

Outline of Medicare Supplement Coverage

Washington State Health Care Authority



See Outlines of Coverage sections for detail about all plans. This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan A available.

Basic Benefits included in all plans:

- **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 subscribers to pay a portion of Part B coinsurance or co-payments.
- **Blood:** First three pints of blood each year.
- **Hospice:** Part A coinsurance

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

*Plan F also has an option called High Deductible Plan F. This high deductible plan pays the same benefits as plan F after one has paid a calendar year \$2,370 deductible. Benefits from High Deductible Plan F will not begin until the out-of-pocket expenses exceed \$2,370. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the contract. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

Washington State Health Care Authority
SUBSCRIPTION CHARGES AND PAYMENT INFORMATION

(Rates effective January 1, 2021)

Eligible By Reason Of Age Subscription Charges - Per Month

PEBB Retiree	PEBB Retiree & Spouse	State Resident	State Resident & Spouse
Plan G \$99.92	Plan G \$194.27	Plan G \$188.70	Plan G \$377.40

Eligible By Reason Of Disability Subscription Charges - Per Month

PEBB Retiree	PEBB Retiree & Spouse	State Resident	State Resident & Spouse
Plan G \$165.96	Plan G \$326.36	Plan G \$320.79	Plan G \$641.58

Please Note: The subscription charge amount charged is the same for all plan subscribers with certificates like yours. However, the actual amount a plan subscriber pays can vary depending on if and how much the group contributes toward a particular class of subscribers' subscription charges.

SUBSCRIPTION CHARGE INFORMATION

We (Premera) can only raise your subscription charges if we raise the subscription charges for all certificates like yours in this state.

DISCLOSURES

Use this outline to compare benefits and subscription charges among plans.

READ YOUR CERTIFICATE VERY CAREFULLY

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

RIGHT TO RETURN CERTIFICATE

If you find that you are not satisfied with your certificate, you may return it to 7001 220th St. S.W., Mountlake Terrace, Washington 98043-2124. If you send the certificate back to us within 30 days after you receive it, we will treat the certificate as if it had never been issued and all of your payments will be returned.

CERTIFICATE REPLACEMENT

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

NOTICE

This certificate may not fully cover all of your medical costs. Neither Premera nor its producers 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

Be sure to answer truthfully and completely all questions. Review the application carefully before you sign it. Be certain that all information has been properly recorded.

**G 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*			
Semi-private 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
Once lifetime reserve days are used: • Additional 365 days • Beyond the additional 365 days	\$0 \$0	100% of Medicare eligible expenses \$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 \$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

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the carrier 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 plan's Basic 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 (continued):

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

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

SERVICES	MEDICARE PAYS	PLAN G PAYS	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 \$203 of Medicare approved amounts*	\$0	\$0	\$203 (Part B Deductible)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (above Medicare approved amounts)	\$0	100%	\$0
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$203 of Medicare approved amounts*	\$0	\$0	\$203 (Part B Deductible)
Remainder of Medicare approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES			
Tests for diagnostic services	100%	\$0	\$0
MEDICARE (PARTS A & B)			
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*	\$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

Discrimination is Against the Law

Premera Blue Cross (Premera) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-722-1471 (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 800-722-1471 (TTY: 711)。

CHU Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-722-1471 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-722-1471 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-722-1471 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-722-1471 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 800-722-1471 (телетайп: 711).

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។ ចូរទូរស័ព្ទ 800-722-1471 (TTY: 711)។

注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。800-722-1471 (TTY:711) まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች በገጻ ሊያግዙዎት ተዘጋጅተዋል። ወደ ሚክተለው ቁጥር ይደውሉ 800-722-1471 (መስማት ለተሳናቸው: 711)።

XIYEEFFANNA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-722-1471 (TTY: 711).

ملحوظة: إذا كنت تتحدث انكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-722-1471 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-722-1471 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-722-1471 (TTY: 711).

ប្រែប្រួល: ប្រសិនបើ អ្នកនិយាយភាសាខ្មែរ, ការបំប្រែភាសាឯកសារ គឺអាចមានសំរាប់អ្នក។ ចូរទូរស័ព្ទ 800-722-1471 (TTY: 711)។

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-722-1471 (TTY: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-722-1471 (ATS : 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-722-1471 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-722-1471 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-722-1471 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-722-1471 (TTY: 711) تماس بگیرید.