	
Male	Female	Male	Female
195.64	170.12	217.51	189.14
195.64	170.12	217.51	189.14
195.64	170.12	217.51	189.14
206.40	179.48	229.47	199.54
217.15	188.83	241.44	209.95
227.91	198.19	253.40	220.35
237.69	206.69	264.27	229.81
247.48	215.20	275.15	239.27
257.26	223.70	286.02	248.72
267.04	232.20	296.90	258.17
276.82	240.72	307.78	267.64
285.63	248.37	317.57	276.15
294.43	256.03	327.36	284.66
303.23	263.68	337.14	293.17
312.03	271.34	346.94	301.68
320.84	279.00	356.72	310.19
327.68	284.95	364.34	316.81
334.53	290.90	371.94	323.42
341.38	296.85	379.56	330.05
348.23	302.80	387.17	336.67
355.08	308.76	394.78	343.29
358.01	311.31	398.05	346.13
360.94	313.87	401.30	348.96
363.88	316.42	404.57	351.81
366.82	318.97	407.83	354.64
369.75	321.52	411.09	357.48

Only available to those Medicare eligible prior to Jan. 1, 2020

Rates valid through March 31, 2025. Premium is based on your gender and age as of April 1, 2024. Premium payment may be made monthly.

*See page 20 for information regarding household premium discount.

MONTHLY PREMIUMS | STANDARD – Tobacco User

AREA 1 (ZIP Codes 680-681)

Age	Plan A		Plan B		Plan G		Plan L		Plan N	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
65	227.39	197.73	285.16	247.96	206.42	179.50	158.01	137.40	148.09	128.77
66	227.39	197.73	285.16	247.96	206.42	179.50	158.01	137.40	148.09	128.77
67	227.39	197.73	285.16	247.96	206.42	179.50	158.01	137.40	148.09	128.77
68	239.89	208.60	300.84	261.60	217.78	189.37	166.71	144.96	156.23	135.85
69	252.41	219.48	316.53	275.24	229.13	199.24	175.39	152.51	164.38	142.94
70	264.91	230.35	332.21	288.88	240.48	209.12	184.08	160.07	172.53	150.02
71	276.28	240.24	346.47	301.28	250.80	218.08	191.99	166.94	179.93	156.46
72	287.65	250.13	360.73	313.68	261.12	227.07	199.89	173.82	187.34	162.90
73	299.02	260.02	374.99	326.08	271.44	236.03	207.79	180.69	194.74	169.34
74	310.39	269.90	389.24	338.47	281.77	245.01	215.69	187.56	202.14	175.77
75	321.76	279.79	403.50	350.87	292.08	253.98	223.58	194.42	209.55	182.22
76	332.00	288.69	416.34	362.03	301.38	262.07	230.70	200.60	216.21	188.01
77	342.22	297.59	429.17	373.19	310.66	270.14	237.81	206.79	222.87	193.80
78	352.45	306.48	441.99	384.34	319.96	278.23	244.92	212.97	229.54	199.60
79	362.69	315.38	454.83	395.51	329.25	286.30	252.03	219.16	236.20	205.39
80	372.92	324.28	467.66	406.66	338.53	294.37	259.14	225.34	242.87	211.19
81	380.88	331.20	477.64	415.34	345.75	300.66	264.67	230.15	248.05	215.69
82	388.84	338.12	487.62	424.02	352.98	306.94	270.21	234.96	253.23	220.20
83	396.80	345.04	497.60	432.70	360.20	313.22	275.74	239.77	258.41	224.71
84	404.75	351.96	507.59	441.38	367.43	319.50	281.26	244.58	263.60	229.22
85	412.72	358.89	517.56	450.06	374.65	325.78	286.79	249.38	268.78	233.72
86	416.12	361.85	521.85	453.78	377.75	328.48	289.17	251.45	271.00	235.65
87	419.54	364.82	526.12	457.50	380.84	331.17	291.54	253.51	273.22	237.59
88	422.95	367.78	530.39	461.21	383.95	333.87	293.90	255.57	275.45	239.52
89	426.36	370.75	534.68	464.94	387.04	336.56	296.28	257.63	277.67	241.45
90+	429.77	373.71	538.95	468.65	390.14	339.25	298.65	259.70	279.88	243.38

Plan C		Plan F	
Male	Female	Male	Female
264.68	230.16	294.28	255.90
264.68	230.16	294.28	255.90
264.68	230.16	294.28	255.90
279.24	242.82	310.46	269.97
293.79	255.47	326.66	284.05
308.35	268.13	342.84	298.12
321.58	279.64	357.55	310.91
334.82	291.15	372.26	323.71
348.05	302.66	386.98	336.50
361.28	314.16	401.69	349.29
374.53	325.67	416.41	362.10
386.44	336.03	429.66	373.61
398.35	346.39	442.90	385.13
410.26	356.74	456.14	396.64
422.17	367.10	469.38	408.16
434.08	377.46	482.62	419.67
443.34	385.51	492.93	428.63
452.61	393.57	503.22	437.58
461.87	401.62	513.52	446.54
471.13	409.68	523.82	455.50
480.40	417.74	534.12	464.45
484.37	421.19	538.53	468.29
488.34	424.64	542.94	472.12
492.31	428.10	547.36	475.97
496.28	431.55	551.77	479.80
500.25	435.00	556.18	483.64

Only available to those Medicare eligible prior to Jan. 1, 2020

Rates valid through March 31, 2025. Premium is based on your gender and age as of April 1, 2024. Premium payment may be made monthly.

MONTHLY PREMIUMS | STANDARD – Tobacco User

AREA 1 (ZIP Codes 680-681) – Household Discount Applied*

Age	Plan A		Plan B		Plan G		Plan L		Plan N	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
65	193.28	168.07	242.39	210.77	175.46	152.57	134.31	116.79	125.88	109.45
66	193.28	168.07	242.39	210.77	175.46	152.57	134.31	116.79	125.88	109.45
67	193.28	168.07	242.39	210.77	175.46	152.57	134.31	116.79	125.88	109.45
68	203.91	177.31	255.71	222.36	185.11	160.96	141.70	123.22	132.80	115.47
69	214.55	186.56	269.05	233.95	194.76	169.35	149.08	129.63	139.72	121.50
70	225.17	195.80	282.38	245.55	204.41	177.75	156.47	136.06	146.65	127.52
71	234.84	204.20	294.50	256.09	213.18	185.37	163.19	141.90	152.94	132.99
72	244.50	212.61	306.62	266.63	221.95	193.01	169.91	147.75	159.24	138.46
73	254.17	221.02	318.74	277.17	230.72	200.63	176.62	153.59	165.53	143.94
74	263.83	229.41	330.85	287.70	239.50	208.26	183.34	159.43	171.82	149.40
75	273.50	237.82	342.97	298.24	248.27	215.88	190.04	165.26	178.12	154.89
76	282.20	245.39	353.89	307.73	256.17	222.76	196.09	170.51	183.78	159.81
77	290.89	252.95	364.79	317.21	264.06	229.62	202.14	175.77	189.44	164.73
78	299.58	260.51	375.69	326.69	271.97	236.50	208.18	181.02	195.11	169.66
79	308.29	268.07	386.61	336.18	279.86	243.35	214.23	186.29	200.77	174.58
80	316.98	275.64	397.51	345.66	287.75	250.21	220.27	191.54	206.44	179.51
81	323.75	281.52	405.99	353.04	293.89	255.56	224.97	195.63	210.84	183.34
82	330.51	287.40	414.48	360.42	300.03	260.90	229.68	199.72	215.25	187.17
83	337.28	293.28	422.96	367.79	306.17	266.24	234.38	203.80	219.65	191.00
84	344.04	299.17	431.45	375.17	312.32	271.57	239.07	207.89	224.06	194.84
85	350.81	305.06	439.93	382.55	318.45	276.91	243.77	211.97	228.46	198.66
86	353.70	307.57	443.57	385.71	321.09	279.21	245.79	213.73	230.35	200.30
87	356.61	310.10	447.20	388.87	323.71	281.49	247.81	215.48	232.24	201.95
88	359.51	312.61	450.83	392.03	326.36	283.79	249.81	217.23	234.13	203.59
89	362.41	315.14	454.48	395.20	328.98	286.08	251.84	218.99	236.02	205.23
90+	365.30	317.65	458.11	398.35	331.62	288.36	253.85	220.74	237.90	206.87

Plan C		Plan F	
Male	Female	Male	Female
224.98	195.64	250.14	217.51
224.98	195.64	250.14	217.51
224.98	195.64	250.14	217.51
237.35	206.40	263.89	229.47
249.72	217.15	277.66	241.44
262.10	227.91	291.41	253.40
273.34	237.69	303.92	264.27
284.60	247.48	316.42	275.15
295.84	257.26	328.93	286.02
307.09	267.04	341.44	296.90
318.35	276.82	353.95	307.78
328.47	285.63	365.21	317.57
338.60	294.43	376.46	327.36
348.72	303.23	387.72	337.14
358.84	312.03	398.97	346.94
368.97	320.84	410.23	356.72
376.84	327.68	418.99	364.34
384.72	334.53	427.74	371.94
392.59	341.38	436.49	379.56
400.46	348.23	445.25	387.17
408.34	355.08	454.00	394.78
411.71	358.01	457.75	398.05
415.09	360.94	461.50	401.30
418.46	363.88	465.26	404.57
421.84	366.82	469.00	407.83
425.21	369.75	472.75	411.09

Only available to those Medicare eligible prior to Jan. 1, 2020

Rates valid through March 31, 2025. Premium is based on your gender and age as of April 1, 2024. Premium payment may be made monthly.

*See page 20 for information regarding household premium discount.

MONTHLY PREMIUMS | PREFERRED – Non-Tobacco User

AREA 2 (ZIP Codes 683-685)

Age	Plan A		Plan B		Plan G		Plan L		Plan N	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
65	208.14	180.99	261.02	226.97	188.95	164.30	144.64	125.77	135.55	117.87
66	208.14	180.99	261.02	226.97	188.95	164.30	144.64	125.77	135.55	117.87
67	208.14	180.99	261.02	226.97	188.95	164.30	144.64	125.77	135.55	117.87
68	219.58	190.94	275.37	239.45	199.34	173.34	152.59	132.69	143.00	124.35
69	231.04	200.90	289.73	251.94	209.73	182.37	160.54	139.60	150.47	130.84
70	242.48	210.85	304.08	264.42	220.12	191.41	168.50	146.52	157.92	137.32
71	252.89	219.90	317.14	275.77	229.56	199.62	175.73	152.81	164.69	143.21
72	263.29	228.95	330.19	287.12	239.02	207.84	182.97	159.10	171.48	149.11
73	273.70	238.00	343.24	298.47	248.46	216.05	190.20	165.39	178.25	155.00
74	284.11	247.05	356.28	309.81	257.91	224.27	197.43	171.68	185.02	160.89
75	294.52	256.10	369.33	321.16	267.35	232.48	204.65	177.96	191.81	166.79
76	303.89	264.25	381.09	331.38	275.86	239.88	211.16	183.62	197.90	172.09
77	313.25	272.39	392.83	341.59	284.36	247.27	217.67	189.28	204.00	177.39
78	322.61	280.53	404.57	351.80	292.87	254.67	224.18	194.94	210.11	182.70
79	331.98	288.68	416.32	362.02	301.37	262.06	230.69	200.60	216.20	188.00
80	341.34	296.82	428.06	372.23	309.87	269.45	237.20	206.26	222.31	193.31
81	348.63	303.16	437.20	380.17	316.48	275.20	242.26	210.66	227.04	197.43
82	355.91	309.49	446.34	388.12	323.09	280.95	247.33	215.07	231.79	201.56
83	363.20	315.83	455.47	396.06	329.71	286.70	252.39	219.47	236.53	205.68
84	370.48	322.16	464.61	404.01	336.32	292.45	257.45	223.87	241.28	209.81
85	377.78	328.50	473.74	411.95	342.93	298.20	262.51	228.27	246.02	213.93
86	380.89	331.21	477.66	415.36	345.77	300.67	264.68	230.16	248.06	215.70
87	384.02	333.93	481.57	418.76	348.60	303.13	266.86	232.05	250.09	217.47
88	387.14	336.64	485.48	422.16	351.44	305.60	269.02	233.93	252.13	219.24
89	390.26	339.36	489.41	425.57	354.27	308.06	271.19	235.82	254.16	221.01
90+	393.38	342.07	493.32	428.97	357.11	310.53	273.37	237.71	256.19	222.77

Plan C		Plan F	
Male	Female	Male	Female
242.27	210.67	269.36	234.23
242.27	210.67	269.36	234.23
242.27	210.67	269.36	234.23
255.60	222.26	284.18	247.11
268.92	233.84	299.00	260.00
282.24	245.43	313.81	272.88
294.35	255.96	327.28	284.59
306.48	266.50	340.75	296.30
318.58	277.03	354.21	308.01
330.69	287.56	367.68	319.72
342.82	298.10	381.16	331.44
353.72	307.58	393.28	341.98
364.62	317.06	405.40	352.52
375.52	326.54	417.52	363.06
386.42	336.02	429.64	373.60
397.33	345.50	441.76	384.14
405.80	352.87	451.19	392.34
414.29	360.25	460.61	400.53
422.76	367.62	470.04	408.73
431.24	374.99	479.47	416.93
439.73	382.37	488.90	425.13
443.36	385.53	492.94	428.64
446.99	388.69	496.97	432.15
450.63	391.85	501.02	435.67
454.26	395.01	505.06	439.18
457.90	398.17	509.09	442.69

Only available to those Medicare eligible prior to Jan. 1, 2020

Rates valid through March 31, 2025. Premium is based on your gender and age as of April 1, 2024. Premium payment may be made monthly.

MONTHLY PREMIUMS | PREFERRED – Non-Tobacco User

AREA 2 (ZIP Codes 683-685) – Household Discount Applied*

Age	Plan A		Plan B		Plan G		Plan L		Plan N	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
65	176.92	153.84	221.87	192.92	160.61	139.65	122.94	106.90	115.22	100.19
66	176.92	153.84	221.87	192.92	160.61	139.65	122.94	106.90	115.22	100.19
67	176.92	153.84	221.87	192.92	160.61	139.65	122.94	106.90	115.22	100.19
68	186.64	162.30	234.06	203.53	169.44	147.34	129.70	112.79	121.55	105.70
69	196.38	170.76	246.27	214.15	178.27	155.01	136.46	118.66	127.90	111.21
70	206.11	179.22	258.47	224.76	187.10	162.70	143.22	124.54	134.23	116.72
71	214.96	186.91	269.57	234.40	195.13	169.68	149.37	129.89	139.99	121.73
72	223.80	194.61	280.66	244.05	203.17	176.66	155.52	135.23	145.76	126.74
73	232.64	202.30	291.75	253.70	211.19	183.64	161.67	140.58	151.51	131.75
74	241.49	209.99	302.84	263.34	219.22	190.63	167.82	145.93	157.27	136.76
75	250.34	217.68	313.93	272.99	227.25	197.61	173.95	151.27	163.04	141.77
76	258.31	224.61	323.93	281.67	234.48	203.90	179.49	156.08	168.21	146.28
77	266.26	231.53	333.91	290.35	241.71	210.18	185.02	160.89	173.40	150.78
78	274.22	238.45	343.88	299.03	248.94	216.47	190.55	165.70	178.59	155.29
79	282.18	245.38	353.87	307.72	256.16	222.75	196.09	170.51	183.77	159.80
80	290.14	252.30	363.85	316.40	263.39	229.03	201.62	175.32	188.96	164.31
81	296.34	257.69	371.62	323.14	269.01	233.92	205.92	179.06	192.98	167.82
82	302.52	263.07	379.39	329.90	274.63	238.81	210.23	182.81	197.02	171.33
83	308.72	268.46	387.15	336.65	280.25	243.69	214.53	186.55	201.05	174.83
84	314.91	273.84	394.92	343.41	285.87	248.58	218.83	190.29	205.09	178.34
85	321.11	279.22	402.68	350.16	291.49	253.47	223.13	194.03	209.12	181.84
86	323.76	281.53	406.01	353.06	293.90	255.57	224.98	195.64	210.85	183.34
87	326.42	283.84	409.33	355.95	296.31	257.66	226.83	197.24	212.58	184.85
88	329.07	286.14	412.66	358.84	298.72	259.76	228.67	198.84	214.31	186.35
89	331.72	288.46	416.00	361.73	301.13	261.85	230.51	200.45	216.04	187.86
90+	334.37	290.76	419.32	364.62	303.54	263.95	232.36	202.05	217.76	189.35

Plan C		Plan F	
Male	Female	Male	Female
205.93	179.07	228.96	199.10
205.93	179.07	228.96	199.10
205.93	179.07	228.96	199.10
217.26	188.92	241.55	210.04
228.58	198.76	254.15	221.00
239.90	208.62	266.74	231.95
250.20	217.57	278.19	241.90
260.51	226.52	289.64	251.85
270.79	235.48	301.08	261.81
281.09	244.43	312.53	271.76
291.40	253.38	323.99	281.72
300.66	261.44	334.29	290.68
309.93	269.50	344.59	299.64
319.19	277.56	354.89	308.60
328.46	285.62	365.19	317.56
337.73	293.67	375.50	326.52
344.93	299.94	383.51	333.49
352.15	306.21	391.52	340.45
359.35	312.48	399.53	347.42
366.55	318.74	407.55	354.39
373.77	325.01	415.56	361.36
376.86	327.70	419.00	364.34
379.94	330.39	422.42	367.33
383.04	333.07	425.87	370.32
386.12	335.76	429.30	373.30
389.21	338.44	432.73	376.29

Only available to those Medicare eligible prior to Jan. 1, 2020

Rates valid through March 31, 2025. Premium is based on your gender and age as of April 1, 2024. Premium payment may be made monthly.

*See page 20 for information regarding household premium discount.

MONTHLY PREMIUMS | STANDARD – Tobacco User

AREA 2 (ZIP Codes 683-685)

Age	Plan A		Plan B		Plan G		Plan L		Plan N	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
65	239.36	208.14	300.17	261.02	217.29	188.95	166.33	144.64	155.88	135.55
66	239.36	208.14	300.17	261.02	217.29	188.95	166.33	144.64	155.88	135.55
67	239.36	208.14	300.17	261.02	217.29	188.95	166.33	144.64	155.88	135.55
68	252.52	219.58	316.67	275.37	229.24	199.34	175.48	152.59	164.45	143.00
69	265.69	231.04	333.19	289.73	241.18	209.73	184.62	160.54	173.04	150.47
70	278.85	242.48	349.70	304.08	253.14	220.12	193.77	168.50	181.61	157.92
71	290.82	252.89	364.71	317.14	264.00	229.56	202.09	175.73	189.40	164.69
72	302.79	263.29	379.72	330.19	274.87	239.02	210.41	182.97	197.20	171.48
73	314.76	273.70	394.73	343.24	285.73	248.46	218.73	190.20	204.99	178.25
74	326.72	284.11	409.72	356.28	296.60	257.91	227.05	197.43	212.78	185.02
75	338.69	294.52	424.73	369.33	307.45	267.35	235.35	204.65	220.58	191.81
76	349.47	303.89	438.25	381.09	317.24	275.86	242.84	211.16	227.59	197.90
77	360.24	313.25	451.75	392.83	327.01	284.36	250.32	217.67	234.60	204.00
78	371.00	322.61	465.26	404.57	336.80	292.87	257.81	224.18	241.62	210.11
79	381.78	331.98	478.77	416.32	346.57	301.37	265.29	230.69	248.63	216.20
80	392.54	341.34	492.27	428.06	356.35	309.87	272.78	237.20	255.65	222.31
81	400.93	348.63	502.77	437.20	363.95	316.48	278.60	242.26	261.10	227.04
82	409.30	355.91	513.29	446.34	371.56	323.09	284.43	247.33	266.56	231.79
83	417.69	363.20	523.79	455.47	379.16	329.71	290.25	252.39	272.01	236.53
84	426.06	370.48	534.30	464.61	386.77	336.32	296.07	257.45	277.47	241.28
85	434.44	377.78	544.80	473.74	394.37	342.93	301.89	262.51	282.92	246.02
86	438.03	380.89	549.31	477.66	397.64	345.77	304.39	264.68	285.26	248.06
87	441.62	384.02	553.81	481.57	400.89	348.60	306.89	266.86	287.60	250.09
88	445.21	387.14	558.31	485.48	404.16	351.44	309.37	269.02	289.94	252.13
89	448.80	390.26	562.82	489.41	407.41	354.27	311.87	271.19	292.29	254.16
90+	452.39	393.38	567.31	493.32	410.68	357.11	314.37	273.37	294.61	256.19

Plan C		Plan F	
Male	Female	Male	Female
278.61	242.27	309.77	269.36
278.61	242.27	309.77	269.36
278.61	242.27	309.77	269.36
293.94	255.60	326.80	284.18
309.25	268.92	343.85	299.00
324.58	282.24	360.88	313.81
338.51	294.35	376.37	327.28
352.45	306.48	391.86	340.75
366.37	318.58	407.34	354.21
380.30	330.69	422.83	367.68
394.24	342.82	438.33	381.16
406.77	353.72	452.27	393.28
419.31	364.62	466.21	405.40
431.85	375.52	480.15	417.52
444.39	386.42	494.09	429.64
456.92	397.33	508.03	441.76
466.67	405.80	518.87	451.19
476.43	414.29	529.70	460.61
486.18	422.76	540.55	470.04
495.92	431.24	551.39	479.47
505.68	439.73	562.23	488.90
509.86	443.36	566.88	492.94
514.04	446.99	571.52	496.97
518.22	450.63	576.17	501.02
522.40	454.26	580.82	505.06
526.58	457.90	585.46	509.09

Only available to those Medicare eligible prior to Jan. 1, 2020

Rates valid through March 31, 2025. Premium is based on your gender and age as of April 1, 2024. Premium payment may be made monthly.

MONTHLY PREMIUMS | STANDARD – Tobacco User

AREA 2 (ZIP Codes 683-685) – Household Discount Applied*

Age	Plan A		Plan B		Plan G		Plan L		Plan N	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
65	203.46	176.92	255.14	221.87	184.70	160.61	141.38	122.94	132.50	115.22
66	203.46	176.92	255.14	221.87	184.70	160.61	141.38	122.94	132.50	115.22
67	203.46	176.92	255.14	221.87	184.70	160.61	141.38	122.94	132.50	115.22
68	214.64	186.64	269.17	234.06	194.85	169.44	149.16	129.70	139.78	121.55
69	225.84	196.38	283.21	246.27	205.00	178.27	156.93	136.46	147.08	127.90
70	237.02	206.11	297.24	258.47	215.17	187.10	164.70	143.22	154.37	134.23
71	247.20	214.96	310.00	269.57	224.40	195.13	171.78	149.37	160.99	139.99
72	257.37	223.80	322.76	280.66	233.64	203.17	178.85	155.52	167.62	145.76
73	267.55	232.64	335.52	291.75	242.87	211.19	185.92	161.67	174.24	151.51
74	277.71	241.49	348.26	302.84	252.11	219.22	192.99	167.82	180.86	157.27
75	287.89	250.34	361.02	313.93	261.33	227.25	200.05	173.95	187.49	163.04
76	297.05	258.31	372.51	323.93	269.65	234.48	206.41	179.49	193.45	168.21
77	306.20	266.26	383.99	333.91	277.96	241.71	212.77	185.02	199.41	173.40
78	315.35	274.22	395.47	343.88	286.28	248.94	219.14	190.55	205.38	178.59
79	324.51	282.18	406.95	353.87	294.58	256.16	225.50	196.09	211.34	183.77
80	333.66	290.14	418.43	363.85	302.90	263.39	231.86	201.62	217.30	188.96
81	340.79	296.34	427.35	371.62	309.36	269.01	236.81	205.92	221.93	192.98
82	347.90	302.52	436.30	379.39	315.83	274.63	241.77	210.23	226.58	197.02
83	355.04	308.72	445.22	387.15	322.29	280.25	246.71	214.53	231.21	201.05
84	362.15	314.91	454.15	394.92	328.75	285.87	251.66	218.83	235.85	205.09
85	369.27	321.11	463.08	402.68	335.21	291.49	256.61	223.13	240.48	209.12
86	372.33	323.76	466.91	406.01	337.99	293.90	258.73	224.98	242.47	210.85
87	375.38	326.42	470.74	409.33	340.76	296.31	260.86	226.83	244.46	212.58
88	378.43	329.07	474.56	412.66	343.54	298.72	262.96	228.67	246.45	214.31
89	381.48	331.72	478.40	416.00	346.30	301.13	265.09	230.51	248.45	216.04
90+	384.53	334.37	482.21	419.32	349.08	303.54	267.21	232.36	250.42	217.76

Plan C		Plan F	
Male	Female	Male	Female
236.82	205.93	263.30	228.96
236.82	205.93	263.30	228.96
236.82	205.93	263.30	228.96
249.85	217.26	277.78	241.55
262.86	228.58	292.27	254.15
275.89	239.90	306.75	266.74
287.73	250.20	319.91	278.19
299.58	260.51	333.08	289.64
311.41	270.79	346.24	301.08
323.25	281.09	359.41	312.53
335.10	291.40	372.58	323.99
345.75	300.66	384.43	334.29
356.41	309.93	396.28	344.59
367.07	319.19	408.13	354.89
377.73	328.46	419.98	365.19
388.38	337.73	431.83	375.50
396.67	344.93	441.04	383.51
404.97	352.15	450.24	391.52
413.25	359.35	459.47	399.53
421.53	366.55	468.68	407.55
429.83	373.77	477.90	415.56
433.38	376.86	481.85	419.00
436.93	379.94	485.79	422.42
440.49	383.04	489.74	425.87
444.04	386.12	493.70	429.30
447.59	389.21	497.64	432.73

Only available to those Medicare eligible prior to Jan. 1, 2020

Rates valid through March 31, 2025. Premium is based on your gender and age as of April 1, 2024. Premium payment may be made monthly.

*See page 20 for information regarding household premium discount.

MONTHLY PREMIUMS | PREFERRED – Non-Tobacco User

AREA 3 (ZIP Codes 686-689)

Age	Plan A		Plan B		Plan G		Plan L		Plan N	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
65	212.30	184.61	266.24	231.51	192.72	167.59	147.53	128.29	138.26	120.23
66	212.30	184.61	266.24	231.51	192.72	167.59	147.53	128.29	138.26	120.23
67	212.30	184.61	266.24	231.51	192.72	167.59	147.53	128.29	138.26	120.23
68	223.97	194.76	280.87	244.24	203.33	176.81	155.65	135.34	145.86	126.84
69	235.66	204.92	295.53	256.98	213.92	186.02	163.75	142.39	153.48	133.46
70	247.33	215.07	310.16	269.71	224.52	195.24	171.87	149.45	161.08	140.07
71	257.94	224.30	323.48	281.29	234.15	203.61	179.25	155.87	167.99	146.07
72	268.56	233.53	336.79	292.86	243.80	212.00	186.62	162.28	174.91	152.09
73	279.17	242.76	350.11	304.44	253.43	220.37	194.00	168.70	181.82	158.10
74	289.79	251.99	363.41	316.01	263.07	228.76	201.38	175.11	188.72	164.11
75	300.41	261.22	376.72	327.58	272.70	237.13	208.75	181.52	195.64	170.13
76	309.97	269.54	388.71	338.01	281.38	244.68	215.39	187.29	201.86	175.53
77	319.51	277.84	400.69	348.42	290.05	252.22	222.03	193.07	208.08	180.94
78	329.06	286.14	412.66	358.84	298.73	259.76	228.66	198.84	214.31	186.35
79	338.62	294.45	424.65	369.26	307.40	267.30	235.30	204.61	220.52	191.76
80	348.17	302.76	436.63	379.67	316.06	274.84	241.94	210.39	226.75	197.18
81	355.61	309.22	445.94	387.77	322.81	280.70	247.10	214.87	231.59	201.38
82	363.03	315.68	455.26	395.88	329.55	286.57	252.28	219.37	236.43	205.59
83	370.47	322.15	464.58	403.98	336.30	292.43	257.44	223.86	241.26	209.79
84	377.89	328.60	473.90	412.09	343.04	298.30	262.60	228.35	246.11	214.01
85	385.33	335.07	483.22	420.19	349.79	304.16	267.76	232.84	250.94	218.21
86	388.51	337.83	487.22	423.67	352.69	306.68	269.98	234.76	253.02	220.01
87	391.70	340.61	491.21	427.14	355.57	309.19	272.19	236.69	255.09	221.82
88	394.88	343.37	495.19	430.60	358.47	311.71	274.40	238.61	257.17	223.62
89	398.07	346.15	499.19	434.08	361.35	314.22	276.62	240.54	259.24	225.43
90+	401.25	348.91	503.18	437.55	364.25	316.74	278.83	242.46	261.31	227.23

Plan C		Plan F	
Male	Female	Male	Female
247.12	214.88	274.75	238.91
247.12	214.88	274.75	238.91
247.12	214.88	274.75	238.91
260.71	226.71	289.86	252.05
274.29	238.52	304.98	265.20
287.89	250.34	320.09	278.34
300.24	261.08	333.82	290.28
312.60	271.83	347.56	302.23
324.96	282.57	361.30	314.17
337.31	293.31	375.03	326.11
349.67	304.06	388.78	338.07
360.79	313.73	401.14	348.82
371.91	323.40	413.51	359.57
383.03	333.07	425.87	370.32
394.15	342.74	438.23	381.07
405.27	352.41	450.60	391.82
413.92	359.93	460.21	400.19
422.57	367.46	469.82	408.54
431.22	374.97	479.44	416.90
439.86	382.49	489.06	425.27
448.52	390.02	498.68	433.63
452.23	393.24	502.79	437.21
455.93	396.46	506.91	440.79
459.64	399.69	511.04	444.38
463.35	402.91	515.16	447.96
467.05	406.13	519.28	451.54

Only available to those Medicare eligible prior to Jan. 1, 2020

Rates valid through March 31, 2025. Premium is based on your gender and age as of April 1, 2024. Premium payment may be made monthly.

MONTHLY PREMIUMS | PREFERRED – Non-Tobacco User

AREA 3 (ZIP Codes 686-689) – Household Discount Applied*

Age	Plan A		Plan B		Plan G		Plan L		Plan N	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
65	180.45	156.92	226.30	196.78	163.81	142.45	125.40	109.05	117.52	102.20
66	180.45	156.92	226.30	196.78	163.81	142.45	125.40	109.05	117.52	102.20
67	180.45	156.92	226.30	196.78	163.81	142.45	125.40	109.05	117.52	102.20
68	190.37	165.55	238.74	207.60	172.83	150.29	132.30	115.04	123.98	107.81
69	200.31	174.18	251.20	218.43	181.83	158.12	139.19	121.03	130.46	113.44
70	210.23	182.81	263.64	229.25	190.84	165.95	146.09	127.03	136.92	119.06
71	219.25	190.65	274.96	239.10	199.03	173.07	152.36	132.49	142.79	124.16
72	228.28	198.50	286.27	248.93	207.23	180.20	158.63	137.94	148.67	129.28
73	237.29	206.35	297.59	258.77	215.42	187.31	164.90	143.39	154.55	134.38
74	246.32	214.19	308.90	268.61	223.61	194.45	171.17	148.84	160.41	139.49
75	255.35	222.04	320.21	278.44	231.79	201.56	177.44	154.29	166.29	144.61
76	263.47	229.11	330.40	287.31	239.17	207.98	183.08	159.20	171.58	149.20
77	271.58	236.16	340.59	296.16	246.54	214.39	188.73	164.11	176.87	153.80
78	279.70	243.22	350.76	305.01	253.92	220.80	194.36	169.01	182.16	158.40
79	287.83	250.28	360.95	313.87	261.29	227.20	200.00	173.92	187.44	163.00
80	295.94	257.35	371.14	322.72	268.65	233.61	205.65	178.83	192.74	167.60
81	302.27	262.84	379.05	329.60	274.39	238.59	210.03	182.64	196.85	171.17
82	308.58	268.33	386.97	336.50	280.12	243.58	214.44	186.46	200.97	174.75
83	314.90	273.83	394.89	343.38	285.85	248.57	218.82	190.28	205.07	178.32
84	321.21	279.31	402.81	350.28	291.58	253.55	223.21	194.10	209.19	181.91
85	327.53	284.81	410.74	357.16	297.32	258.54	227.60	197.91	213.30	185.48
86	330.23	287.16	414.14	360.12	299.79	260.68	229.48	199.55	215.07	187.01
87	332.94	289.52	417.53	363.07	302.23	262.81	231.36	201.19	216.83	188.55
88	335.65	291.86	420.91	366.01	304.70	264.95	233.24	202.82	218.59	190.08
89	338.36	294.23	424.31	368.97	307.15	267.09	235.13	204.46	220.35	191.62
90+	341.06	296.57	427.70	371.92	309.61	269.23	237.01	206.09	222.11	193.15

Plan C		Plan F	
Male	Female	Male	Female
210.05	182.65	233.54	203.07
210.05	182.65	233.54	203.07
210.05	182.65	233.54	203.07
221.60	192.70	246.38	214.24
233.15	202.74	259.23	225.42
244.71	212.79	272.08	236.59
255.20	221.92	283.75	246.74
265.71	231.06	295.43	256.90
276.22	240.18	307.10	267.04
286.71	249.31	318.78	277.19
297.22	258.45	330.46	287.36
306.67	266.67	340.97	296.50
316.12	274.89	351.48	305.63
325.58	283.11	361.99	314.77
335.03	291.33	372.50	323.91
344.48	299.55	383.01	333.05
351.83	305.94	391.18	340.16
359.18	312.34	399.35	347.26
366.54	318.72	407.52	354.36
373.88	325.12	415.70	361.48
381.24	331.52	423.88	368.59
384.40	334.25	427.37	371.63
387.54	336.99	430.87	374.67
390.69	339.74	434.38	377.72
393.85	342.47	437.89	380.77
396.99	345.21	441.39	383.81

Only available to those Medicare eligible prior to Jan. 1, 2020

Rates valid through March 31, 2025. Premium is based on your gender and age as of April 1, 2024. Premium payment may be made monthly.

*See page 20 for information regarding household premium discount.

MONTHLY PREMIUMS | STANDARD – Tobacco User

AREA 3 (ZIP Codes 686-689)

Age	Plan A		Plan B		Plan G		Plan L		Plan N	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
65	244.15	212.30	306.17	266.24	221.63	192.72	169.66	147.53	159.00	138.26
66	244.15	212.30	306.17	266.24	221.63	192.72	169.66	147.53	159.00	138.26
67	244.15	212.30	306.17	266.24	221.63	192.72	169.66	147.53	159.00	138.26
68	257.57	223.97	323.01	280.87	233.83	203.33	178.99	155.65	167.74	145.86
69	271.00	235.66	339.85	295.53	246.01	213.92	188.31	163.75	176.50	153.48
70	284.43	247.33	356.69	310.16	258.20	224.52	197.65	171.87	185.24	161.08
71	296.63	257.94	372.00	323.48	269.28	234.15	206.13	179.25	193.18	167.99
72	308.84	268.56	387.31	336.79	280.37	243.80	214.62	186.62	201.14	174.91
73	321.05	279.17	402.62	350.11	291.44	253.43	223.10	194.00	209.09	181.82
74	333.26	289.79	417.92	363.41	302.53	263.07	231.59	201.38	217.03	188.72
75	345.47	300.41	433.23	376.72	313.60	272.70	240.06	208.75	224.99	195.64
76	356.46	309.97	447.02	388.71	323.59	281.38	247.69	215.39	232.14	201.86
77	367.44	319.51	460.79	400.69	333.55	290.05	255.33	222.03	239.29	208.08
78	378.42	329.06	474.56	412.66	343.54	298.73	262.96	228.66	246.45	214.31
79	389.41	338.62	488.35	424.65	353.51	307.40	270.60	235.30	253.60	220.52
80	400.40	348.17	502.12	436.63	363.47	316.06	278.23	241.94	260.77	226.75
81	408.95	355.61	512.83	445.94	371.23	322.81	284.17	247.10	266.32	231.59
82	417.49	363.03	523.55	455.26	378.99	329.55	290.12	252.28	271.89	236.43
83	426.04	370.47	534.27	464.58	386.74	336.30	296.05	257.44	277.45	241.26
84	434.58	377.89	544.99	473.90	394.50	343.04	301.99	262.60	283.02	246.11
85	443.13	385.33	555.70	483.22	402.26	349.79	307.92	267.76	288.58	250.94
86	446.79	388.51	560.30	487.22	405.59	352.69	310.47	269.98	290.97	253.02
87	450.45	391.70	564.89	491.21	408.91	355.57	313.02	272.19	293.36	255.09
88	454.11	394.88	569.47	495.19	412.24	358.47	315.56	274.40	295.74	257.17
89	457.78	398.07	574.07	499.19	415.56	361.35	318.11	276.62	298.13	259.24
90+	461.44	401.25	578.66	503.18	418.89	364.25	320.66	278.83	300.51	261.31

Plan C		Plan F	
Male	Female	Male	Female
284.18	247.12	315.96	274.75
284.18	247.12	315.96	274.75
284.18	247.12	315.96	274.75
299.82	260.71	333.34	289.86
315.44	274.29	350.73	304.98
331.07	287.89	368.10	320.09
345.28	300.24	383.90	333.82
359.50	312.60	399.69	347.56
373.70	324.96	415.49	361.30
387.90	337.31	431.29	375.03
402.12	349.67	447.10	388.78
414.91	360.79	461.31	401.14
427.70	371.91	475.53	413.51
440.49	383.03	489.75	425.87
453.27	394.15	503.97	438.23
466.06	405.27	518.19	450.60
476.00	413.92	529.25	460.21
485.96	422.57	540.29	469.82
495.90	431.22	551.36	479.44
505.84	439.86	562.42	489.06
515.80	448.52	573.48	498.68
520.06	452.23	578.21	502.79
524.32	455.93	582.95	506.91
528.59	459.64	587.70	511.04
532.85	463.35	592.43	515.16
537.11	467.05	597.17	519.28

Only available to those Medicare eligible prior to Jan. 1, 2020

Rates valid through March 31, 2025. Premium is based on your gender and age as of April 1, 2024. Premium payment may be made monthly.

MONTHLY PREMIUMS | STANDARD – Tobacco User

AREA 3 (ZIP Codes 686-689) – Household Discount Applied*

Age	Plan A		Plan B		Plan G		Plan L		Plan N	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
65	207.53	180.45	260.24	226.30	188.39	163.81	144.21	125.40	135.15	117.52
66	207.53	180.45	260.24	226.30	188.39	163.81	144.21	125.40	135.15	117.52
67	207.53	180.45	260.24	226.30	188.39	163.81	144.21	125.40	135.15	117.52
68	218.93	190.37	274.56	238.74	198.76	172.83	152.14	132.30	142.58	123.98
69	230.35	200.31	288.87	251.20	209.11	181.83	160.06	139.19	150.02	130.46
70	241.77	210.23	303.19	263.64	219.47	190.84	168.00	146.09	157.45	136.92
71	252.14	219.25	316.20	274.96	228.89	199.03	175.21	152.36	164.20	142.79
72	262.51	228.28	329.21	286.27	238.31	207.23	182.43	158.63	170.97	148.67
73	272.89	237.29	342.23	297.59	247.72	215.42	189.63	164.90	177.73	154.55
74	283.27	246.32	355.23	308.90	257.15	223.61	196.85	171.17	184.48	160.41
75	293.65	255.35	368.25	320.21	266.56	231.79	204.05	177.44	191.24	166.29
76	302.99	263.47	379.97	330.40	275.05	239.17	210.54	183.08	197.32	171.58
77	312.32	271.58	391.67	340.59	283.52	246.54	217.03	188.73	203.40	176.87
78	321.66	279.70	403.38	350.76	292.01	253.92	223.52	194.36	209.48	182.16
79	331.00	287.83	415.10	360.95	300.48	261.29	230.01	200.00	215.56	187.44
80	340.34	295.94	426.80	371.14	308.95	268.65	236.50	205.65	221.65	192.74
81	347.61	302.27	435.91	379.05	315.55	274.39	241.54	210.03	226.37	196.85
82	354.87	308.58	445.02	386.97	322.14	280.12	246.60	214.44	231.11	200.97
83	362.13	314.90	454.13	394.89	328.73	285.85	251.64	218.82	235.83	205.07
84	369.39	321.21	463.24	402.81	335.32	291.58	256.69	223.21	240.57	209.19
85	376.66	327.53	472.34	410.74	341.92	297.32	261.73	227.60	245.29	213.30
86	379.77	330.23	476.25	414.14	344.75	299.79	263.90	229.48	247.32	215.07
87	382.88	332.94	480.16	417.53	347.57	302.23	266.07	231.36	249.36	216.83
88	385.99	335.65	484.05	420.91	350.40	304.70	268.23	233.24	251.38	218.59
89	389.11	338.36	487.96	424.31	353.23	307.15	270.39	235.13	253.41	220.35
90+	392.22	341.06	491.86	427.70	356.06	309.61	272.56	237.01	255.43	222.11

Plan C		Plan F	
Male	Female	Male	Female
241.55	210.05	268.57	233.54
241.55	210.05	268.57	233.54
241.55	210.05	268.57	233.54
254.85	221.60	283.34	246.38
268.12	233.15	298.12	259.23
281.41	244.71	312.88	272.08
293.49	255.20	326.31	283.75
305.57	265.71	339.74	295.43
317.64	276.22	353.17	307.10
329.71	286.71	366.60	318.78
341.80	297.22	380.03	330.46
352.67	306.67	392.11	340.97
363.54	316.12	404.20	351.48
374.42	325.58	416.29	361.99
385.28	335.03	428.37	372.50
396.15	344.48	440.46	383.01
404.60	351.83	449.86	391.18
413.07	359.18	459.25	399.35
421.51	366.54	468.66	407.52
429.96	373.88	478.06	415.70
438.43	381.24	487.46	423.88
442.05	384.40	491.48	427.37
445.67	387.54	495.51	430.87
449.30	390.69	499.54	434.38
452.92	393.85	503.57	437.89
456.54	396.99	507.59	441.39

Only available to those Medicare eligible prior to Jan. 1, 2020

Rates valid through March 31, 2025. Premium is based on your gender and age as of April 1, 2024. Premium payment may be made monthly.

*See page 20 for information regarding household premium discount.

MONTHLY PREMIUMS | PREFERRED – Non-Tobacco User

AREA 4 (ZIP Codes 690-693)

Age	Plan A		Plan B		Plan G		Plan L		Plan N	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
65	218.55	190.04	274.07	238.32	198.39	172.52	151.87	132.06	142.33	123.76
66	218.55	190.04	274.07	238.32	198.39	172.52	151.87	132.06	142.33	123.76
67	218.55	190.04	274.07	238.32	198.39	172.52	151.87	132.06	142.33	123.76
68	230.56	200.49	289.14	251.42	209.31	182.01	160.22	139.32	150.15	130.57
69	242.59	210.95	304.22	264.54	220.21	191.49	168.57	146.58	157.99	137.38
70	254.60	221.39	319.29	277.64	231.13	200.98	176.92	153.85	165.81	144.19
71	265.53	230.90	332.99	289.56	241.04	209.60	184.52	160.45	172.93	150.37
72	276.46	240.40	346.70	301.48	250.97	218.23	192.11	167.06	180.05	156.57
73	287.39	249.90	360.40	313.39	260.88	226.85	199.71	173.66	187.16	162.75
74	298.31	259.40	374.10	325.30	270.81	235.48	207.30	180.26	194.27	168.93
75	309.24	268.91	387.80	337.22	280.72	244.10	214.89	186.86	201.40	175.13
76	319.08	277.46	400.14	347.95	289.66	251.87	221.72	192.80	207.80	180.69
77	328.91	286.01	412.47	358.67	298.58	259.63	228.56	198.74	214.20	186.26
78	338.74	294.56	424.80	369.39	307.51	267.40	235.39	204.69	220.61	191.84
79	348.58	303.11	437.14	380.12	316.44	275.16	242.22	210.63	227.01	197.40
80	358.41	311.66	449.47	390.84	325.36	282.92	249.06	216.57	233.42	202.98
81	366.07	318.32	459.06	399.18	332.30	288.96	254.37	221.19	238.40	207.30
82	373.71	324.96	468.65	407.53	339.25	295.00	259.70	225.82	243.38	211.64
83	381.36	331.62	478.24	415.86	346.19	301.04	265.01	230.44	248.36	215.96
84	389.01	338.27	487.84	424.21	353.13	307.07	270.32	235.06	253.35	220.30
85	396.66	344.93	497.43	432.55	360.08	313.11	275.64	239.68	258.32	224.63
86	399.94	347.77	501.55	436.13	363.06	315.70	277.92	241.67	260.46	226.49
87	403.22	350.63	505.65	439.70	366.03	318.29	280.20	243.65	262.60	228.34
88	406.49	353.47	509.76	443.27	369.01	320.88	282.47	245.63	264.73	230.20
89	409.78	356.33	513.88	446.85	371.98	323.46	284.75	247.61	266.87	232.06
90+	413.05	359.17	517.98	450.42	374.96	326.06	287.03	249.60	268.99	233.91

Plan C		Plan F	
Male	Female	Male	Female
254.38	221.20	282.83	245.94
254.38	221.20	282.83	245.94
254.38	221.20	282.83	245.94
268.38	233.37	298.39	259.47
282.36	245.53	313.95	273.00
296.36	257.70	329.50	286.52
309.07	268.76	343.64	298.82
321.80	279.83	357.78	311.12
334.51	290.88	371.92	323.41
347.23	301.94	386.06	335.71
359.96	313.01	400.21	348.01
371.40	322.96	412.94	359.08
382.85	332.91	425.67	370.15
394.30	342.87	438.39	381.21
405.74	352.82	451.12	392.28
417.19	362.78	463.85	403.35
426.09	370.51	473.75	411.96
435.00	378.26	483.64	420.56
443.90	386.00	493.54	429.17
452.80	393.74	503.44	437.78
461.71	401.49	513.34	446.39
465.53	404.81	517.58	450.07
469.34	408.12	521.82	453.76
473.16	411.44	526.07	457.45
476.97	414.76	530.31	461.14
480.79	418.08	534.55	464.82

Only available to those Medicare eligible prior to Jan. 1, 2020

Rates valid through March 31, 2025. Premium is based on your gender and age as of April 1, 2024. Premium payment may be made monthly.

MONTHLY PREMIUMS | PREFERRED – Non-Tobacco User

AREA 4 (ZIP Codes 690-693) – Household Discount Applied*

Age	Plan A		Plan B		Plan G		Plan L		Plan N	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
65	185.77	161.53	232.96	202.57	168.63	146.64	129.09	112.25	120.98	105.20
66	185.77	161.53	232.96	202.57	168.63	146.64	129.09	112.25	120.98	105.20
67	185.77	161.53	232.96	202.57	168.63	146.64	129.09	112.25	120.98	105.20
68	195.98	170.42	245.77	213.71	177.91	154.71	136.19	118.42	127.63	110.98
69	206.20	179.31	258.59	224.86	187.18	162.77	143.28	124.59	134.29	116.77
70	216.41	188.18	271.40	235.99	196.46	170.83	150.38	130.77	140.94	122.56
71	225.70	196.26	283.04	246.13	204.88	178.16	156.84	136.38	146.99	127.81
72	234.99	204.34	294.69	256.26	213.32	185.50	163.29	142.00	153.04	133.08
73	244.28	212.41	306.34	266.38	221.75	192.82	169.75	147.61	159.09	138.34
74	253.56	220.49	317.98	276.50	230.19	200.16	176.20	153.22	165.13	143.59
75	262.85	228.57	329.63	286.64	238.61	207.48	182.66	158.83	171.19	148.86
76	271.22	235.84	340.12	295.76	246.21	214.09	188.46	163.88	176.63	153.59
77	279.57	243.11	350.60	304.87	253.79	220.69	194.28	168.93	182.07	158.32
78	287.93	250.38	361.08	313.98	261.38	227.29	200.08	173.99	187.52	163.06
79	296.29	257.64	371.57	323.10	268.97	233.89	205.89	179.04	192.96	167.79
80	304.65	264.91	382.05	332.21	276.56	240.48	211.70	184.08	198.41	172.53
81	311.16	270.57	390.20	339.30	282.45	245.62	216.21	188.01	202.64	176.20
82	317.65	276.22	398.35	346.40	288.36	250.75	220.74	191.95	206.87	179.89
83	324.16	281.88	406.50	353.48	294.26	255.88	225.26	195.87	211.11	183.57
84	330.66	287.53	414.66	360.58	300.16	261.01	229.77	199.80	215.35	187.25
85	337.16	293.19	422.82	367.67	306.07	266.14	234.29	203.73	219.57	190.94
86	339.95	295.60	426.32	370.71	308.60	268.34	236.23	205.42	221.39	192.52
87	342.74	298.04	429.80	373.74	311.13	270.55	238.17	207.10	223.21	194.09
88	345.52	300.45	433.30	376.78	313.66	272.75	240.10	208.79	225.02	195.67
89	348.31	302.88	436.80	379.82	316.18	274.94	242.04	210.47	226.84	197.25
90+	351.09	305.29	440.28	382.86	318.72	277.15	243.98	212.16	228.64	198.82

Plan C		Plan F	
Male	Female	Male	Female
216.22	188.02	240.41	209.05
216.22	188.02	240.41	209.05
216.22	188.02	240.41	209.05
228.12	198.36	253.63	220.55
240.01	208.70	266.86	232.05
251.91	219.04	280.07	243.54
262.71	228.45	292.09	254.00
273.53	237.86	304.11	264.45
284.33	247.25	316.13	274.90
295.15	256.65	328.15	285.35
305.97	266.06	340.18	295.81
315.69	274.52	351.00	305.22
325.42	282.97	361.82	314.63
335.15	291.44	372.63	324.03
344.88	299.90	383.45	333.44
354.61	308.36	394.27	342.85
362.18	314.93	402.69	350.17
369.75	321.52	411.09	357.48
377.31	328.10	419.51	364.79
384.88	334.68	427.92	372.11
392.45	341.27	436.34	379.43
395.70	344.09	439.94	382.56
398.94	346.90	443.55	385.70
402.19	349.72	447.16	388.83
405.42	352.55	450.76	391.97
408.67	355.37	454.37	395.10

Only available to those Medicare eligible prior to Jan. 1, 2020

Rates valid through March 31, 2025. Premium is based on your gender and age as of April 1, 2024. Premium payment may be made monthly.

*See page 20 for information regarding household premium discount.

MONTHLY PREMIUMS | STANDARD – Tobacco User

AREA 4 (ZIP Codes 690-693)

Age	Plan A		Plan B		Plan G		Plan L		Plan N	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
65	251.33	218.55	315.18	274.07	228.15	198.39	174.65	151.87	163.68	142.33
66	251.33	218.55	315.18	274.07	228.15	198.39	174.65	151.87	163.68	142.33
67	251.33	218.55	315.18	274.07	228.15	198.39	174.65	151.87	163.68	142.33
68	265.14	230.56	332.51	289.14	240.70	209.31	184.26	160.22	172.68	150.15
69	278.97	242.59	349.85	304.22	253.24	220.21	193.85	168.57	181.69	157.99
70	292.79	254.60	367.18	319.29	265.80	231.13	203.46	176.92	190.69	165.81
71	305.36	265.53	382.94	332.99	277.20	241.04	212.20	184.52	198.86	172.93
72	317.93	276.46	398.70	346.70	288.61	250.97	220.93	192.11	207.06	180.05
73	330.49	287.39	414.46	360.40	300.01	260.88	229.66	199.71	215.24	187.16
74	343.06	298.31	430.21	374.10	311.43	270.81	238.40	207.30	223.42	194.27
75	355.63	309.24	445.97	387.80	322.83	280.72	247.12	214.89	231.61	201.40
76	366.94	319.08	460.16	400.14	333.10	289.66	254.98	221.72	238.97	207.80
77	378.25	328.91	474.34	412.47	343.37	298.58	262.84	228.56	246.33	214.20
78	389.55	338.74	488.52	424.80	353.64	307.51	270.70	235.39	253.70	220.61
79	400.87	348.58	502.71	437.14	363.90	316.44	278.56	242.22	261.06	227.01
80	412.17	358.41	516.89	449.47	374.17	325.36	286.42	249.06	268.44	233.42
81	420.98	366.07	527.91	459.06	382.15	332.30	292.53	254.37	274.16	238.40
82	429.77	373.71	538.95	468.65	390.13	339.25	298.65	259.70	279.89	243.38
83	438.57	381.36	549.98	478.24	398.12	346.19	304.76	265.01	285.61	248.36
84	447.36	389.01	561.02	487.84	406.10	353.13	310.87	270.32	291.35	253.35
85	456.16	396.66	572.04	497.43	414.09	360.08	316.98	275.64	297.07	258.32
86	459.93	399.94	576.78	501.55	417.52	363.06	319.61	277.92	299.53	260.46
87	463.70	403.22	581.50	505.65	420.93	366.03	322.23	280.20	301.98	262.60
88	467.47	406.49	586.22	509.76	424.36	369.01	324.84	282.47	304.44	264.73
89	471.24	409.78	590.96	513.88	427.78	371.98	327.47	284.75	306.90	266.87
90+	475.01	413.05	595.68	517.98	431.21	374.96	330.09	287.03	309.34	268.99

Plan C		Plan F	
Male	Female	Male	Female
292.54	254.38	325.26	282.83
292.54	254.38	325.26	282.83
292.54	254.38	325.26	282.83
308.64	268.38	343.14	298.39
324.72	282.36	361.04	313.95
340.81	296.36	378.93	329.50
355.43	309.07	395.19	343.64
370.07	321.80	411.45	357.78
384.69	334.51	427.71	371.92
399.31	347.23	443.97	386.06
413.95	359.96	460.25	400.21
427.11	371.40	474.88	412.94
440.28	382.85	489.52	425.67
453.44	394.30	504.15	438.39
466.61	405.74	518.79	451.12
479.77	417.19	533.43	463.85
490.00	426.09	544.81	473.75
500.25	435.00	556.19	483.64
510.49	443.90	567.57	493.54
520.72	452.80	578.96	503.44
530.97	461.71	590.35	513.34
535.36	465.53	595.22	517.58
539.74	469.34	600.09	521.82
544.13	473.16	604.98	526.07
548.52	476.97	609.86	530.31
552.91	480.79	614.73	534.55

Only available to those Medicare eligible prior to Jan. 1, 2020

Rates valid through March 31, 2025. Premium is based on your gender and age as of April 1, 2024. Premium payment may be made monthly.

MONTHLY PREMIUMS | STANDARD – Tobacco User

AREA 4 (ZIP Codes 690-693) – Household Discount Applied*

Age	Plan A		Plan B		Plan G		Plan L		Plan N	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
65	213.63	185.77	267.90	232.96	193.93	168.63	148.45	129.09	139.13	120.98
66	213.63	185.77	267.90	232.96	193.93	168.63	148.45	129.09	139.13	120.98
67	213.63	185.77	267.90	232.96	193.93	168.63	148.45	129.09	139.13	120.98
68	225.37	195.98	282.63	245.77	204.59	177.91	156.62	136.19	146.78	127.63
69	237.12	206.20	297.37	258.59	215.25	187.18	164.77	143.28	154.44	134.29
70	248.87	216.41	312.10	271.40	225.93	196.46	172.94	150.38	162.09	140.94
71	259.56	225.70	325.50	283.04	235.62	204.88	180.37	156.84	169.03	146.99
72	270.24	234.99	338.89	294.69	245.32	213.32	187.79	163.29	176.00	153.04
73	280.92	244.28	352.29	306.34	255.01	221.75	195.21	169.75	182.95	159.09
74	291.60	253.56	365.68	317.98	264.72	230.19	202.64	176.20	189.91	165.13
75	302.29	262.85	379.07	329.63	274.41	238.61	210.05	182.66	196.87	171.19
76	311.90	271.22	391.14	340.12	283.13	246.21	216.73	188.46	203.12	176.63
77	321.51	279.57	403.19	350.60	291.86	253.79	223.41	194.28	209.38	182.07
78	331.12	287.93	415.24	361.08	300.59	261.38	230.09	200.08	215.64	187.52
79	340.74	296.29	427.30	371.57	309.31	268.97	236.78	205.89	221.90	192.96
80	350.34	304.65	439.36	382.05	318.04	276.56	243.46	211.70	228.17	198.41
81	357.83	311.16	448.72	390.20	324.83	282.45	248.65	216.21	233.04	202.64
82	365.30	317.65	458.11	398.35	331.61	288.36	253.85	220.74	237.91	206.87
83	372.78	324.16	467.48	406.50	338.40	294.26	259.05	225.26	242.77	211.11
84	380.26	330.66	476.87	414.66	345.18	300.16	264.24	229.77	247.65	215.35
85	387.74	337.16	486.23	422.82	351.98	306.07	269.43	234.29	252.51	219.57
86	390.94	339.95	490.26	426.32	354.89	308.60	271.67	236.23	254.60	221.39
87	394.14	342.74	494.27	429.80	357.79	311.13	273.90	238.17	256.68	223.21
88	397.35	345.52	498.29	433.30	360.71	313.66	276.11	240.10	258.77	225.02
89	400.55	348.31	502.32	436.80	363.61	316.18	278.35	242.04	260.86	226.84
90+	403.76	351.09	506.33	440.28	366.53	318.72	280.58	243.98	262.94	228.64

Plan C		Plan F	
Male	Female	Male	Female
248.66	216.22	276.47	240.41
248.66	216.22	276.47	240.41
248.66	216.22	276.47	240.41
262.34	228.12	291.67	253.63
276.01	240.01	306.88	266.86
289.69	251.91	322.09	280.07
302.12	262.71	335.91	292.09
314.56	273.53	349.73	304.11
326.99	284.33	363.55	316.13
339.41	295.15	377.37	328.15
351.86	305.97	391.21	340.18
363.04	315.69	403.65	351.00
374.24	325.42	416.09	361.82
385.42	335.15	428.53	372.63
396.62	344.88	440.97	383.45
407.80	354.61	453.42	394.27
416.50	362.18	463.09	402.69
425.21	369.75	472.76	411.09
433.92	377.31	482.43	419.51
442.61	384.88	492.12	427.92
451.32	392.45	501.80	436.34
455.06	395.70	505.94	439.94
458.78	398.94	510.08	443.55
462.51	402.19	514.23	447.16
466.24	405.42	518.38	450.76
469.97	408.67	522.52	454.37

Only available to those Medicare eligible prior to Jan. 1, 2020

Rates valid through March 31, 2025. Premium is based on your gender and age as of April 1, 2024. Premium payment may be made monthly.

*See page 20 for information regarding household premium discount.

Important Information

Premium Information

Blue Cross and Blue Shield of Nebraska can only raise your premium if we raise the premium for all policies like yours in this state. Your premium may change each year as you age, and that change will be made on the annual renewal date, and the rate will be calculated using your attained age as of the renewal date. If you move your permanent residence, it may result in a premium change.

Your contract is guaranteed renewable. It cannot be canceled because of the number of claims you file or the amount of benefits you collect. It should be expected that your premiums will increase whenever Medicare deductibles or coinsurance provisions change, or when higher medical costs increase.

Household Premium Discount

You are eligible for a household premium discount if you currently have a person residing in your home (but no more than three people, age 60 or older), who is: a) your legal spouse; or b) a person at least 18 years of age with whom you have resided continuously for the last 12 months. The discount on the premium will be 15%. The policy's household premium discount will be removed if the other adult no longer resides with you (other than in the case of his or her death).

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 Blue Cross and Blue Shield of Nebraska.

Right To Return Policy

If you find that you are not satisfied with your policy, you may return it to:

Blue Cross and Blue Shield of Nebraska
P.O. Box 3248
Omaha, NE 68180-0001

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

These policies may not fully cover all of your medical costs.

Neither Blue Cross and Blue Shield of Nebraska nor its agents are connected with Medicare.

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

Complete Answers Are Very Important

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. Blue Cross and Blue Shield of Nebraska 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.

NOTES

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	YOU PAY
HOSPITALIZATION* **Semiprivate room and board, general nursing, 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: • While using 60 lifetime reserve days • Once lifetime reserve days are used: - 365 additional days - Beyond the additional 365 days	 All but $816 a day $0 $0	 $816 a day 100% of Medicare-eligible expenses $0	 $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			
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 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.

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	YOU PAY
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT **Expenses include physician's services; inpatient and outpatient medical and surgical services and supplies; physical, occupational and speech therapy; and diagnostic tests and 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
PARTS A AND 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	$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	YOU PAY
HOSPITALIZATION* **Semiprivate room and board, general nursing, 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: • While using 60 lifetime reserve days • Once lifetime reserve days are used: - 365 additional days - Beyond the additional 365 days	 All but $816 a day $0 $0	 $816 a day 100% of Medicare-eligible expenses $0	 $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			
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 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.

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	YOU PAY
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT **Expenses include physician's services; inpatient and outpatient medical and surgical services and supplies; physical, occupational and speech therapy; and diagnostic tests and 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
PARTS A AND 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	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

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	YOU PAY
HOSPITALIZATION* **Semiprivate room and board, general nursing, 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: • While using 60 lifetime reserve days • Once lifetime reserve days are used: - 365 additional days - Beyond the additional 365 days	 All but $816 a day $0 $0	 $816 a day 100% of Medicare-eligible expenses $0	 $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			
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 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.

PLAN G | 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 G PAYS	YOU PAY
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT **Expenses include physician's services; inpatient and outpatient medical and surgical services and supplies; physical, occupational and speech therapy; and diagnostic tests and 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	100%	$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
PARTS A AND 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	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

Other Benefits – Not Covered By Medicare

SERVICES	MEDICARE PAYS	PLAN G 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 United States.**			
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	YOU PAY
HOSPITALIZATION* **Semiprivate room and board, general nursing, 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: • While using 60 lifetime reserve days • Once lifetime reserve days are used: - 365 additional days - Beyond the additional 365 days	 All but $816 a day $0 $0	 $816 a day 100% of Medicare-eligible expenses $0	 $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			
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 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.

PLAN N | 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 N PAYS	YOU PAY
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT **Expenses include physician's services; inpatient and outpatient medical and surgical services and supplies; physical, occupational and speech therapy; and diagnostic tests and 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 $20 per office visit and $50 per emergency room visit copayment amount**	Up to $20 per office visit and up to $50 per emergency room visit**
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
PARTS A AND 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	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

Other Benefits – Not Covered By Medicare

SERVICES	MEDICARE PAYS	PLAN N 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 United States.**			
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

**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.

PLAN L
Medicare (Part A)

* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $3,530 each calendar year. The amounts that count toward your annual limit are noted with diamonds (◆) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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 L PAYS	YOU PAY
HOSPITALIZATION ** **Semiprivate room and board, general nursing, miscellaneous services and supplies.**			
First 60 days	All but $1,632	$1,224 (75% of Part A deductible)	$408 (25% of Part A deductible) ◆
61st through 90th day	All but $408 a day	$408 a day	$0
91st day and after: • While using 60 lifetime reserve days • Once lifetime reserve days are used: - 365 additional days - Beyond the additional 365 days	 All but $816 a day $0 $0	 $816 a day 100% of Medicare-eligible expenses $0	 $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 $153 a day	Up to $51 a day ◆
101st day and after	$0	$0	All costs
BLOOD			
First three pints	$0	75%	25% ◆
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	75% of copayment/coinsurance	25% of copayment/ coinsurance ◆

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

PLAN L | 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 L PAYS	YOU PAY
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT **Expenses include physician's services; inpatient and outpatient medical and surgical services and supplies; physical, occupational and speech therapy; and diagnostic tests and durable medical equipment.**			
First $240 of Medicare-approved amounts ****	$0	$0	$240 (Part B deductible) **** ◆
Preventive Benefits for Medicare-covered services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5% ◆
Part B excess charges (above Medicare-approved amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $3,530) *
BLOOD			
First three pints	$0	75%	25% ◆
Next $240 of Medicare-approved amounts ****	$0	$0	$240 (Part B deductible) ◆
Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5% ◆
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES			
	100%	$0	$0
PARTS A AND 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	$0	$240 (Part B deductible) ◆
Remainder of Medicare-approved amounts	80%	15%	5% ◆

* This plan limits your annual out-of-pocket payment for Medicare-approved amounts to $3,530 per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

***** Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare.*

PLAN C | Medicare (Part A)

Hospital Services – Per Benefit Period | Only available for individuals who were Medicare eligible before Jan. 1, 2020.

* 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	YOU PAY
HOSPITALIZATION* **Semiprivate room and board, general nursing, 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: • While using 60 lifetime reserve days • Once lifetime reserve days are used: - 365 additional days - Beyond the additional 365 days	 All but $816 a day $0 $0	 $816 a day 100% of Medicare-eligible expenses $0	 $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			
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 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.

PLAN C | Medicare (Part B)

Medical Services – Per Calendar Year

Only available for individuals who were Medicare eligible before Jan. 1, 2020.

* 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 C PAYS	YOU PAY
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT **Expenses include physician's services; inpatient and outpatient medical and surgical services and supplies; physical, occupational and speech therapy; and diagnostic tests and 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
PARTS A AND 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

SERVICES	MEDICARE PAYS	PLAN C 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 Unites States.**			
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 | Only available for individuals who were Medicare eligible before Jan. 1, 2020.

* 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	YOU PAY
HOSPITALIZATION* **Semiprivate room and board, general nursing, 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: • While using 60 lifetime reserve days • Once lifetime reserve days are used: - 365 additional days - Beyond the additional 365 days	 All but $816 a day $0 $0	 $816 a day 100% of Medicare-eligible expenses $0	 $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			
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 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.

PLAN F | Medicare (Part B)

Medical Services – Per Calendar Year

Only available for individuals who were Medicare eligible before Jan. 1, 2020.

* 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	YOU PAY
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT **Expenses include physician's services; inpatient and outpatient medical and surgical services and supplies; physical, occupational and speech therapy; and diagnostic tests and 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	100%	$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
PARTS A AND 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

SERVICES	MEDICARE PAYS	PLAN F 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 United States.**			
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

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