



This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" 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.

BASIC BENEFITS:

- Hospitalization – Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- Medical Expenses – Part B coinsurance (generally 20% of Medicare-approved expenses), or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.
- Blood – First 3 pints of blood each year.
- Hospice – Part A coinsurance.

A	Basic Benefits, including 100% Part B Coinsurance						
B	Basic Benefits, including 100% Part B Coinsurance		Part A Deductible				
D	Basic Benefits, including 100% Part B Coinsurance	Skilled Nursing Facility Coinsurance	Part A Deductible			Foreign Travel Emergency	
G G¹	Basic Benefits, including 100% Part B Coinsurance	Skilled Nursing Facility Coinsurance	Part A Deductible		Part B Excess (100%)	Foreign Travel Emergency	
K	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	50% Skilled Nursing Facility Coinsurance	50% Part A Deductible				Out-of-pocket limit \$6,220; paid at 100% after limit reached
L	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	75% Skilled Nursing Facility Coinsurance	75% Part A Deductible				Out-of-pocket limit \$3,110; paid at 100% after limit reached
M	Basic Benefits, including 100% Part B Coinsurance	Skilled Nursing Facility Coinsurance	50% Part A Deductible			Foreign Travel Emergency	
N	Basic Benefits, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER	Skilled Nursing Facility Coinsurance	Part A Deductible			Foreign Travel Emergency	

Only available if Medicare-eligible before 2020

C	Basic Benefits, including 100% Part B Coinsurance	Skilled Nursing Facility Coinsurance	Part A Deductible	Part B Deductible		Foreign Travel Emergency	
F F¹	Basic Benefits, including 100% Part B Coinsurance	Skilled Nursing Facility Coinsurance	Part A Deductible	Part B Deductible	Part B Excess (100%)	Foreign Travel Emergency	

¹ These high deductible plans pay the same benefits as Plans F and G after one has paid a calendar-year \$2,370 deductible. Benefits from High Deductible Plans F and G will not begin until out-of-pocket expenses are \$2,370. Out-of-pocket expenses for these deductibles 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.

Monthly Premium Rates effective April 1, 2021

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.

	Plan A	Plan F	High Deductible Plan F¹	Plan G	High Deductible Plan G¹	Plan N
Under Age 65	\$589.54	\$819.81	\$376.81	\$739.75	\$314.01	\$598.35
Age 65	\$122.33	\$171.73	\$63.22	\$125.72	\$60.24	\$121.34
Age 66	\$126.29	\$177.37	\$65.21	\$129.85	\$62.14	\$125.19
Age 67	\$130.41	\$183.05	\$67.35	\$133.99	\$64.18	\$129.22
Age 68	\$134.53	\$188.86	\$69.32	\$138.26	\$66.06	\$133.40
Age 69	\$138.80	\$194.84	\$71.59	\$142.63	\$68.22	\$137.61
Age 70	\$144.41	\$202.82	\$74.52	\$148.48	\$71.02	\$143.24
Age 71	\$149.53	\$210.15	\$77.06	\$153.83	\$73.44	\$148.38
Age 72	\$154.80	\$217.45	\$79.70	\$159.19	\$75.95	\$153.38
Age 73	\$160.06	\$224.94	\$82.37	\$164.66	\$78.49	\$158.69
Age 74	\$165.50	\$232.61	\$85.17	\$170.28	\$81.17	\$164.16
Age 75	\$173.25	\$243.57	\$89.18	\$178.31	\$84.98	\$171.88
Age 76	\$179.51	\$252.38	\$92.36	\$184.75	\$88.02	\$178.01
Age 77	\$185.91	\$261.38	\$95.56	\$191.33	\$91.06	\$184.30
Age 78	\$192.51	\$270.84	\$98.88	\$198.27	\$94.23	\$190.90
Age 79	\$199.44	\$280.49	\$102.36	\$205.33	\$97.54	\$197.66
Age 80+	\$206.69	\$290.80	\$106.09	\$212.87	\$101.10	\$204.91

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.

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

Services	Medicare Pays	Plan A Pays	You Pay
Hospitalization² Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,484	\$0	\$1,484 (Part A deductible)
61st through 90th day	All but \$371 a day	\$371 a day	\$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but \$742 a day	\$742 a day	\$0
– Additional 365 days once Lifetime Reserve days are used	\$0	100% of Medicare-eligible expenses	\$0 ³
Beyond the additional 365 days	\$0	\$0	All costs
Skilled Nursing Facility Care² 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 \$185.50 a day	\$0	Up to \$185.50 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

² 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.

³ 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.

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 \$203 of Medicare-approved amounts ⁴	\$0	\$0	\$203 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (above Medicare-approved amounts)	\$0	\$0	All costs
Blood			
First 3 pints	\$0	All costs	\$0
Next \$203 of Medicare-approved amounts ⁴	\$0	\$0	\$203 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services — Tests for Diagnostic Services	100%	\$0	\$0

MEDICARE (PARTS A & 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 \$203 of Medicare-approved amounts ⁴	\$0	\$0	\$203 (Part B deductible)
– Remainder of Medicare-approved amounts	80%	20%	\$0

⁴ Once you have been billed \$203 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Plan F

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

Services	Medicare Pays	Plan F Pays	You Pay
Hospitalization² Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,484	\$1,484 (Part A deductible)	\$0
61st through 90th day	All but \$371 a day	\$371 a day	\$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but \$742 a day	\$742 a day	\$0
– Additional 365 days once Lifetime Reserve days are used	\$0	100% of Medicare-eligible expenses	\$0 ³
Beyond the additional 365 days	\$0	\$0	All costs
Skilled Nursing Facility Care² 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 \$185.50 a day	Up to \$185.50 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

Plan F

MEDICARE (PART B) — MEDICAL SERVICES — PER 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 \$203 of Medicare-approved amounts ⁴	\$0	\$203 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (above Medicare-approved amounts)	\$0	100%	\$0
Blood			
First 3 pints	\$0	All costs	\$0
Next \$203 of Medicare-approved amounts ⁴	\$0	\$203 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services — Tests for Diagnostic Services	100%	\$0	\$0
MEDICARE (PARTS A & 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 \$203 of Medicare-approved amounts ⁴	\$0	\$203 (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

Services	Medicare Pays	After You Pay \$2,370 Deductible ¹ , Plan F Pays	In Addition to \$2,370 Deductible ¹ , You Pay
Hospitalization² Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,484	\$1,484 (Part A deductible)	\$0
61st through 90th day	All but \$371 a day	\$371 a day	\$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but \$742 a day	\$742 a day	\$0
– Additional 365 days once Lifetime Reserve days are used	\$0	100% of Medicare- eligible expenses	\$0 ³
Beyond the additional 365 days	\$0	\$0	All costs
Skilled Nursing Facility Care² 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 \$185.50 a day	Up to \$185.50 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

High Deductible Plan F

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

Services	Medicare Pays	After You Pay \$2,370 Deductible ¹ , Plan F Pays	In Addition to \$2,370 Deductible ¹ , 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 \$203 of Medicare-approved amounts ⁴	\$0	\$203 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (above Medicare-approved amounts)	\$0	100%	\$0
Blood			
First 3 pints	\$0	All costs	\$0
Next \$203 of Medicare-approved amounts ⁴	\$0	\$203 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services — Tests for Diagnostic Services	100%	\$0	\$0

MEDICARE (PARTS A & B)

Services	Medicare Pays	After You Pay \$2,370 Deductible ¹ , Plan F Pays	In Addition to \$2,370 Deductible ¹ , You Pay
Home Health Care Medicare-approved Services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
– First \$203 of Medicare-approved amounts ⁴	\$0	\$203 (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

Services	Medicare Pays	Plan G Pays	You Pay
Hospitalization² Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,484	\$1,484 (Part A deductible)	\$0
61st through 90th day	All but \$371 a day	\$371 a day	\$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but \$742 a day	\$742 a day	\$0
– Additional 365 days once Lifetime Reserve days are used	\$0	100% of Medicare-eligible expenses	\$0 ³
Beyond the additional 365 days	\$0	\$0	All costs
Skilled Nursing Facility Care² 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 \$185.50 a day	Up to \$185.50 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

Plan G

MEDICARE (PART B) — MEDICAL SERVICES — PER 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 \$203 of Medicare-approved amounts ⁴	\$0	\$0	\$203 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (above Medicare-approved amounts)	\$0	100%	\$0
Blood			
First 3 pints	\$0	All costs	\$0
Next \$203 of Medicare-approved amounts ⁴	\$0	\$0	\$203 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services — Tests for Diagnostic Services	100%	\$0	\$0

MEDICARE (PARTS A & B)

Services	Medicare Pays	Plan G Pays	You Pay
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
– First \$203 of Medicare-approved amounts ⁴	\$0	\$0	\$203 (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

Services	Medicare Pays	After You Pay \$2,370 Deductible ¹ , Plan G Pays	In Addition to \$2,370 Deductible ¹ , You Pay
Hospitalization² Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,484	\$1,484 (Part A deductible)	\$0
61st through 90th day	All but \$371 a day	\$371 a day	\$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but \$742 a day	\$742 a day	\$0
– Additional 365 days once Lifetime Reserve days are used	\$0	100% of Medicare- eligible expenses	\$0 ³
Beyond the additional 365 days	\$0	\$0	All costs
Skilled Nursing Facility Care² 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 \$185.50 a day	Up to \$185.50 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

High Deductible Plan G

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

Services	Medicare Pays	After You Pay \$2,370 Deductible ¹ , Plan G Pays	In Addition to \$2,370 Deductible ¹ , 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 \$203 of Medicare-approved amounts ⁴	\$0	\$0	\$203 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (above Medicare-approved amounts)	\$0	100%	\$0
Blood			
First 3 pints	\$0	All costs	\$0
Next \$203 of Medicare-approved amounts ⁴	\$0	\$0	\$203 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services — Tests for Diagnostic Services	100%	\$0	\$0

MEDICARE (PARTS A & B)

Services	Medicare Pays	After You Pay \$2,370 Deductible ¹ , Plan G Pays	In Addition to \$2,370 Deductible ¹ , You Pay
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
– First \$203 of Medicare-approved amounts ⁴	\$0	\$0	\$203 (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

Services	Medicare Pays	Plan N Pays	You Pay
Hospitalization² Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,484	\$1,484 (Part A deductible)	\$0
61st through 90th day	All but \$371 a day	\$371 a day	\$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but \$742 a day	\$742 a day	\$0
– Additional 365 days once Lifetime Reserve days are used	\$0	100% of Medicare-eligible expenses	\$0 ³
Beyond the additional 365 days	\$0	\$0	All costs
Skilled Nursing Facility Care² 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 \$185.50 a day	Up to \$185.50 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

Plan N

MEDICARE (PART B) — MEDICAL SERVICES — PER 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 \$203 of Medicare-approved amounts ⁴	\$0	\$0	\$203 (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 \$203 of Medicare-approved amounts ⁴	\$0	\$0	\$203 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services — Tests for Diagnostic Services	100%	\$0	\$0
MEDICARE (PARTS A & 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 \$203 of Medicare-approved amounts ⁴	\$0	\$0	\$203 (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.

Medicare Supplement insurance plans are offered by 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.