

# 2024 Outline of Coverage

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**Providence Medicare Supplement (Medigap)**

**April 1, 2024 – March 31, 2025**

**This plan is available in all counties in the state of Oregon.**

## Premium information

We at Providence Health Assurance can only raise your premium if we raise the premium for all policies like yours in Oregon. The policy coverage shall be guaranteed renewable, but Providence Health Assurance reserves the right to change premiums and any renewal premium increases. On each annual anniversary of your Plan Renewal Date of 04/01, premiums will increase due to the increase in your age.

## Read your policy very carefully

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

## Right to return policy

If you find that you are not satisfied with your policy, you may return it to:

Providence Medicare Supplement  
Enrollment Department  
PO Box 14590  
Salem, OR 97309

If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

## Policy replacement

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

## Notice

This policy may not fully cover all of your medical costs.

Neither Providence Health Assurance nor its agents are connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult <https://www.medicare.gov/publications/10050-Medicare-and-You.pdf> 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.

# Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak with a Customer Service representative at **971-345-4013** or **1-888-231-9287 (TTY: 711)**, 8 a.m. to 5 p.m. (Pacific Time), Monday-Friday.

## Understanding the benefits

- Review the full list of benefits found in the Medicare Supplement policy, especially for those services for which you routinely see a doctor. Visit **ProvidenceMedicareSupplement.com** to view a copy of the policy or call **971-345-4013** or **1-888-231-9287 (TTY: 711)** to request a copy.

## Understanding important rules

- Use this outline to compare benefits and premiums among policies. This outline shows benefits and premiums of policies sold for effective dates on or after April 1, 2024.
- 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.
- If you find that you are not satisfied with your policy, you may return it to Providence Health Assurance. If you decide you do not want to purchase this policy for any reason, you may notify us within 30 days after delivery and your insurance will be deemed void from its effective date, and premium payments received will be returned to you.

Please contact us at: Providence Medicare Supplement  
Enrollment Department  
PO Box 14590  
Salem, OR 97309

- If you are replacing another health insurance policy, do NOT cancel your existing policy until you have actually received your new policy and are sure you want to keep it.
- This policy may not fully cover all of your medical costs. This Outline of Coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult the "Medicare & You" handbook for more details or visit **<https://www.medicare.gov/publications/10050-Medicare-and-You.pdf>**. Neither Providence Health Assurance nor its Producers are connected with Medicare.
- When you fill out the application for the new policy, be sure to answer truthfully and complete all questions about your medical and health history. Providence Health Assurance 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.

## When you join Providence

You're part of something bigger than an insurance policy. You are part of a community of care focused on your health and well-being. To help you make the right health care decisions, we're providing this Outline of Coverage, a brief guide that breaks down what we would cover and what you would pay if you have Providence Medicare Supplement Plan A, G, or N. To be clear, this summary of benefits is just that, a summary. It does not list every service that we cover, nor every limitation or exclusion.

For a complete list of services that we cover, please refer to the Supplement policy. You can request a printed copy by visiting [ProvidenceMedicareSupplement.com](https://www.providencehealthcare.org/medicare-supplement) or by calling our Customer Service department at one of the numbers listed in the "Get in touch" section below.

## Plan overview

Medicare Supplement (also referred to as Medigap) insurance can help cover some expenses not paid by Medicare Parts A and B alone. These Supplement plans are designed to help with some of the out-of-pocket costs associated with Medicare, like deductibles, coinsurance and copayments, making your costs more predictable and more affordable. Other features include:

- You are able to keep your own doctor who accepts Medicare patients
- You can see any specialist without a referral
- There are no claim forms to fill out
- Coverage goes with you anywhere in the U.S. when you travel, and some plans cover overseas international travel

If you are in Original Medicare (Parts A and B) and buy a Supplement policy, Medicare will pay its portion of the claim, then your Supplement policy will pay its portion. Medicare Supplement policies are named by letter, Plans A through N. These are not to be confused with Medicare Parts A, B, C, and D; they are different. Supplement benefits are standardized and regulated by the State of Oregon's Division of Financial Regulation. A Medicare Supplement policy cannot be used if you also enroll in a Medicare Advantage plan.

Providence is currently offering Plans A, G, and N. Medicare Supplement Plan A offers just the Basic Benefits but has lower monthly premiums with higher out-of-pocket costs for things like skilled nursing facility Coinsurance and Part B Excess Charges. Plan G offers the most supplemental coverage, paying many of your out-of-pocket costs for Medicare-approved services. Consider this plan if you are willing to pay a higher monthly premium in exchange for more health care coverage and lower out-of-pocket costs. Plan N covers the Part B coinsurance, but you pay copayments for covered doctor office and emergency room visits in exchange for a mid-range monthly premium. Please see below for further details regarding coverage benefits for Plans A, G, and N.

## Who can join?

You are eligible for these Medicare Supplement plans if you are age 65 or older or qualify for Medicare due to a disability, are enrolled in Medicare Parts A and B and are not duplicating Medicare supplement coverage from another plan (for example, Medicare Advantage). You must also reside in our service area for this Supplement coverage, which is defined as all counties in Oregon.

## Get in touch

Questions? We are here to help Monday through Friday from 8 a.m. to 5 p.m. (Pacific Time).

- **971-345-4013** or **1-888-231-9287 (TTY: 711)**
- You can also visit us online at [ProvidenceMedicareSupplement.com](https://www.providencehealthcare.org/medicare-supplement)

## Helpful resources

- To learn more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook, view it online at <https://www.medicare.gov/publications/10050-Medicare-and-You.pdf> or request a printed copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, seven days a week. TTY users should call **1-877-486-2048**.

# Medicare Supplement

## Benefit chart of Medicare Supplement plans sold on or after June 1, 2010

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. Providence Health Plan offers Plans A, G, and N (shaded in the table 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 <sup>1</sup> | K                    | L                    | M   | N                              | C  | F <sup>1</sup> |
| 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%                  | ✓   | ✓<br>Copays apply <sup>3</sup> | ✓  | ✓              |
| Blood (first three pints per calendar year)  | ✓                                 | ✓ | ✓ | ✓              | 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 <sup>2</sup>   |                                   |   |   |                | \$7,060 <sup>2</sup> | \$3,530 <sup>2</sup> |     |                                |  |                |

<sup>1</sup> 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.

<sup>2</sup> 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.

<sup>3</sup> Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to \$20 for some office visits and up to a \$50 co-payment for emergency room visits that do not result in an inpatient admission.

# Plan A

| Hospital Services (Medicare - Part A) per benefit period   |  |  |                                    |                             |
|--|--|--|------------------------------------|-----------------------------|
| Benefits   |  | Medicare Pays  | Plan A Pays                        | You Pay                     |
| <b>Hospitalization<sup>1</sup></b><br>Semi-private room and board, general nursing and miscellaneous services and supplies.  | First 60 days  | All but \$1,632  | \$0                                | \$1,632 (Part A deductible) |
|  | Days 61-90   | All but \$408 per day  | \$408 per day                      | \$0                         |
|  | Days 91-150 while using 60 lifetime reserve days             | All but \$816 per day  | \$816 per day                      | \$0                         |
|  | After lifetime reserve days are used, an additional 365 days | \$0  | 100% of Medicare-eligible expenses | \$0 <sup>2</sup>            |
|  | Beyond the additional 365 days                               | \$0  | \$0                                | All costs                   |
| <b>Skilled Nursing Facility Care<sup>1</sup></b><br>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                         |
|  | Days 21-100  | All but \$204.00 per day   | \$0                                | Up to \$204.00 per day      |
|  | Days 101 and later   | \$0  | \$0                                | All costs                   |
| <b>Blood</b>   | First 3 pints  | \$0  | 3 pints                            | \$0                         |
|  | Additional amounts   | 100%   | \$0                                | \$0                         |
| <b>Hospice Care</b><br>Available as long as you meet Medicare's requirements, your doctor certifies that you are terminally ill and you elect to receive these services.   |  | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance     | \$0                         |

<sup>1</sup>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.

## Medical Services (Medicare - Part B) per benefit period

| Benefits   |   | Medicare Pays | Plan A Pays   | You Pay                   |
|--|---|---------------|---------------|---------------------------|
| <b>Medical Expenses</b><br>Includes treatment 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 \$240 of Medicare-approved amounts <sup>3</sup> | \$0           | \$0           | \$240 (Part B deductible) |
|  | Remainder of Medicare-approved amounts                | Generally 80% | Generally 20% | \$0                       |
| <b>Part B Excess Charges</b><br>15% above Medicare-approved amounts  |   | \$0           | \$0           | All costs                 |
| <b>Blood</b>   | First 3 pints   | \$0           | All costs     | \$0                       |
|  | Next \$240 of Medicare-approved amounts <sup>3</sup>  | \$0           | \$0           | \$240 (Part B deductible) |
|  | Remainder of Medicare-approved amounts                | 80%           | 20%           | \$0                       |
| <b>Clinical Laboratory Services</b>  | Tests for diagnostic services                         | 100%          | \$0           | \$0                       |

<sup>2</sup> **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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.

<sup>3</sup> Once you have been billed \$240 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

## Home Health Care - Approved Services (Medicare - Parts A and B)

| Benefits   |  | Medicare Pays | Plan A Pays | You Pay                   |
|--|--|---------------|-------------|---------------------------|
| <b>Home Health Care</b><br>Medicare-approved services          | Medically necessary skilled care services and medical supplies | 100%          | \$0         | \$0                       |
| <b>Durable Medical Equipment</b><br>Medicare-approved services | First \$240 of Medicare-approved amounts <sup>3</sup>          | \$0           | \$0         | \$240 (Part B deductible) |
|  | Remainder of Medicare-approved amounts                         | 80%           | 20%         | \$0                       |

<sup>3</sup> Once you have been billed \$240 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

**Note:** You may be eligible for a discount of up to 20% off your monthly premium if you (1) are married or live with a domestic partner or adult at the same physical address, or (2) have lived with at least one, but no more than three other adults 18 years of age or older, in the last 12 months at the same physical address. The household discount is not available to those living in a one-person household, or in an assisted living facility.



# Plan G

| Hospital Services (Medicare - Part A) per benefit period   |  |  |                                    |                  |
|--|--|--|------------------------------------|------------------|
| Benefits   |  | Medicare Pays  | Plan G Pays                        | You Pay          |
| <b>Hospitalization<sup>1</sup></b><br>Semi-private room and board, general nursing and miscellaneous services and supplies.  | First 60 days  | All but \$1,632  | \$1,632 (Part A deductible)        | \$0              |
|  | Days 61-90   | All but \$408 per day  | \$408 per day                      | \$0              |
|  | Days 91-150 while using 60 lifetime reserve days             | All but \$816 per day  | \$816 per day                      | \$0              |
|  | After lifetime reserve days are used, an additional 365 days | \$0  | 100% of Medicare-eligible expenses | \$0 <sup>2</sup> |
|  | Beyond the additional 365 days                               | \$0  | \$0                                | All costs        |
| <b>Skilled Nursing Facility Care<sup>1</sup></b><br>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              |
|  | Days 21-100  | All but \$204.00 per day   | Up to \$204.00 per day             | \$0              |
|  | Days 101 and later   | \$0  | \$0                                | All costs        |
| <b>Blood</b>   | First 3 pints  | \$0  | 3 pints                            | \$0              |
|  | Additional amounts   | 100%   | \$0                                | \$0              |
| <b>Hospice Care</b><br>Available as long as you meet Medicare's requirements, your doctor certifies that you are terminally ill and you elect to receive these services.   |  | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance     | \$0              |

<sup>1</sup>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.

## Medical Services (Medicare - Part B) per benefit period

| Benefits  |   | Medicare Pays | Plan G Pays   | You Pay                   |
|---|---|---------------|---------------|---------------------------|
| <b>Medical Expenses</b><br>Includes treatment 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 \$240 of Medicare-approved amounts <sup>3</sup> | \$0           | \$0           | \$240 (Part B deductible) |
|   | Remainder of Medicare-approved amounts                | Generally 80% | Generally 20% | \$0                       |
| <b>Part B Excess Charges</b><br>15% above Medicare-approved amounts   |   | \$0           | 100%          | \$0                       |
| <b>Blood</b>  | First 3 pints   | \$0           | All costs     | \$0                       |
|   | Next \$240 of Medicare-approved amounts <sup>3</sup>  | \$0           | \$0           | \$240 (Part B deductible) |
|   | Remainder of Medicare-approved amounts                | 80%           | 20%           | \$0                       |
| <b>Clinical Laboratory Services</b>   | Tests for diagnostic services                         | 100%          | \$0           | \$0                       |

<sup>2</sup> NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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.

<sup>3</sup> Once you have been billed \$240 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

## Home Health Care - Approved Services (Medicare - Parts A and B)

| Benefits   |  | Medicare Pays | Plan G Pays | You Pay                   |
|--|--|---------------|-------------|---------------------------|
| Home Health Care Medicare-approved services          | Medically necessary skilled care services and medical supplies | 100%          | \$0         | \$0                       |
| Durable Medical Equipment Medicare-approved services | First \$240 of Medicare-approved amounts <sup>3</sup>          | \$0           | \$0         | \$240 (Part B deductible) |
|  | Remainder of Medicare-approved amounts                         | 80%           | 20%         | \$0                       |

## Other Benefits (not covered by Medicare)

| Benefits  |                                | Medicare Pays | Plan G Pays                                   | You Pay  |
|---|--------------------------------|---------------|---|--|
| Foreign Travel Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States. | 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 |

<sup>3</sup> Once you have been billed \$240 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

**Note:** You may be eligible for a discount of up to 20% off your monthly premium if you (1) are married or live with a domestic partner or adult at the same physical address, or (2) have lived with at least one, but no more than three other adults 18 years of age or older, in the last 12 months at the same physical address. The household discount is not available to those living in a one-person household, or in an assisted living facility.

# Plan N

| Hospital Services (Medicare - Part A) per benefit period   |  |  |                                    |                  |
|--|--|--|------------------------------------|------------------|
| Benefits   |  | Medicare Pays  | Plan N Pays                        | You Pay          |
| <b>Hospitalization<sup>1</sup></b><br>Semi-private room and board, general nursing and miscellaneous services and supplies.  | First 60 days  | All but \$1,632  | \$1,632 (Part A deductible)        | \$0              |
|  | Days 61-90   | All but \$408 per day  | \$408 per day                      | \$0              |
|  | Days 91-150 while using 60 lifetime reserve days             | All but \$816 per day  | \$816 per day                      | \$0              |
|  | After lifetime reserve days are used, an additional 365 days | \$0  | 100% of Medicare-eligible expenses | \$0 <sup>2</sup> |
|  | Beyond the additional 365 days                               | \$0  | \$0                                | All costs        |
| <b>Skilled Nursing Facility Care<sup>1</sup></b><br>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              |
|  | Days 21-100  | All but \$204.00 per day   | Up to \$204.00 per day             | \$0              |
|  | Days 101 and later   | \$0  | \$0                                | All costs        |
| <b>Blood</b>   | First 3 pints  | \$0  | 3 pints                            | \$0              |
|  | Additional amounts   | 100%   | \$0                                | \$0              |
| <b>Hospice Care</b><br>Available as long as you meet Medicare's requirements, your doctor certifies that you are terminally ill and you elect to receive these services.   |  | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance     | \$0              |

<sup>1</sup>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.

## Medical Services (Medicare - Part B) per benefit period

| Benefits   |   | Medicare Pays | Plan N Pays   | You Pay   |
|--|---|---------------|---|---|
| <b>Medical Expenses</b><br>Includes treatment 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 \$240 of Medicare-approved amounts <sup>3</sup> | \$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 you are 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 you are admitted to any hospital and the emergency visit is covered as a Medicare Part A expense. |
| <b>Part B Excess Charges</b><br>15% above Medicare-approved amounts  |   | \$0           | \$0   | All excess charges  |
| <b>Blood</b>   | First 3 pints   | \$0           | All costs   | \$0   |
|  | Next \$240 of Medicare-approved amounts <sup>3</sup>  | \$0           | \$0   | \$240 (Part B deductible)   |
|  | Remainder of Medicare-approved amounts                | 80%           | 20%   | \$0   |
| <b>Clinical Laboratory Services</b>  | Tests for diagnostic services                         | 100%          | \$0   | \$0   |

<sup>2</sup> **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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.

<sup>3</sup> Once you have been billed \$240 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

## Home Health Care - Approved Services (Medicare - Parts A and B)

| Benefits                         |  | Medicare Pays   | Plan N Pays | You Pay |                           |
|----------------------------------|--|---|-------------|---------|---------------------------|
| <b>Home Health Care</b>          |  |   |             |         |                           |
| Medicare-approved services       | Medically necessary skilled care services and medical supplies | 100%  | \$0         | \$0     |                           |
| <b>Durable Medical Equipment</b> |  |   |             |         |                           |
|                                  | Medicare-approved services                                     | First \$240 of Medicare-approved amounts <sup>3</sup> | \$0         | \$0     | \$240 (Part B deductible) |
|                                  |  | Remainder of Medicare-approved amounts                | 80%         | 20%     | \$0                       |

## Other Benefits (not covered by Medicare)

| Benefits              |  | Medicare Pays                  | Plan N Pays | You Pay                                       |  |
|-----------------------|--|--------------------------------|-------------|---|--|
| <b>Foreign Travel</b> |  |                                |             |   |  |
|                       | Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States. | 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 |

<sup>3</sup> Once you have been billed \$240 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

**Note:** You may be eligible for a discount of up to 20% off your monthly premium if you (1) are married or live with a domestic partner or adult at the same physical address, or (2) have lived with at least one, but no more than three other adults 18 years of age or older, in the last 12 months at the same physical address. The household discount is not available to those living in a one-person household, or in an assisted living facility.