BlueCross BlueShield of Montana

Outline of Medicare Supplement Coverage — Standard Benefits for Plan A, Plan F, High Deductible Plan F[1], Plan G, High Deductible Plan G[1], Plan G Plus, High Deductible Plan G Plus and Plan N

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.

Blue Cross and Blue Shield of Montana does not offer those plans shaded in gray below.

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

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G[1]	K[2]	L[2]	M	N	C	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Medicare Part B coinsurance or copayment	✔	✔	✔	✔	50%	75%	✔	copays apply[3]	✔	✔
Blood (first three pints)	✔	✔	✔	✔	50%	75%	✔	✔	✔	✔
Part A hospice care coinsurance or copayment	✔	✔	✔	✔	50%	75%	✔	✔	✔	✔
Skilled nursing facility coinsurance			✔	✔	50%	75%	✔	✔	✔	✔
Medicare Part A deductible		✔	✔	✔	50%	75%	50%	✔	✔	✔
Medicare Part B deductible									✔	✔
Medicare Part B excess charges				✔						✔
Foreign travel emergency (up to plan limits)			✔	✔			✔	✔	✔	✔
Out-of-pocket limit in 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 an inpatient admission.

Blue Cross and Blue Shield of Montana a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

INNOVATIVE BENEFITS FOR PLAN G PLUS AND HIGH DEDUCTIBLE PLAN G PLUS

VISION BENEFIT:

- **Eyeglasses or contact lenses (conventional or disposable)**
- **A routine eye exam includes:**
  - Examination of orbits
  - Test vision acuity
  - Gross visual testing by confrontation or other means
  - Ocular motility
  - Examination of pupils
  - Measurement of intraocular pressure
  - Ophthalmoscopic examination with pupillary dilation

DENTAL SERVICES:

Your dental benefits include coverage for the following covered services as long as these services are rendered to you by a dentist, a dental auxiliary, or a physician.

- **Diagnostic evaluations**
  - Periodic oral evaluations
  - Problem focused oral evaluations, whether limited, detailed, or extensive
  - Comprehensive oral evaluations for new or established patients
  - Oral examinations
- **Preventive**
  - Prophylaxis: professional cleaning, scaling, and polishing of the teeth
  - Topical fluoride application
- **Diagnostic radiographs**
  - Full-mouth and panoramic films
  - Bitewing films
  - Periapical films, as necessary for diagnosis
- **Basic restorative dental services**
  - Amalgams restorations
  - Resin-based composite restorations
  - Sedative fillings
    - Removal or retained coronal remnants
    - Removal of erupted tooth or exposed root
- **Non-surgical extractions**

HEARING SERVICES:

- Access to one routine hearing exam per calendar year at no cost
- Advanced hearing aid member fee with charge of $699 per hearing aid
- Premium hearing aid member fee with charge of $999 per hearing aid

Monthly Premium Rates effective May 1, 2024

Blue Cross and Blue Shield of Montana can only raise your premium if we raise the premium for all policies like yours in Montana. Premiums change at age 65 and every year thereafter up to age 80. An increase in a health insurance premium shall not be effective without written notice to the policyholder as required by law.

	Non-Tobacco							
	Plan A	Plan F	High Deductible Plan F[1]	Plan G	High Deductible Plan G[1]	Plan G Plus	High Deductible Plan G[1] Plus	Plan N
Under Age 65	$675.98	$940.02	$417.45	$848.22	$382.67	$868.54	$402.99	$686.08
Age 65	$140.31	$196.96	$72.50	$149.14	$69.09	$169.46	$89.41	$138.37
Age 66	$144.84	$203.44	$74.78	$154.05	$71.26	$174.37	$91.58	$142.76
Age 67	$149.57	$209.94	$77.24	$158.94	$73.60	$179.26	$93.92	$147.37
Age 68	$154.30	$216.61	$79.49	$164.02	$75.75	$184.34	$96.07	$152.12
Age 69	$159.19	$223.47	$82.09	$169.20	$78.23	$189.52	$98.55	$156.93
Age 70	$165.62	$232.61	$85.46	$176.15	$81.44	$196.47	$101.76	$163.35
Age 71	$171.50	$241.02	$88.37	$182.49	$84.22	$202.81	$104.54	$169.23
Age 72	$177.54	$249.40	$91.40	$188.84	$87.10	$209.16	$107.42	$174.91
Age 73	$183.58	$258.00	$94.45	$195.34	$90.01	$215.66	$110.33	$180.97
Age 74	$189.81	$266.79	$97.68	$202.00	$93.08	$222.32	$113.40	$187.22
Age 75	$198.70	$279.37	$102.27	$211.53	$97.45	$231.85	$117.77	$196.02
Age 76	$205.88	$289.47	$105.91	$219.16	$100.95	$239.48	$121.27	$203.01
Age 77	$213.23	$299.80	$109.59	$226.98	$104.43	$247.30	$124.75	$210.19
Age 78	$220.81	$310.65	$113.40	$235.22	$108.07	$255.54	$128.39	$217.72
Age 79	$228.74	$321.72	$117.40	$243.59	$111.85	$263.91	$132.17	$225.42
Age 80 +	$237.06	$333.54	$121.67	$252.54	$115.95	$272.86	$136.27	$233.69

Monthly Premium Rates effective May 1, 2024

Blue Cross and Blue Shield of Montana can only raise your premium if we raise the premium for all policies like yours in Montana. Premiums change at age 65 and every year thereafter up to age 80. An increase in a health insurance premium shall not be effective without written notice to the policyholder as required by law.

	Tobacco							
	Plan A	Plan F	High Deductible Plan F[1]	Plan G	High Deductible Plan G[1]	Plan G Plus	High Deductible Plan G[1] Plus	Plan N
Under Age 65	$675.98	$940.02	$417.45	$848.22	$382.67	$868.54	$402.99	$686.08
Age 65	$161.35	$226.50	$83.37	$171.51	$79.45	$194.87	$102.82	$159.12
Age 66	$166.56	$233.95	$85.99	$177.15	$81.94	$200.52	$105.31	$164.17
Age 67	$172.00	$241.43	$88.82	$182.78	$84.64	$206.14	$108.00	$169.47
Age 68	$177.44	$249.10	$91.41	$188.62	$87.11	$211.99	$110.48	$174.93
Age 69	$183.06	$256.99	$94.40	$194.58	$89.96	$217.94	$113.33	$180.46
Age 70	$190.46	$267.50	$98.27	$202.57	$93.65	$225.94	$117.02	$187.85
Age 71	$197.22	$277.17	$101.62	$209.86	$96.85	$233.23	$120.22	$194.61
Age 72	$204.17	$286.81	$105.11	$217.16	$100.16	$240.53	$123.53	$201.14
Age 73	$211.11	$296.70	$108.61	$224.64	$103.51	$248.00	$126.87	$208.11
Age 74	$218.28	$306.80	$112.33	$232.30	$107.04	$255.66	$130.41	$215.30
Age 75	$228.50	$321.27	$117.61	$243.25	$112.06	$266.62	$135.43	$225.42
Age 76	$236.76	$332.89	$121.79	$252.03	$116.09	$275.40	$139.46	$233.46
Age 77	$245.21	$344.77	$126.02	$261.02	$120.09	$284.39	$143.46	$241.71
Age 78	$253.93	$357.24	$130.41	$270.50	$124.28	$293.87	$147.64	$250.37
Age 79	$263.05	$369.97	$135.01	$280.12	$128.62	$303.49	$151.99	$259.23
Age 80 +	$272.61	$383.57	$139.92	$290.42	$133.34	$313.78	$156.71	$268.74

You have the option to purchase any of the Medicare Supplement benefit plans shown on the front cover in white as Standard Plans.

PREMIUM INFORMATION

Blue Cross and Blue Shield of Montana can only raise your premium if we raise the premium for all policies like yours in the state. We will not change your premium or cancel your policy because of poor health. Premiums change at age 65 and every year thereafter up to age 80. An increase in a health insurance premium shall not be effective without written notice to the policyholder as required by law.

TOBACCO USE

Blue Cross and Blue Shield of Montana (BCBSMT) defines a tobacco user as a person who is using or has used any tobacco products in the last 6 months prior to the date of enrollment for a plan. This includes but is not limited to cigarettes, cigars, smokeless tobacco products, electronic cigarettes, dissolvable tobacco products, and vaping.

PREMIUM DISCOUNTS

A Blue Cross and Blue Shield of Montana Medicare Supplement premium discount may be available. Eligibility criteria are described below. If you are eligible for a discount, the discount will be applied to your next bill and remain in effect as long as you are enrolled in your BCBSMT Medicare Supplement plan. Discounts cannot be combined; only one type of discount per member is permitted.

SPOUSAL/PARTNER DISCOUNT

You may be eligible for a discount if you enrolled in a BCBSMT Medicare Supplement Policy issued with an effective date on or after May 1, 2022, and you reside with a spouse or domestic partner. The discount is 10%.

CONTINUE WITH BLUE℠ DISCOUNT

You may be eligible for a discount if you enrolled in a BCBSMT Medicare Supplement policy issued with an effective date on or after May 1, 2023 and you were enrolled in a Blue Cross and Blue Shield commercial group or individual health insurance coverage plan and that coverage was within one year of your BCBSMT Medicare Supplement policy becoming effective. The discount is 7%.

BLUE FAMILY DISCOUNT℠

You may be eligible for a discount if you enrolled in a BCBSMT Medicare Supplement policy issued with an effective date on or after May 1, 2024 and you meet the criteria for both the Spousal/Partner Discount AND the Continue with Blue Discount. The discount is 12%.

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 YOUR POLICY

If you find that you are not satisfied with your policy, you may return it to **Medicare Supplement Membership, 3645 Alice Street, Helena, MT 59601**.

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 will 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 Blue Cross and Blue Shield of Montana nor its agents are connected with Medicare. This Outline of Coverage does not give you all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare & 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 services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan A Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,632	$0	$1,632 (Part A deductible)
61st through 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $816 a day	$816 a day	$0
– Additional 365 days once Lifetime Reserve days are used	$0	100% of Medicare-eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $204 a day	$0	Up to $204 a day
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

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, such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-approved amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Medicare-approved amounts)	$0	$0	All costs
Blood			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-approved amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services — Tests for Diagnostic Services	100%	$0	$0

MEDICARE (PARTS A & B)

Services	Medicare Pays	Plan A Pays	You Pay
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 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	You Pay
Hospitalization* Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A deductible)	$0
61st through 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $816 a day	$816 a day	$0
– Additional 365 days once Lifetime Reserve days are used	$0	100% of Medicare-eligible expenses	$0***
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

Plan F

MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR

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

Services	Medicare Pays	Plan F Pays	You Pay
Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment, such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-approved amounts*	$0	$240 (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Medicare-approved amounts)	$0	100%	$0
Blood			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-approved amounts*	$0	$240 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services — Tests for Diagnostic Services	100%	$0	$0

MEDICARE (PARTS A & B)

Services	Medicare Pays	Plan F Pays	You Pay
Home Health Care Medicare-approved Services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
– First $240 of Medicare-approved amounts*	$0	$240 (Part B deductible)	$0
– Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

Foreign Travel — Not Covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

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

Services	Medicare Pays	After You Pay $2,800 Deductible**, Plan F Pays	In Addition to $2,800 Deductible**, You Pay
Hospitalization* Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A deductible)	$0
61st through 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $816 a day	$816 a day	$0
– Additional 365 days once Lifetime Reserve days are used	$0	100% of Medicare-eligible expenses	$0***
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

High Deductible Plan F

MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR

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

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

Services	Medicare Pays	After You Pay $2,800 Deductible**, Plan F Pays	In Addition to $2,800 Deductible**, You Pay
Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment, such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-approved amounts*	$0	$240 (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Medicare-approved amounts)	$0	100%	$0
Blood			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-approved amounts*	$0	$240 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services — Tests for Diagnostic Services	100%	$0	$0

High Deductible Plan F

MEDICARE (PARTS A & B)			
Services	**Medicare Pays**	**After You Pay $2,800 Deductible**, Plan F Pays**	**In Addition to $2,800 Deductible**, You Pay**
Home Health Care Medicare-approved Services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
– First $240 of Medicare-approved amounts*	$0	$240 (Part B deductible)	$0
– Remainder of Medicare-approved amounts	80%	20%	$0
OTHER BENEFITS – NOT COVERED BY MEDICARE			
Foreign Travel — Not Covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Plan 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, and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A deductible)	$0
61st through 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $816 a day	$816 a day	$0
– Additional 365 days once Lifetime Reserve days are used	$0	100% of Medicare-eligible expenses	$0***
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

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, such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-approved amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Medicare-approved amounts)	$0	100%	$0
Blood			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-approved amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services — Tests for Diagnostic Services	100%	$0	$0

MEDICARE (PARTS A & B)

Services	Medicare Pays	Plan G Pays	You Pay
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

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 G

MEDICARE (PART A) — HOSPITAL SERVICES — PER BENEFIT PERIOD

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

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

Services	Medicare Pays	After You Pay $2,800 Deductible**, Plan G Pays	In Addition to $2,800 Deductible**, You Pay
Hospitalization* Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A deductible)	$0
61st through 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $816 a day	$816 a day	$0
– Additional 365 days once Lifetime Reserve days are used	$0	100% of Medicare-eligible expenses	$0***
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

High Deductible 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.

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

Services	Medicare Pays	After You Pay $2,800 Deductible**, Plan G Pays	In Addition to $2,800 Deductible**, You Pay
Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment, such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-approved amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Medicare-approved amounts)	$0	100%	$0
Blood			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-approved amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services — Tests for Diagnostic Services	100%	$0	$0

MEDICARE (PARTS A & B)

Services	Medicare Pays	After You Pay $2,800 Deductible**, Plan G Pays	In Addition to $2,800 Deductible**, You Pay
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

High Deductible Plan G

OTHER BENEFITS – NOT COVERED BY MEDICARE			
Services	**Medicare Pays**	**After You Pay $2,800 Deductible**, Plan G Pays**	**In Addition to $2,800 Deductible**, You Pay**
Foreign Travel — Not Covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Plan G Plus

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 Plus Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A deductible)	$0
61st through 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $816 a day	$816 a day	$0
– Additional 365 days once Lifetime Reserve days are used	$0	100% of Medicare-eligible expenses	$0***
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

Plan G Plus

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 Plus Pays	You Pay
Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment, such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-approved amount*	$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 3 pints	$0	All costs	$0
Next $240 of Medicare-approved amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services — Tests for Diagnostic Services	100%	$0	$0

MEDICARE (PARTS A & B)

Services	Medicare Pays	Plan G Plus Pays	You Pay
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

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 Plus

INNOVATIVE BENEFITS

DENTAL

Services	Medicare Pays	Plan G Plus Pays	You Pay
Diagnostic Evaluations			
In-Network	$0	100%	$0
Out-of-Network	$0	50%	50%
Preventive Services			
In-Network	$0	100%	$0
Out-of-Network	$0	50%	50%
Diagnostic Radiographs			
In-Network	$0	100%	$0
Out-of-Network	$0	50%	50%
Basic Restorative Services**	$0	50%	50%
Non-Surgical Extractions			
In-Network	$0	75%	25%
Out-of-Network	$0	50%	50%

VISION

Services	Medicare Pays	Plan G Plus Pays	You Pay
Annual Routine Examination			
In-Network	$0	100%	$0
Out-of-Network	$0	All except $40	$40
Materials Allowance			
In-Network	$0	$130	Remaining Balance
Out-of-Network	$0	$65	Remaining Balance

HEARING***

Services	Medicare Pays	Plan G Plus Pays	You Pay
Annual Routine Examination	$0	100%	$0
Hardware Discounts	$0	Generally 30%	Remaining Balance

**** Once per tooth per calendar year.

***** All services must be received in-network.

High Deductible Plan G Plus

MEDICARE (PART A) — HOSPITAL SERVICES — PER BENEFIT PERIOD

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

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

Services	Medicare Pays	After You Pay $2,800 Deductible**, Plan G Plus Pays	In Addition to $2,800 Deductible**, You Pay
Hospitalization* Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A deductible)	$0
61st through 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $816 a day	$816 a day	$0
– Additional 365 days once Lifetime Reserve days are used	$0	100% of Medicare-eligible expenses	$0***
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Car* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

High Deductible Plan G Plus

MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR

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

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

Services	Medicare Pays	After You Pay $2,800 Deductible**, Plan G Plus Pays	In Addition to $2,800 Deductible**, You Pay
Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment, such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-approved amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Medicare-approved amounts)	$0	100%	$0
Blood			
First 3 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

High Deductible Plan G Plus

MEDICARE (PARTS A & B)			
Services	**Medicare Pays**	**After You Pay $2,800 Deductible**, Plan G Plus Pays**	**In Addition to $2,800 Deductible**, You Pay**
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			
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 G Plus

INNOVATIVE BENEFITS

DENTAL

Services	Medicare Pays	Plan G Plus Pays	You Pay
Diagnostic Evaluations			
In-Network	$0	100%	$0
Out-of-Network	$0	50%	50%
Preventive Services			
In-Network	$0	100%	$0
Out-of-Network	$0	50%	50%
Diagnostic Radiographs			
In-Network	$0	100%	$0
Out-of-Network	$0	50%	50%
Basic Restorative Services**	$0	50%	50%
Non-Surgical Extractions			
In-Network	$0	75%	25%
Out-of-Network	$0	50%	50%

VISION

Services	Medicare Pays	Plan G Plus Pays	You Pay
Annual Routine Examination			
In-Network	$0	100%	$0
Out-of-Network	$0	All except $40	$40
Materials Allowance			
In-Network	$0	$130	Remaining Balance
Out-of-Network	$0	$65	Remaining Balance

HEARING***

Services	Medicare Pays	Plan G Plus Pays	You Pay
Annual Routine Examination	$0	100%	$0
Hardware Discounts	$0	Generally 30%	Remaining Balance

**** Once per tooth per calendar year.

***** All services must be received in-network.

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, and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A deductible)	$0
61st through 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $816 a day	$816 a day	$0
– Additional 365 days once Lifetime Reserve days are used	$0	100% of Medicare-eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

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, such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-approved amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (above Medicare-approved amounts)	$0	$0	All costs
Blood			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-approved amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services — Tests for Diagnostic Services	100%	$0	$0

MEDICARE (PARTS A & B)

Services	Medicare Pays	Plan N Pays	You Pay
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 N

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 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

Important Information about Quotes for Medicare Supplement
Quoted prices are based on the criteria specified during your search. This illustration is subject to Blue Cross and Blue Shield of Montana's rating or underwriting and approval, as appropriate, and does not guarantee rates, coverage or effective date. Furthermore, rates are subject to change if any of the information you have provided changes when and if a policy is approved. In addition, Blue Cross and Blue Shield of Montana reserves the right to change rates from time to time. Not connected with or endorsed by the U.S. Government or Federal Medicare Program.

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