

Medicare Supplement Coverage Options



Mailing address: PO Box 15112, Albany, New York 12212
Physical address: 257 West Genesee Street, Buffalo, New York 14202

Benefit Chart of Medicare Supplement Plans Sold on or After January 1, 2010 Including Revisions Effective January 1, 2023

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

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A*	B*	D	G* ¹	K ²	L ²	M	N* ³	C*	F* ^{1*}
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or Copayment	✓	✓	✓	✓	50%	75%	✓	✓ copay applies ³	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2023					\$6,940	\$3,470				

1. Plans F and G also have a high deductible option which require first paying a plan deductible of \$2,700 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G is only available on or after January 1, 2020, and does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.
2. Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.
3. Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to \$20 for some office visits and up to a \$50 co-payment for emergency room visits that do not result in an inpatient admission.

PREMIUM INFORMATION

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

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

PLAN TYPE	MONTHLY PREMIUM	QUARTERLY PREMIUM	SEMIANNUAL PREMIUM	ANNUAL PREMIUM
Plan A	\$253.46	\$760.38	\$1,520.76	\$3,041.52
Plan B	\$267.66	\$802.98	\$1,605.96	\$3,211.92
Plan C	\$332.54	\$997.62	\$1,995.24	\$3,990.48
Plan F	\$501.43	\$1,504.29	\$3,008.58	\$6,017.16
Plan F*	\$101.38	\$304.14	\$608.28	\$1,216.56
Plan G	\$257.08	\$771.24	\$1,542.48	\$3,084.96
Plan N	\$213.79	\$641.37	\$1,282.74	\$2,565.48

Rates effective 01/01/2023

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to Highmark Blue Cross Blue Shield of Western New York, Attention: Consumer Sales, PO Box 15112, Albany, New York 12212. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

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

NOTICE

This policy may not fully cover all of your medical costs. Neither Highmark Blue Cross Blue Shield of Western New York, nor its agents are connected with Medicare.

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

COMPLETE ANSWERS ARE VERY IMPORTANT

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

PLAN A

MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN A PAYS	WITH PLAN A YOU PAY
<p>HOSPITALIZATION*</p> <p>Semiprivate room and board, general nursing, and miscellaneous services and supplies</p> <p>First 60 days</p> <p>61st through 90th day</p> <p>91st day and after:</p> <p style="padding-left: 20px;">While using 60 Lifetime Reserve days</p> <p style="padding-left: 20px;">Once Lifetime Reserve days are used:</p> <p style="padding-left: 40px;">- Additional 365 days (lifetime)</p> <p style="padding-left: 40px;">- Beyond the additional 365 days</p>	<p>All but \$1,600</p> <p>All but \$400 a day</p> <p>All but \$800 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>\$400 a day</p> <p>\$800 a day</p> <p>100% of Medicare-eligible expenses</p> <p>\$0</p>	<p>\$1,600 (Part A deductible)</p> <p>\$0</p> <p>\$0</p> <p>\$0</p> <p>All costs</p>
<p>SKILLED NURSING FACILITY CARE*</p> <p>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</p> <p>First 20 days</p> <p>21st through 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$200 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$200 a day</p> <p>All costs</p>
<p>BLOOD (per calendar year)</p> <p>First three pints</p> <p>Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>Three pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p>HOSPICE CARE</p> <p>You must meet Medicare's requirements, including a doctor's certification of terminal illness</p>	<p>All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care</p>	<p>Medicare copayments/coinsurance</p>	<p>\$0</p>

PLAN A

MEDICARE (PART B) MEDICAL SERVICES PER CALENDAR YEAR

* Once you have been billed \$226 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN A PAYS	WITH PLAN A YOU PAY
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$226 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$226 (Part B deductible) \$0
Part B excess charges (above Medicare-approved amounts)	\$0	\$0	All costs
BLOOD First three pints Next \$226 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$226 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

MEDICARE PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment First \$226 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$226 (Part B deductible) \$0
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PLAN B

MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN B PAYS	WITH PLAN B YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days 61 st through 90 th day 91 st day and after: While using 60 Lifetime Reserve days Once Lifetime Reserve days are used: - Additional 365 days (lifetime) - Beyond the additional 365 days	All but \$1,600 All but \$400 a day All but \$800 a day \$0 \$0	\$1,600 (Part A deductible) \$400 a day \$800 a day 100% of Medicare-eligible expenses \$0	\$0 \$0 \$0 \$0 All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st through 100 th day 101 st day and after	All approved amounts All but \$200 a day \$0	\$0 \$0 \$0	\$0 Up to \$200 a day All costs
BLOOD (per calendar year) First three pints Additional amounts	\$0 100%	Three pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayments/coinsurance	\$0

PLAN B

MEDICARE (PART B) MEDICAL SERVICES PER CALENDAR YEAR

* Once you have been billed \$226 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN B PAYS	WITH PLAN B YOU PAY
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$226 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$226 (Part B deductible) \$0
Part B excess charges (above Medicare-approved amounts)	\$0	\$0	All costs
BLOOD First three pints Next \$226 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$226 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

MEDICARE PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment First \$226 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$226 (Part B deductible) \$0
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PLAN C

MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN C PAYS	WITH PLAN C YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days 61 st through 90 th day 91 st day and after: While using 60 Lifetime Reserve days Once Lifetime Reserve days are used: - Additional 365 days (lifetime) - Beyond the additional 365 days	All but \$1,600 All but \$400 a day All but \$800 a day \$0 \$0	\$1,600 (Part A deductible) \$400 a day \$800 a day 100% of Medicare-eligible expenses \$0	\$0 \$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 21 st through 100 th day 101 st day and after	All approved amounts All but \$200 a day \$0	\$0 Up to \$200 a day \$0	\$0 \$0 All costs
BLOOD (per calendar year) First three pints Additional amounts	\$0 100%	Three pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayments/coinsurance	\$0

PLAN C

MEDICARE (PART B) MEDICAL SERVICES PER CALENDAR YEAR

* Once you have been billed \$226 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendaryear.

SERVICES	MEDICARE PAYS	PLAN C PAYS	WITH PLAN C YOU PAY
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$226 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$226 (Part B deductible) Generally 20%	\$0 \$0
Part B excess charges (above Medicare-approved amounts)	\$0	\$0	All costs
BLOOD First three pints Next \$226 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$226 (Part B deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

MEDICARE PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment First \$226 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$226 (Part B deductible) 20%	\$0 \$0 \$0
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OTHER BENEFITS NOT COVERED BY MEDICARE

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

MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN F PAYS	WITH PLAN F YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days 61 st through 90 th day 91 st day and after: While using 60 Lifetime Reserve days Once Lifetime Reserve days are used: - Additional 365 days (lifetime) - Beyond the additional 365 days	All but \$1,600 All but \$400 a day All but \$800 a day \$0 \$0	\$1,600 (Part A deductible) \$400 a day \$800 a day 100% of Medicare-eligible expenses \$0	\$0 \$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 21 st through 100 th day 101 st day and after	All approved amounts All but \$200 a day \$0	\$0 Up to \$200 a day \$0	\$0 \$0 All costs
BLOOD (per calendar year) First three pints Additional amounts	\$0 100%	Three pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayments/coinsurance	\$0

PLAN F

MEDICARE (PART B) MEDICAL SERVICES PER CALENDAR YEAR

* Once you have been billed \$226 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN F PAYS	WITH PLAN F YOU PAY
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$226 of Medicare-approved amounts*	\$0	\$226 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B excess charges (above Medicare-approved amounts)	\$0	All costs	\$0
BLOOD			
First three pints	\$0	All costs	\$0
Next \$226 of Medicare-approved amounts*	\$0	\$226 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

MEDICARE PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment	100%	\$0	\$0
First \$226 of Medicare-approved amounts*	\$0	\$226 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0

OTHER BENEFITS NOT COVERED BY MEDICARE

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

HIGH-DEDUCTIBLE PLAN F

MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD

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

** **This high-deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2,700 deductible. Benefits from the high-deductible F plan will not begin until out-of-pocket expenses are \$2,700. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by this policy. This includes Medicare deductibles for Part A & Part B, but does not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	PLAN F+ PAYS	WITH PLAN F+ YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days 61 st through 90 th day 91 st day and after: While using 60 Lifetime Reserve days Once Lifetime Reserve days are used: - Additional 365 days (lifetime) - Beyond the additional 365 days	All but \$1,600 All but \$400 a day All but \$800 a day \$0 \$0	\$1,600 (Part A deductible) \$400 a day \$800 a day 100% of Medicare-eligible expenses \$0	\$0 \$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 21 st through 100 th day 101 st day and after	All approved amounts All but \$200 a day \$0	\$0 Up to \$200 a day \$0	\$0 \$0 All costs
BLOOD (per calendar year) First three pints Additional amounts	\$0 100%	Three pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayments/coinsurance	\$0

HIGH-DEDUCTIBLE PLAN F

MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD

* Once you have been billed \$226 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

** **This high-deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2,700 deductible. Benefits from the high-deductible F plan will not begin until out-of-pocket expenses are \$2,700. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by this policy. This includes Medicare deductibles for Part A & Part B, but does not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	PLAN F+ PAYS	WITH PLAN F+ YOU PAY
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$226 of Medicare-approved amounts*	\$0	\$226 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B excess charges (above Medicare-approved amounts)	\$0	All costs	\$0
BLOOD			
First three pints	\$0	All costs	\$0
Next \$226 of Medicare-approved amounts*	\$0	\$226 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

HIGH-DEDUCTIBLE PLAN F

MEDICARE (PART B) MEDICAL SERVICES PER CALENDAR YEAR

- * Once you have been billed \$226 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.
- ** **This high-deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2,700 deductible. Benefits from the high-deductible F plan will not begin until out-of-pocket expenses are \$2,700. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by this policy. This includes Medicare deductibles for Part A & Part B, but does not include the plan's separate foreign travel emergency deductible.**

MEDICARE PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment	100%	\$0	\$0
First \$226 of Medicare-approved amounts*	\$0	\$226 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0

OTHER BENEFITS NOT COVERED BY MEDICARE

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

PLAN G

MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN G PAYS	WITH PLAN G YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days 61 st through 90 th day 91 st day and after: While using 60 Lifetime Reserve days Once Lifetime Reserve days are used: - Additional 365 days (lifetime) - Beyond the additional 365 days	All but \$1,600 All but \$400 a day All but \$800 a day \$0 \$0	\$1,600 (Part A deductible) \$400 a day \$800 a day 100% of Medicare-eligible expenses \$0	\$0 \$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 21 st through 100 th day 101 st day and after	All approved amounts All but \$200 a day \$0	\$0 Up to \$200 a day \$0	\$0 \$0 All costs
BLOOD (per calendar year) First three pints Additional amounts	\$0 100%	Three pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayments/coinsurance	\$0

PLAN G

MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD

* Once you have been billed \$226 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN G PAYS	WITH PLAN G YOU PAY
MEDICAL EXPENSES			
IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$226 of Medicare-approved amounts*	\$0	\$0	\$226 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B excess charges (above Medicare-approved amounts)	\$0	All costs	\$0
BLOOD			
First three pints	\$0	All costs	\$0
Next \$226 of Medicare-approved amounts*	\$0	\$0	\$226 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

MEDICARE PARTS A & B

HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies			
Durable medical equipment			
First \$226 of Medicare-approved amounts*	\$0	\$0	\$226 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0

OTHER BENEFITS NOT COVERED BY MEDICARE

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

PLAN N

MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN N PAYS	WITH PLAN N YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days 61 st through 90 th day 91 st day and after: While using 60 Lifetime Reserve days Once Lifetime Reserve days are used: - Additional 365 days (lifetime) - Beyond the additional 365 days	All but \$1,600 All but \$400 a day All but \$800 a day \$0 \$0	\$1,600 (Part A deductible) \$400 a day \$800 a day 100% of Medicare-eligible expenses \$0	\$0 \$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 21 st through 100 th day 101 st day and after	All approved amounts All but \$200 a day \$0	\$0 Up to \$200 a day \$0	\$0 \$0 All costs
BLOOD (per calendar year) First three pints Additional amounts	\$0 100%	Three pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayments/coinsurance	\$0

PLAN N

MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD

* Once you have been billed \$226 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN N PAYS	WITH PLAN N YOU PAY
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$226 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$0 Balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	\$226 (Part B deductible) Up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered a Medicare Part A expense.
Part B excess charges (above Medicare-approved amounts)	\$0	\$0	All costs
BLOOD First three pints Next \$226 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$226 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

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

MEDICARE PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment	100%	\$0	\$0
First \$226 of Medicare-approved amounts*	\$0	\$0	\$226 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0

OTHER BENEFITS NOT COVERED BY MEDICARE

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



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ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-833-735-4515 (TTY 711). 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-833-735-4515 (TTY 711)。

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