

Outline of Coverage Plan A, Plan D, Plan G, Plan N

Members Health Insurance Company, Columbia TN

TEXAS FARM BUREAU HEALTH PLANS

Insured by Members Health Insurance Company

Home Office:

P.O. Box 1424, Columbia, TN, 38402-1424

1-877-500-0140



**TEXAS FARM BUREAU®
HEALTH PLANS**

Insured by Members Health Insurance Company

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BENEFIT CHART OF MEDICARE SUPPLEMENT PLANS SOLD ON OR AFTER JANUARY 1, 2020



Only applicants first eligible for Medicare before 2020 may purchase Plan C, F and High Deductible F

	MEDICARE SUPPLEMENT INSURANCE PLANS								FIRST ELIGIBLE BEFORE 2020 ONLY	
BENEFITS	A	B	D	G ¹	K	L	M	N	C	F ¹
Medicare Part A coinsurance and hospital costs (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or co-payment	✓	✓	✓	✓	50%	75%	✓	✓ Copays apply ³	✓	✓
Blood (first 3 pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or co-payment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility care co-payment			✓	✓	50%	75%	✓	✓	✓	✓
Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Part B deductible									✓	✓
Part B excess charge				✓						✓
Foreign travel emergency (up to plan limits)			80%	80%			80%	80%	80%	80%
Out-of-pocket limit ²				\$3,610 ²	\$7,220 ²					

¹Plans F and G also have a high deductible option which require paying a plan deductible of \$2,870 before the plan begins to pay. Once the plan deductible is met, the plan pays one hundred percent (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.

²For Plans K and L, after you meet your out-of-pocket yearly limit and your yearly Part B deductible (\$257 in 2025), the plan pays 100% of covered services for the rest of the calendar year.

³Plan 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 don't result in an inpatient admission.

PREMIUM INFORMATION

We, Texas Farm Bureau Health Plans, insured by Members Health Insurance Company, can raise your premium at any time with 60-day notice. However, we can only raise your premium if we raise the premiums for all policies of the same class and issued on the same policy form as yours in the State of Texas. Any premium increase must be approved by Texas Department of Insurance. The Medicare Supplement Insurance coverage is age-rated. Your premium will be based on your current age and adjusted annually each birthday. Refer to the following premium chart for the premium applicable to the Medicare Supplement Insurance plans offered by Members Health Insurance Company.

Monthly premiums will be paid through authorized automatic deductions from your bank account. Premium payments are due on the 1st or 15th of each month depending on your selected payment date upon applying.

DISCLOSURE

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 for any reason, you may return it to
Texas Farm Bureau Health Plans, insured by Members Health Insurance Company
P.O. Box 1424
Columbia, Tennessee 38402-1424

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

The Policy may not fully cover all of your medical costs. Texas Farm Bureau Health Plans, insured by Members Health Insurance Company is not connected with Medicare.

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

LIMITATIONS AND EXCLUSIONS

The group policy will not cover expenses due to a pre-existing condition that you may have unless the expense is incurred six (6) months or more after your certificate effective date. A “pre-existing condition” is a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months prior to your certificate effective date.

You must wait six (6) months from your certificate effective date before you can receive benefits for a pre-existing condition under the group policy. However, the six (6) month pre-existing condition waiting period may be waived or reduced in the following situations:

1. If, as of the date of your enrollment application you are in Medicare open enrollment and you had a continuous period of creditable coverage or had prior coverage for at least six (6) months, we will not exclude benefits based on a pre-existing condition.
2. If, as of the date of your enrollment application you are in Medicare open enrollment and had a continuous period of creditable coverage or had prior coverage for less than six (6) months, we will reduce the period of the pre-existing condition limitation by the time covered under such prior coverage.
3. If, as of the date of your enrollment application, your coverage under the group policy replaced another Medicare Supplement Insurance plan, we will waive any time periods applicable to the pre-existing condition limitation provision provided under the certificate to the extent such time was spent under the prior policy or certificate.
4. If, as of the date of your enrollment application, your coverage under the group policy replaced another Medicare Supplement Insurance policy or certificate which had been in effect for at least six (6) months, your coverage under the group policy will not apply the six (6) month Pre-Existing Condition limitation requirement.
5. If, as of the date of your enrollment application, you qualified for guaranteed issue coverage provided under the group policy, the six (6) month pre-existing condition limitation will be waived.
6. If, as of the date of your enrollment application, you are in Medicare open enrollment, are under age 65 and eligible for Medicare due to Amyotrophic Lateral Sclerosis (ALS) or End-Stage Renal Disease (ESRD), the six (6) month pre-existing condition limitation will be waived.

The group policy does not provide benefits for:

1. Expenses incurred while the group policy or your coverage under the group policy is not in force;
2. Hospital or Skilled Nursing Facility Confinement expenses incurred by you during a Medicare Part A benefit period that begins while the group policy or your coverage under the group policy is not in force. However, coverage for your medical condition requiring the confinement will be covered under the group policy on the earlier of: (a) the date the confinement ends; or (b) six (6) months from your certificate effective date.

LIMITATIONS AND EXCLUSIONS (Continued)

However, this limitation will not apply if you meet the following requirements:

- a. You had a period of creditable coverage of at least six (6) months as of the date of your enrollment application; and
 - b. You are sixty-five (65) years of age or older; and
 - c. You meet at least one (1) of the following:
 - (1) You made application for coverage under the group policy within six (6) months of attaining sixty-five (65) years of age; or
 - (2) You enrolled within sixty-three (63) days following termination of coverage under a group health insurance plan; or
 - (3) You enrolled within sixty-three (63) days of a Medicare Supplement Insurance policy or plan that terminated because: (a) the issuer became insolvent; (b) the issuer substantially violated a material provision of the Medicare Supplement Insurance policy or plan; or (c) the issuer or agent misrepresented the coverage to you when it was sold; or
 - (4) You purchased your coverage under the group policy within sixty-three (63) days of your disenrollment from a Medicare Risk HMO, Medicare Advantage HMO, PACE, or a Medicare Supplement Insurance Select policy or plan because:
 - (a) Your prior carrier discontinued providing benefits to the service area;
 - (b) You moved out of the service area; the carrier substantially violated a material provision of the policy or plan; or the issuer or agent materially misrepresented the Medicare Supplement Insurance plan to you when it was sold; or
 - (c) Other reasons specified by Health and Human Services (HHS).
3. Services and supplies which are not Medicare-eligible expenses, unless specifically included in the group policy;
 4. Any expenses payable by Medicare, whether or not you are enrolled for Medicare;
 5. Any Medicare deductible or copayment/coinsurance not included as a covered benefit under the group policy;
 6. Services for which a charge is not normally made in the absence of insurance;
 7. Expenses for benefits that are not covered under the group policy; or
 8. Any Insured enrolled in a Medicare Advantage Plan.

REFUND OF PREMIUM

Upon our receipt of your written notice to terminate coverage under the group policy, we will terminate your coverage effective on the date requested and any unearned premium from the date of cancellation shall be refunded. In the event of your death, we will refund any portion of the unearned benefit to your beneficiary or estate.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. Texas Farm Bureau Health Plans, insured by Member's Health Insurance Company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. Review the application carefully before you sign it. Be certain that all information has been properly recorded.

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OUTLINE OF COVERAGE - MEDICARE SUPPLEMENT PLAN A

All dollar amounts shown are the 2025 original Medicare numbers. The benefits and costs shown are for plans effective **on or after January 1, 2025**.

SERVICES	ORIGINAL MEDICARE PAYS	MEDICARE SUPPLEMENT PLAN A	
		PLAN PAYS	YOU PAY
Medicare (Part A) hospital services per benefit period			
Hospitalization ¹ - Semi-private room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,676	\$0	\$1,676 (Part A deductible)
61st through 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after (while using 60 lifetime reserve days)	All but \$838 a day	\$838 a day	\$0
Once lifetime reserve days are used, additional 365 days	\$0	100% of Medicare-eligible expenses	\$0 ¹
Beyond the additional 365 days	\$0	\$0	All costs
Skilled nursing facility care ² - You must meet Medicare's requirements, including having been in a hospital for at least three days and having entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	100%	\$0	\$0
21st through 100th day	All but \$209.50 a day	\$0	Up to \$209.50 a day
101st day and after	\$0	\$0	All costs
Blood			
First 3 pints	\$0	All costs	\$0
Remainder of Medicare approved amounts	100%	\$0	\$0
Hospice care - You must meet Medicare's requirements, including a doctor's certification of terminal illness			
Hospice care	All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care.	Medicare co-payment/coinsurance	\$0

¹Notice: When your Medicare Part A hospital benefits are exhausted, Texas Farm Bureau Health Plans, insured by Member's Health Insurance Company, stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional three hundred sixty-five (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.

²A 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	ORIGINAL MEDICARE PAYS	MEDICARE SUPPLEMENT PLAN A	
		PLAN PAYS	YOU PAY
Medicare Part B medical services per calendar year 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, and durable medical equipment			
First \$257 of Medicare-approved amounts (Part B deductible ³)	\$0	\$0	\$257
Remainder of Medicare-approved amounts (after deductible is met)	Generally 80%	Generally 20%	\$0
Part B excess charges (above Medicare-approved amounts)	\$0	\$0	All costs
Blood			
First 3 pints	\$0	3 pints	\$0
Next \$257 of Medicare approved amounts ³	\$0	\$0	\$257 (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	\$0
Clinical laboratory services			
Tests for diagnostic services	100%	\$0	\$0
Parts A & B Home health care - Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment - first \$257 of Medicare-approved amounts (Part B deductible ³)	\$0	\$0	\$257
Remainder of Medicare-approved amounts for durable medical equipment (after deductible is met)	80%	20%	\$0
Other benefits - Services not covered by Medicare Foreign Travel - Emergency care services beginning during the first 60 days of each trip outside the U.S.			
\$250 foreign travel deductible that must be met once each calendar year	\$0	\$0	All costs
Remainder of charges after the foreign travel deductible is met, up to a lifetime maximum of \$50,000 ⁴	\$0	\$0	All costs

³The Part B deductible needs to be met only once each calendar year (January 1 - December 31). Once you have been billed \$257 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

⁴Member pays all amounts over \$50,000.

OUTLINE OF COVERAGE - MEDICARE SUPPLEMENT PLAN D

All dollar amounts shown are the 2025 original Medicare numbers. The benefits and costs shown are for plans effective **on or after January 1, 2025**.

SERVICE	ORIGINAL MEDICARE PAYS	MEDICARE SUPPLEMENT PLAN D	
		PLAN PAYS	YOU PAY
Medicare (Part A) hospital services per benefit period			
Hospitalization¹ - Semi-private room and board, general nursing, and miscellaneous services, and supplies			
First 60 days	All but \$1,676	\$1,676 (Part A deductible)	\$0
61st through 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after (while using 60 lifetime reserve days)	All but \$838 a day	\$838 a day	\$0
Once lifetime reserve days are used, additional 365 days	\$0	100% of Medicare-eligible expenses	\$0 ¹
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 three days and having entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	100%	\$0	\$0
21st through 100th day	All but \$209.50 a day	Up to \$209.50 a day	\$0
101st day and after	\$0	\$0	All costs
Blood			
First 3 pints	\$0	All costs	\$0
Remainder of Medicare approved amounts	100%	\$0	\$0
Hospice care - You must meet Medicare’s requirements, including a doctor’s certification of terminal illness			
Hospice care	All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care.	Medicare co-payment/coinsurance	\$0

¹Notice: When your Medicare Part A hospital benefits are exhausted, Texas Farm Bureau Health Plans, insured by Member's Health Insurance Company, stands in the place of Medicare and pays whatever amount Medicare would have paid for up to an additional 365 days. During this time, the hospital can't bill you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

²A 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.

SERVICE	ORIGINAL MEDICARE PAYS	MEDICARE SUPPLEMENT PLAN D	
		PLAN PAYS	YOU PAY
Medicare Part B medical services per calendar year 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, and durable medical equipment			
First \$257 of Medicare-approved amounts (Part B deductible ³)	\$0	\$0	\$257
Remainder of Medicare-approved amounts (after deductible is met)	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 \$257 of Medicare approved amounts ³	\$0	\$0	\$257 (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	\$0
Clinical laboratory services			
Tests for diagnostic services	100%	\$0	\$0
Parts A & B Home health care - Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment - first \$257 of Medicare-approved amounts (Part B deductible ³)	\$0	\$0	\$257
Remainder of Medicare-approved amounts for durable medical equipment (after deductible is met)	80%	20%	\$0
Other benefits - Services not covered by Medicare Foreign Travel - Emergency care services beginning during the first 60 days of each trip outside the U.S.			
\$250 foreign travel deductible that must be met once each calendar year	\$0	\$0	\$250
Remainder of charges after the foreign travel deductible is met, up to a lifetime maximum of \$50,000 ⁴	\$0	80%	20%

³The Part B deductible needs to be met only once each calendar year (January 1 - December 31). Once you have been billed \$257 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

⁴Member pays all amounts over \$50,000.

OUTLINE OF COVERAGE - MEDICARE SUPPLEMENT PLAN G

All dollar amounts shown are the 2025 original Medicare numbers. The benefits and costs shown are for plans effective **on or after January 1, 2025**.

SERVICES	ORIGINAL MEDICARE PAYS	MEDICARE SUPPLEMENT PLAN G	
		PLAN PAYS	YOU PAY
Medicare (Part A) hospital services per benefit period			
Hospitalization ¹ - Semi-private room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,676	\$1,676 (Part A deductible)	\$0
61st through 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after (while using 60 lifetime reserve days)	All but \$838 a day	\$838 a day	\$0
Once lifetime reserve days are used, additional 365 days	\$0	100% of Medicare-eligible expenses	\$0 ¹
Beyond the additional 365 days	\$0	\$0	All costs
Skilled nursing facility care ² - You must meet Medicare's requirements, including having been in a hospital for at least three days and having entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	100%	\$0	\$0
21st through 100th day	All but \$209.50	Up to \$209.50 a day	\$0
101st day and after	\$0	\$0	All costs
Blood			
First 3 pints	\$0	All costs	\$0
Remainder of Medicare approved amounts	100%	\$0	\$0
Hospice care - You must meet Medicare's requirements, including a doctor's certification of terminal illness			
Hospice care	All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care.	Medicare co-payment/coinsurance	\$0

¹Notice: When your Medicare Part A hospital benefits are exhausted, Texas Farm Bureau Health Plans, insured by Member's Health Insurance Company, stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional three hundred sixty-five (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.

²A 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	ORIGINAL MEDICARE PAYS	MEDICARE SUPPLEMENT PLAN G	
		PLAN PAYS	YOU PAY
Medicare Part B medical services per calendar year			
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, and durable medical equipment			
First \$257 of Medicare-approved amounts (Part B deductible ³)	\$0	\$0	\$257
Remainder of Medicare-approved amounts (after deductible is met)	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 \$257 of Medicare approved amounts ³	\$0	\$0	\$257 (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	\$0
Clinical laboratory services			
Tests for diagnostic services	100%	\$0	\$0
Parts A & B Home health care - Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment - first \$257 of Medicare-approved amounts (Part B deductible ³)	\$0	\$0	\$257
Remainder of Medicare-approved amounts for durable medical equipment (after deductible is met)	80%	20%	\$0
Other benefits - Services not covered by Medicare			
Foreign Travel - Emergency care services beginning during the first 60 days of each trip outside the U.S.			
\$250 foreign travel deductible that must be met once each calendar year	\$0	\$0	\$250
Remainder of charges after the foreign travel deductible is met, up to a lifetime maximum of \$50,000 ⁴	\$0	80%	20%

³The Part B deductible needs to be met only once each calendar year (January 1 - December 31). Once you have been billed \$257 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

⁴Member pays all amounts over \$50,000.

OUTLINE OF COVERAGE - MEDICARE SUPPLEMENT PLAN N

All dollar amounts shown are the 2025 original Medicare numbers. The benefits and costs shown are for plans effective **on or after January 1, 2025**.

SERVICES	ORIGINAL MEDICARE PAYS	MEDICARE SUPPLEMENT PLAN N	
		PLAN PAYS	YOU PAY
Medicare (Part A) hospital services per benefit period			
Hospitalization ¹ - Semi-private room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,676	\$1,676 (Part A deductible)	\$0
61st through 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after (while using 60 lifetime reserve days)	All but \$838 a day	\$838 a day	\$0
Once lifetime reserve days are used, additional 365 days	\$0	100% of Medicare-eligible expenses	\$0 ¹
Beyond the additional 365 days	\$0	\$0	All costs
Skilled nursing facility care ² - You must meet Medicare’s requirements, including having been in a hospital for at least three days and having entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	100%	\$0	\$0
21st through 100th day	All but \$209.50 a day	Up to \$209.50 a day	\$0
101st day and after	\$0	\$0	All costs
Blood			
First 3 pints	\$0	All costs	\$0
Remainder of Medicare approved amounts	100%	\$0	\$0
Hospice care - You must meet Medicare’s requirements, including a doctor’s certification of terminal illness			
Hospice care	All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care.	Medicare co-payment/coinsurance	\$0

¹Notice: When your Medicare Part A hospital benefits are exhausted, Texas Farm Bureau Health Plans, insured by Member's Health Insurance Company, stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional three hundred sixty-five (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.

²A 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	ORIGINAL MEDICARE PAYS	MEDICARE SUPPLEMENT PLAN N	
		PLAN PAYS	YOU PAY
Medicare Part B medical services per calendar year			
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, and durable medical equipment			
First \$257 of Medicare-approved amounts (Part B deductible ³)	\$0	\$0	\$257
Remainder of Medicare-approved amounts (after deductible is met)	Generally 80%	Balance, other than up to a \$20 office visit and up to a \$50 emergency visit. The co-payment 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 co-payment 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 \$257 of Medicare approved amounts ³	\$0	\$0	\$257 (Part B deductible)
Additional amounts	80%	20%	\$0
Clinical laboratory services			
Tests for diagnostic services	100%	\$0	\$0
Parts A & B Home health care - Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment - first \$257 of Medicare-approved amounts (Part B deductible ³)	\$0	\$0	\$257
Remainder of Medicare-approved amounts for durable medical equipment (after deductible is met)	80%	20%	\$0
Other benefits - Services not covered by Medicare			
Foreign Travel - Emergency care services beginning during the first 60 days of each trip outside the U.S.			
\$250 foreign travel deductible that must be met once each calendar year	\$0	\$0	\$250
Remainder of charges after the foreign travel deductible is met, up to a lifetime maximum of \$50,000 ⁴	\$0	80%	20%

³The Part B deductible needs to be met only once each calendar year (January 1 - December 31). Once you have been billed \$257 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

⁴Member pays all amounts over \$50,000.

HOW TO FIND A PLAN FOR YOU

To find your estimated monthly premium costs, follow these steps:

1. Find your rating area based off the table below
2. Use the tables on pages 14-16] to find the corresponding rating area table and tobacco use
3. Once you find the correct table, scroll down the first column to find your age. Your premium will be shown at the right based on whether you're male or female and whether you use tobacco if your applying outside of your Medicare Supplement Open Enrollment Period and are not eligible for a Guaranteed Issue Right
4. Find the plan option that's right for you.

Area Assignment by Zip Code

AREA 1		AREA 2		AREA 3	
754	755	750	751	772	774
756	757	752	753	775	776
758	759	760	761		
763	765	762	764		
766	768	767	770		
769	773	777	784		
778	779				
780	781				
782	783				
785	786				
787	788				
789	790				
791	792				
793	794				
795	796				
797	798				
799	885				

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Premium Rates Area - 1

Zip Codes: 754, 755, 756, 757, 758, 759, 763, 765, 766, 768, 769, 773, 778, 779, 780, 781, 782, 783, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 885

Non-Tobacco								
AGE	Plan A		Plan D		Plan G		Plan N	
	Male	Female	Male	Female	Male	Female	Male	Female
Under Age 65 ESRD/ALS	122.73	109.64	135.59	121.42	298.99	267.71	226.69	202.55
Under Age 65	674.63	608.98	-	-	-	-	-	-
65	122.73	109.64	135.59	121.42	149.49	133.86	113.34	101.28
66	122.73	109.64	135.59	121.42	149.49	133.86	113.34	101.28
67	122.73	109.64	135.59	121.42	149.49	133.86	113.34	101.28
68	122.73	109.64	135.59	121.42	149.49	133.86	113.34	101.28
69	127.52	113.97	142.29	127.48	156.88	140.54	119.04	106.43
70	132.52	118.50	149.29	133.81	164.60	147.53	125.00	111.83
71	137.75	123.23	156.61	140.43	172.67	154.83	131.23	117.46
72	143.21	128.17	164.26	147.35	181.10	162.45	137.74	123.35
73	148.92	133.34	172.24	154.58	189.91	170.43	144.53	129.50
74	154.89	138.74	180.59	162.13	199.12	178.76	151.64	135.93
75	161.13	144.38	189.32	170.02	208.74	187.46	159.06	142.64
76	167.64	150.28	198.43	178.27	218.80	196.56	166.82	149.66
77	174.45	156.44	207.96	186.89	229.30	206.07	174.93	157.00
78	181.57	162.88	217.92	195.90	240.28	216.00	183.41	164.67
79	189.00	169.60	228.32	205.31	251.76	226.38	192.26	172.68
80	196.77	176.63	239.19	215.15	263.75	237.23	201.51	181.05
81	204.89	183.98	250.55	225.43	276.28	248.57	211.18	189.80
82	213.38	191.66	262.43	236.17	289.37	260.41	221.29	198.94
83	222.25	199.68	274.83	247.39	303.06	272.79	231.85	208.49
84	231.51	208.07	287.80	259.12	317.36	285.73	242.88	218.48
85	241.20	216.83	301.35	271.38	332.30	299.25	254.41	228.91
86	251.32	225.98	315.50	284.19	347.91	313.38	266.46	239.81
87	261.89	235.55	330.30	297.58	364.23	328.14	279.05	251.20
88	272.94	245.55	345.76	311.57	381.28	343.57	292.21	263.11
89	284.49	256.00	361.92	326.18	399.10	359.69	305.96	275.55
90	296.56	266.91	378.80	341.46	417.72	376.54	320.33	288.55
91 - 120	309.17	278.32	396.44	357.42	437.18	394.14	335.35	302.14

Premium Rates Area - 1

Zip Codes: 754, 755, 756, 757, 758, 759, 763, 765, 766, 768, 769, 773, 778, 779, 780, 781, 782, 783, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 885

Tobacco								
AGE	Plan A		Plan D		Plan G		Plan N	
	Male	Female	Male	Female	Male	Female	Male	Female
Under Age 65 ESRD/ALS	135.00	120.60	149.15	133.56	328.89	294.48	249.36	222.81
Under Age 65	742.09	669.88	-	-	-	-	-	-
65	135.00	120.60	149.15	133.56	164.44	147.24	124.68	111.40
66	135.00	120.60	149.15	133.56	164.44	147.24	124.68	111.40
67	135.00	120.60	149.15	133.56	164.44	147.24	124.68	111.40
68	135.00	120.60	149.15	133.56	164.44	147.24	124.68	111.40
69	140.27	125.37	156.52	140.23	172.57	154.59	130.95	117.08
70	145.77	130.35	164.22	147.19	181.06	162.28	137.50	123.01
71	151.52	135.55	172.27	154.47	189.94	170.31	144.35	129.20
72	157.53	140.99	180.68	162.08	199.21	178.70	151.51	135.68
73	163.82	146.67	189.47	170.03	208.90	187.47	158.99	142.45
74	170.38	152.61	198.65	178.34	219.03	196.63	166.80	149.52
75	177.24	158.82	208.25	187.02	229.62	206.21	174.97	156.91
76	184.41	165.30	218.28	196.10	240.68	216.22	183.51	164.63
77	191.90	172.08	228.76	205.58	252.23	226.67	192.43	172.70
78	199.72	179.16	239.71	215.49	264.31	237.60	201.75	181.13
79	207.90	186.56	251.15	225.84	276.93	249.02	211.49	189.94
80	216.45	194.30	263.11	236.66	290.12	260.95	221.66	199.15
81	225.38	202.38	275.61	247.97	303.91	273.42	232.30	208.78
82	234.72	210.82	288.67	259.78	318.31	286.46	243.42	218.83
83	244.47	219.65	302.32	272.13	333.36	300.07	255.03	229.34
84	254.67	228.87	316.58	285.04	349.09	314.30	267.17	240.32
85	265.32	238.51	331.48	298.52	365.53	329.18	279.85	251.80
86	276.45	248.58	347.05	312.61	382.70	344.72	293.11	263.79
87	288.08	259.11	363.33	327.33	400.65	360.96	306.96	276.32
88	300.24	270.10	380.34	342.72	419.41	377.93	321.43	289.42
89	312.94	281.60	398.11	358.80	439.01	395.66	336.56	303.11
90	326.21	293.61	416.68	375.60	459.49	414.19	352.36	317.41
91 - 120	340.09	306.16	436.09	393.16	480.90	433.56	368.88	332.35

Premium Rates Area - 2

Zip Codes: 750, 751, 752, 753, 760, 761, 762, 764, 767, 770, 777, 784

Non-Tobacco								
AGE	Plan A		Plan D		Plan G		Plan N	
	Male	Female	Male	Female	Male	Female	Male	Female
Under Age 65 ESRD/ALS	128.89	115.15	142.40	127.51	314.00	281.16	238.07	212.72
Under Age 65	708.51	639.57	-	-	-	-	-	-
65	128.89	115.15	142.40	127.51	157.00	140.58	119.04	106.36
66	128.89	115.15	142.40	127.51	157.00	140.58	119.04	106.36
67	128.89	115.15	142.40	127.51	157.00	140.58	119.04	106.36
68	128.89	115.15	142.40	127.51	157.00	140.58	119.04	106.36
69	133.92	119.70	149.44	133.88	164.76	147.60	125.02	111.78
70	139.18	124.45	156.79	140.53	172.87	154.94	131.28	117.44
71	144.67	129.42	164.48	147.48	181.34	162.60	137.82	123.36
72	150.41	134.61	172.50	154.75	190.20	170.61	144.65	129.54
73	156.40	140.04	180.90	162.34	199.45	178.99	151.79	136.00
74	162.67	145.71	189.66	170.27	209.12	187.74	159.26	142.75
75	169.22	151.63	198.83	178.56	219.23	196.88	167.05	149.81
76	176.06	157.82	208.40	187.22	229.79	206.43	175.20	157.18
77	183.21	164.29	218.41	196.28	240.82	216.42	183.72	164.89
78	190.69	171.06	228.86	205.74	252.35	226.85	192.62	172.94
79	198.50	178.12	239.79	215.62	264.40	237.75	201.92	181.35
80	206.66	185.51	251.21	225.95	277.00	249.15	211.63	190.14
81	215.19	193.22	263.14	236.75	290.16	261.05	221.79	199.33
82	224.10	201.28	275.61	248.03	303.91	273.49	232.40	208.93
83	233.41	209.71	288.64	259.82	318.28	286.50	243.49	218.96
84	243.14	218.52	302.25	272.14	333.29	300.08	255.08	229.45
85	253.31	227.72	316.48	285.01	348.99	314.28	267.19	240.41
86	263.94	237.33	331.35	298.46	365.39	329.12	279.84	251.86
87	275.05	247.38	346.89	312.52	382.52	344.62	293.07	263.82
88	286.65	257.88	363.13	327.21	400.43	360.82	306.89	276.32
89	298.78	268.85	380.09	342.57	419.15	377.76	321.33	289.39
90	311.45	280.32	397.83	358.61	438.70	395.45	336.42	303.04
91 - 120	324.70	292.30	416.35	375.37	459.14	413.94	352.19	317.31

Premium Rates Area - 2

Zip Codes: 750, 751, 752, 753, 760, 761, 762, 764, 767, 770, 777, 784

Tobacco								
AGE	Plan A		Plan D		Plan G		Plan N	
	Male	Female	Male	Female	Male	Female	Male	Female
Under Age 65 ESRD/ALS	141.78	126.67	156.64	140.26	345.40	309.28	261.88	233.99
Under Age 65	779.36	703.53	-	-	-	-	-	-
65	141.78	126.67	156.65	140.27	172.70	154.64	130.94	117.00
66	141.78	126.67	156.65	140.27	172.70	154.64	130.94	117.00
67	141.78	126.67	156.65	140.27	172.70	154.64	130.94	117.00
68	141.78	126.67	156.65	140.27	172.70	154.64	130.94	117.00
69	147.31	131.67	164.38	147.27	181.24	162.36	137.53	122.96
70	153.10	136.90	172.47	154.59	190.16	170.43	144.41	129.19
71	159.14	142.36	180.92	162.23	199.47	178.86	151.60	135.69
72	165.45	148.07	189.76	170.22	209.22	187.67	159.12	142.49
73	172.04	154.04	198.98	178.57	219.40	196.89	166.97	149.60
74	178.94	160.28	208.63	187.30	230.03	206.51	175.18	157.03
75	186.14	166.79	218.71	196.42	241.15	216.57	183.76	164.79
76	193.67	173.60	229.24	205.95	252.77	227.07	192.72	172.90
77	201.53	180.72	240.25	215.90	264.90	238.06	202.09	181.37
78	209.76	188.17	251.75	226.31	277.59	249.54	211.88	190.23
79	218.35	195.93	263.77	237.18	290.84	261.53	222.11	199.48
80	227.33	204.06	276.33	248.55	304.70	274.07	232.80	209.16
81	236.71	212.54	289.45	260.42	319.18	287.16	243.97	219.26
82	246.51	221.41	303.17	272.83	334.30	300.84	255.64	229.82
83	256.75	230.68	317.50	285.80	350.11	315.15	267.84	240.86
84	267.45	240.37	332.48	299.35	366.62	330.09	280.59	252.39
85	278.64	250.49	348.13	313.51	383.89	345.71	293.91	264.45
86	290.33	261.06	364.48	328.31	401.93	362.03	307.83	277.04
87	302.56	272.12	381.58	343.78	420.77	379.08	322.37	290.20
88	315.32	283.67	399.44	359.94	440.47	396.90	337.58	303.96
89	328.66	295.74	418.10	376.82	461.07	415.54	353.46	318.33
90	342.60	308.35	437.61	394.47	482.57	435.00	370.06	333.35
91 - 120	357.17	321.53	457.99	412.91	505.05	455.33	387.41	349.04

Premium Rates Area - 3

Zip Codes: 772, 774, 775, 776

Non-Tobacco								
AGE	Plan A		Plan D		Plan G		Plan N	
	Male	Female	Male	Female	Male	Female	Male	Female
Under Age 65 ESRD/ALS	142.43	127.24	157.36	140.90	346.97	310.68	263.07	235.06
Under Age 65	782.91	706.72	-	-	-	-	-	-
65	142.43	127.24	157.36	140.90	173.49	155.34	131.53	117.53
66	142.43	127.24	157.36	140.90	173.49	155.34	131.53	117.53
67	142.43	127.24	157.36	140.90	173.49	155.34	131.53	117.53
68	142.43	127.24	157.36	140.90	173.49	155.34	131.53	117.53
69	147.98	132.26	165.13	147.94	182.06	163.10	138.15	123.52
70	153.79	137.52	173.26	155.29	191.02	171.20	145.06	129.77
71	159.86	143.01	181.75	162.97	200.38	179.68	152.29	136.31
72	166.20	148.75	190.62	171.00	210.17	188.53	159.84	143.14
73	172.83	154.74	199.89	179.38	220.39	197.78	167.73	150.28
74	179.75	161.01	209.58	188.15	231.08	207.45	175.98	157.74
75	186.99	167.55	219.70	197.31	242.24	217.55	184.59	165.54
76	194.55	174.40	230.28	206.88	253.91	228.11	193.60	173.68
77	202.45	181.55	241.34	216.89	266.11	239.14	203.01	182.20
78	210.71	189.02	252.89	227.34	278.85	250.67	212.84	191.09
79	219.34	196.82	264.96	238.26	292.17	262.72	223.12	200.39
80	228.36	204.98	277.58	249.68	306.08	275.31	233.86	210.11
81	237.78	213.51	290.77	261.61	320.62	288.46	245.08	220.26
82	247.63	222.42	304.54	274.07	335.82	302.21	256.80	230.87
83	257.92	231.73	318.94	287.10	351.70	316.58	269.06	241.96
84	268.67	241.46	333.99	300.71	368.29	331.59	281.86	253.54
85	279.91	251.63	349.71	314.94	385.63	347.28	295.24	265.65
86	291.65	262.25	366.14	329.80	403.75	363.67	309.23	278.30
87	303.92	273.36	383.31	345.34	422.69	380.81	323.84	291.52
88	316.75	284.96	401.25	361.57	442.48	398.71	339.11	305.34
89	330.15	297.08	420.00	378.53	463.15	417.42	355.07	319.78
90	344.15	309.75	439.60	396.26	484.76	436.97	371.74	334.86
91 - 120	358.79	322.99	460.07	414.79	507.35	457.40	389.17	350.63

Premium Rates Area - 3

Zip Codes: 772, 774, 775, 776

Tobacco								
AGE	Plan A		Plan D		Plan G		Plan N	
	Male	Female	Male	Female	Male	Female	Male	Female
Under Age 65 ESRD/ALS	156.67	139.96	173.10	154.99	381.67	341.75	289.38	258.57
Under Age 65	861.20	777.39	-	-	-	-	-	-
65	156.67	139.96	173.09	154.99	190.84	170.87	144.69	129.28
66	156.67	139.96	173.09	154.99	190.84	170.87	144.69	129.28
67	156.67	139.96	173.09	154.99	190.84	170.87	144.69	129.28
68	156.67	139.96	173.09	154.99	190.84	170.87	144.69	129.28
69	162.78	145.49	181.64	162.73	200.27	179.41	151.97	135.87
70	169.17	151.27	190.58	170.82	210.12	188.32	159.57	142.75
71	175.85	157.31	199.92	179.27	220.42	197.65	167.52	149.94
72	182.82	163.63	209.68	188.10	231.19	207.38	175.83	157.46
73	190.11	170.21	219.88	197.32	242.43	217.56	184.51	165.31
74	197.73	177.11	230.53	206.96	254.19	228.20	193.58	173.52
75	205.69	184.31	241.67	217.04	266.46	239.31	203.05	182.09
76	214.01	191.84	253.31	227.57	279.30	250.92	212.96	191.05
77	222.70	199.71	265.47	238.57	292.72	263.05	223.31	200.42
78	231.78	207.92	278.18	250.07	306.74	275.74	234.13	210.20
79	241.27	216.50	291.46	262.09	321.39	288.99	245.43	220.43
80	251.20	225.48	305.34	274.65	336.69	302.84	257.24	231.12
81	261.56	234.86	319.84	287.77	352.68	317.31	269.58	242.28
82	272.39	244.66	335.00	301.48	369.40	332.43	282.48	253.96
83	283.71	254.90	350.84	315.81	386.87	348.24	295.96	266.15
84	295.54	265.61	367.39	330.78	405.12	364.75	310.05	278.89
85	307.90	276.79	384.68	346.43	424.19	382.01	324.77	292.21
86	320.82	288.48	402.75	362.78	444.13	400.04	340.15	306.13
87	334.31	300.70	421.64	379.87	464.96	418.89	356.22	320.67
88	348.43	313.46	441.38	397.73	486.73	438.58	373.02	335.87
89	363.17	326.79	462.00	416.39	509.47	459.16	390.57	351.75
90	378.57	340.73	483.56	435.89	533.24	480.67	408.92	368.35
91 - 120	394.67	355.29	506.08	456.27	558.09	503.14	428.09	385.69

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